BEST PRACTICES: ADAP AND INSURANCE PURCHASING

NASTAD’S TECHNICAL ASSISTANCE MEETING

Tonya King, MPA
Ryan White Part B Program Director

JULY 29 – 31, 2015
BEST PRACTICES: ADAP AND INSURANCE PURCHASING

• Program History
  ▫ Changes in TennCare, Tennessee’s Medicaid program, impacted the Ryan White Part B Program:
    – July 2002 – closure of enrollment to uninsurable/medically eligible with incomes > 100% FPL
    – 2005 – TennCare Reform
    – 2009 – Settlement of 20 year old court case allowing TennCare to re-determine eligibility for individuals that were formerly SSI eligible
  ▫ Requested and received additional State funding for HIV/AIDS from legislature (recurring due to community advocacy efforts)
  ▫ Regional consortium lead agents were funded to administer insurance purchasing programs in five areas.
  ▫ In 2007, moved to sole source contract/administrative agent to oversee Insurance Assistance Program.
  ▫ In 2009, released RFP for IAP vendor to reduce administrative costs.
BEST PRACTICES: ADAP AND INSURANCE PURCHASING

• Program History continued
  ▫ Program enrollment –
    – Clients must have met eligibility criteria.
    – Clients had access to insurance through employer, private policy or had certificate of insurability from TennCare disenrollment.
    – Insurance must meet certain requirements (pre-ACA):
      ▪ Provide pharmaceutical coverage.
      ▪ Have no less than a $50,000 lifetime cap.
      ▪ Pre-existing condition clause periods must have been met.
    – Assistance limited to $1,500/month or $18,000/year.

<table>
<thead>
<tr>
<th>FFY</th>
<th>HDAP Enrollment</th>
<th>HDAP % Growth</th>
<th>IAP Enrollment</th>
<th>IAP % Growth</th>
<th>Total Enrollment</th>
<th>Total % Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007-08</td>
<td>1,933</td>
<td>n/a</td>
<td>1,438*</td>
<td>n/a</td>
<td>3,371</td>
<td>n/a</td>
</tr>
<tr>
<td>2008-09</td>
<td>2,308</td>
<td>19%</td>
<td>1,356**</td>
<td>-6%</td>
<td>3,664</td>
<td>9%</td>
</tr>
<tr>
<td>2009-10</td>
<td>2,673</td>
<td>16%</td>
<td>1,633*</td>
<td>20%</td>
<td>4,306</td>
<td>18%</td>
</tr>
<tr>
<td>2010-11</td>
<td>3,172</td>
<td>19%</td>
<td>1,647*</td>
<td>&lt;1%</td>
<td>4,819</td>
<td>12%</td>
</tr>
<tr>
<td>2011-12</td>
<td>3,530</td>
<td>11%</td>
<td>1,744*</td>
<td>6%</td>
<td>5,274</td>
<td>9%</td>
</tr>
<tr>
<td>2012-13</td>
<td>4,060</td>
<td>15%</td>
<td>1,918*</td>
<td>10%</td>
<td>5,978</td>
<td>13%</td>
</tr>
</tbody>
</table>
BEST PRACTICES: ADAP AND INSURANCE PURCHASING

• Program History continued
  ▫ Based on cost effectiveness, in fall 2014 decided to purchase insurance through federal Marketplace for clients that 1) currently on PCIP, 2) would be penalized, 3) were most medically needy, and 4) other ADAP enrollees that were ACA eligible.
  ▫ Decided to use current Insurance Assistance Program model.
    – Reviewed Blue Cross/Blue Shield of Tennessee policy’s only because TDH had contract with carrier and five HIV Centers of Excellence clinics are located in metro, county or regional health departments.
    – Recommended five best policies for population.
  ▫ Partnered with Tennessee Primary Care Association to use CACs at COE and CBOs across the state to assist with enrollment. Medical Case Managers were staff primarily charged with enrollment assistance.
# BEST PRACTICES: ADAP AND INSURANCE PURCHASING

- 2013 ACA Enrollment Results

<table>
<thead>
<tr>
<th>Target Population</th>
<th>Number to be Enrolled</th>
<th>Number Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCIP</td>
<td>72</td>
<td>72</td>
</tr>
<tr>
<td>DPO</td>
<td>38</td>
<td>33</td>
</tr>
<tr>
<td>HDAP (100 – 300% FPL)</td>
<td>1,314</td>
<td>471</td>
</tr>
<tr>
<td>Non-Targeted</td>
<td>0</td>
<td>296</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,424</strong></td>
<td><strong>872</strong></td>
</tr>
</tbody>
</table>
BEST PRACTICES: ADAP AND INSURANCE PURCHASING

• 2014 ACA Open Enrollment
  □ Convened Part B Services and Advisory Committee to decide whether to expand Insurance Assistance Program during open enrollment to include:
    – Enrolling remaining/new HDAP clients with incomes 100 – 300% FPL
    – Expand enrollment efforts outside ACA Marketplace targeting HDAP clients with incomes below 100% FPL
    – Target Ryan White Part B eligible Medicare Part D clients
### BEST PRACTICES: ADAP AND INSURANCE PURCHASING

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Current IAP (2,359)</th>
<th>Med Pt D:</th>
<th>HDAP to IAP Expansion</th>
<th>Residual HDAP</th>
<th>Remaining HDAP</th>
<th>Medicare Part D</th>
<th>Total Cost</th>
<th>Less Rebates</th>
<th>Program Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$11,586,586</td>
<td>50% (768)</td>
<td>&lt;100% FPL: None</td>
<td>&lt;100% FPL: 100% (2360)</td>
<td>$16,632,972 (3,033 * $5,484)</td>
<td>$4,733,952 (768 * $6,164)</td>
<td>$37,306,719</td>
<td>(-) $17,757,400 (3,800 * $4,673)</td>
<td>$19,549,319</td>
</tr>
<tr>
<td><strong>New IAP</strong></td>
<td>$11,586,586</td>
<td>100% (1,536)</td>
<td>&lt;100% FPL: 100% (2360)</td>
<td>&lt;100% FPL: None</td>
<td>$22,032,941 (1,853 * various $)</td>
<td>$4,733,952 (768 * $6,164)</td>
<td>$48,515,331</td>
<td>(-) $23,271,540 (4,980 * $4,673)</td>
<td>$25,243,791</td>
</tr>
<tr>
<td></td>
<td>$11,586,586</td>
<td>100% (1,536)</td>
<td>&lt;100% FPL: None</td>
<td>&lt;100% FPL: None</td>
<td>$44,065,882 (3,706 * various $)</td>
<td>$9,467,904 (1,546 * $6,164)</td>
<td>$65,120,372</td>
<td>(-) $35,519,473 (7,601 * $4673)</td>
<td>$29,600,899</td>
</tr>
</tbody>
</table>
BEST PRACTICES: ADAP AND INSURANCE PURCHASING

• **Option #1**
  ▫ Enroll 50% of Phase 2 HDAP Clients in IAP
  ▫ Enroll 50% of Medicare Part D Clients in IAP
  ▫ (No enrollment of HDAP Clients < 100%)
  ▫ Incremental Cost = $19,549,319 - $17,594,204 = (+) $1,955,115

• **Option #2**
  ▫ Enroll 50% of Phase 2 HDAP Clients in IAP
  ▫ Enroll 50% of Medicare Part D Clients in IAP
  ▫ Enroll 50% of HDAP Clients < 100%
  ▫ Incremental Cost = $25,243,791 - $17,594,204 = (+) $7,649,587

• **Option #3**
  ▫ Enroll 100% of Phase 2 HDAP Clients in IAP
  ▫ Enroll 100% of Medicare Part D Clients in IAP
  ▫ Enroll 100% of HDAP Clients < 100%
  ▫ Incremental Cost = $29,600,899 - $17,594,204 = (+) $12,006,695
BEST PRACTICES: ADAP AND INSURANCE PURCHASING

• Additional Considerations
  ▫ Factors that may drive costs down
    – Medicaid expansion (lower premiums for clients < 100% FPL)
    – Lower uptake of IAP expansion than expected
      ▪ Narrow open enrollment period
      ▪ Limited number of enrollment specialists
  ▫ Factors that may drive costs up
    – Increasing program enrollment (10% increase in FY 13-14)
    – Increasing insurance costs
    – Changes in rebate income
  ▫ Safety “switch”
    – TCA Rules allow program to limit services pending availability of funds (including capping enrollment)
BEST PRACTICES: ADAP AND INSURANCE PURCHASING

• Committee’s Recommendation
  ▫ Option #2
    – Enroll 50% of Phase 2 HDAP Clients in IAP: capped at 693
      ▪ 100 – 200% - 444
      ▪ 200 – 300% - 253
    – Enroll 50% of Medicare Part D Clients in IAP – capped at 768
    – Enroll 50% of HDAP Clients < 100% - capped at 1,180
    – Incremental Cost = $25,243,791 - $17,594,204 = (+) $7,649,587

▫ Central Office Monitoring
  – IAP vendors weekly enrollment reports
  – Expenditures for IAP and HDAP
  – Rebate income

▫ MCM Strategic Planning
  – Narrow window of open enrollment
  – Prioritizing clients
### BEST PRACTICES: ADAP AND INSURANCE PURCHASING

- **2014 ACA Enrollment Results**

<table>
<thead>
<tr>
<th>Target Population</th>
<th>Number to be Enrolled</th>
<th>Number Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>HDAP &lt;100% FPL</td>
<td>1,180</td>
<td>893</td>
</tr>
<tr>
<td>HDAP 100 – 300 FPL</td>
<td>693</td>
<td>315</td>
</tr>
<tr>
<td>Medicare Part D</td>
<td>1,180</td>
<td>250</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3,053</td>
<td>1,458</td>
</tr>
</tbody>
</table>
THANK YOU
INSURANCE PURCHASING IN THE NEW WORLD WITH THE AFFORDABLE CARE ACT

Richard Aleshire, MSW
Program Manager, HIV Client Services
Office of Infectious Disease
Washington State Department of Health
July 30, 2015
WASHINGTON STATE OVERVIEW

General Population
- 7.1 million (2014 estimate)

New HIV diagnoses
- ~510 new cases / year

Prevalent HIV Cases
- 12,275+ persons living with HIV (26% of all PLWH in WA in ADAP)

Clients in ADAP / Health Insurance Program
- ADAP = 3,165 (June 2015)
- Percentage of clients with Insurance = 96%
- Evergreen Health Insurance Program = 1,796 (57% - June 2015)
Geographic Distribution of New HIV Cases, Washington State, 2009-2013 (n = 2,589)

Data reported to the Department of Health as of June 30, 2014. Dots are randomized within Census Tracts to protect patient privacy.
WASHINGTON STATE OVERVIEW (con’t.)

State that:

- Expanded Medicaid
- Has its own health benefit exchange
- Fully embraced the ACA
- Uses an Insurance Benefits Manager (IBM)
- Evergreen Health Insurance Program (EHIP) a division of Lifelong (the largest ASO in the Pacific North West)
- Generous support from State Legislature for HIV program
- Good relationship with and support from our Office of the Insurance Commissioner
SERVICES COVERED

- Premium costs for various policies:
  - Medicare PDP’s and MA-PD’s
  - ESI (employer sponsored insurance)
  - State High Risk Insurance Pool
  - Health Benefit Exchange plans
  - COBRA
  - Plans outside the exchange (for undocumented clients)
- Deductible up to $2,000
- Co-pays and co-insurance to wrap around insurance (for HIV related medical visits, procedures and lab work from a long list of covered services)
## TOTAL CLIENTS IN WA ADAP

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>1,638</td>
<td>51%</td>
</tr>
<tr>
<td>Dual Eligible</td>
<td>201</td>
<td>6%</td>
</tr>
<tr>
<td>Medicaid only</td>
<td>5</td>
<td>0%</td>
</tr>
<tr>
<td>Health Benefit Exchange Plan</td>
<td>644</td>
<td>20%</td>
</tr>
<tr>
<td>Miscellaneous (ESI, COBRA, other)</td>
<td>276</td>
<td>9.5%</td>
</tr>
<tr>
<td>Insured outside the Exchange (undocumented)*</td>
<td>276</td>
<td>9.5%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>125</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3,165</td>
<td>100%</td>
</tr>
</tbody>
</table>

*we can purchase outside the exchange for undocumented although companies are making it harder (requiring SSN or extra pieces of ID – we have gone to our OIC to file a complaint, which was successful)*
<table>
<thead>
<tr>
<th>Category</th>
<th>King County (Seattle)</th>
<th>Other Counties</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of enrollees during the month</td>
<td>964</td>
<td>854</td>
<td>1818</td>
</tr>
<tr>
<td>New apps received this month</td>
<td>26</td>
<td>19</td>
<td>45</td>
</tr>
<tr>
<td>New enrollees this month</td>
<td>25</td>
<td>20</td>
<td>45</td>
</tr>
<tr>
<td>New payables this month</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Disenrolled this month</td>
<td>31</td>
<td>14</td>
<td>45</td>
</tr>
<tr>
<td>Current enrollees in COBRA Plans</td>
<td>8</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Current enrollees in DSHS Plans</td>
<td>24</td>
<td>10</td>
<td>34</td>
</tr>
<tr>
<td>Current enrollees in Group Plans</td>
<td>44</td>
<td>32</td>
<td>76</td>
</tr>
<tr>
<td>Current enrollees in Individual Plans</td>
<td>46</td>
<td>58</td>
<td>104</td>
</tr>
<tr>
<td>Current enrollees in Individual-Smoker Plans</td>
<td>9</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>Current enrollees in Individual-HBE Plans</td>
<td>422</td>
<td>222</td>
<td>644</td>
</tr>
<tr>
<td>Current enrollees in PDPs</td>
<td>181</td>
<td>225</td>
<td>406</td>
</tr>
<tr>
<td>Current enrollees in MA-PDs</td>
<td>76</td>
<td>171</td>
<td>247</td>
</tr>
<tr>
<td>Current enrollees in WSHIP Plans</td>
<td>133</td>
<td>121</td>
<td>254</td>
</tr>
<tr>
<td>Current enrollees in WSHIP-Smoker Plans</td>
<td>13</td>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td>Total Unduplicated Clients</td>
<td>950</td>
<td>846</td>
<td>1,796</td>
</tr>
<tr>
<td>Clients with More than One Payment</td>
<td>6</td>
<td>4</td>
<td>10</td>
</tr>
</tbody>
</table>
WHY ARE WE NOT PAYING FOR EVERYONE’S INSURANCE PREMIUMS?

Although 96% of our clients have insurance, only 57% of them are having their premium paid by us via our IBM.

- Some have insurance through their employer and either they don’t want the risk of disclosure or their employer won’t accept a check for their portion of the insurance.

- Many are on Medicare and either have a no-premium plan or one that is low cost and they want to pay it themselves.

- Some clients want to pay their own premium as feeling that to be their responsibility or their ability to contribute.
RELATIONSHIP BETWEEN DOH, OUR IBM AND CASE MANAGEMENT

- DOH is the ultimate responsible party and makes the final decisions regarding which policies we will pay and develops policy
- The Case Manager helps identify those on their caseload that need insurance or may be in a policy that they want to switch during open enrollment; they refer the client to the IBM for further assistance
- The Insurance Benefits Manager (IBM) assists clients by providing them information about different plans so that they make decisions about the best policy for them while at the same time following the policies of DOH
- The IBM is the “sponsorship representative” and can assist the client enter information into our HBE
- The IBM makes payments to the various carriers on behalf of DOH
- DOH contracts with both Case Management and the IBM
CHOOSING PLANS IN OUR MARKETPLACE

- Working with DOH ADAP, EHIP (our IBM) reviews and evaluates plan benefits annually.
- We jointly determine the most cost effective plans based on Rx coverage and other factors.
- This may not get done until right as Open Enrollment begins.
- In general, EHIP can pay for Silver, Gold, and Platinum plans on the Exchange.
CHOICE OF PLANS DEPENDS ON:

- The plan must have at minimum 50% Drug Coverage
- Must not have a Cap on Coverage (covers all essential health benefits)
- Maximum Out Of Pocket cannot exceed $6,350
- Deductible cannot be more than $2,000
- ARV’s must be on the formulary
- We do not cover/pay for:
  - Mail Order Only Plans
  - Catastrophic Plans
  - Health Savings Accounts (HSA Plans)
  - Bronze Plans
  - “Exclusive Network” Plans
## PLANS OFFERED IN THE EXCHANGE

<table>
<thead>
<tr>
<th></th>
<th>2014 Carriers</th>
<th>2015 Carriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Platinum</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Gold</td>
<td>10</td>
<td>22</td>
</tr>
<tr>
<td>Silver</td>
<td>17</td>
<td>53</td>
</tr>
<tr>
<td>Bronze</td>
<td>12</td>
<td>29</td>
</tr>
<tr>
<td>Catastrophic</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>111</td>
</tr>
</tbody>
</table>

**TOTAL CARRIERS:**

- 2014: 41
- 2015: 111
PLAN APPLICATIONS TO THE EXCHANGE

2016 Carriers (potential) 13

- Platinum 17
- Gold 57
- Silver 99
- Bronze 70
- Catastrophic 3
- Total 246
CURRENT ENROLLMENT IN THE HBE AS OF 6/30/2015 = 644 (20%)

- Platinum – 5
- Gold – 442
- Silver – 194
- Bronze – 3*

*they came to us with these and can’t change now – something is better than nothing – we will be helping them change at open enrollment
APTC

- Program is required to “vigorously pursue” refunds a client receives from the IRS as a result of client income reported to the Washington Health Benefit Exchange being reported too high resulting in a credit owed to the client.

- DOH collects:
  - IRS Form 1040 or 1040A
    (whichever they filed – clients who received a 1095A are not allowed to file a 1040EZ)
  - Health Benefit Exchange Form 1095-A
  - IRS Form 8962 – Premium Tax Credit Worksheet

- The information a person includes on Form 8962 will be used to indicate whether that person is owed a refund or owes the IRS money because of an advance premium tax credit overpayment.

- Line 46 on IRS Form 1040 indicates excess premium tax credits a person owes to the IRS

- Line 69 on IRS Form 1040 indicates net premium tax credit (i.e., amount owed to the taxpayer as refund, which the taxpayer owes to DOH)
VIGOROUS PURSUIT

- DOH and its Insurance Benefit Manager (IBM) developed a letter to clients about APTC’s and what they should do. (sent out on 2-5-15)
- DOH sent an email to all HIV MCM regarding APTC’s and program requirements. (sent on 3-30-15)
- DOH and the IBM held a webinar for HIV MCM regarding what we know and how they can help. (held on 4-22-15)
- IBM sent a 2nd letter to clients about what to do and where to send their refund from the IRS to DOH and what to do if they have a penalty
- DOH sent a letter to clients about how to properly update income with DOH and the Exchange throughout the year to avoid owing ADAP or IRS at tax time for CY2015.