MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Insurance Premium and Cost Sharing Assistance Policy & Procedure Guidelines

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Michigan Department of Health and Human Services

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HRSA Definition

Health Insurance Premium and Cost Sharing Assistance (HIPCA) provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance. The service provision consists of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services, and pharmacy benefits that provide a full range of HIV medications for eligible clients; and/or
- Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients; and/or
- Paying cost sharing on behalf of the client.

To use HRSA Ryan White HIV/AIDS Program (RWHAP) funds for health insurance premium assistance (not standalone dental insurance assistance), a RWHAP Part recipient must implement a methodology that incorporates the following requirements:

- Ensure that clients obtain health care coverage that at a minimum, includes 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/ambulatory health services; **and**
- Assess and compare the aggregate cost of paying for the health care coverage (including all other sources of premium and cost sharing assistance) is cost-effective in the aggregate versus paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services

To use HRSA RWHAP funds for standalone dental insurance premium assistance, a RWHAP Part recipient must implement a methodology that incorporates the following requirement:

- Assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental insurance is cost effective in the aggregate, and allocate funding to HIPCA only when to be determined to be cost-effective

For additional information, please see HRSA Policy Clarification Notice 16-02 and HRSA Policy Clarification Notice 18-01

PURPOSE

HIPCA provides assistance for Ryan White Parts A, B, C, D and Care Coordination clients based on the need and recommendation of the Case Manager, Supervisor or Director. Sub-recipients and clients must vigorously pursue and rigorously document other sources of premium and cost-sharing assistance to ensure RW is the Payer of Last Resort.

POLICY

Sub-Recipients and clients must vigorously pursue other sources of premium and cost sharing assistance to ensure RW remains the payor of last resort. Any persons living with HIV (PLWH) requesting HIPCA payments for insurance premiums, co-pays or laboratory bills should apply for relevant agencies/resources that may be able to assist with coverage or payments. All HIPCA request must be related to HIV care and treatment.

> Payer of Last Resort: In accordance with federal regulations, RWHAP funds are intended to fill gaps in care and to serve as a payer of last resort. This ensures that RW funds are not used for services that could be reasonably paid by another funding source
>
> Vigorously Pursue and Rigorously Document: Sub-recipients are expected to vigorously pursue enrollment into healthcare coverage for which their clients may be eligible for and to rigorously document the steps taken to get the client enrolled in other healthcare coverage.

ELIGIBILITY REQUIREMENTS

- Must be HIV-positive
- Must be a resident of Michigan
- Must be low income (income not to exceed 500% of the Federal Poverty Level/FPL)
- Must be underinsured or uninsured for Ryan White services that are reimbursable through third party payers

ALLOWABLE SERVICES

Funds may be used for eligible clients to receive or maintain health insurance or medical benefits under a health insurance program. This includes out-of-pocket costs such as insurance premium payments, co-payments, coinsurance, and deductibles.

Medical Copays, Coinsurance and Deductibles

HIPCA funds should only be used when the client lacks the ability to pay.

If requesting copay, coinsurance or deductible coverage, the following must be provided:

1. Itemized bill from a medical provider showing the insurance adjustment
2. Date the MIDAP application was submitted and/or denial from MIDAP of the inability to cover the copay, coinsurance or deductible
3. Services **must be related to HIV Care**

Dental

The Michigan Dental Program (MDP) provide dental coverage for PLWH that do not have private dental insurance coverage. Clients may have Medicaid and qualify for MDP.

If requesting dental coverage, the following must be provided:

1. Denial from MDP or copy of private insurance that does not cover dental
2. Detailed medical bill of services provided
3. If client has insurance and services are not covered 100%, an itemized bill with the insurance adjustment must be submitted

HIV or other related Prescription Copays

HIPCA funds should ONLY be used when the client lacks the ability to pay or in emergency situations when MIDAP approval is delayed.

> **Example:** The clients deductible has not been met. The client can request HIPCA funds to cover the cost of the medication copays. However, the medications must be related to HIV care or be on the MIDAP Formulary.

If requesting medication copays, the following must be provided:

1. Itemized bill from the pharmacy listing all of the medications. The medication must be HIV related to HIV care and/or be on the MIDAP Formulary
2. Insurance adjustments must be listed on the bill from the pharmacy showing what the insurance company paid
3. Date the MIDAP application was submitted and/or denial from MIDAP of the inability to cover copays or the full cost of the medication

Health Insurance Premiums

HIPCA funds should only be used for premium assistance when the client lacks the ability to pay and is not eligible for MIDAP Premium Assistance. The Premium Assistance Program through MIDAP assists clients in paying health insurance premiums. More information can be found in the glossary about this program.

If requesting premium assistance, the following must be provided:

1. Date the MIDAP application was submitted and/or a denial from MIDAP of the inability to cover Premium Assistance at this time
    a) **COBRA:** a copy of the COBRA election form including the most recent detailed invoice* from the insurance company
    b) **Medicare Part C:** a copy of the most recent detailed invoice from the insurance company
    c) **Medicare Part D**: a copy of the most recent detailed invoice from the insurance company
    d) **Medigap Plan**: a copy of the most recent detailed invoice from the insurance company
    e) **Qualified Health Plan:** a copy of marketplace eligibility letter and a copy of the most recent detailed invoice from the insurance company
2. The invoice **must include** the name and address of where the payment needs to be made, total amount due, and patient account number.

Vision

Documentation of early detection, care, treatment, and prevention of vision problems for eye conditions related to the client's HIV status must be provided:

- Eye Exam: Standard eye exam every two years with a maximum cost of $150.00
- Frames and Lenses: Standard frames and lenses are covered every two years
- Maximum cost for basic frames and standard plastic lenses $200.00
- Standard plastic poly-carbonite for ages 18 and under only
- Lenses coverage includes single vision, bifocals, trifocal and UV treatment

Vaccines

All recommended adult vaccines should be covered by all Michigan local health departments. Health departments utilize sliding fee scales for patients that are under/uninsured. Clients with no insurance or those who have insurance that does not cover routine vaccines, may be charged a sliding scale vaccine administration fee (currently $0-$23 per vaccine) based upon income. Clients will need to check with the clinic to verify which vaccines qualify for this sliding fee scale. HIPCA can pay for the remaining balance when a case manager submits a completed HIPCA request form with all supporting documentation attached.

- For a complete listing of all local health departments, please visit the Michigan Association of Local Public Health (MALPH) here
- The vaccine requisition form can be found here

If a client receives their vaccine(s) at a location other than the local health department, the case manager must provide justification regarding specific barriers such as transportation, distance/mileage, accessibility, stigma, and discrimination. (i.e., transportation barriers, stigma) .

Covered Vaccines

- MMR (measles, mumps, and rubella)
- Tdap (tetanus, diphtheria, and whopping cough)
- Hepatitis A and Hepatitis B
- Shingrix (recombinant Zoster vaccine to prevent Shingles)
- Influenza (annual)
- Pneumonia every five years (age dependent)
- Gardasil 9 (HPV)
- Meningococcal

If your agency is funded to administer vaccinations, HIPCA funds cannot be used to help pay for vaccinations.

LABS

Labs must be related to an HIV diagnosis or ordered by a healthcare provider. Additional documentation may be requested regarding labs if the HIPCA Needs Request form is lacking sufficient documentation.

Complete Blood Panel

- Complete Blood Count (CBC)
- Blood chemistry tests/Basic metabolic panel
- Lipoprotein Panel

Below is the process for setting up the MDHHS-Bureau of Laboratories MIDAP Testing for HIV Viral Load and HIV CD4/CD8:

Step 1: Set up Testing	Contact the Michigan Drug Assistance Program Coordinator, Shelli Doll at Dolls@michigan.gov. MIDAP will communicate with MDHHS Bureau of Laboratories (BOL) Matthew Bashore, for client creation, testing supply and education
Step 2: Client Creation for Reporting	The BOL will work with the agency on how they would like to receive their reports. Client creation is based on the reporting method chosen below: a. USPS mail: client needs to only provide the agency name, address, and phone number. Reports will be sent through USPS mail service. The average turnaround time is 5-7 days. b. Fax transmission: Reports will be automatically faxed to a secure fax number when results are posted. Turnaround time is 2-3 days. c. Electronic Test Order and Reporting (ETOR): Online ordering and reporting
Step 3: Order Supplies	Supplies are ordered through the MDHHS-BOL Laboratory Kit Order Tracking System LKOTS) https://milkots.michigan.gov/login a. Order Kit #13-CD4/CD8 & Viral Load Testing Kit for HIV-1
Step 4: Specimen Collection	a. HIV Viral Load – EDTA Preserved Plasma – Ship Cold • Collect in a lavender top EDTA tube • Spin to separated plasma from red blood cells • Pour off into polypropylene tubes – label with a unique identifier • 2 ml plasma is necessary for testing b. HIV CD4/CD8 – Whole Blood – Room Temperature • Collect in a lavender top EDTA tube • Label with a unique identifier • Sample must be tested within 48 hours of draw
Step 5: Form Completion and Shipping	a. Complete Microbiology/Virology Test Requisition Form DCH – 0583 www.michigan.gov/mdhhslab (one form per patient) b. The form must match the label exactly how it is on the specimen c. Enter the following on the DCH-0583 • Name and address of the facility submitting the sample • Agency Code # • Phone and fax number • National Provider Identifier (NPI) • Patient information, including MIDAP ID, date and time of sample collection • Under **HIV TESTING**: check ☒ CD4/CD8 (EDTA whole blood) and ☒ HIV-1 VIRAL LOAD (EDTA Plasma)

DOLLAR AMOUNT MINIMUNM

Agencies are reasonably expected to vigorously pursue and rigorously document resources, funds and services utilized to ensure RWHAP funds are payer of last resort. Please ensure on the HIPCA Needs Request form to provide all agency denials and attach all supporting documentation. The HIPCA Needs Request forms will only be accepted with requests of a minimum of $10.00

UNALLOWABLE SERVICES

- Direct payments to clients
- Health Insurance plans that do not cover HIV-treatment drugs; specifically, the plan must cover at least one drug in each class of core antiretroviral therapeutics from the HHS clinical guidelines as well as appropriate primary care services.
- Medications not listed on the MIDAP Formulary (unless deemed medically necessary by prescriber) A link to the most updated is listed here: MIDAP Formulary
- Any cost associated with liability risk pools.
- RWHAP funds cannot be used to cover costs associated with Social Security.
- Funds may not be used to pay fines or tax obligations incurred by clients for not maintaining health insurance coverage required by the Affordable Care Act (ACA).
- Funds may not be used to make out-of-pocket payments for inpatient hospitalization and/or emergency department care.
- Funds may not be used to support plans that offer only catastrophic coverage or supplemental insurance that assists only with hospitalization.
- Funds must not be extended for Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage *if a client is eligible* for other coverage that provides the required minimal level of coverage at a cost-effective price.
- Vision Services Not Covered
    - Cataract Surgery
    - Contact Lenses
    - Laser Surgery
    - Polarized lenses
    - Scratch guard
    - Standard anti-reflective coating
    - Tint

PROCEDURE FOR REQUESTING HIPCA FUNDS

Clients with Case Manager (CM): If a client is assigned to an agency and/or clinic, the agency and/or clinic must submit the HIPCA Claims form on behalf of the client.

1. Case Manager will complete and submit the **HIPCA Needs Request** form, including all required supporting documentation, ensuring the following is included: HIPCA Needs Request Form
    a. CAREWare URN# and/or MIDAP ID
    b. Amount Requested & Payment Due Date
    c. Date of MIDAP and/or Medicaid application, if applicable
    d. Name and address of payee
    e. Patient account number on listed the invoice
    f. Description of Need: Provide a brief description of need
    g. How the need relates to the client's HIV care

h. Agency Denials (e.g., MIDAP, RWB, Medicaid): Agency denials must be provided to ensure the Payer of Last Resort requirement is met
i. Case Manager Signature & Date
j. Supervisor Signature & Date

2. The following documentation must be attached to the **HIPCA Needs Request** form:
   a. Detailed invoice/itemized bill from the medical provider or insurance company that shows the insurance adjustment and balance due.
   b. The date of service must be within one year of submission to HIPCA to be eligible for reimbursement
   c. The statement date on the bill must be within the six weeks of submission to HIPCA
   d. Services must be related to the client's HIV care. If the information is not evident on the paperwork/invoice as being relevant to the client's HIV care, the HIPCA Committee will return the request for additional information. If it is not evident on the paperwork/invoice, the HIPCA committee may request additional information.

Submitting the HIPCA Paperwork to MDHHS

1. Submit the HIPCA Needs Request form with all supporting documentation to MDHHS for review
2. MDHHS will review the HIPCA request within two weeks of receiving the request.
3. After the HIPCA request has been reviewed, MDHHS will document the approval and/or denial with notes in the CAREWare Case Notes section.
4. After payment has been sent to the vendor, MDHHS will document payment in CAREWare Case Notes section, add the HIPCA service & total amount paid.
5. If the HIPCA Needs Request form is incomplete or lacking sufficient documentation, MDHHS will document this in the CAREWare Case Notes section. It is the responsibility of the Case Manager to check the CAREWare Case Notes section for all correspondence from MDHHS regarding approvals, denials and/or communication regarding further information needed to complete the HIPCA request.

Subrecipient Requirements

1. All HIPCA Requests and supporting documentation must be kept on file
2. Documentation of services must be documented in CAREWare by utilizing the MCM or Non-Medical Case Manager (NMCM) support sub-service category
3. Check CAREWare Case Notes for correspondence from MDHHS regarding status of HIPCA requests
4. The HIPCA Needs Request form must be filled out completely and documentation submitted, or additional information may be request and payment could be delayed.

RESOURCES

VISION RESOURCES

Lions Club Provides financial assistance to individuals for eye care through local clubs. http://www.lionsclubs.org/

New Eyes for the Needy: Purchases basic prescription glasses for people in financial need in the U.S. Telephone: (973) 376-4903. Website: http://www.new-eyes.org/

Eyecare America: Provides comprehensive eye exams and care for up to one year, often at no out-of-pocket expense to eligible to those 65 and older through its seniors and Diabetes Eye Care Programs. http://eyecareamerica.org

Michigan 211:
https://www.navigateresources.net/hwmi/MatchList.aspx?k;;0;;N;0;0;Glasses/Contact%20Lenses

DIABETES RESOURCES

American Diabetes Association: Provides assistance for people with diabetes that need help paying or insulin or other diabetes medications https://insulinhelp.org/

Inside Rx: Discounted prices for several different types of medications http://www.insiderx.com

Xeris: Assists with the cost of glucagon, may pay as little as zero 1-877-694-8653

Lilly Cares Foundation: A non-profit organization separate from Lilly that provides insulin for eligible patients. Learn more about the eligibility criteria at www.lillycares.com

Novo Nordisk Inc.: For $99.00, people with diabetes can get up to three vials or two packs of FlexPen®/FlexTouch®/PenFill® pens, of any combination of Novo Nordisk Inc. insulins with a prescription. 1-844-668-6463

PRESCRIPTION ASSISTANCE PROGRAMS

Partnership for Prescription Assistance Helps people without prescription coverage get medications for free or at a very low cost https://medicineassistancetool.org/

Rx Assist Comprehensive database of pharmaceutical assistance programs https://www.rxassist.org/

Rx Hope Helps people get medications for free or for a very small copay
https://www.rxhope.com/home.aspx

GoodRx: Contains a comprehensive database of medications, prices and discounts
https://www.goodrx.com/

Inside Rx: Complete database of medications, prices, and discounts https://insiderx.com/

Blink Health: Discounted prices for many medications https://www.blinkhealth.com/

GLOSSARY

Advanced Premium Tax Credit: A tax credit a person can take in advance to lower their monthly health insurance payment or "monthly premium" when they apply for coverage in the Health Insurance Marketplace. When an individual applies for coverage in the Marketplace, they estimate their expected income for the year. If they qualify for a premium tax credit based on that estimate, they can use that amount to lower their monthly premium.

Affordable Care Act/Qualified Health Plan/Marketplace Plan: An insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements under the Affordable Care Act. All qualified health plans meet the Affordable Care Act requirement for having health coverage, known as "minimum essential coverage." Or more information about the Affordable Care Act or to enroll or update a plan, please visit the Healthcare.gov website

Balance Billing: This is the balance remaining on a bill that your plan does not cover.

Example: Your provider's charge is $100.00, and the allowed amount is $80.00, the provider may bill you for the remaining $20.00. This most often happens when you see an out-of-network provider.

Coordination of Benefits: If a person has two or more health insurance plans and the insurance companies are trying to figure out who is responsible for paying for the same medical or prescription claim.

Coinsurance: The percentage of health care costs a person is responsible for after they have met their deductible.

Example: A health insurance plan allowed amount for an office visit is $100.00 and your office visit is $20.00

- If you have paid your deductible: You pay 20% of $100.00, or $20.00 The insurance company pays the rest.
- If you have not met your deductible: You pay the full allowed amount, $100.00

Copays: A fixed amount (e.g., $20.00) a person pays for a covered health care service (office visits, lab tests) after their deductible has been met.

Cost-Sharing: The share of costs covered by your insurance that you pay out of your own pocket (sometimes called "out-of-pocket costs"). This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it does not include premiums, balance billing amounts for out-of-network providers, penalties a person may have to pay or the cost of non-covered services. Cost-sharing in Medicaid and CHIP also includes premiums.

Cost-Sharing Reductions: Discounts that reduce the amount a person pays for certain services covered by a health insurance plan a person purchases through the ACA/Marketplace. An individual can get a discount if their income is below a certain level and if they choose a Silver Level plan **OR** if they are a member of a federally recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act Corporation.

Deductible: The amount a person is expected to pay for covered health care services during their coverage period (usually one year) year before their health insurance plan begins to pay.

> **Example:** If your deductible is $1000, your plan will not pay anything until you've met your $1000 deductible for covered health care services subject to the deductible

Insurance Assistance Program: The Insurance Assistance Program (IAP) assists persons living with HIV maintain their health insurance benefits that are facing financial difficulty by paying health insurance premiums for eligible individuals. For more information, please visit the Insurance Assistance Program website

Medicaid: Insurance program that provides comprehensive healthcare services to low-income adults, children, pregnant women, the elderly, and people with disabilities.

Medicare Part A (Hospital Insurance): Covers inpatient hospital care, skilled nursing facility, hospice, lab tests, surgery, home health care. For more information, please visit What Part A covers | Medicare

Medicare Part B (Medical Insurance): Covers doctor and other health care providers' services and outpatient care. Part B also covers durable medical equipment, home health care, and some preventive services. For more information, please visit What Part B covers | Medicare

Medicare Part C (Medicare Advantage Plan): A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Part C helps cover the cost of medication related copays, deductibles, co-insurance, and insurance premiums. It also includes Medicare Part A, B & D and usually additional services may be included depending on the plan that is chose (vision, hearing, dental). For more information, please visit Medicare Advantage Plans | Medicare

Medicare Part D (Prescription Plan): A program that helps pay for prescription drugs for people with Medicare who join a plan that includes Medicare prescription drug coverage. There are two ways to get Medicare prescription drug coverage: through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare. For more information, please visit Drug coverage (Part D) | Medicare

Medigap Policy (Supplemental Health Insurance): A health insurance policy that is used to fill the "gaps" in Original Medicare Coverage. Medigap policies help pay some of the health care costs that the Original Medicare does not cover. For more information, please visit What's Medicare Supplement Insurance (Medigap)? | Medicare

Metal Level Plans: Levels in the plans in the Health Insurance Marketplace sometimes referred to as "metal levels". Each level is based on a different percentage of what you will pay, and the insurance company will pay. The total cost includes premiums, deductibles, and out-of-pocket costs like copayments and coinsurance.

Insurance Coverage	Bronze Plan	Silver Plan	Gold Plan	Platinum Plan
Percentage your insurer covers for all covered services combined	60%	70%	80%	90%
Percentage you pay until you hit your plan's spending limit	40%	30%	20%	10%

Michigan Drug Assistance Program (MIDAP): The Michigan Drug Assistance Program (MIDAP) is a federally funded program that provided HIV-related (and other related medications) to eligible applicants who have limited or no access to insurance coverage. For more information or to enroll in the program, please visit the MIDAP website.

Open Enrollment: The yearly period when people can enroll in a health insurance plan.

Premiums: The amount a person pays each month towards their health insurance. In addition to a monthly premium, a person must pay for other costs for their health care including a deductible, copays, and coinsurance. If you have a Marketplace plan, you may be able to lower your costs with a premium tax credit.

When shopping for a plan, keep in mind that the plan with the lowest monthly premium may not be the best match for you. A plan with a slightly higher premium but a lower deductible may save you a lot more money.

After you first enroll in a Marketplace plan, you must first pay your premium directly to the insurance company—not to the Marketplace.

Premium Assistance Program: The Premium Assistance (PA) Program helps to cover costs associated with a health insurance policy, including co-payments, deductibles, coinsurance, or premiums to purchase and maintain health insurance coverage. In order to be eligible and enroll in the PA program, a client must first be approved for the MIDAP program. The PA program assists eligible clients pay premiums for:

- COBRA
- Medicare Part C (Advantage Plan)
- Medicare Part D (Prescription Plan) and D
- Affordable Care Act/Qualified Health Plans through the Marketplace

For more information and to enroll in premium assistance, please visit the Premium Assistance Program website

Special Enrollment Period (SEP): A period of time when a person can sign up for health insurance. During 2021, a person can enroll in Marketplace health coverage through August 15 due to the COVID-19 emergency.

A person may also qualify for a Special Enrollment Period (SEP) at any time if they have had any certain life events, including losing health coverage, moving, getting married, having a baby or adopting a child. Depending on the SEP event, a person may have 60 days before or 60 days following the event to enroll in a plan.