October 24, 2000

# AIDS/HIV HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

Iowa
Department
of
Human Services

Page

# OVERVIEW

The AIDS/HIV Health Insurance Premium Payment Program (HIPP) pays for continuing health insurance coverage for people living with AIDS or HIV-related illnesses who can no longer pay their insurance premiums.

When the person is enrolled in a policy that provides health insurance coverage to other members of the family, the program pays only that portion of the premium required for coverage for the policyholder with AIDS or an HIV-related illness, unless modification would result in a loss of coverage for the person living with AIDS or HIV-related illness.

This program is funded with 100% state funds. It was originally established by 1992 Iowa Acts, Second Extraordinary Session, Chapter 1001, section 409, subsection 6. Its authorization is renewed annually in the Department's appropriations bill.

The HIPP Unit in the Division of Medical Services administers the program. The HIPP unit is responsible for:

- Maintaining the application log.
- Determining initial and ongoing eligibility.
- Tracking expenditures and reserving funds for future premium payments.
- Tracking the remaining unobligated funds.
- Maintaining the waiting list.

County office responsibility is to receive applications, as referenced in chapter 8-M, **AIDS/HIV HEALTH INSURANCE PREMIUM PAYMENT PROGRAM**.

## Confidentiality

**Legal reference:** Iowa Code Section 141.23; 441 IAC 75.22(10)

The Department must protect the confidentiality of people applying for or participating in the program. When it is necessary to contact a third party to obtain information in order to determine initial or ongoing eligibility, have the client sign form 470-0429, *Consent to Release or Obtain Information*, authorizing the Department to make the contact.

When contacts are made, acknowledge only that information is needed to determine eligibility for public assistance. In no case acknowledge that a person has AIDS or an HIV-related illness without express written consent of the client.

## Definitions

In this chapter:

- "AIDS" means acquired immune deficiency syndrome, as defined by the Centers for Disease Control of the United States Department of Health and Human Services.
- "HIV" means the human immunodeficiency virus identified as the causative agent of AIDS.
- "Health insurance" means protection that provides payment of benefits for covered sickness or injury.
- "Group health insurance" means any plan available through an employer to provide health care to the employer's employees, former employees, or the families of the employees or former employees. This includes self-insured employer plans.

## APPLICATION PROCESSING

**Legal reference:** 441 IAC 75.22(2)"a" and "b"

People applying for the program must complete form 470-2953, *AIDS/HIV Health Insurance Premium Payment Application*, which is included in Comm. 99, "The Iowa AIDS/HIV Health Insurance Premium Payment Program." Comm. 99 contains a business reply envelope to send the application directly to the HIPP Unit. However, applicants can also file the application at the county DHS office.

An application is considered filed on the date it is stamped in any DHS county office or in Central Office, Division of Medical Services. If the county office receives the application:

- The application is date stamped.
- The IM worker immediately calls the HIPP Unit to get a log number.
- After entering the log number, the IM worker sends the application and any accompanying documents to the HIPP Unit via state mail in a sealed envelope.

When the application is received in the HIPP Unit, date stamp the application. Since applicants are served on a "first come, first served" basis, it is important that applications are logged in upon receipt.

If portions of the application are not complete, photocopy the pages needing completion. Return the original pages to the applicant with a letter identifying what questions need completion. The applicant has ten calendar days in which to provide the information.

Make a decision on an application within 30 days from the date the application is filed. If the applicant will lose insurance coverage due to nonpayment of premiums before a decision is made, presumed eligibility may be granted under certain circumstances. See **Presumed Eligibility**.

Since a limited amount of funding is appropriated to support the program, when an applicant is approved, "reserve" funds necessary to maintain the insurance policy through the end of the fiscal year. These reserved funds are considered obligated.

> Ms. C is approved for the AIDS/HIV HIPP program. Premium payments of $100 per month are made beginning with the month of October. To ensure that Ms. C is able to participate in the program until the end of the fiscal year, $900 of the total appropriation is "reserved" for payment of Ms. C's premiums ($100 per month for October through June).
>
> If Ms. C loses eligibility to participate in the program, any unspent amount of the obligated funds becomes available for other applicants.

When the actual premium expenditures plus the reserved funds equal the appropriation, deny all subsequent applications for the program. If the applicant would be eligible for the program except for the lack of funding, place the applicant's name on a waiting list. Mail a *Notice of Decision* within ten calendar days informing the applicant that all funding has been obligated. State in the notice that either:

- The applicant meets eligibility requirements but no funds are available, so the applicant will be placed on the waiting list, or
- The applicant does not meet eligibility requirements.

When funding becomes available, consider the first applicant on the waiting list for participation in the program.

## Waiting List

**Legal reference:** 441 IAC 75.22(2)"d"

Place applicants on a statewide waiting list according to the order in which the completed applications were filed. If more than one application is received at one time, enter the applicants on the waiting list on the basis of the day of the month of the applicant's birthday, with the lowest number being first on the waiting list. Decide any further tie by the month of birth, January being month one and the lowest number.

1. Mr. G applies for the AIDS/HIV HIPP program and meets all eligibility criteria. However, there are no unobligated funds with which to pay his health insurance premiums. Therefore, a *Notice of Decision* is sent to Mr. G denying participation in the program. Mr. G's name is added to the waiting list, based on the date his application was filed.

2. Same as Example 1, except that Mr. M also files an application on the same day as Mr. G. Mr. G's birthday is February 19. Mr. M's birthday is December 10. Mr. M's name is placed on the waiting list first.

3. Same as Example 2, except that both Mr. G and Mr. M were born on the nineteenth of the month. In this case, since Mr. G's birth date is in February and Mr. M's birth date is in December, Mr. G's name is placed on the waiting list first.

# ELIGIBILITY

The following sections explain:

- Nonfinancial eligibility requirements.
- Resource eligibility requirements.
- Income eligibility requirements.
- Presumed eligibility.

## Nonfinancial Eligibility

**Legal reference:** 441 IAC 75.22(249A)

An applicant or recipient must meet the following nonfinancial eligibility requirements in order to qualify for participation in the AIDS/HIV HIPP program:

- Be a resident of Iowa. See 8-C, **RESIDENCY**.
- Be ineligible for any Medicaid coverage group. **Exception:** Applicants in the Medically Needy program who are required to meet a spenddown or use the insurance premium to get a zero spenddown are considered to meet this requirement.

> Ms. Z applies for the AIDS/HIV HIPP program. She is eligible for the Medically Needy program with a $200 spenddown. (The health insurance is being used as a deduction.) If she is otherwise eligible, Ms. Z's premiums will be paid under the AIDS/HIV HIPP program.

  If it appears that Medicaid eligibility exists, the person is required to apply for Medicaid. HIPP participation is denied or canceled with timely notice if the person fails to comply.

- Have a physician's statement (form 470-2958, *Physician's Verification of Diagnosis*) verifying that the policyholder or the policyholder's spouse has an AIDS or HIV diagnosis, and that the illness either:
  - Does not allow the person to work in the current position, or
  - Has resulted in a reduction in the number of hours that the person can work.
- Be the policyholder or the spouse of the policyholder of an individual or group health plan that is cost-effective based on the amount of premium and the services covered under the plan. For example if the premium is $300 per month ($3,600 annually) but the policy pays a maximum of $3,000 per year, the policy is not cost-effective.

## Resources

**Legal reference:** 441 IAC 75.22(1)"f"

The countable liquid resources must not exceed $10,000 per household. When determining eligibility, consider the resources of the applicant, the applicant's spouse, and the applicant's children under age 18 who are living with the applicant. Examples of countable liquid resources are:

- Unobligated cash
- Bank accounts
- Stocks
- Bonds

Resources that do not count are those that meet the IRS definition of a retirement account, such as IRAs, Keogh plans, IPERS, and deferred compensation accounts.

The applicant or recipient must provide verification before initial or ongoing eligibility can be granted. **Exception:** Resources do not have to be verified to grant presumed eligibility. See **Presumed Eligibility**.

## Income

**Legal reference:** 441 IAC 75.22(1)"e" and 75.22(2)

When determining income eligibility, consider the gross earned and unearned income of the applicant, the applicant's spouse, and the applicant's children under age 18 who live with the applicant. The gross income of the household cannot exceed 300% of the federal poverty level for the same size family. (See 8-E, **SSI-Related Limits**.)

Use the definition of countable income used by the SSI program, but do not use the SSI policies regarding deductions, deeming, diversions, and filing units. See 8-E:

- **INCOME POLICIES FOR SSI-RELATED COVERAGE GROUPS**
- **TYPES OF SSI-RELATED INCOME**
- **SSI-RELATED IN-KIND INCOME**
- **SSI-RELATED SELF-EMPLOYMENT INCOME**
- **SSI-RELATED VETERANS AFFAIRS PAYMENTS**

You must verify income before granting initial or ongoing eligibility, but you can grant presumed eligibility without income verification. See **Presumed Eligibility**.

1. Household composition: Ms. K, age 35, diagnosed with AIDS
Sally, age 10
Susie, age 8

The household has the following monthly income:

| | | | |
|---|---|---|---|
| Ms. K: | $ | 650 | Social security disability |
| | $ | 300 | Child support |
| | $ | 3 | Prorated interest income (paid quarterly) |
| Sally: | $ | 250 | Social security |
| | $ | 3 | Prorated interest income (paid quarterly) |
| Susie: | $ | 250 | Social security |
| | $ | 3 | Prorated interest income (paid quarterly) |

SSI policy does not consider infrequent unearned income of less than $20 when determining eligibility. Therefore, the interest income is not considered toward the income limit.

The household's total countable gross income is $1,450 per month. Since the countable income is less than 300% of the federal poverty level for a three-person household, eligibility is approved if all other criteria are met.

2. Household composition: Mr. M, aged 27, diagnosed with AIDS
Mrs. M, aged 26

The household has the following monthly income:

| | | | |
|---|---|---|---|
| Mr. M: | $ | 950 | Disability income through previous employer |
| Mrs. M: | $ | 2,500 | Earned income |
| Total | $ | 3,450 | |

Since the gross income exceeds the income limit for a two-person household, the application is denied.

(**Note:** SSI policy allows a $20 general disregard of unearned income and $65 + 1/2 of earned income. These disregards are not allowed when determining the amount of income to consider toward the limit.)

## Presumed Eligibility

**Legal reference:** 441 IAC 75.22(3)

The applicant may be presumed eligible to participate in the program for a period of two calendar months or until a decision regarding eligibility can be made, whichever is earlier.

The goal of presumed eligibility is to allow the Department to pay premiums for policies that may otherwise lapse before an eligibility determination can be made. Presumed eligibility is granted when the insurance policy will lapse, but the person appears to be eligible for the program, based on income and resource statements made on the application and verification of the person's diagnosis.

Presumed eligibility is granted when:

- The application is accompanied by a completed form 470-2958, *Physician's Verification of Diagnosis*, verifying that the policyholder has an AIDS or an HIV-related illness.
- The application is accompanied by a premium statement from the insurance carrier indicating the policy will lapse before an eligibility determination can be made.
- It can be reasonably anticipated that the applicant will be determined eligible based on income and resource statements made on the application.

Premiums may be paid for a maximum of two months during the presumed eligibility period. After this time, the person must be determined eligible or premium payments will end.

Review all applications for completeness within two working days of receipt. If a formal eligibility determination can be made before the lapse of the policy, do not grant presumed eligibility.

If the application is accompanied by a policy cancellation notice and a completed form 470-2958, *Physician's Verification of Diagnosis*, review the income and resource sections of the application. If it appears the applicant will meet income and resource limits, grant presumed eligibility.

If the income and resource sections of the application are not complete, return the form to the applicant for completion. Do not grant presumed eligibility unless these sections of the application are complete.

Notify the applicant of the decision to grant presumed eligibility and the time period for which premiums may be paid. Presumed eligibility ends when the eligibility process is completed. Timely notice is not required to end premium payments when it is determined the person is not eligible to participate in the program.

## PREMIUM PAYMENT

**Legal reference:** 441 IAC 75.22(4), 75.22(5), and 75.21(6)

Premium payments begin the month of application or the effective date of eligibility, whichever is later.

When the person is enrolled in a policy that provides health insurance coverage to other members of the family, only that portion of the premium required to maintain coverage for the policyholder with AIDS or an HIV-related illness is paid, unless modification of the policy would result in a loss of coverage for the person with AIDS or HIV-related illness.

1. Mr. J and his family are enrolled in the group health insurance plan through Mr. J's employer. Mr. J has AIDS and is unable to maintain full-time employment. Since Mr. J's hours have been reduced, he no longer qualifies for health insurance benefits through the employer.

   Mr. J may elect to continue the coverage for 18 months under the COBRA provisions. (The employer no longer shares in the cost of the insurance plan.) The premium is $130.00 per month to continue carrying insurance coverage for Mr. J. Family coverage is $450.00 per month. Under the AIDS/HIV HIPP program, only Mr. J's premium will be paid.

2. Same as Example 1, except that Mr. J's policy states that if Mr. J requests any amendments to the policy, the insurance carrier has the right to require underwriting. (Underwriting is the process by which the insurance carrier reviews the health history of the family and may deny coverage of certain persons or illnesses) before approving any amendments.

   Since Mr. J has AIDS, the insurance carrier is likely to drop his coverage if he requests to change the policy from family to single coverage. The Department will pay the cost of the family coverage in order to maintain coverage for Mr. J.

Verify the date premiums are due and the frequency of payments. For non-employer-related health plans, a premium notice that establishes the amount of the premium and the frequency it is paid serves as verification. For employer-related health plans, obtain a completed form 470-3036, *Employer Verification of Insurance Coverage*, to:

- Verify the effective date of coverage and the amount of the premium, and
- Determine if the employer will accept direct payment of premiums.

Enter the due date and the frequency of premium payments on the Premium Payment Detail Information screen of the HIPP system. Warrants are generated automatically based on this information until:

- The information changes, or
- The policy end date is reached (e.g. COBRA coverage).

Make payments of health insurance premiums in accordance with HIPP policy.

Use form 470-3683, *Notice of Premium Payment--State Only*, to notify the household that the Department will pay the health insurance premium. The form identifies:

- The people for whom the premium is being paid.
- The date premium payments will begin.
- The amount of the payments.
- How often the premiums will be paid.
- Specific information regarding the insurance carrier.

## CONTINUING ELIGIBILITY

**Legal reference:** 441 IAC 75.27(7), 75.22(8), and 75.22(9)

Review the circumstances of the household quarterly to ensure that the household continues to be eligible. Form 470-2877, *AIDS/HIV Health Insurance Premium Payment Program Review*, is mailed to the client in the last month of the quarter.

If the review form is returned incomplete or if additional information is needed, the client has ten calendar days to provide the requested information. If not provided, cancel payment of premiums with timely notice.

If it appears that the client may be eligible for Medicaid, the client must apply for Medicaid as a condition of continued eligibility for the AIDS/HIV HIPP program. If the person becomes eligible for Medicaid, premium payments shall be paid under the HIPP program if all other eligibility factors are met.

## Canceling Premium Payments

**Legal reference:** 441 IAC 75.27(7), 75.22(8), and 75.22(9)

Cancel premium payments when one of the following conditions occurs:

- The person becomes eligible for Medicaid and the premium is paid under HIPP.
- The insurance coverage is no longer available.
- Funding for the program is exhausted.
- The person with AIDS or HIV-related illness dies.
- The person no longer meets eligibility requirements.
- The person does not provide requested information.

## Notice Requirements

**Legal reference:** 441 IAC 7.7(1)

Send a timely and adequate notice to inform the recipient of a decision to discontinue payment of health insurance premiums when the recipient no longer meets eligibility requirements of the program or fails to cooperate in providing information to establish eligibility.

Provide a timely notice when:

- The person no longer meets eligibility requirements
- The person does not provide requested information

Provide an adequate notice:

- To inform the applicant of the initial decision regarding eligibility to participate in the program.
- To inform the client that premiums are being discontinued in the following circumstances:
  - Medicaid eligibility has been attained and premium payments will be made under the HIPP program.
  - The insurance policy is no longer available.
  - Funding for the program is exhausted.
  - The person with AIDS or an HIV-related illness dies.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

October 24, 2000

**GENERAL LETTER NO. 5-C-4**

ISSUED BY: Bureau of Health Care Purchasing and Quality Management, Division of Medical Services

SUBJECT: Employees' Manual, Title 5, Chapter C, ***AIDS/HIV HEALTH INSURANCE PREMIUM PAYMENT PROGRAM***, Title page, new; Contents (page 1), new; and pages 1 through 12, new.

**Summary**

This chapter contains worker instructions for the operation of the AIDS/HIV Health Insurance Premium Payment Program.

**Effective Date**

Immediately

**Material Superseded**

None

**Additional Information**

Refer questions about this general letter to your regional benefit payment administrator.