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 | ADMINISTRATIVE DIRECTIVE |
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TRANSMITTAL: 91 ADM-54

TO: Commissioners of
 Social Services

DIVISION: Medical
 Assistance

DATE: December 31, 1991

SUBJECT: AIDS: Health Insurance Continuation Program for Persons with
 AIDS (AIDS Health Insurance Program)

SUGGESTED
 DISTRIBUTION: Medical Assistance Staff Third Party Resource Staff
 Public Assistance Staff
 Adult Services Staff
 Fair Hearing Staff
 CASA/Long Term Care Coordinators
 Staff Development Coordinators

CONTACT
 PERSON: General: Bobbi Krusik, 1-800-342-3715, extension
 3-5562; MA Eligibility: your MA Eligibility County
 Representative, 1-800-342-3715, extension 3-7851 or
 your New York City Representative at (212) 417-4853

ATTACHMENTS: See Appendix I for listing of Attachments

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
		358 360-7.5(i)	104 369-k.-n.		COBRA 1985 (P.L. 99-272)

I. PURPOSE

The purpose of this Administrative Directive is to provide instructions to social services districts for implementation of the Health Insurance Continuation Program for Persons with AIDS (AIDS Health Insurance Program).

II. BACKGROUND

A substantial number of persons with AIDS are employed at the onset of the disease and have health insurance coverage under a group health plan maintained by their employer. As the disease progresses and persons become more incapacitated, they are no longer able to work or can work on a part-time basis only. Health insurance coverage is lost because of inability to pay the premiums. Eventually, the costs of care consume any financial assets persons have; they spend down to the Medical Assistance (MA) eligibility levels and become MA recipients.

Chapter 165 of the Laws of 1991 allows the MA program to pay health insurance premiums on behalf of all eligible persons entitled to continuation coverage under provisions of Section 10002 of the Consolidated Omnibus Reconciliation Act (COBRA) of 1985, when cost-effective to do so. Chapter 165 also establishes a Health Insurance Continuation Program for Persons with AIDS (AIDS Health Insurance Program) which permits the use of MA funds for payment of health insurance premiums for persons with AIDS (PWA) or HIV-related illness who are no longer able to work or can work for a reduced amount of hours only and who do not qualify for benefits under the COBRA Continuation Coverage Program (CCP).

III. PROGRAM IMPLICATIONS

A. Impact

Use of MA monies to assist PWA or persons with HIV-related illness in maintaining their health insurance coverage minimizes the likelihood that such persons will impoverish themselves and become fully eligible for MA. Potential MA expenditures for hospital inpatient, emergency room, outpatient, and clinic services will be deferred or averted. Continuity of care for individuals can be maintained through treatment by existing providers.

B. Definitions

As used in this directive, the following definitions apply:

1. Program: the AIDS Health Insurance Program.

2. Health Insurance: Insurance or an employee benefit plan against sickness, ailment or bodily injury of the employee and, if covered, his or her dependents, other than
 - a. insurance or an employee benefit plan providing disability benefits; or
 - b. benefits received under the MA program.
3. Health Insurance Costs: the premiums or contributions paid for health insurance by or on behalf of a person with AIDS or HIV-related illness; does not include deductibles or co-payments.
4. Persons with AIDS (PWA) or HIV-Related Illness: persons who are diagnosed as having acquired immune deficiency syndrome (AIDS) as defined by the Center for Disease Control or who have illnesses, other than AIDS, which are included in the standard for Clinical/Symptomatic HIV illness established by the AIDS Institute of the New York State Department of Health.
5. Poverty Line: the official federal income poverty line applicable to a family of the same size as the applicant's family.
6. Conversion Right: the privilege to change an insurance policy to a direct payment contract without requiring evidence of insurability; right is applicable to persons upon termination of the insurance coverage that was available to them through their employer (including continuation coverage under state or federal law).

C. Eligibility Criteria

In order for a PWA or a person with HIV-related illness to be eligible for the program, certain criteria must be met.

1. The person must be unemployed, have participated in the health insurance plan provided by his or her prior employer, and be eligible to continue his or her participation in the plan or to convert his or her coverage to individual coverage; or
2. The person must be employed, have participated in the health insurance plan offered by his or her prior employer, be eligible to continue his or her participation in the plan or to convert his or her coverage to individual coverage, and be ineligible to participate in the health insurance plan that his or her current employer provides (because, for example, the plan excludes coverage for a pre-existing condition), or the current employer does not offer a plan; or
3. The person must be self-employed or have been self-employed, have maintained health insurance coverage while self-employed,

and be eligible to continue his or her participation in the plan or to convert his or her coverage to individual coverage; and

4. The person must reside in a household whose net household income, as determined by the Supplemental Security Income (SSI) budgeting methodology does not exceed 185 percent of the poverty line.

Medical and remedial expenses such as clinic services, dental services, and home health services, incurred during the month of application for the program, cannot be deducted to determine net household income; and

5. The person must be ineligible for benefits under the MA program, including the CCP.

All household resources are exempt from the eligibility determination for the program. In addition, there is no requirement for a cost-effectiveness test.

D. Budgeting Methodology

Policies outlined in the recently issued Administrative Directive, "COBRA Continuation Coverage Program", are applicable for determinations of financial eligibility under the AIDS Health Insurance Program, except that household resources and cost-effectiveness must not be considered in such determinations. Therefore, if an adult PWA or a person with HIV-related illness in a household is determined to be financially eligible for the program based on his or her income, any children under the age of 18 residing in the household will automatically be eligible for the program. If the PWA or the person with HIV-related illness is under the age of 18, meets the employment eligibility criteria identified in section III.C. of this directive, and resides in a household with an adult or adults determined to be financially ineligible for the program, a separate eligibility determination must be made for the PWA or the person with HIV-related illness under the age of 18.

E. Time Frame for Determining Eligibility

Under COBRA requirements, persons in employee groups of 20 or more generally have 60 days from the date of termination of employment/reduction in hours or the date of the coverage continuation notice from the plan administrator, whichever is later, to elect to continue their health insurance coverage. COBRA continuation provisions are not applicable to persons in employee groups of less than 20 employees. However, continuation rights for such persons are governed by the New York State Insurance Law and must be exercised no later than 31 days after termination of employment.

State Insurance Law also establishes time frames for election of conversion rights following the continuation period. Depending

on the type of insurance contract, this may be 31 days after termination of prior insurance or 45 days after termination of employment or the group policy.

Persons seeking benefits under the AIDS Health Insurance Program may be applying for the program at various times during various continuation or conversion election periods. Districts may have to work within short time frames to determine eligibility for the program and must not delay payment of premiums pending receipt of documentation verifying financial eligibility for the program or ineligibility for MA.

F. Payment

Payments must be made in full for the health insurance premiums of persons determined to be eligible under the program. Payment cannot be made for out-of-pocket expenses such as deductibles or co-payments which may be incurred by eligible persons. Also, payment cannot be made to purchase health insurance which persons do not have.

First premiums must be paid within specified time frames as required by COBRA or by New York State Insurance Law. Failure to make timely payment will result in termination of coverage. Subsequent payments must be made at frequencies required by each person's health insurance plan and may vary from person to person. Plans may require payments on a monthly, quarterly, or semi-annual basis.

In the event that payments have been made for premiums of persons subsequently determined to be ineligible for the program, social services districts may request voluntary repayment of the premium amount. Or, districts may pursue recovery of the payment under provisions of Section 104 of the Social Services Law.

Attachment I summarizes health insurance continuation rights under COBRA and the New York State Insurance Law, including time frames for election periods and first premium payments. Conversion rights under the State Insurance Law are also summarized in this Attachment.

G. Reimbursement

Federal financial participation (FFP) is not available for health insurance premiums paid under the AIDS Health Insurance Program. Costs of premiums are shared equally by the state and social services districts.

H. Discontinuance of Benefits under Program

A person's eligibility for benefits under the program must be discontinued if the person:

1. fails to complete the MA application or refuses to supply required documentation for determining MA eligibility ; or

2. is determined to reside in a household whose net income exceeds 185 percent of the poverty line; or
3. becomes eligible for benefits under the Medicare program. Under COBRA requirements, duration of continuation coverage for persons whose employment is terminated or reduced and who are determined to be totally disabled according to Title II or Title XIV of the Social Security Act is limited to 29 months. Upon expiration of coverage, the person becomes eligible for benefits under Medicare; or
4. becomes eligible for benefits under the MA program, including the CCP; or
5. establishes residence in another state.

IV. REQUIRED ACTION

Social services districts must take the following actions to implement the program:

A. Determine Eligibility of Persons for the Program

Social services districts must conduct a face-to-face interview with each person applying for the program or with an authorized representative applying on the person's behalf (e.g., a relative, significant other, staff person from an AIDS Care Center). To initially authorize payment of health insurance premiums, only limited personal information and documentation of medical eligibility must be obtained. Net household income may be based on the applicant's or authorized representative's verbal statement; verification is not required. Determination of MA eligibility or ineligibility may also be pended.

1. Documentation of Medical Eligibility

A person or authorized representative applying for the program on the person's behalf must provide a letter or written statement from a physician indicating that the person has AIDS, HIV infection or symptoms of HIV disease, or, must authorize the release of medical documentation by his/her physician to the social services district by completing and signing the Department of Health (DOH)-2557, "Authorization for Release of Confidential HIV-Related Information." Completion of the DSS-486 (Disability Determination) by a physician is not required. All medical documentation must be kept confidential.

2. Household Income

Net household income must not exceed 185 percent of the poverty line according to the following income standard:

Income Standard*	Household Size	
	<u>One</u>	<u>Two</u>
Net Annual Income	\$12,247	\$16,428
Net Monthly Income	\$ 1,020	\$ 1,369

*185 percent of the poverty line effective July 1, 1991

B. Authorize Payment of Health Insurance Premiums for Eligible Persons

Districts may authorize payments of health insurance premiums on behalf of eligible persons for a maximum period of twelve months. However, because persons will be in various stages of disease, an annual authorization period may not be appropriate for every person. Depending on a person's medical status and other factors such as the person's premium schedule, the authorization period may need to be shorter.

A determination of MA eligibility or ineligibility must be made no later than the fourth month after initial authorization of premium payments under the AIDS Health Insurance Program. Districts must advise each person who will receive benefits under the program, or the individual applying for benefits on behalf of the person, of the need for completion of the MA application as a condition of continued eligibility for the program. Districts must also inform each person that failure to comply with this requirement will result in discontinuation of benefits under the program.

Reauthorization of benefits under the program must be based on the eligibility criteria identified in section III.C of this directive. Districts must continue to make determinations of MA eligibility or ineligibility according to the guidelines in the preceding paragraph.

Persons receiving benefits under the program will not be issued MA identification cards.

C. Notify Persons of Eligibility for, Denial, or Discontinuance of Program Benefits

Districts must provide persons with written notice of eligibility for or denial of benefits under the AIDS Health Insurance Program. Districts must also notify persons of discontinuance of benefits under the program. Persons are entitled to fair hearing rights according to 18 NYCRR, Part 358.

A standard written notice must be used. Attachment III, "Notice of Action on Application/Benefit for Medical Assistance Payment of Health Insurance Premiums Under the AIDS Health Insurance Program", presents the standard notice. Districts should reproduce the notice, without modification, until such time as it becomes available from the Department.

If benefits are discontinued because the person does not complete the MA application, or fails to provide the necessary documentation for determining MA eligibility within the allowable four months, or the documentation provided shows that the person does not meet the eligibility requirements for the program specified in section III.C. of this directive, MA payment of the person's health insurance premiums must be terminated. In these situations, the person must be sent an adequate notice of discontinuance, but is not entitled to aid continuing (continued MA payment of the person's health insurance premiums) if a fair hearing is requested.

If benefits under the program are discontinued because the person is determined to be eligible for MA, the person must be sent the standard notice and the DSS-3622 advising him or her of MA eligibility. If benefits under the program are discontinued because the PWA or HIV-related illness is determined to be eligible for benefits under the CCP, the person must be sent the standard CCP notice included in the recently issued Administrative Directive, "COBRA Continuation Coverage Program" in addition to the standard notice for the AIDS Health Insurance Program.

D. Pay Health Insurance Premiums on Behalf of Eligible Persons

Districts must obtain information which will enable payment of the premiums to be made. This would include the amount of the premium, the frequency of the payments, the dates by which premiums must be made and any other required information, such as the policy number.

Payments will usually be made directly to the insurance company or to the employer. When a premium is paid through a payroll deduction, the eligible person may be reimbursed.

If an eligible person or an authorized representative on behalf of the person has paid the insurance premium in advance of initially applying for the program, the person or the representative may be reimbursed for any payment made as of the first of the month 3 months before the date of application, if otherwise eligible during that period. In no event may reimbursement be made for a coverage period prior to July 1, 1991. If, because of time constraints, a person or an authorized representative has paid the insurance premium after applying for the program in order to ensure the continued availability of the coverage, the person or representative may also be reimbursed for that payment.

Social services districts other than New York City may elect to have health insurance premiums for eligible persons paid by the Benefits Issuance and Control System (BICS). Or, if the number of

eligible persons is limited, districts may make the payments directly and retroactively claim reimbursement for expenditures on the Schedule E.

E. Complete and Submit Reports to the Department

Social services districts must submit semi-annual reports on the program to the Department. The reports must be prepared on a standard form. The standard reporting instrument is found in Attachment II. Districts experiencing no program activity during a particular reporting period will not be expected to complete the total report, but must complete and submit a selected portion as instructed on the instrument.

Districts should duplicate Attachment II for reporting purposes. For the first program report only, the report should be prepared for the nine month period beginning July 1, 1991, and ending March 31, 1992. This report should be submitted 30 business days following the end of the reporting period. Subsequent reports should be prepared for six month intervals thereafter, beginning with the April 1, 1992-September 30, 1992 reporting period and submitted 30 business days following the end of each reporting period.

V. SYSTEMS IMPLICATIONS

A. WMS - Upstate

Effective October 28, 1991, WMS support became available to enable BICS to pay health insurance premiums of persons determined eligible for the program. In BICS districts, these payments should be entered into voucher processing and paid through BICS as any other health insurance payments. The Composites will identify these expenditures under the RF-2, Schedule E HMOP breakout.

MA Coverage Code 17 (HEALTH INSURANCE CONTINUATION ONLY), in conjunction with Payment Type Code L4 (HEALTH INSURANCE CONTINUATION-185 PERCENT POVERTY), will enable health insurance premium payments to be made for qualifying PWAs or persons with HIV-related illness whose income does not exceed 185 percent of the poverty line. Entry of Coverage Code 17 is allowed only for Case Type 20 individuals, and requires entry of Payment Type Code L4, L5, or L6 (See the recently issued Administrative Directive, "COBRA Continuation Coverage Program" for information regarding the use of Codes L5 and L6). Coverage Code 17 recipients are entitled to MA payment of the health insurance premium only and will receive no other MA benefit. Also, FFP will not be available for health insurance premiums paid with Payment Type Code L4, regardless of the Individual Categorical Code entered on screen 3 of WMS.

When a determination is made that a person eligible for the program may be potentially eligible for one month outpatient coverage or six month inpatient coverage via the excess income program, Coverage Code 17 should be initially authorized. If the monthly or

six month excess is met, districts should enter Coverage Code 02 (Outpatient Coverage) or 01, respectively, for the period that the spenddown has been met. If the Authorization To Date of the transaction containing the initially entered Coverage Code 17 extends beyond the 02 or 01 coverage period, WMS will generate Coverage Code 17 with a coverage To Date equal to the Authorization To Date, as is currently done with Coverage Codes 06 and 09.

Screen 6 edits for Payment Type Code L4 are similar to those for Payment Type 24 (Health Insurance Premium), with the following exceptions:

1. L4 requires Special Claiming Category Code R (All Other -FNP); and
2. The Premium Payment Date cannot precede July 1, 1991; and
3. Entry of Code L4 is permitted only if the case contains at least one individual with Coverage Code 17.

If a PWA or a person with HIV-related illness initially authorized with Coverage Code 17 and Payment Type Code L4 becomes eligible for the CCP, Code L5 should be used for subsequent premium payments in order to obtain federal participation. It may also be necessary to upgrade the coverage from Code 17, if, for example, the individual qualifies for 01 (Full) or 02 (Outpatient) Coverage. However, if such a coverage upgrade becomes necessary, and if the previously entered L4 payment line is displayed on Line 1 of screen 6 during the U/M transaction, Error #820 (Payment Type Code L4 Requires Coverage Code 17) will be generated due to the absence of a person with Coverage Code 17. In order to prevent the L4 payment line from being "pulled down" during subsequent transactions, it is recommended that Issuance Code 2 (Once Only) be included during the entry of the L4 payment line. Although Issuance Code 2 will prevent the payment line from being displayed during subsequent transactions, the payment line will be available on Inquiry until a subsequent payment line is entered on Line 1 of screen 6.

B. WMS - New York City

Instructions for New York City procedures will be forthcoming.

VI. ADDITIONAL INFORMATION

A major exclusion in many existing group health insurance policies is coverage for drugs. The AIDS Drug Assistance Program (ADAP) provides assistance to persons with AIDS or HIV related illness who meet certain income standards. For example: a household of one whose liquid assets do not exceed \$25,000 and whose gross annual income is \$44,000 is eligible.

Persons eligible for the AIDS Health Insurance Program will usually be eligible for ADAP and, if not receiving benefits under that program, should be referred to the program for completion of the established application process. Requests for applications or questions regarding

ADAP can be directed to the program's toll-free hotline at 1-800-542-2437 or by writing to:

ADAP
P.O.Box 2052
Empire Station
Albany, New York 12220

VII.EFFECTIVE DATES

The requirements in this directive are effective January 1, 1992, retroactive to July 1, 1991. Social services districts should submit their first program report to the Department, by May 15, 1992, for the nine month period beginning July 1, 1991 and ending March 31, 1992. The report should be submitted to:

Bobbi Krusik
New York State Department of Social Services
DMA-LTC
P.O. Box 1935
Albany, New York 12201-1935

Jo-Ann A. Costantino
Deputy Commissioner

Listing of Attachments

- ATTACHMENT I: Health Insurance Conversion and Continuation Requirements
(not available on-line)
- ATTACHMENT II: AIDS Health Insurance Program, Semi-Annual Report
(available on line)
- ATTACHMENT III: Notice of Action on Application /Benefit for Medical
Assistance Payment of Health Insurance Premiums Under the
AIDS Health Insurance Program (not available on-line)

AIDS HEALTH INSURANCE PROGRAM
SEMI-ANNUAL REPORT

I. IDENTIFYING INFORMATION

- A. Social Services District: _____
- B. Name and Title of Person _____
Completing Report: _____
- C. Telephone Number: (_ _ _) _ _ _ - _ _ _ _
- D. Reporting Period: From: _ _ / _ _ / _ _ To: _ _ / _ _ / _ _
- E. Date of Report Completion: _ _ / _ _ / _ _
- F. Did you have any program activity during this reporting period?
- _____ No. DO NOT COMPLETE ANY REMAINING SECTIONS OF THIS REPORT.
- _____ Yes. COMPLETE ALL REMAINING SECTIONS OF THIS REPORT.

II. ACTIVITY SUMMARY

Complete the following table indicating the total number of persons who applied for the program during the reporting period. Of this number, enter the number of persons who were accepted for the program, the number rejected, and the number discontinued from the program during the reporting period. In the final column, indicate the total number of persons, by sex, in the program at the end of the reporting period. The total number of persons discontinued from the program during the reporting period and the total number of persons, by sex, in the program at the end of the reporting period should be reported as cumulatives on all reports submitted after your initial report.

Persons Applying for Program	Persons Accepted	Persons Rejected	Persons Discontinued	Persons In Program	
				Male (#)	Female (#)
(#)	(#)	(#)	(#)	(#)	(#)

III. PERSONS IN PROGRAM, BY MONTH

Show the number of persons in the program at the end of each month in the reporting period. The total number of persons for all months should match the number of persons shown in the ACTIVITY SUMMARY section above.

Persons in Program	Persons in Program
Month 1: _____	Month 4: _____
Month 2: _____	Month 5: _____
Month 3: _____	Month 6: _____

IV. REASONS FOR DISCONTINUANCE FROM PROGRAM

Indicate the number of persons who were discontinued from the program during the reporting period for each of the reasons shown.

<u># of Persons</u>	<u>Reason</u>
_____	failed to complete the MA application or to provide necessary documentation for determining MA eligibility.
_____	documentation verified income exceeded 185 percent of the poverty line.
_____	became eligible for benefits under Medicare.
_____	became eligible for benefits under the MA program, including the CCP.
_____	established residence in another state.
_____	other (identify): _____

V. PREMIUM PAYMENTS

Indicate the total dollar amount of health insurance premiums paid during the reporting period. Show the distribution of these premiums by indicating the number of premiums in each payment range shown.

Total premiums paid: \$_____

Distribution of premiums: #_____less than \$250

#_____ \$250-\$500

#_____over \$500

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END OF REPORT

Submit semi-annual report no later than thirty business days after end of reporting period to:

Ms. Bobbi Krusik
New York State Department of Social Services
DMA-LTC
P.O. Box 1935
Albany, New York 12201-1935