ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 93 ADM-28

DIVISION: Health and Long Term Care

TO: Commissioners of Social Services

DATE: September 16, 1993

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

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, User ID AW0670; MA Eligibility: Elsie Kirk, 1-800-342-3715, extension 3-5509, User ID 0ME310, 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.
91 ADM-54 91 ADM-53 87 ADM-40 92 INF-36	91 ADM-54	358 360-7.5(i) 360-8.1.	104 369-k.-n.		COBRA 1985 (P.L. 99-272) Chapter 501, Laws of 1992

I. PURPOSE

The purpose of this Administrative Directive is to advise social services districts of the policies and procedures for administration of the AIDS Health Insurance Program (AHIP). This directive includes the policies and procedures originally found in 91 ADM-54 and revised policies concerning the:

A. continuation of eligibility for AHIP once an individual becomes eligible for Medicare (Page 6);

B. net household income standards for AHIP (Page 7);

C. time frame for determining Medical Assistance (MA) eligibility or ineligibility after initial authorization of health insurance premium payments under AHIP (Page 8);

D. recertification of benefits under AHIP (Page 9); and

E. content and frequency of required reports about AHIP (Pages 10-11).

This directive also identifies certain changes in continuation requirements under the New York State Insurance Law as amended by Chapter 501 of the Laws of 1992.

II. BACKGROUND

Chapter 165 of the Laws of 1991 allowed the Medical Assistance (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 Budget Reconciliation Act (COBRA) of 1985, when cost- effective to do so. Chapter 165 also established a Health Insurance Continuation Program for Persons with AIDS (AIDS Health Insurance Program [AHIP]) which permits the use of MA funds for payment of health insurance premiums for persons with AIDS (PWA) or persons with HIV-related disease 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) or the MA program.

III. PROGRAM IMPLICATIONS

A. Impact

Use of MA monies to assist PWA or persons with HIV-related disease 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. AHIP: the AIDS Health Insurance Program.

2. CCP: the COBRA Continuation Coverage Program.

3. 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.

4. Health Insurance Costs: the premiums or contributions paid for health insurance by or on behalf of a person with AIDS or HIV-related disease; does not include deductibles or co-payments.

5. Persons with AIDS (PWA) or HIV-Related Disease: persons who are diagnosed as having acquired immune deficiency syndrome (AIDS) as defined by the Centers for Disease Control and Prevention or who have illnesses, other than AIDS, which are included in the standard for Clinical/Symptomatic HIV disease established by the AIDS Institute of the New York State Department of Health and specified in 92 INF-36.

6. Poverty Line: the official federal income poverty line applicable to a household of the same size as the applicant's household; revised annually.

7. Conversion Right: the privilege to change an insurance policy to a direct payment contract without requiring evidence of insurability; this 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

For a PWA or a person with HIV-related disease to be eligible for AHIP, the following 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, using the Supplemental Security Income (SSI)-related budgeting methodology, does not exceed 185 percent of the poverty line.

   Incurred medical and remedial expenses such as clinic services, dental services, and home health services, cannot be deducted to determine net household income for AHIP; and

5. The person must be ineligible for benefits under the MA program, including the COBRA Continuation Coverage Program (CCP).

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

D. Budgeting Methodology

Policies outlined in 91 ADM-53, "COBRA Continuation Coverage Program", are applicable for determinations of financial eligibility under AHIP, 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 disease in a household is determined to be financially eligible for AHIP based on his/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 disease 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 AHIP, a separate eligibility determination must be made for the PWA or the person with HIV-related disease 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. Continuation rights of persons in these employee groups are governed by the New York State Insurance Law. Chapter 501 of the Laws of 1992 amended the State Insurance Law to expand the time frame for election of continuation coverage from 31 days to 60 days from the date of termination of employment. This change is consistent with COBRA election requirements.

State Insurance Law also establishes time frames for election of conversion rights following the continuation period. These time frames were not affected by Chapter 501 and continue to depend on the type of insurance contract involved.

Persons seeking benefits under AHIP may be applying for the program at various times during continuation or conversion election periods. Districts may have to determine eligibility within short time frames in order to prevent permanent loss of an individual's health insurance coverage. Districts 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 for AHIP. 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 already 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 among plans. Plans may require payments on a monthly, quarterly, or semi-annual basis.

If premium payments have been made for persons subsequently determined to be ineligible for AHIP, 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 as amended by Chapter 501 of the Laws of 1992, 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 AHIP. Costs of premiums are shared equally by the state and social services districts.

H. Discontinuance of Benefits under AHIP

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

1. is determined to reside in a household whose net income exceeds 185 percent of the poverty line; or

2. becomes eligible for benefits under the MA program, including the COBRA Continuation Coverage Program (CCP); or

3. establishes residence in another state; or

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

Under COBRA and New York State Insurance Law requirements as amended by Chapter 501 of the Laws of 1992, duration of continuation coverage is limited to 29 months for a person whose employment is terminated or reduced and who is determined to be totally disabled according to Title II or Title XIV of the Social Security Act. Upon expiration of coverage, the person becomes eligible for benefits under Medicare.

Policy reflected in 91 ADM-54 prohibited the continuance of benefits under AHIP if a PWA or a person with HIV-related disease became eligible for Medicare benefits. This policy has been changed. If a person receiving benefits under AHIP becomes eligible for Medicare, and the provision of Medicare benefits in combination with the benefits under AHIP would be cost-effective, the person may now receive benefits under both programs. Cost-effectiveness determinations must be made by social services districts according to requirements in 87 ADM-40, except that deductibles and co-payments are not used to calculate cost-effectiveness.

IV. REQUIRED ACTION

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

A. Determine Eligibility of Persons for AHIP

Social services districts must conduct a face-to-face interview with each person applying for AHIP 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.

1. Documentation of Medical Eligibility

A person or authorized representative applying for AHIP 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 New York State 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 according to 18 NYCRR, Part 360-8.1.

2. Personal Information

A person or authorized representative applying for AHIP on the person's behalf must provide proof of citizenship status and residency. If this documentation is not available at the time of application for the program, a verbal statement attesting to citizenship and residency may be accepted.

3. Household Income

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

Income Standard*	Household Size	
	One	Two
Net Annual Income	$ 12,894	$ 17,445
Net Monthly Income	$ 1,074	$ 1,453

*185 percent of the poverty line effective July 1, 1993-December 31, 1993

The income standard is updated annually; updated figures are included in an Administrative Directive issued yearly by the New York State Department of Social Services (NYSDSS).

B. Authorize Payment of Health Insurance Premiums for Eligible Persons

Districts may initially 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.

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

C. Determine Eligibility of Persons for MA

Districts must advise each person who will receive benefits under AHIP, 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 AHIP. Districts must also inform each person that failure to comply with this requirement, or to supply required documentation for determination of MA eligibility, will result in discontinuation of health insurance premium payments under AHIP.

The time frame for determining MA eligibility or ineligibility has been revised. Under former policy, this determination was required to be made no later than the fourth month after initial authorization of premium payments under AHIP. The revised policy extends the time frame to five months. If a PWA or person with HIV-related disease has income below the MA income eligibility level but has resources above the MA resources level, the individual should be considered for eligibility under AHIP.

In some situations, a person may be eligible for AHIP and also eligible for MA through spend-down. Depending on the type and scope of coverage included in the person's health insurance policy, one of these eligibility options for payment of health insurance premiums may be more advantageous for the individual than the other. Districts should discuss the options with the person so the individual can choose the eligibility option which is most beneficial.

D. Reauthorize Payment of Health Insurance Premiums for Eligible Persons

Reauthorization of benefits under AHIP must be based on the eligibility criteria identified in section III.C of this directive. To redetermine eligibility for AHIP, districts must follow the procedures in section IV.A. of this directive, except that redocumentation of medical eligibility is not required.

Reauthorization of payments of health insurance premiums and redetermination of MA eligibility or ineligibility must continue to be made according to the guidelines in sections IV.B. and IV.C. of this directive.

E. Notify Persons of Decisions Concerning Eligibility for AHIP

Districts must notify persons of the decision to authorize, deny, reauthorize, or discontinue payment of health insurance premiums under AHIP on the DSS-4329, "Notice of Action on Application/Benefit for Medical Assistance Payment of Health Insurance Premiums Under the AIDS Health Insurance Program" (Attachment 3). Persons are entitled to fair hearing rights according to 18 NYCRR, Part 358.

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 five months, or the documentation provided shows that the person does not meet the eligibility criteria 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 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 DSS-4329 and the DSS-3622 advising him or her of MA eligibility. If benefits under the program are discontinued because the PWA or the person with HIV-related disease is determined to be eligible for benefits under the CCP, the person must be sent the standard CCP notice included in 91 ADM-53 in addition to the DSS-4329.

F. 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 paid, 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 AHIP, 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. Reimbursement cannot 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 AHIP 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.

G. Complete and Submit Reports to the Department

Changes have been made in the content and frequency of the required reports on AHIP as follows:

1. The reporting form found in 91 ADM-54 has been revised to eliminate all client numerical data including statistics related to discontinuance from the program. Client census data will be generated internally by the New York State Department of Social Services (NYSDSS) on a quarterly basis;

2. Districts must report only the total amount of health insurance premiums paid during each reporting period; and

3. Reports must be submitted to the NYSDSS on a quarterly rather than semi-annual basis to assure that expenditure information is collected for the same period of time as client census data and to facilitate fiscal and program monitoring by the NYSDSS.

The revised reporting form is found in Attachment II. For reporting purposes, this attachment should be duplicated. The quarterly reporting periods and due dates for report submittal are listed on the reporting form and in Section VII. of this directive.

Districts should begin to use the revised reporting form for submission of the quarterly report for the period beginning July 1, 1993 and ending September 30, 1993. This report and all subsequent quarterly reports should be submitted to the NYSDSS 30 business days after the end of the reporting period.

Districts having no AHIP clients during a reporting period and districts having AHIP clients but no payments for health insurance premiums during the reporting period must continue to complete a portion of the reporting form. Reports must be submitted within the time frame specified in the preceding paragraph.

V. SYSTEMS IMPLICATIONS

A. WMS - Upstate

1. Coverage Code and Payment Type Code

MA Coverage Code 17 (HEALTH INSURANCE CONTINUATION ONLY), in conjuction 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 disease 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 91 ADM-53 for information regarding the use of Codes L5 and L6 except that the list of Coverage Codes in that directive has been expanded to include 16, 32, and 33). 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.

2. Excess Income and AHIP

When a determination is made that a person eligible for AHIP may be potentially eligible for one month outpatient coverage or six month inpatient coverage through 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 spend-down 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.

3. Screen 6 Edits

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

a. L4 requires Special Claiming Category Code R (All Other - FNP); and

b. The Premium Payment Date cannot precede July 1, 1991; and

c. Entry of Code L4 is permitted only if the case contains at least one individual with Coverage Code 17.

4. Eligibility for the CCP; Coverage Code Upgrades

If a PWA or a person with HIV-related disease 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. BICS - Upstate

BICS supports issuance and claiming of AHIP indirect payments to vendors. AHIP payments authorized on WMS as indirects with Payment Type Code L4 can be selected for system generated vouchers, or added to manual vouchers. After successful voucher processing and indirect check generation, these payments will be claimed on BICS Composites claim RF-2, Schedule E, line item HMOP.

C. WMS - New York City

Instructions for New York City procedures will be forthcoming.

VI. ADDITIONAL INFORMATION

The AIDS Drug Assistance Program (ADAP) provides medication assistance to persons with AIDS or HIV-related disease 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 ADAP 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

A. Adjustments in the net household income standards for AHIP are retroactive to July 1, 1993.

B. Changes in the State Insurance Law resulting from Chapter 501 of the Laws of 1992 were effective April 1, 1993.

C. Quarterly reporting periods and due dates for report submittal to the NYSDSS are as follows:

Reporting Period	Due Date
January 1-March 31	May 15
April 1-June 30	August 15
July 1-September 30	November 15
October 1-December 31	February 15 of the following year

Quarterly reporting for 1993 should begin with the July 1-September 30 cycle.

Reports should be manually or electronically submitted to:

Bobbi Krusik
New York State Department of Social Services
Division of Health and Long Term Care
40 North Pearl Street
Albany, New York 12243

User ID AW0670

D. The following policies are effective October 1, 1993:

1. Continuance of benefits under AHIP if an individual becomes eligible for Medicare and a determination is made by the social services district that continuance of AHIP benefits in combination with Medicare benefits would be cost-effective; and

2. Extension of the period for determination of MA eligibility or ineligibility from four to five months; and

3. Exemption of the need for redocumentation of medical eligibility to redetermine eligibility for AHIP.

E. All other policies in this directive are retroactive to July 1, 1991, including, but not limited to:

1. Use of the budgeting methodology in 91 ADM-53 for determination of financial eligibility under AHIP; and

2. Exemption of household resources and cost-effectiveness test from the eligibility determination for AHIP; and

3. Authorization of payments for health insurance premiums for eligible persons for twelve months; and

4. Use of the DSS-4329 to notify persons of decisions concerning eligibility for AHIP; and

5. Reimbursement to clients or authorized representatives for health insurance premiums under the conditions identified in Section IV.F. of this directive.

Sue Kelly
Deputy Commissioner

Listing of Attachments

ATTACHMENT I: Health Insurance Continuation and Conversion Requirements (available on-line)

ATTACHMENT II: AIDS Health Insurance Program, Quarterly Report (available on-line)

ATTACHMENT III: DSS 4329, "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
QUARTERLY REPORT

1. Social Services District: _____

2. Name and Title of Person Completing Report: _____

   _____

3. Telephone Number: (_ _ _) _ _ _ - _ _ _ _

4. Reporting Period: From: _ _ / _ _ / _ _ To: _ _ / _ _ / _ _

5. Did you have any clients in the AIDS Health Insurance Program during this reporting period?

   ____ No. END OF REPORT.

   ____ Yes. GO TO QUESTION 6.

6. Were any health insurance premium payments made for these clients during the reporting period?

   ____ No. END OF REPORT.

   ____ Yes. GO TO QUESTION 7.

7. What was the total dollar amount of these payments?

   $ _____.

Submit this report according to the following schedule:

Reporting Period	Due Date
January 1-March 31	May 15
April 1-June 30	August 15
July 1-September 30	November 15
October 1-December 31	February 15 of the following year

Submit each report manually or electronically to:

Bobbi Krusik
New York State Department of Social Services
Division of Health and Long Term Care
40 N. Pearl Street
Albany, New York 12243

User ID AW06070