Health Insurance Premium and Cost Sharing Assistance

Service Definition

Health Insurance Premium and Cost Sharing Assistance (HIPCSA) provides financial assistance for eligible people living with HIV (PLWH) to cover the cost of expenses related to accessing health care.

Assistance types available under this service include:

- Purchasing health insurance that provides full medical care and pharmacy benefits that provide a full range of HIV medications.
- Paying co-pays, coinsurance, and deductibles on behalf of the client.
- Providing funds to contribute to a client's Medicare Part D true out-of-pocket (TrOOP) costs. That is, the maximum amount they would need to spend each year on medications covered by their **prescription drug plan** before they reach the "catastrophic" level of coverage.

HIPCSA services funded by the Wisconsin Communicable Disease Harm Reduction (CDHR) Section may only be received after it is determined the cost cannot be covered by the Wisconsin AIDS Drug Assistance Program (ADAP) or the Insurance Assistance Program (IAP). Providers must also have a contract with the Wisconsin Communicable Disease Harm Reduction Sections to provide HIPCSA.

Subrecipients providing HIPCSA must comply with the Universal Standards of Care, as well as these additional standards:

Standard 1: Health Insurance Premium and Cost Sharing Assistance services must be delivered in accordance with the Wisconsin Ryan White Part B Eligibility and Recertification Policy and Procedures.

Providers are responsible to determine eligibility at enrollment and to confirm eligibility annually.

Documentation

Client records must document that the client is living with HIV, resides in Wisconsin, and has household income under 500 percent FPL at initial enrollment in accordance with the Wisconsin Ryan White Part B Eligibility Policy, linked above.

Standard 2: HIPCSA payments cannot duplicate ADAP/IAP payments.

Clients with income under or equal to 300 percent FPL must be assessed for eligibility for the CDHR Section's ADAP and IAP.

The subrecipient can provide HIPSCA services if the client is **not** eligible for the ADAP/ IAP programs or if the cost is not ADAP allowable.

The subrecipient must assist the client, as needed, with applying to the ADAP/IAP programs as soon as possible and coordinate assistance to the client in the interim.

Documentation

Client record must document determination that costs were not ADAP allowable or that subrecipient organization was taking steps to assist client with applying for ADAP as soon as possible.

Standard 3: Payments for HIPCSA services are made only as a payer of last resort.

The Health Insurance Premium and Cost-Sharing service category is meant to supplement the Wisconsin ADAP and IAP programs. Clients who are eligible for ADAP or IAP assistance must be referred to those programs first.

The subrecipient must ensure that HIPCSA funds are used only to make payments for services where both of the following criteria are met:

- The client meets appropriate eligibility requirements as identified by the Wisconsin CDHR Section; **and**
- The services for which payments are made are not eligible for payment by Medicaid or a third-party payer and/or have not been paid for.

Documentation

Client records related to claims paid must include documentation that no other payer sources (insurance or other programs) were available, or if available, that they were billed as the primary payer source.

The CDHR Section must be repaid for any improper payments made by the HIPCSA provider within 60 days of discovery.

Standard 4: HIPCSA payments for health insurance premiums must meet allowable coverage and cost requirements.

The subrecipient must have a system in place to assess health insurance coverage for adequate coverage and cost requirements prior to making payments.

Adequate coverage is defined by HRSA guidelines as:

- Providing at least one U.S. Food and Drug Administration (FDA) approved medicine in each drug class of core antiretroviral medicines outlined in the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as appropriate HIV outpatient or ambulatory health services,[1] as well as,
- An annual premium cost not exceeding $10,000.[2]

[1] HRSA PCN 18-01, Clarifications Regarding the Use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance, pp. 2-3.

[2]The Wisconsin Communicable Disease Harm Reduction Section may waive this cap on annual premium costs if the HIPSCA provider can demonstrate that the client has imminent need for the services covered under the plan and that the Wisconsin Communicable Disease Harm Reduction Section's cost of paying for the health insurance (including all other sources of premium and cost sharing assistance) is cost-effective in the aggregate versus paying

Documentation

Client and accounting records must document evidence that health insurance premiums meet allowable coverage and cost requirements as above.

Standard 5: HIPCSA payments for prescription eyewear copayments involve an eye condition that is related to HIV.

When HIPCSA payments involve copayment for prescription eyewear, including prescription sunglasses, a physician must provide written statement that the eye condition is related to HIV.[3]

Documentation

The client record must include a written statement from a physician if one or more copayments were made for prescription eyewear.

Standard 6: HIPCSA payments for Medicare and Medicaid must meet allowable cost sharing requirements.

To ensure sufficient health care coverage for clients, HIPCSA payments for Medicare Part B, C, and/or D premiums are allowable when made in combination with at least one additional type of Medicare or Medicaid.

For example, payments for Medicare Part B premiums must be made in combination with payments for Medicare Part D premiums.

If a client uses Medicaid health care coverage, HIPCSA funds may be used to pay for any remaining premium amounts not covered by Medicaid.

Note: While providers are required to ask clients using Medicaid for a co-pay (if the client has one), the provider cannot deny service if the client does not have funds for or refuses to pay for the co-pay. Therefore, Ryan White Part B funds from this service category should **not** be used to pay co-pays for Medicaid clients.

Documentation

Client and accounting records must document HIPCSA payments made for Medicare and Medicaid meet allowable requirements.

Standard 7: HIPSCA services must not involve cost sharing for services that are disallowed by HRSA, which includes payments for inpatient care.

Funds cannot be used to pay premiums or cost sharing assistance for Medicare Part A, which exclusively covers inpatient care,[4] or used to cover costs associated with the creation, capitalization or administration of a liability risk pool or costs associated with Social Security.

for the full cost for medications and other appropriate HIV outpatient/ambulatory health services. Waiver requests should be submitted to the Wisconsin Communicable Disease Harm Reduction Section on an individual basis and no premium payments should be made until the waiver is granted.

[3] HRSA Part B Program Monitoring Standards, Section B, part 7, p. 12.

[4] HRSA PCH 18-01, Clarifications Regarding the Use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance, p. 5.

Payments must not made for any bills that are considered "bad debt." If a bill has been sent to a private collection agency, the bill is considered a debt that has been determined to be uncollectable. It is therefore "bad debt" and is an unallowable cost for federal funds.[5] In some cases, the client or subrecipient providing HIPCSA may be able to work with the organization that originally issued the bill to have the bill removed from the collections agency and paid under the original billing party system. Patient Assistance Programs at billing agency must be attempted to be unitized before using HIPSCA to pay these debts.

Documentation

Client and claim records must clearly document services were allowable under HRSA guidelines. Client records must document other programs applied for when applicable.

Standard 8: Subrecipients must effectively monitor and manage expenditures.

Subrecipients must have a system in place to monitor and manage expenditures to ensure that funding will be available throughout the program year. Subrecipients must promptly report projected shortfalls or under-expenditure of grant funds to the Wisconsin CDHR Section.

The maximum amount a subrecipient can pay towards a client's medical bills cannot exceed $10,000 in a calendar year, and the maximum amount paid towards a single medical bill cannot exceed $5,000. There is no limit to the number of times a client can use this service in a calendar year. This cap applies only to medical bill payments, not to payments for insurance premiums.

Subrecipients cannot use a lower payment cap if the subrecipient medical bill payment program uses Ryan White Part B funding.

In extenuating circumstances, a subrecipient can, at their discretion and in consultation with the Wisconsin CDHR Section, choose to pay more than $5,000 on a single medical bill or allow the client to exceed the $10,000 cap.

In deciding whether exceeding the cap is warranted, subrecipients are expected to use their discretion in balancing the best interest of the client and the limited nature of Ryan White funding and to thoroughly document the reasons.

The subrecipient must have a system in place to detect and address inaccurate claims. This error-detection system may include a required analysis of individual claims exceeding a predetermined dollar amount or analyzing a statistically significant sample of claims for accuracy and justification.

Documentation

Subrecipient claim records must document expenditures by instance and by client for the calendar year.

Communications with the Wisconsin CDHR Section regarding projected shortfalls or under-expenditure of grants funds and resolution must be documented.

[5] See 45 CFR §75.426 for more information.

Any identified excess spending situation must have documentation of consultation with the Wisconsin CDHR Section.

Documentation of how the error-detection system functions and results of all analyses must be available to Wisconsin CDHR Section staff upon request.

Standard 9: No payments can be made directly to clients, family, or household members.

The subrecipient must have systems in place that ensure that claims payments are made to appropriate service providers and not to clients or improper individuals.

Documentation

Policies and procedures must be in place to ensure that payments are made only to appropriate vendors.

Standard 10: HIPCSA funding must only be used solely for the costs of client assistance.

Subrecipients receiving funding for HIPCSA can bill the Wisconsin CDHR Section only for the amount spent directly on client assistance.

Staff time, agency operations, or other administrative costs associated with providing this service category are unallowable.

Documentation

Accounting records must document adherence to this requirement.

Standard 11: Properly submitted claims from participating and non-participating care providers must be paid in a timely manner.

All reasonable efforts are made to ensure that properly submitted claims from care providers are paid within 30 days of receipt or disputes/questions are sent to the care provider within 30 days of receipt.

Documentation

Claims data recorded by the subrecipient must include the date that that the claim was received and the date that payment was made.

Client records must contain evidence that claims payments were made within 30 days from the date that the claim was received.

Standard 12: Billing issues must be reported by service providers, case managers, or clients and are promptly resolved to ensure the client's access to services.

Subrecipients must make all reasonable efforts to assist, support, and cooperate in the event of claims processing or payment dispute. Technical assistance from the Wisconsin CDHR Section is available to resolve chronic or systemic billing problems, when identified.

Billing problems must be promptly communicated between the Wisconsin CDHR Section and the subrecipient and resolution will be expedited.

Documentation

Subrecipients must document communications with Wisconsin CDHR Section staff regarding billing problems and resolution thereof.

Standard 13: If a client is deemed ineligible for HIPCSA services, the client ineligibility must be documented.

For a client to be deemed ineligible for HIPCSA services, one of the following criteria must be true. The client:

- Reached the maximum dollar amount of assistance, and no waiver was requested or approved.
- Experienced a household income increase that rose above the limits.
- Failed to notify the program of changes in eligibility factors.
- Moved out of the region or jurisdiction.
- Submitted false or misleading information to the program.*
- Was otherwise unwilling to abide by the requirements of the program.*
- Died.

*Requires a warning and 30 days' notice.

Documentation

The client record must include documentation of criteria used to determine client ineligibility.

Standard 14: Clients may be discharged for behavioral reasons or for violations of policies, with due warning and 30 days' notice.

Removing clients from HIPCSA services for behavioral reasons or for violation of program policies must be used as a last resort. Clients cannot be removed from HIPCSA services for missing appointments or being out of medical care.

Prior to discharge, clients must receive a warning from the subrecipient, which involves the following steps:

1. Document that the client has a clear pattern of violation of HIPCSA guidelines.
2. Give the client notice that if they do not change this behavior, they may be removed from the program. This notice must be given verbally either in person or through a real-time phone conversation and offered in writing including specific information on what behavior the client is expected to change. All notices must be documented.
3. Inform the client's referring provider either over the phone or in person that the client is in danger of losing their HIPCSA assistance. This cannot be done through an email or voicemail—the provider must speak directly to the client's case manager.
4. Inform the Wisconsin CDHR Section that a client is in danger of being disenrolled and summarize the reason for the decision to disenroll the client.
5. If the pattern of behavior continues, the subrecipient must continue to document this information. After issuing this warning, the subrecipient must wait at least 30 days before proceeding to giving the client 30 days' notice as described below.

Prior to discharge, a client must be given 30 days' notice by the subrecipient, which involves the following steps:

1. Inform the client that their HIPCSA services will end 30 days from the date the client is informed. The subrecipient must inform the client through a face-to-face meeting or a real-time phone conversation and give the client a written document explaining they will be removed from the program.
2. Inform the client's referring provider either over the phone or in person that the client's HIPSCA services will be discontinued in 30 days. This cannot be done through an email or voicemail—the provider must speak directly to the client's case manager.
3. Inform the Wisconsin CDHR Section that the client is being disenrolled and summarize the reason for the decision to disenroll the client, including written confirmation from the client's case manager that the case manager received this information.

Documentation

The client record must document that discharge warning steps were followed and that the 30-day notice was provided, if required.

If the client refuses written documentation of the notice, subrecipient organizations must document this.

Did you know?

In 2020, 96 percent of Ryan White Part B clients in Wisconsin who accessed HIPCSA services were virally suppressed.

Source: 2020 RSR

Immigrants who are not United States citizens are nearly three times as likely to be uninsured as Americans as a whole. If they are undocumented that rises to six times as likely.

Source: Health Coverage of Immigrants. 2019, Henry J. Kaiser Family Foundation: Washington D.C.

The Latinx or Hispanic community is the largest group of uninsured and underinsured people in the U.S. and are twice as likely to lack health insurance as the overall U.S. population. These rates have remained high due to immigration status, economic barriers, educational status, and employers who do not offer benefits to low-wage-earning Latinx or Hispanic people.

Source: Shared Values, Distinct Cultures: HIV Care for Latinos in the U.S. Luis Scaccabarrozzi ACRIA and GMHC. Aug. 31, 2013, www.thebodypro.com/article/shared-values-distinct-cultures-hiv-care-for-latin

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Black Americans were more than one-third more likely to lack health coverage than white Americans in 2018.

Source: Kates, J. and L. Dawson, Insurance Coverage Changes for People with HIV Under the ACA. 2017, Henry J. Kaiser Family Foundation: Washington D.C.