

Clarifications Regarding Clients Eligible for Private Health Insurance and Coverage of Services by Ryan White HIV/AIDS Program

Policy Clarification Notice (PCN) #13-04 (Revised 9/13/2013)

Relates to HAB Policy #13-01, #13-02, #13-05

Scope of Coverage: Ryan White Parts A, B, C, D, and Part F where funding supports direct care and treatment services.

Purpose of PCN

This policy notice clarifies HRSA policy regarding the Ryan White HIV/AIDS Program (RWHAP) and its relationship to clients' eligibility and enrollment in private health insurance.

Background

By statute, RWHAP funds may not be used "for any item or service to the extent that payment has been made, or can reasonably be expected to be made..." by another payment source.¹ This means grantees must assure that funded providers make reasonable efforts to secure non-RWHAP funds whenever possible for services to individual clients. Grantees and their contractors are expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance) to extend finite RWHAP grant resources to new clients and/or needed services.

The RWHAP will continue to be the payer of last resort and will continue to provide those RWHAP services not covered, or partially covered, by public or private health insurance plans.

This PCN clarifies how the RWHAP payer of last resort requirement applies to clients eligible for private health insurance coverage. Grantees and subgrantees should also refer to *Policy Clarification Notice #13-01: Clarifications Regarding Medicaid-Eligible Clients and Coverage of Services by Ryan White HIV/AIDS Program* (<http://hab.hrsa.gov/manageyourgrant/pinspals/1301pcnmedicaideligible.pdf>) to understand the RWHAP expectations and requirements for individuals who may be eligible for Medicaid.

¹ See Sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1), and 2671(i) of the Public Health Service Act.

Instructions

Client Eligibility and Enrollment into Private Health Insurance

For policy years beginning on or after January 1, 2014, insurers will be prohibited from denying coverage because of a pre-existing condition, including HIV/AIDS, and many RWHAP clients may become newly eligible for private health insurance.

Because the RWHAP is the payer of last resort, RWHAP grantees and subgrantees must make every reasonable effort to ensure all uninsured RWHAP clients enroll in any health coverage options for which they may be eligible. This means that grantees and subgrantees are expected to ensure that clients who are determined by the state Medicaid agency and/or the Marketplace to be ineligible for public programs (Medicaid, CHIP, Medicare, etc.) are also assessed for eligibility for private health insurance (e.g., employer-sponsored health plans and health plans offered through the Marketplace).

Under existing guidance, grantees and subgrantees must make every reasonable effort to ensure eligible uninsured RWHAP clients expeditiously enroll in private health insurance plans whenever possible, and inform clients about any consequences for not enrolling. Specifically, RWHAP clients should be informed that under the Affordable Care Act, starting in 2014, if someone can afford it but doesn't have health insurance coverage,² they may have to pay a fee.³ Some individuals may be exempt from the Affordable Care Act's requirement to enroll in health coverage. In these circumstances, the Health Insurance Marketplace or the Internal Revenue Service (IRS) will provide individuals with certificates of exemption if they meet certain criteria.⁴ RWHAP clients who obtain a certificate of exemption may continue to receive services through the RWHAP. Under no

² To meet the individual responsibility requirement under the Affordable Care Act individuals will need coverage such as individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE or certain other coverage. See HealthCare.gov, What if someone doesn't have health insurance?, <https://www.healthcare.gov/what-if-someone-doesnt-have-health-coverage-in-2014>. See also Internal Revenue Service, Questions and Answers on the Individual Shared Responsibility payment Question #5, <http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision>.

³ Starting January 1, 2014, if someone doesn't have a health plan that qualifies as minimum essential coverage, he or she may have to pay a fee that increases every year: from 1% of income (or \$95 per adult, whichever is higher) in 2014 to 2.5% of income (or \$695 per adult) in 2016. The fee for children is half the adult amount. The fee is paid on the 2014 federal income tax form, which is completed in 2015. See HealthCare.gov, What if someone doesn't have health insurance?, <https://www.healthcare.gov/what-if-someone-doesnt-have-health-coverage-in-2014>.

⁴ Individuals may be exempt from paying the fee for failing to enroll in minimum essential coverage if they (1) are members of a religious sect that is recognized as conscientiously opposed to accepting any insurance benefits and adhere to the tenets of that sect; (2) are members of a recognized health care sharing ministry; (3) are members of a federally recognized Indian tribe; (4) have household income below the minimum threshold for filing a tax return; (5) only went without the required coverage for a short coverage gap of less than three consecutive months during the year; (6) were certified by a Health Insurance Marketplace as having suffered a hardship that makes them unable to obtain coverage; (7) cannot afford coverage because the minimum amount the individual must pay for premiums is more than eight percent of the individual's household income; (8) are in jail, prison or similar penal institution or correctional facility after the disposition of charges; and (9) are not U.S. citizens, U.S. nationals, or aliens lawfully present in the U.S. See IRS, Questions on Individual Shared Responsibility Provision Question #6, <http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision>.

circumstances may RWHAP funds be used to pay the fee for a client's failure to enroll in minimum essential coverage.

Grantees should be aware that clients can only enroll in a private health plan during an open enrollment period,⁵ unless they qualify for a special enrollment period based on a qualifying life event, such as moving to a new state, eligibility changes for premium tax credits and/or cost-sharing reductions, or loss of employer-sponsored coverage.⁶ If a client misses the open enrollment period and cannot enroll, it is expected that the grantee will make every reasonable effort to ensure the client enrolls into a private health plan upon the next open enrollment period. If a client qualifies for a special enrollment period, it is expected that the grantee will make every effort to ensure the client enrolls in a private health plan before the special enrollment period closes.

HAB will require grantees to maintain policies regarding the required process for the pursuit of enrollment for all clients, to document the steps during their pursuit of enrollment for all clients, and establish stronger monitoring and enforcement of subgrantee processes to ensure that clients are enrolled in coverage options for which they qualify. If after extensive documented efforts on the part of the grantee, the client remains unenrolled in health care coverage, the client may continue to receive services through the RWHAP.

It is also expected that RWHAP grantees collect and maintain documentation verifying client eligibility for other health coverage or a certificate of exemption from the Marketplace or IRS. *See Policy Clarification Notice #13-02: Clarifications on Ryan White Program Client Eligibility Determinations and Recertifications Requirement* (<http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1302clienteligibility.pdf>).

Effective Date of Coverage

Individuals enrolling in a new private health plan may experience a gap in coverage between submission of their enrollment application and the date on which the health plan will begin to pay for services received by the individual. Generally, payments for items or services will not be made, or cannot reasonably be expected to be made, by the health plan until the effective date of coverage begins. As such, RWHAP funds may be used to pay for items or services up until a client's effective date of coverage if those items or services are not covered by any other funding source. RWHAP funds may not be used to pay for items or services received on or after the effective date of coverage if they are covered by the client's insurance plan. In the event that RWHAP-funded services were provided on or after the effective date of coverage, grantees and subgrantees providing those services must

⁵ The initial open enrollment period for the individual Marketplaces will be from October 1, 2013, through March 31, 2014. After the initial open enrollment period, annual open enrollment will occur from October 15 to December 7 every year. See 45 CFR 155.410.

⁶ See 45 CFR 155.420(d) for more examples of events that may trigger a special enrollment period.

make every reasonable effort to collect payment from the private insurance plan for those RWHAP-funded services.

Coverage of Services by Ryan White HIV/AIDS Program for Clients Enrolled in Private Health Insurance

Once a client is enrolled in a private health plan, RWHAP funds may only be used to pay for any Ryan White HIV/AIDS Program services not covered or partially covered by the client's private health plan.

In addition, RWHAP grantees are strongly encouraged to use RWHAP funds to help clients purchase and maintain health insurance coverage, if cost-effective and in accordance with RWHAP policy. *See Policy Clarification Notice #13-05 Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance* (<http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1305premiumcostsharing.pdf>).

Health Plan Provider Networks

RWHAP funds generally may not be used to pay for services that the client receives from a provider that does not belong to the client's health plan's network, unless the client is receiving services that could not have been obtained from an in-network provider.

Some health plans may have "tiered" networks that require individuals to pay more to see some providers. As such, providers in any covered tier are not considered "out-of-network." Grantees and subgrantees are not prohibited from using RWHAP funds to pay for out-of-pocket expenses when the client receives services from a provider in a higher-cost tier, including client out-of-pocket expenses. However, the effect of such payments on available resources should be considered by grantees and subgrantees prior to making such allocations.