

DSHS HIV Care Services Parts A and B Meeting

April 23-24, 2015
Holiday Inn Midtown in Austin, Texas

Interim Guidance to Texas Administrative Agents on Health Insurance Assistance Services

Key Points

Health Insurance in the ACA Era

- Federal law and policy and state policy require that RWHAP and State Services funds be used as **payment of last resort** for eligible HIV-related services.
- Health insurance can offer a cost advantage for some clients, but it is **not** automatically the best alternative for every client.
- The guidance should be considered when making allocations and business rules for health insurance assistance at an administrative level, and at the client level, carefully consider the guidance to help decide if paying health insurance costs is an affordable and feasible alternative.

Local Insurance and Clinical Services Costs

- Insurance is preferred when it provides a cost advantage to delivering direct services. You should not support requests for health insurance assistance if providing assistance will result in a greater overall expenditure for the clinical services, including ADAP, needed by the client.
- When calculating the per client allocation for clinical services at the HSDA/EMA/TGA level it is a best practice to develop a local estimate of the per client expenditures for covered services.
- DSHS has developed a workbook to assist in calculating these costs for each HSDA. This will give you an idea of the clinical costs that will be avoided by providing Health Insurance Assistance.

Making Decisions about Health Insurance Assistance Services at the Client Level

- COBRA (employer based insurance) - Before extending assistance for employer-based insurance, consider not only the premium, but the cost-sharing and copayment requirements.
- Loss of employer-based insurance triggers a special enrollment period for the Marketplace. Clients have 90 days from the loss of employer-based insurance to enroll in a Marketplace plan as an alternative to COBRA. **When assistance is requested for a COBRA plan, a comparison must be made to available Marketplace coverage before making a commitment to support the costs of the COBRA plan.**
- Persons between 100% and 200% FPL qualify for premium reductions and reduced cost sharing that can make the cost of Marketplace plans comparable to or lower than direct service costs, especially when ADAP costs are considered.
- Persons with household incomes between 100% and 250% FPL are eligible for reduced out of pocket maximums (OOP) when they choose Silver Level plans.
- Persons under 100% FPL do **not** qualify for reduced insurance costs on the Marketplace.
- Carefully consider the possible maximum expenditure on insurance (1 year of premiums plus the maximum out of pocket costs) **before** making a commitment to assist with insurance costs for clients under 100%. **You can decline to provide insurance assistance if plan costs greatly exceed costs of directly delivered care.** If a client is under 100% FPL or over 250% FPL, Gold or Platinum plans may provide a cost advantage for clients with high clinical costs.
- **When providing insurance assistance for a Marketplace plan**
 - ✓ The client must take the advance premium credit,
 - ✓ If the client is between 100% and 250% FPL, the client **must** select a Silver Plan
 - ✓ Clients must report changes in income, family size, tobacco use or residence promptly through Healthcare.gov. Processes must be in place to review financial eligibility information on a regular basis (i.e. no less often than every 6 months).

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Making Allocating and Budgeting Decisions for Insurance Assistance Services

- Refer to **Appendix B** in the Interim Guidance for the average premiums and OOP maximums for Single member households with varying levels of income.
- Insurance costs have two basic components - the **premium** and the **out of pocket** maximum.
- **Premiums**
 - ✓ Marketplace premiums depend on the age and income of clients, and whether or not they smoke. Premiums are higher for older people and smokers compared to younger people and those who do not use tobacco.
 - ✓ People with household incomes between 100% and 400% of FPL are eligible for tax credits that lower the cost of premiums.
 - ✓ Clients that are eligible for tax credits must take the advance premium tax credit.
 - ✓ Premiums have to be paid every month, and will not vary in cost as long as client income does not change.
 - ✓ Changes in a client's income, family size, tobacco use and residency must be reported promptly. **Failure to report changes in circumstances to the Marketplace can result in unplanned taxes or overpayments. AAs should have a process in place to assist clients in promptly reporting changes to HealthCare.gov.**
- **Out of Pocket (OOP) Maximums**
 - ✓ Marketplace plans have caps on the amount of money that a client must pay out of pocket. OOP costs include co-pays and co-insurance fees for drugs and medical services. Once someone reaches an out of pocket limit, the insurance pays for 100% of the medical service costs. OOP maximums are much lower for persons between 100% and 200% of FPL who purchase Silver level plans compared to costs for other plans for people at this income level.
 - ✓ When a coverage period starts, insured clients may have very high copayments/co insurance charges, especially for HIV treatment drugs or other "4th tier" or "specialty drugs".
 - ✓ Copayment/coinsurance charges stop once the client reaches the OOP maximum for the plan. If a plan has a \$2,500 OOP maximum, once the OOP payments total that amount, there are no more copayments/co-insurance charges.
 - ✓ OOP charges are "front loaded." **They are much higher at the beginning of a coverage year than at the end.**
 - ✓ OOP maximums do not include premium payments. Copayments/Co-insurance payments made for out of network services do not count towards meeting OOP caps.
 - ✓ If your area uses a monthly cap to control costs for Health Insurance Assistance services, these policies must be reconsidered in light of the Marketplace provisions that cap OOP expenses for persons between 100% and 250% FPL.
 - ✓ Since OOP payments are front loaded, you should expect much higher requests for co-payment assistance at the beginning of a plan year, but these payments will stop completely once the maximum is reached.
 - ✓ While this may create complications related to budgeting and cash flow, the overall cost of insurance obtained through the Marketplace is still reasonable.
 - ✓ Monthly caps may still make sense for employer based plans with continuing co-payments, but these policies may put affordable Marketplace coverage out of reach for clients.
 - ✓ Carefully review your area's cost-containment policies to assure that the policies will work for Marketplace plans.