

COMPARING AGGREGATE COSTS FOR SERVICE AND HEALTH INSURANCE

Estimation methodology and workbook

ACA Coverage Mandate

Most of your clients with household income above 138% poverty must have coverage with a qualified health plan or pay a fine

The Ryan White Program is not a qualified health plan

HRSA guidance on comparison of insurance assistance and direct services costs *(HAB PCN #13-05)*

If resources are available, Part A planning bodies and Ryan White Part B, C and D grantees may choose to prioritize and allocate funding to health insurance premium and cost-sharing assistance... The grantee must determine how to operationalize the health insurance premium and cost-sharing assistance program...to:

- (1) assure they are buying health insurance that at a minimum, includes at least one drug in each class of core antiretroviral therapeutics from the *HHS Clinical Guidelines for the Treatment of HIV/AIDS* as well as appropriate primary care services; and
- (2) assess and compare the **aggregate cost** of paying for the health insurance option versus paying for the full cost for medications and other appropriate primary care services.

METHOD FOR DETERMINING LOCAL COSTS FOR CLINICAL SERVICES FOR COST COMPARISON

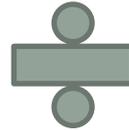
Required by HRSA Policy for Parts A, B, C, D

Methods for Determining Local Costs

- For areas with Part B/SS only this method must be used
- Strongly recommend to Part A Planning Councils that an integrated Part A and Part B & SS clinical cost estimate be developed using these methods
- Areas that want to include Part C & D in the local cost estimate can work with DSHS to incorporate these funding streams

Overview of methodology

(Local allocations for covered clinical services
from all funding streams



Unique count of clients across these services)



Average ADAP cost

Information needed for calculation

- Most recent allocations for Part A, Part B & State Services
- Unique client count for clinical services (from DSHS)
- ADAP costs (from DSHS)

enter all allocations for each HSDA/EMA

Enter allocations here

HSDA 1				
Service Category	CY 2015 (Allocation/Expenditure)			
	Part A	Part B	State Services	Total
AOMC				\$0
Local Pharmacy Asst				\$0
Oral Health				\$0
Medical Case Mgmt				\$0
Mental Health Svcs				\$0
Health Insurance Asst				\$0
Linguistic Services				\$0
TOTAL	\$0	\$0	\$0	\$0
(Check)				\$0

There is room for 6 HSDAs

HSDA allocations sum up into an area-wide total in the top table on the worksheet

AREA NAME				
Service Category	CY 2015 (Allocation/Expenditure)			
	Part A	Part B	State Services	Total
AOMC	\$0	\$0	\$0	\$0
Local Pharmacy Asst	\$0	\$0	\$0	\$0
Oral Health	\$0	\$0	\$0	\$0

Pull out covered clinical services

AOMC/Primary Medical Care

Local Pharmacy Asst

Mental Health Srvs

Medical Nutritional Tx

Home & Community Based

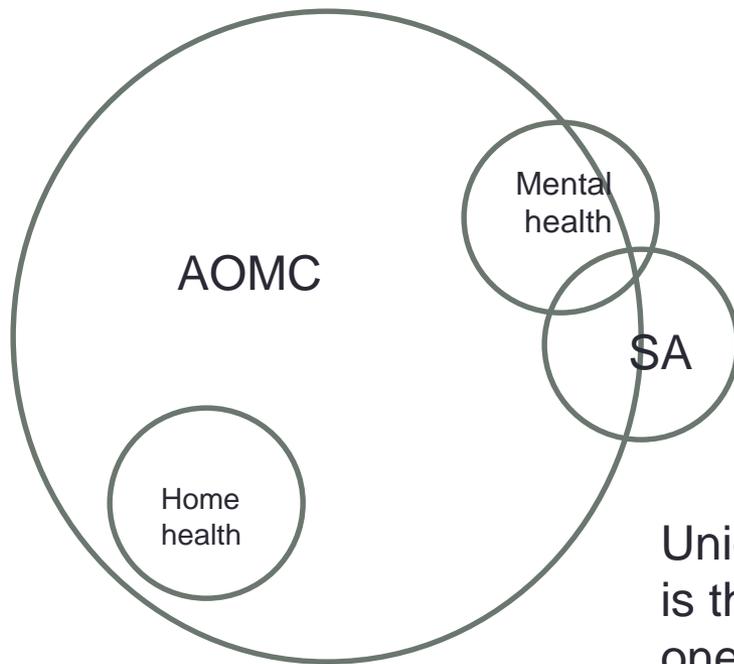
Early Intervention Srvs (C&T)

Home Health

Hospice

Substance Abuse Tx (out and in patient)

Create unique client count for covered clinical services



The unique client count takes into account that many clients have more than one service paid by RW/SS

Unique client count for covered clinical services is the number of clients with one or more covered clinical services paid by RW parts or SS

Comparing Client Counts

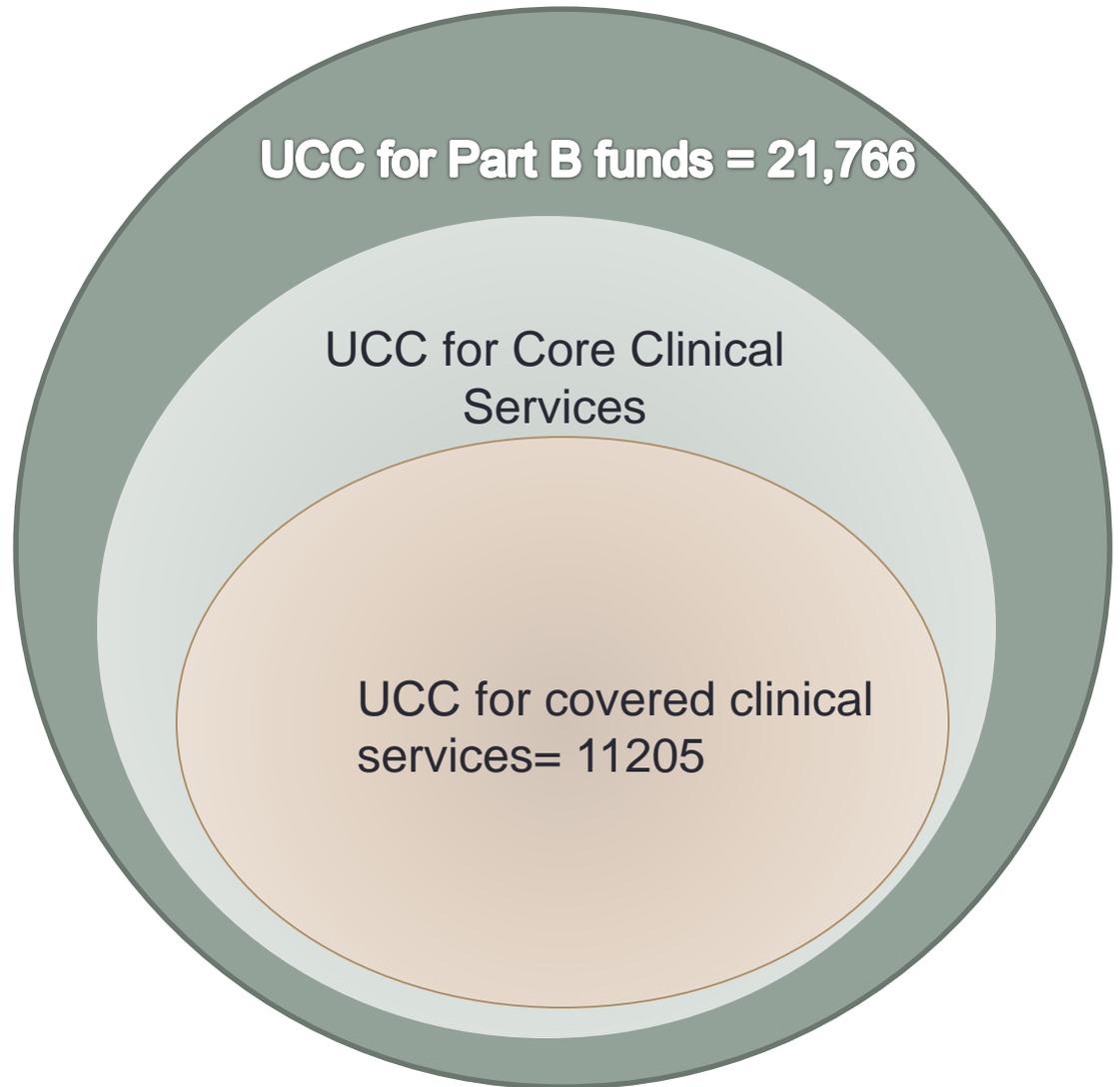
Covered medical services' for only Part A funds: 15950

Covered medical services' for only Part C funds: 5608

Covered medical services' for only Part D funds: 912

Covered medical services' for only SS funds: 5938

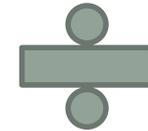
Covered medical services' for only Part A+B+SS funds: 22385



calculate per client aggregate allocation for covered clinical services

Final allocations
across Parts & SS for

- AOMC/Primary Medical Care
- Local Pharmacy Asst
- Mental Health Srvs
- Medical Nutritional Tx
- Home & Community Based
- Early Intervention Srvs (C&T)
- Home Health
- Hospice
- Substance Abuse Tx (out and in patient)



unique clinical
client count



Average ADAP expenditure on dispensed drugs

\$5,790.93

HEALTH INSURANCE COSTS

Insurance Costs

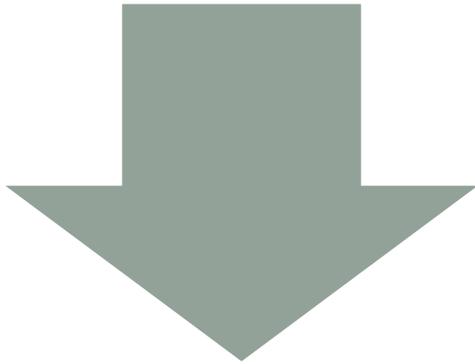
insurance premiums



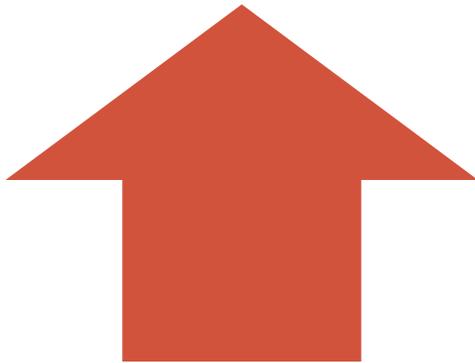
out of pocket payment requirements
(OOP, copays, deductibles)

Premiums on Marketplace

Vary by local market



younger people
non-smokers
between 100% and 400% FPL



older people
Smokers (tobacco users)
Under 100% or over 400% FPL

Marketplace Premium Tax Credits

Tax credits are available to those earning 100% - 400% FPL (\$11,670-\$46,680)

- Tax credits reduce the premium cost
- Reductions on a sliding scale based on household income
- Tax credits can be used at any plan level (bronze, silver, gold, platinum), but not for catastrophic coverage

Income	Annual Premium Limit
100-150% FPL	\$234.57- \$703.70
150-200% FPL	\$703.70- \$1,479.76
200-250% FPL	\$1,479.76 - \$2,363.18
250-300% FPL	\$2,363.18 - \$3,346.956
300-400% FPL	\$3,346.96 - \$4,462.61

Increases due to tobacco use

- Premiums for smokers can be up to 50% higher and smoking surcharges cannot be paid by tax credit



41% of PLWH



59% of PLWH

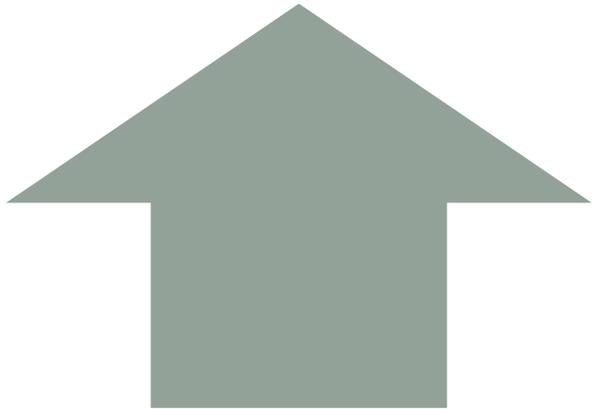
Cost Sharing (OOP) on Marketplace



Income 100-200% FPL capped at \$2,300

Income 200-250% FPL capped at \$3,300

Must purchase Silver level plan



Under 100% or over 250% FPL

Capped at \$6600

Cost-Sharing Subsidies and Out Of Pocket (OOP) Maximums

Cost-Sharing Subsidies: Available for an applicant: (1) whose income is between 100-250% FPL and (2) who chooses a Silver plan

Includes:

1. Deductible (if any)
2. Co-insurance for *in-network* services
3. Co-pays for *in-network* services

Does NOT Include:

1. Premium
2. Costs for *out-of-network* services

Income	OOP Max
<100% FPL	\$6,600
100-150% FPL	\$2,250
150-200% FPL	\$2,250
200-250% FPL	\$5,200
>250%	\$6,600

Texas Marketplace Costs by Income

FPL	Ave Premium	Ave OOP max	Total Cost
<100%	\$5,039.83	\$6,107.16	\$11,146.99
100 -132%	\$1,547.53	\$856.22	\$2,403.75
133 -149%	\$1,880.68	\$856.22	\$2,736.90
150 -199%	\$2,125.13	\$1,754.48	\$3,879.60
200%	\$3,020.50	\$1,754.48	\$4,774.98

Maximum Marketplace Insurance Costs adjusted by age and smoking surcharge for 2015

	<100% FPL	100	133	150	200
Dallas + Tarrant	\$11,284.88	\$2,993.03	\$3,338.03	\$4,433.41	\$5,358.01
Houston	\$11,462.50	\$2,896.94	\$3,228.14	\$3,407.54	\$4,903.39
Austin	\$11,251.85	\$3,355.36	\$3,689.32	\$3,868.26	\$5,246.45
San Antonio	\$11,487.50	\$3,615.98	\$3,856.23	\$4,118.43	\$5,133.31
El Paso	\$11,414.36	\$4,099.04	\$4,340.18	\$4,623.44	\$5,476.55
All other Texas (based on Area 26)	\$11,093.28	\$2,326.81	\$2,575.21	\$2,899.58	\$4,790.14

Based on prior example of expected per client expenditure of \$7,285 insurance costs for those under 100% are out of range

Insurance costs for those between 100% and 200% are in range

PREPARING

Getting ready for enrollment for 2016

- Estimate allocations for covered clinical services
 - Compare to insurance
- Look at client income profiles & current insurance assistance clients
 - Learn about special enrollment periods for potential COBRA clients
- Revise policies to incorporate Marketplace plan characteristics
- Work with CM and insurance providers
 - Register clients on healthcare.gov
 - Use PAPs (for uninsured) and co-pay programs (for insured) more aggressively
 - Take CAC training
 - Develop relationships with Navigators & CAC
- In reach to clients between 100%-200% FPL who are using clinical services
 - Peer-based advocacy for HI?

Drafting DSHS and local policy: Probable Elements

- POLR requirement that insurance must be pursued – public and private
- *Registration of all clients on healthcare.gov*
- *General expectation for client cost-sharing when reasonable given client's income*
- *Preference for tax transcript for income verification*
- *Mandate use of manufacturer co-pay assistance if available*

- *If RW/SS funds are used for assistance:*
- Insurance assistance supported only for policies that offer comparable services and aggregate costs below expected direct costs
 - Requirement for development of local cost estimate
- Parameters of assistance for employer plans
 - Client may not decline employer insurance if it offers comparable services & reasonable cost to client
 - COBRA assistance must consider availability of Marketplace plans and expected costs (refer client for navigator/CAC assistance)
 - Client must receive assistance on use of manufacturer co-pay assistance (when available)
- Parameters for Marketplace
 - Must take advance premium tax credit
 - Funds may **not** be used to pay tax penalty
 - Must select Silver plan if between 100 – 200% FPL
 - Changes in household income, tobacco use, residence must be reported to Healthcare.gov
 - Do not permit payment of charges for out of network providers without prior approval

In summary

Program management requires a solid understanding of the available cost reductions available under ACA

- Premium tax credits are available for persons with household income 100 - 400% FPL
- Silver plans with reduced cost sharing available to persons with household income 100- 250% FPL
- Persons under 100% FPL do **not** qualify for reduced insurance costs on the Marketplace

Federal policy requires Part A and B grantees to determine cost comparison points for direct delivery of services and health insurance assistance costs

- Cost comparison points must include costs of clinical services covered by health insurance and must include ADAP costs

Local and State policies on health insurance assistance should reflect ACA requirements and local cost comparison points

- Do **not** support requests for health insurance assistance if providing assistance will result in a greater overall expenditure for the clinical services, including ADAP, needed by the client.

- When providing assistance for a Marketplace plan the client **must** take the advance premium tax credit (APTC)
- If the client is between 100% and 250% FPL, the client **must** select a Silver Plan.
- Changes in a client's income, family size, tobacco use and residency must be reported promptly.
- Administrative Agencies must ensure funded agencies have processes in place to assist clients in promptly reporting changes to HealthCare.gov
- OOP cost controls do not include out of network charges. AAs must implement policies that do not permit payment of insurance charges resulting from use of out of network providers without prior approval by the AA/Grantee

Local allocations and expenditure monitoring must reflect the design of Marketplace plans

- When a coverage period starts, insured clients may have very high copayments/co insurance charges, especially for HIV treatment drugs or other "4th tier" or "specialty drugs". Copayment/coinsurance charges stop once the client reaches the OOP maximum for the plan, but costs are **much higher at the beginning of a coverage year than at the end**
- Area cost containment policies must work for Marketplace plans, and not set monthly caps or restrictions that would discourage use of Marketplace plans with front loaded costs if the annual costs of the coverage are reasonable
- Policies must require client cost sharing when appropriate