Health Insurance Premium and Cost Sharing Assistance Service Standard

Texas Department of State Health Services, HIV Care Services Group — HIV/STD Program | Texas DSHS

Subcategories	Service Units
Dental Co-Insurance	Per payment
Dental Co-Payment	Per payment
Dental Deductible	Per payment
Dental Premium	Per month
Health Insurance Premium and Cost-Sharing Assistance	Per payment
Medical Co-Insurance	Per payment
Medical Co-Payment	Per payment
Medical Deductible	Per payment
Medical Premium	Per month
Pharmacy Co-Payment	Per prescription

Health Resources and Services Administration (HRSA) Description:

Health Insurance Premium and Cost Sharing Assistance (HIA) 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 and ambulatory health services and pharmacy benefits that provide a full range of HIV medications for eligible clients;

- Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients;

- Paying cost sharing on behalf of the client; or

- Any combination of the above.

Program Guidance:

The following DSHS policies and standards and HRSA Policy Clarification Notices (PCNs) provide additional clarification for allowable uses of this service category:

- HIV/STD Section Policy 260.002: Health Insurance Assistance

- PCN 21-02: Determining Client Eligibility & Payor of Last Resort in the Ryan White HIV/AIDS Program

- PCN 18-01: (Revised 08/30/2018): Clarifications Regarding the Use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost-Sharing Assistance

- PCN 16-02: (Revised 10/22/2018—replaced PCN 10-02): Eligible Individuals & Allowable Uses of Funds and Standalone Dental Insurance Frequently Asked Questions

- PCN 14-01: (Revised 4/3/2015): Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act (ACA) and Frequently Asked Questions for Policy Clarification Notice 14-01

- PCN 13-04: Clarifications Regarding Clients Eligible for Private Health Insurance and Coverage of Services by Ryan White HIV/AIDS Program

Limitations:

HIA cannot be in the form of direct payments to clients. Agencies may not use HIA funds for any of the following:

- Out-of-pocket payments for inpatient hospitalizations and emergency department care;

- Insurance plans offering only catastrophic coverage or supplemental

insurance assisting only with hospitalization; or

- Services that the client receives from a provider that does not belong to the client's health plan's network unless the client receives services that they could not have reasonably obtained from an in-network provider.

Agencies may only use HIA for Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage if a client is not eligible for other coverage that meets the minimum required standards at a cost-effective price.

Paying for health care premiums and cost sharing must be cost-effective in the aggregate compared to the full cost of purchasing medications and medical services. Paying for dental insurance premiums and cost sharing must also be cost-effective in the aggregate compared to the full cost of oral health care services. DSHS performs annual cost-effectiveness analysis and produces benchmark estimates for annual per-client expenditure on covered medical services, as well as covered oral health care services. If the cost of HIA services for an individual client exceeds this benchmark, agencies must provide documentation of the circumstances (see Caps on Assistance in the standard below).

Services:

HIA includes out-of-pocket costs such as premium payments, co-payments, coinsurance, and deductibles. Please refer to HIV/STD Section Policy 260.002, Health Insurance Assistance, and to HIV/STD Section Policy 270.001, Calculation of Estimated Expenditures on Covered Clinical Services, for further clarification and guidance.

Ryan White HIV/AIDS Program (RWHAP)-funded agencies may provide HIA for job or employer-related health insurance coverage and individual and group market plans, including plans available through the federal Health Insurance Marketplace. Agencies must vigorously pursue enrollment in health care coverage for which their clients may be eligible to maximize finite RWHAP grant resources.

Agencies may provide HIA premium assistance when eligible 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 and ambulatory health services.

Agencies should pursue other sources of premium and cost-sharing assistance prior to

HIA, including health insurance assistance available from the Texas HIV Medication Program (THMP) Texas Insurance Assistance Program (TIAP-PLUS), pharmaceutical company cost-savings assistance programs, or advance premium tax credits (APTC) and cost sharing reductions (CSR) available through the Marketplace. Agencies can use HIA funds for eligible services not covered by these programs.

Agencies must not use RWHAP funds to pay for premiums or cost sharing assistance for private health plans that are paid for or reasonably expected to be paid for by Medicaid through the Health Insurance Premium Payment Program and Medicare Savings Programs. However, agencies may use RWHAP funds to pay for any remaining premium or cost sharing amounts not covered by Medicaid.

Agencies may also use HIA funds towards premiums and out-of-pocket payments on Medicare and supplemental insurance policies if the primary purpose of the supplemental policy is to assist with HIV-related outpatient care. Before using HIA, agencies should pursue programs providing premium and cost-sharing assistance such as THMP's State Pharmaceutical Assistance Program (SPAP), Medicare Savings Programs (MSPs), and Extra Help for Medicare Part D. The following rules apply when agencies use HIA funds to pay for Medicare:

- Agencies may not pay for Medicare Part A (hospital insurance) premiums or cost sharing.

- Agencies may use HIA funds to pay for Medicare Part B (outpatient ambulatory health services) premiums and cost sharing but must also pay for the Medicare Part D (medication) premiums or cost sharing.

- Agencies may also use HIA funds to pay for Medicare Part C (Medicare Advantage Plans) premiums and cost sharing assistance when the plan covers both outpatient ambulatory health services and at least one medication in each drug class of core antiretrovirals. If the Medicare Part C plan does not cover at least one medication in each drug class of core antiretrovirals, agencies must also pay for Medicare Part D premiums and cost sharing to meet the RWHAP requirement for health care coverage.

- Agencies may also use HIA funds to pay Medicare Part D Medicare Prescription Drug Coverage premiums or cost sharing in conjunction with paying Medicare Part B.

- Agencies may not use HIA funds to pay premiums for Medicare Part D alone. Agencies may use HIA funds for providing funds to contribute to a client's Medicare Part D true out-of-pocket (TrOOP) costs, as well as certain tax liabilities.

Universal Standards:

Service providers for Health Insurance Premium and Cost-Sharing Assistance must follow HRSA and DSHS Universal Standards 1-## and ##-##.

Service Standards and Measures:

The following standards and measures are guides to improving healthcare outcomes for people living with HIV throughout the State of Texas within the Ryan White Part B and State Services Program.

Standard	Measure
Client Education of Services Available and Limitations: Agencies, or qualified organizations and individuals that provide expert assistance to clients on their health insurance coverage options and available cost reductions, must educate clients regarding the reasonable expectations of eligible plan coverage, the effective dates of coverage, the limitations of healthcare coverage assistance available through HIA, and any expectation for client contribution. As applicable, staff must provide education about the expectations and limitations related to private insurance (including Marketplace), Medicaid, or Medicare, including information about programs providing premium and cost sharing assistance such as the THMP's TIAP-PLUS and SPAP, pharmaceutical company cost-sharing assistance programs, and other state and federal programs including the Health Insurance Premium Payment Program, Medicare Savings Programs, and Extra Help for Medicare Part D. As applicable, HIA staff must educate the client regarding Marketplace premium tax credits, cost-sharing reductions, and the requirement to file income tax returns. See Understanding Premium Tax Credits and Cost-Sharing Reductions. Education must include:	1. Percentage of clients with documentation of education provided regarding reasonable expectations and limitations of healthcare coverage assistance available through HIA. 2. Percentage of clients with documentation of education regarding premium tax credits and cost-sharing reductions, as applicable.

• How to pay the premium, verify enrollment online, and access plan enrollment materials. • The importance of reporting accurate income information on their Marketplace application and reporting to the Marketplace any income, family size, tobacco use, or residence changes throughout the year. • Requirements to take eligible tax credits as advance credits to reduce premiums (if receiving RWHAP funds for premium assistance). • The requirement that those qualifying for Marketplace cost-sharing reductions (CSRs) (usually those with an estimated income of 100 to 250 percent of the Federal Poverty Level that are eligible for premium tax credits) choose a Silver Plan (if receiving HIA for deductibles, copays, and coinsurance). • The requirement that those not eligible for CSRs choose a cost-effective plan that covers needed medications and desired medical providers; these will often be at the Gold "metal level." • The requirement of those receiving APTCs to file federal income taxes and the importance of reconciling APTCs well before the IRS tax filing deadline. Staff must document all relevant education in the client's primary record.	
Health Insurance Plans: Agencies must provide proof that where HIA funds cover premiums, the insurance policy provides comprehensive primary care and a formulary with a full range of HIV medications. The agency must ensure that clients buy health coverage that, at a minimum, includes at	3. Percentage of clients receiving HIA assistance with health care premiums with documentation of health care coverage that includes at least one drug in each class of core ART from HHS treatment guidelines, along with OAHS that meet the requirements of the

least one drug in each class of core anti-retroviral treatment (ART) from the HHS treatment guidelines and outpatient and ambulatory health services that meet the requirements of the ACA law for essential health benefits. Staff must document this in the client's primary record.	ACA law for essential health benefits.
Dental Insurance Plans: Agencies must provide proof that where HIA funds cover standalone dental insurance premiums, the dental insurance policy provides comprehensive oral healthcare services.	4. Percentage of clients receiving assistance for standalone dental insurance premiums with documentation that the dental insurance policy provides comprehensive oral healthcare services. (Pilot Measure)
Health Insurance Marketplace: Agencies may pay health insurance premiums for clients enrolled in plans through the Health Insurance Marketplace. When clients are enrolled in Marketplace plans, agencies must follow best practices for cost-effectiveness. **Marketplace Eligibility Determination:** When individuals apply for health coverage, the Marketplace will provide them with written notice of their eligibility determination and an annual redetermination notice. Staff must document the Marketplace notice of eligibility determination or annual redetermination notice as part of the RWHAP HIA eligibility determination. **Premium Tax Credits:** Clients receiving HIA assistance with premiums must take tax credits they are eligible for in advance. **Cost-Sharing Reductions:** To receive assistance with out-of-pocket payments, clients eligible for Marketplace cost-	5. Percentage of clients receiving premium assistance for plans purchased on the Health Insurance Marketplace with documentation of a Marketplace Eligibility Determination Notice or other official documentation that includes: (Pilot Measure) • The estimated income for the coverage year used to determine eligibility; • The amount of premium tax credit available; and • The eligibility status for extra savings (Marketplace Cost Sharing Reductions). 6. Percentage of clients receiving premium assistance for plans purchased on the Health Insurance Marketplace with documentation that the client took any eligible tax credits in advance. (Pilot Measure) 7. Percentage of clients qualifying for Marketplace cost-sharing reductions with documentation that the client is enrolled in a Silver plan, if the client receives copay, coinsurance, or deductible assistance. (Pilot Measure)

sharing reductions, also called "extra savings", must enroll in a Silver Plan. **Reconciliation of Tax Credits:** HIA providers must track the source and use of funds for RWHAP activities, including excess Premium Tax Credits. Clients enrolled in Marketplace plans will receive Form 1095-A (Health Insurance Marketplace Statement) and should file, with help if needed, Form 8962 (Premium Tax Credit) and one of the Form 1040 series of individual income tax returns. See PCN 14-01. Agencies may fund professional income tax preparation under the Other Professional Services service category. If a client's actual premium tax credit, as calculated on their tax return, is more than the client's APTC, the client may receive a payment from the IRS. Subrecipients must vigorously pursue these excess premium tax credit funds from clients and must document this in the client file.	8. Percentage of clients receiving premium assistance for plans purchased on the Health Insurance Marketplace with documentation of tax credit reconciliation, including: (Pilot Measure) a. Verification that the client filed a federal income tax return for the tax years in which the client received an APTC. b. Documentation that agency vigorously pursued any excess premium tax credits paid to the client by the IRS.
Premiums, Deductibles, Co-payments, and Co-insurance: Eligible clients with job or employer-based insurance coverage, qualified health plans (QHPs), Medicare, or Medicaid plans can receive assistance to offset cost-sharing these programs may impose. Agencies will ensure premium payments made directly to a health or dental insurance vendor occur within five business days of an approved request. If Memorandums of Understanding (MOU) are in place with the vendor that supersede the 5-business day turnaround, agencies must produce the MOU at the time of monitoring.	9. Percentage of clients receiving HIA for premiums with documentation that agency made insurance premium payments to the vendor within five business days of the approved request. 10. Percentage of clients receiving cost sharing assistance with documentation that the medical or dental provider first billed insurance for the full claim and the remainder is the client's portion only. (Pilot Measure)

Invoices and bills received should reflect that the provider billed the insurance provider first, and the remainder is the client's portion (deductible, co-pay, co-insurance).	
Prescription Eyewear: When agencies use HIA funds for co-pays on prescription eyewear, agencies must keep documentation from the client's medical provider stating that the eye condition is related to the client's HIV or vision correction is necessary to support HIV treatment.	11. Percentage of clients receiving assistance for prescription eyewear with documentation from the client's medical provider that vision services relate to HIV or are necessary to support HIV treatment.
Caps on Assistance: Requests to provide HIA for plans exceeding yearly HIA benchmarks must include a documented exception reason or waiver approval. Reasons for exceeding the yearly cap may include: • Special circumstances exist making financial support of health insurance necessary to preserve the health of the client. • HIA provides a cost savings over payment for direct services. • Coverage of ongoing policies began prior to the development of local eligibility criteria for HIA; a client's enrollment in more cost-efficient coverage must occur at the earliest opportunity. When an agency pays for a client's COBRA, the agency must document diligent effort to ensure this is the most cost-effective form of insurance for the client and reevaluate this during open enrollment periods.	12. Percentage of clients with documentation of the exception type or a waiver approved by the Administrative Agency, if the total amount of HIA for either health care or dental coverage exceeds the per client per calendar year cap. (Pilot Measure)

Agencies must document that when the client is not eligible for premium tax credits, the use of HIA for the full cost Marketplace coverage is cost-effective or necessary for the health of the client.	

References:

Division of Metropolitan HIV/AIDS Programs, HIV/AIDS Bureau (HAB). Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients. Health Resources and Services Administration, June 2023.

Division of State HIV/AIDS Programs, HIV/AIDS Bureau (HAB). Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part B Recipients. Health Resources and Services Administration, June 2023.

Panel on Antiretroviral Guidelines for Adults and Adolescents. "Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV." *Clinical Info (HIV.gov)*, Department of Health and Human Services, 27 Feb. 2024, clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/whats-new-guidelines.

Ryan White HIV/AIDS Program. *Policy Clarification Notice 14-01: Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act*. Health Resources & Services Administration, 3 Apr. 2015.

---. *Policy Clarification Notice 18-01: Clarifications Regarding the Use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance*. Health Resources & Services Administration, 30 Aug. 2018.

---. *Policy Notice 16-02: Eligible Individuals & Allowable Uses of Funds*. Health Resources & Services Administration, 22 Oct. 2018.

---. *Standalone Dental Insurance Frequently Asked Questions*. Health Resources & Services Administration, 13 June 2017.

Texas Department of State Health Services. "260.002 Health Insurance Assistance." *www.dshs.texas.gov*, 2 Nov. 2015, dshs.texas.gov/hivstd/policy/policies/260-002.