**Ryan White HIV/AIDS Program Health Care Coverage Assistance Manual**

The Health Resources and Service Administration’s (HRSA) Ryan White HIV/AIDS Program (RWHAP) provides HIV services to low-income individuals with HIV who have no other health care coverage, and to those who have insurance (e.g., through private health insurance, Medicaid or Medicare). As health care coverage for individuals with HIV has increased – particularly following the coverage expansions of the Affordable Care Act (ACA) – so has the role of RWHAP recipients in ensuring that RWHAP clients have access to comprehensive and affordable health care coverage.

This manual provides an overview of RWHAP payment for clients’ health care coverage costs (referred throughout this manual as “insurance assistance”). This includes statutory authority and federal policy parameters, and considerations for RWHAP recipients across RWHAP Parts for structuring insurance assistance in ways that are cost-effective for RWHAP recipients and that maximize access for clients.

1. **RWHAP Insurance Assistance: Context and Statutory Authority**

***A changing landscape: RWHAP clients and health care coverage status***

The majority of RWHAP clients have some form of health care coverage. The number of RWHAP clients without any form of health care coverage has dropped since the ACA’s coverage expansion reforms went into effect. According to HRSA’s HIV/AIDS Bureau (HAB) RWHAP Data Reports, the percentage of RWHAP clients with no source of health care coverage dropped from 27.6% in 2012 to 19.4% in 2020.[[1]](#footnote-1)  In comparison, AIDS Drug Assistance Program (ADAP) clients are more likely than RWHAP clients to have no source of health care coverage, with NASTAD reporting that 41% of ADAP clients were uninsured in 2019.[[2]](#footnote-2) While there has been little analysis as to why this discrepancy exists, it may be due to the role of ADAP as a safety net primarily for those who are uninsured and under-insured. Even if on a slightly smaller scale, ADAPs have also seen a significant increase in clients with access to health care coverage following ACA implementation. The shift in health care coverage access over the past decade has necessitated that RWHAP recipients build capacity and infrastructure to assist clients to enroll in, afford, and meaningfully use health care coverage.

***Federal laws and policies that govern RWHAP insurance assistance***

The RWHAP statute allows recipients to cover insurance premiums and cost-sharing for insured clients. The insurance must cover at least one U.S. Food and Drug Administration (FDA)- approved medicine in each drug class of core antiretroviral medicines outlined in the federal HIV treatment guidelines as well as appropriate HIV outpatient/ambulatory health services.[[3]](#footnote-3) The federal requirements for cost-effectiveness differ slightly for RWHAP Part A, B, C, and D recipients and for ADAPs (see the summary in Table 1).

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| **Table 1: Cost-Effectiveness Requirements for RWHAP Health Care Coverage Purchase** | |
| **RWHAP ADAP** | **RWHAP Part A, B, C, D** |
| The cost of paying for health care coverage premiums is cost-effective in the aggregate versus paying for the full cost for medications. | The cost of paying for the health care coverage premiums is cost-effective in the aggregate versus paying for the full cost for medications and other appropriate HIV outpatient/ ambulatory health services. |

RWHAP recipients are not obligated to support the *most* cost-effective plan available as long as the relevant above requirement is met. There are different ways to assess cost-effectiveness, and RWHAP recipients may find it helpful to use existing tools (e.g., the ADAP Cost Effectiveness Review tool).[[4]](#footnote-4) More information on assessing the cost of an insurance purchasing program is in section II(5) below.

1. **Elements of an Insurance Assistance Program**

The following table walks through different types of health care coverage costs clients may encounter.

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| **Table 2: Insurance Costs RWHAP Clients May Face** | |
| Premium | Monthly cost of insurance paid directly to the plan |
| Prescription drug cost-sharing | A co-payment (fixed dollar amount) or co-insurance (percentage of the cost of the drug) paid for medication |
| Medical cost-sharing | A co-payment (fixed dollar amount) or co-insurance (percentage for the cost of the service) paid for a medical visit/service |
| Deductible | The amount someone must pay before the insurance plan starts paying benefits. During the deductible phase, individuals must pay the full negotiated cost of the medication or service. |

The following sections will walk through five elements of an insurance purchasing program, highlighting RWHAP considerations and decision points for each topic.

1. ***Assessing Client Eligibility for and Transition to Insurance Coverage and Preparing for Outreach and Enrollment***

As RWHAP recipients anticipate starting a new insurance assistance program or expanding an existing program, there are several steps they can take to project enrollment in the program and project staffing and infrastructure needs. A first step during the planning phase is to forecast eligibility for and enrollment in an assistance program. This means evaluating how many current RWHAP clients could be eligible for assistance as well as how many additional clients would enroll if the RWHAP recipient initiated an insurance assistance program. The chart below segments clients by income and allows programs to evaluate potential client enrollment across different insurance types. The income categories for individual market coverage are correlated to ACA Marketplace and Medicaid expansion eligibility. Programs may not currently have their clients stratified by income in this exact way, but it will be helpful to at least have an idea of how many clients will fit into these income brackets because of the implications for

available coverage.

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| **INDIVIDUAL MARKET** | |
| ***Income*** | ***Individual Market Coverage Option*** |
| Under 100% FPL | If a non-Medicaid expansion state, option for unsubsidized individual market coverage |
| 101-138% FPL | If a non-Medicaid expansion state, option for subsidized Marketplace coverage |
| 139-150% FPL | Heavily subsidized $0 premium and low cost-sharing Marketplace plans available |
| 150-250% FPL | Subsidized Marketplace plans available, including low premiums and cost-sharing |
| 251-400% FPL | Subsidized Marketplace plans available (premium tax credit, sliding scale based on income) |
| Over 400% FPL | Subsidized Marketplace plans available (premium tax credit, sliding scale based on income) |
| Marketplace plans are available to U.S. citizens and lawful permanent residents; however, undocumented immigrants may enroll in unsubsidized individual market plans, depending on the plans available in a state. | |
| **EMPLOYER SPONSORED COVERAGE** | |
| ***Income*** | ***Employer-sponsored coverage options*** |
| There are generally no income requirements for employer-sponsored coverage | Coverage may be available through an employer; in many cases, the employer will pay a portion of the client’s premium. |
| While employer-sponsored coverage is not limited to U.S. citizens or lawful permanent residents, undocumented immigrants are less likely to be in employment where such coverage is available. | |

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| **MEDICARE** | |
| ***Income*** | ***Medicare coverage options*** |
| Under 100% FPL | May be dually eligible for Medicare and Medicaid, so eligible for Medicare Savings Programs (programs run by states that help Medicare beneficiaries with Medicare premiums and cost-sharing). Eligibility for each program is based on income and asset criteria set by the state. Generally, income criteria for each state is 100% FPL or below. |
| Over 100% FPL | May be eligible for Medicare Part A, Part B, Part C, Part D, or supplemental plans.[[5]](#footnote-5) |
| Medicare is available to U.S. citizens and lawful permanent residents; it is not available to undocumented immigrants. | |
| **MEDICAID** | |
| ***Income*** | ***Medicaid coverage options*** |
| Under 138% FPL in Medicaid expansion states | Eligible for Medicaid based on income |
| For non-Medicaid expansion states, income eligibility depends on eligibility category and varies by state | Most common eligibility pathway for people with HIV in non-Medicaid expansion states is disability. Individuals may also be eligible if they meet their state’s income criteria and are pregnant or a parent or caretaker. |
| Several state Medicaid programs provide coverage for undocumented immigrants who meet all other Medicaid eligibility requirements. | |

Much of the client data described above is part of RWHAP client-level data collection. In [PCN 21-02](https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-21-02-determining-eligibility-polr.pdf), HRSA HAB encourages recipients to use electronic data sources to collect and verify client eligibility information, when possible. RWHAP recipients may want to consider data-sharing relationships with their state Medicaid agency to facilitate maintaining data on RWHAP clients currently enrolled in Medicaid.

After a RWHAP recipient projects client eligibility for and potential transition to insurance, there are a number of programmatic decisions that will dictate the structure of the insurance assistance program. The answers to each programmatic decision question below will depend on the structure of the RWHAP recipient, internal capacity and staffing considerations, and overall size of the insurance assistance program.

* **In-house vs. vendor?**

RWHAP recipients may use existing RWHAP staff to take on insurance outreach and enrollment functions, often in addition to RWHAP or ADAP application, eligibility, and enrollment activities, or they may consider hiring additional staff. Keeping this function

in-house can be a good option for programs that have in-house capacity and want to align RWHAP or ADAP application and eligibility processes as much as possible with

insurance enrollment. Other RWHAP recipients choose to contract out certain functions, such as outreach and enrollment, to a network of community-based organizations or an agent or broker. Contracting out certain services may be a good option for RWHAP recipients with limited internal capacity (e.g., staff with requisite expertise). When doing this, RWHAP recipients need to ensure that contracted entities understand any limitations on plan choices available to clients (e.g., based on cost-effectiveness analyses or other criteria) and that there are processes in place to coordinate RWHAP or ADAP insurance assistance program eligibility and enrollment with insurance plan enrollment.

**Navigator Program**

States participating in the federal Marketplace have [Navigators](https://www.cms.gov/files/document/2021-navigator-grant-recipients.pdf), organizations who receive federal funding to help low-income and underserved consumers learn about and enroll in health insurance. State-based Marketplaces have their own Navigators and assisters, which you can find by visiting [your state’s Marketplace website](http://healthcare.gov/marketplace-in-your-state/).

* **Full-time staff vs. seasonal staff?**

Programs also need to decide whether the outreach and enrollment needs will remain steady throughout the year or will surge during annual open enrollment periods (when the annual open enrollment periods for the ACA Marketplaces and Medicare coincide). For some programs, particularly smaller ones, it may make sense to hire seasonal staff or part-time contractors to handle the surge of enrollment activities during these busy seasons, while maintaining a smaller workforce dedicated to outreach and enrollment during the rest of the year.

**Open Enrollment: Know When Clients Can Enroll in Coverage**

Different plans – including Marketplace plans, employer-sponsored plans, and Medicare – all have different rules for when individuals may enroll in coverage. Most have both an annual open enrollment period, when individuals may enroll in or change plans, and special enrollment periods during the year, when individuals who meet certain conditions can enroll in or change plans. The [ACE TA Center](https://targethiv.org/ace) is an excellent resource to help RWHAP recipients navigate these open and special enrollment period rules.

* **External training or certification vs. internal training?**

Programs should also consider how to ensure that anyone doing outreach and enrollment assistance has the requisite training and expertise. Programs in federally facilitated Marketplace states can require anyone working with clients to become a Certified Application Counselor (CAC). CACs are individuals affiliated with a designated organization who have gone through a formal training and certification process on health insurance enrollment. Most state-based Marketplaces have similar designations and training that can be accessed through the state-based Marketplace website. Other programs may choose to pull from existing training programs and create their own insurance enrollment training for staff or contractors working on enrollment.

* **Limited vs. broad parameters for plan selection?**

RWHAP insurance assistance programs must also decide if and how they will limit the plans for which the program will provide assistance. All programs must follow HRSA HAB requirements for plan sufficiency and cost-effectiveness. However, some programs do a more extensive plan assessment, preferring plans that are best for the client (e.g., have a sufficient provider network, affordable non-HIV care, and comprehensive formularies) and best for the program (e.g., have a plan design that maximizes revenue generation). Other programs choose to broaden parameters for plan selection, for instance, allowing clients to select any [silver level](https://www.healthcare.gov/choose-a-plan/plans-categories/) Marketplace plan. Programs that choose to limit the plan options eligible for RWHAP assistance should communicate this with any staff conducting insurance outreach and enrollment activities. For more information on revenue generation considerations, see section II(5) below.

1. ***Premium assistance***

RWHAP recipients that choose to assist clients with insurance premiums as a component of their insurance assistance programs have a number of decisions to make about setting up these programs. Because funds cannot be given directly to clients to pay for insurance, RWHAP recipients must make premium payments directly to the insurer. RWHAP recipients should consider the following questions to determine the infrastructure needed to handle premium assistance payments:

* **In-house vs. vendor?**

Some RWHAP insurance assistance programs, especially those with a relatively small number of clients, choose to process insurance premium payments in-house, or within the agency/health department. This means that the agency or health department actually generates premium checks for clients and sends them to the insurance plan or other payer at a defined interval (e.g., monthly or quarterly). However, other programs, particularly those run through health departments, have time-consuming internal processes for disbursement of funding and find it easier to contract with a third-party or vendor to manage premium payments. Because programs maybe required to bid out contracts through a competitive process, RWHAP recipients should check with their peers for examples of activities included in Requests for Proposals (RFPs) or contracts for third-party vendors, including professional companies like insurance benefits managers and web brokers as well as community-based organizations.

* **Individual payments vs. bulk payments?**

Programs will also have to decide whether to make premium payments on behalf of each individual client (i.e., process a separate check for each client) or negotiate with the insurer to make bulk payments for multiple clients (i.e., cut one check for multiple clients). While processing one check for multiple clients creates some administrative efficiencies, it does come with increased risk if there is any issue with premium payment and receipt. Many programs find a way to balance these considerations – processing smaller groups of clients together to reduce the number of payments that have to be made, but avoiding large batches to mitigate the impact of any premium payment errors or issues.

* **Monthly payments vs. quarterly or semi-annual payments?**

Programs must consider whether they will pay premiums on a monthly basis or whether it can negotiate with the insurer to pay on a quarterly or other basis. The benefit of negotiating a payment on, for instance, a quarterly basis instead of monthly is administrative simplicity. For clients enrolled in unsubsidized individual market plans, a program may find that paying premiums on a quarterly basis is a good option for them. However, this option may cause challenges if eligibility for insurance or subsidies changes frequently. For instance, this option may not work best with clients enrolled in Marketplace plans with premium tax credits, as premium tax credit amounts – and ultimately the premium owed each month by the client – may change if clients have a change in income.

* **What about stand-alone dental plans?**

The ACA allows issuers to sell stand-alone dental plans on the Marketplace. These are separate plans from regular Marketplace medical insurance plans (with separate premiums and cost-sharing) and only cover dental services. ADAPs cannot pay for stand-alone dental plans, but other RWHAP recipients may pay for stand-alone dental plan costs for clients under the Health Insurance Premium and Cost Sharing Assistance category.[[6]](#footnote-6)

* **Are there different premium payment considerations across payers?**

While most insurance plans operate similarly when it comes to premium payments (i.e., monthly, regular premium amounts are due to the insurance plan on behalf of the client), there are some special considerations for certain payers.

* + *Marketplace plans* –For RWHAP clients eligible for premium tax credits, the premium amount the client owes is based on the amount of advance premium tax credit the client is receiving, which is based on income. If a client’s income changes (and they report that change to the Marketplace as they are required to do), and the premium tax credit amount goes up or down, the premium amount the RWHAP recipient pays will also change. It is important to remember that Marketplace enrollees can choose whether or not to take a premium tax credit in advance or to wait to claim it when they file their taxes. RWHAP recipients should ensure that any refunds clients receive from underpayment of advance premium tax credits throughout the year are returned to the program. RWHAP recipients may also assist clients that may owe money to the IRS because of potential overpayments of premium tax credits throughout the year.
  + *Medicare* – While payment for Medicare Part C and Part D premiums is straightforward, there is currently no administratively simple way for RWHAP recipients to pay a client’s Medicare Part B premium if the premium amount is being taken out of the client’s Social Security check. Except in rare circumstances (e.g., for clients with railroad disability benefits), RWHAP recipients are not able to pay these premiums for clients.
  + *Employer-sponsored plans* – Many employer-sponsored plans take the employee’s share of the premium directly out of the employee’s paycheck. A RWHAP recipient making payments on behalf of a client must coordinate with the employer and the employer’s health insurance plan or third-party administrator to make payments to the plan on behalf of the employee. This coordination may raise privacy concerns for the client, which should be considered.

**Third-Party Payment Rule**

In 2016, the U.S. Department of Health and Human Services published a regulation requiring Qualified Health Plans (plans certified by the Marketplace, whether subsidized or unsubsidized) to accept payments from RWHAP recipients made on behalf of clients, including premiums, prescription drug cost-sharing, and medical cost-sharing (45 CFR § 156.1250). Note: this rule only applies to plans certified by the Marketplace and may not apply to large or self-insured employer-plans.

If you think a plan is not complying with this requirement, consider reaching out to your state’s department of insurance.

1. ***Prescription drug cost-sharing assistance***

Prescription drug cost-sharing is one of the most significant obstacles to affordable health care coverage for people with HIV and one of the most important features of a RWHAP insurance assistance program. RWHAP recipients should consider the following questions as they contemplate prescription drug cost-sharing assistance as part of their programs:

* ***In-house vs. vendor?***

Once a program decides to cover prescription drug cost-sharing, one of the first considerations is whether to set up a system in-house (within the RWHAP recipient) to coordinate payments with pharmacies or to contract this function out to a third-party vendor. Given the complexity of pharmacy coordination, many programs choose to use Pharmacy Benefits Managers (PBMs) for this function. PBMs are vendors that specialize in pharmacy services. They are used by many ADAPs to set up relationships with pharmacies for payment of prescription drug cost-sharing on behalf of clients. Smaller programs may be able to manage this function internally, but should ensure staff have the expertise and capacity to manage complex pharmacy relationships.

* ***Pharmacy network or open access?***

Another important consideration is whether to limit the pharmacies clients can use to receive prescription drug cost-sharing assistance. ADAPs may require insured clients to receive cost-sharing assistance through the pharmacy network they use for their full-pay medication assistance programs. Other non-ADAP RWHAP recipients may also consider a more limited pharmacy network for cost-sharing assistance that mirrors their existing contract pharmacy network, if applicable. *If programs elect to limit the pharmacies clients may use to be eligible for cost-sharing assistance, this should be very clearly communicated to clients and front-line enrollment staff.*

* ***Should the RWHAP insurance assistance program mirror the ADAP full-pay formulary?***

ADAPs can only provide assistance for drugs on their formularies. ADAPs may choose to have different formularies depending on insurance coverage: one formulary for uninsured (i.e., full-pay medication) clients and one for insured clients. For insured clients, the ADAP formulary may be more expansive and allow the ADAP to provide cost-sharing on all or most prescription drugs the client receives through their insurance benefit. Other programs have a uniform formulary that applies to both uninsured (i.e., full-pay medication) clients and insured clients. In this situation, insured clients would only be eligible for cost-sharing assistance for the prescription drugs that are on the ADAP’s formulary and would be responsible for any cost-sharing associated with drugs not on the formulary.

As the intent of ADAP is to meet the medication needs of all eligible clients, ADAPs are encouraged to have the most comprehensive formulary possible to minimize any discrepancies in medication availability for clients receiving full-pay medication assistance and those receiving insurance assistance.

* ***What about long-acting injectable antiretrovirals?***

As of December 2022, there is one long-acting injectable antiretroviral approved by the U.S. Food and Drug Administration (FDA) for the treatment of HIV. Unlike oral medications, long-acting injectable medications are administered through a monthly (or longer interval) injection, usually in a doctor’s office or clinical setting. Oral medications are typically covered on a plan’s prescription drug formulary, with a specific co-payment or co-insurance. Long-acting injectable products and other provider-administered drugs and biologics are sometimes covered as a medical benefit. This means it may be more difficult to figure out if the product is covered by a plan, and it is typically subject to a co-insurance (a percent of the cost of the drug) instead of a flat dollar amount co-payment. In addition to the co-insurance associated with the drug, there is also an administration cost and provider visit cost-sharing charged by the provider.

RWHAP insurance assistance programs are able to cover these costs for insured clients. HRSA HAB has clarified that ADAPs may cover both the medication cost-sharing and any cost-sharing associated with a medical visit and administration of the long-acting injectable treatment.[[7]](#footnote-7) The prescription drug cost-sharing is often paid in a similar manner to how oral medication prescription drug cost-sharing is paid—directly to the specialty pharmacy. However, if the long-acting injectable medication is covered as a medical benefit and procured via “buy and bill,” the cost-sharing for the drug would likely be paid to the provider, not to a pharmacy. The administration and provider visit cost-sharing would be paid to the provider in a similar manner that medical cost-sharing is covered (described in section (4) below).

* ***Are there different prescription drug cost-sharing considerations across payers?***

Generally, prescription drug cost-sharing is fairly uniform across payers. However, there are some additional considerations for ADAPs making Medicare Part D cost-sharing payments:

* + *Medicare Part D* – The ACA explicitly allows ADAP cost-sharing made on behalf of Medicare Part D beneficiaries to count as true out-of-pocket costs (or “TrOOP”). This means the cost-sharing ADAPs pay on behalf of clients on Medicare Part D will help clients get through the Medicare coverage gap and into the catastrophic phase, where cost-sharing is lower. The Centers for Medicare & Medicaid Services (CMS) requires ADAPs to enter into a data sharing agreement in order to share data across ADAPs and Medicare Part D plans so that the cost-sharing is appropriately counted toward TrOOP[[8]](#footnote-8).

Waivers or reduction of Part D cost-sharing by safety net pharmacies (e.g., RWHAP clinic pharmacies) can also count toward TrOOP as long as federal funds are not used. However, there are strict rules clinics must follow to comply with the Anti-Kickback statute, which this manual does not cover.

* + *Private insurance (including on and off-Marketplace individual plans and employer-sponsored plans)* ­­– Using dedicated RWHAP funds to cover cost-sharing for eligible clients is generally allowable and is distinct from a waiver of co-payments. RWHAP clinics need to be aware of any requirements in their contracts with private insurers regarding copayments.

1. ***Medical cost-sharing assistance***

Medical cost-sharing – which includes co-payments, co-insurance, and deductibles associated with medical visits and other provider services – can also be a financial barrier for RWHAP clients. However, paying medical cost-sharing on behalf of a RWHAP client is unallowable under ADAP (except for medical cost-sharing associated with the administration of antiretroviral medication on the ADAP formulary), and can be administratively complex for other RWHAP recipients and subrecipients. The following are considerations for RWHAP recipients as they contemplate medical cost-sharing assistance as part of their programs:

* ***In-house vs. vendor?***

Programs will have to decide if they have the in-house capacity within the RWHAP recipient to administer a medical cost-sharing assistance program or if this is an appropriate role for a third-party vendor. Paying medical cost-sharing on behalf of insured clients requires individual relationships with treating providers and a mechanism to pay providers on behalf of clients. Because of the administrative complexity of negotiating multiple arrangements with providers, some programs opt to contract out this function to a “Medical Benefits Manager” or MBM. Similar to a PBM, an MBM serves as the administrator for cost-sharing made on behalf to the RWHAP recipient to participating providers, including setting up payment arrangement and making payments.

* ***Provider network limitations or open access?***

Another important consideration is whether to limit the providers clients can use in order to receive RWHAP insurance assistance for medical cost-sharing. For instance, RWHAP Part B programs who are running statewide insurance assistance programs may choose to limit medical cost-sharing assistance only to services received at RWHAP Part B subrecipient providers with whom the state health department already has a contractual relationship. Other jurisdictions may choose to contract with any provider a RWHAP client may see for services. At least one RWHAP Part B program put in place a pre-paid debit card system for clients to use for allowable cost-sharing services as spelled out by the program, allowing clients to seek care at a broader range of providers.

* ***Are there different medical cost-sharing considerations across payers?***

Generally, medical cost-sharing is fairly uniform across payers. However, there is one additional consideration for private payers:

* + *Private insurance (including on and off-Marketplace individual plans and employer-sponsored plans)* ­­– Using dedicated RWHAP funds to cover cost-sharing for eligible clients is generally allowable and is distinct from a waiver of co-payments. RWHAP clinics need to be aware of any requirements in their contracts with private insurers regarding copayments.

1. ***Assessing the cost of an insurance assistance program***

The considerations described in section I above walk through the HRSA HAB requirements for insurance coverage assistance, including assessing a plan’s cost effectiveness (whether it is less expensive to pay for insurance assistance for clients or provide full-pay medications and/or services). However, programs considering implementing or expanding an insurance assistance program will want to conduct a more granular assessment of cost and potential revenue. The following three scenarios capture the most common ways that programs will be set up and offer considerations for assessing costs.

* ***Scenario 1: ADAP insurance assistance (rebate model)***

An ADAP insurance assistance program that uses a rebate model (i.e., the program pays for drugs from a network of retail pharmacies and then submits for a rebate to the manufacturer, rather than paying an upfront discounted cost) is able to generate “partial pay” rebates for HIV drugs. This means that programs will pay a prescription drug co-pay or co-insurance and submit a rebate to the manufacturer. Manufacturers have different rules when it comes to the circumstances under which they will accept partial pay rebate, and ADAPs should check their ADAP Crisis Task Force rebate agreements as they identify potential costs and revenue for an insurance assistance program (note: these agreements are proprietary and are only accessible to ADAPs).

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| **Program Spending** | **Program funding** | **Program revenue** |
| Prescription drug cost-sharing | ADAP federal award, ADAP Emergency Relief Funds, Part B base or supplemental awarded to ADAP, state funds allocated to ADAP, rebates and program income generated by ADAP, other allocated funding | For ARVs: (Manufacturer ADAP Crisis Task Force rebate *minus* prescription drug cost-sharing) *times* number of monthly fills to reach plan out-of-pocket maximum *times* number of clients [[9]](#footnote-9) |
| Medical cost-sharing |
| Premiums |
| Vendor contracts |
| Staffing   * Payment oversight * Enrollment oversight * Contract oversight |
| Infrastructure   * Data/systems |

* ***Scenario 2: RWHAP insurance assistance (program income model)***

The second scenario is very similar across RWHAP recipients that operate a program income model. Unlike the rebate model described above, in the program income model, programs purchase the drug at a discount (e.g., the 340B price) and then are reimbursed by a payer at a “usual and customary” rate, which is typically much higher than the discounted price at which the drug was purchased. The “spread” between these two prices is program income that is then reinvested into the program (see HRSA HAB Policy Clarification Notice (PCN) [15-03](https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-15-03-program-income.pdf) for more information).

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| **Program Spending** | **Program funding** | **Program revenue** |
| Prescription drug cost-sharing | ADAP federal award, ADAP Emergency Relief Funds, Part B base or supplemental awarded to ADAP, state or local funds allocated to ADAP, rebates generated by ADAP  Health Insurance Premium and Cost-Sharing Assistance (RWHAP Parts A, B, C, and D)  Program income (across RWHAP Parts A, B, C and D) | Usual and customary insurance reimbursement price *minus* purchase price of drug (including ACTF rebate for ADAPs\*) and any relevant pharmacy dispensing or administration fees *times* 12 months per year *times* number of clients  ***\*ADAP is eligible for AIDS Crisis Task Force (ACTF) sub-340B price on certain drugs; all other RWHAP 340B entities are eligible for 340B discounted price*** |
| Medical cost-sharing |
| Premiums |
| Vendor contracts |
| Staffing   * Payment oversight * Enrollment oversight * Contract oversight |
| Infrastructure   * Data/systems |

* ***Scenario 3: RWHAP cost-sharing assistance only (no revenue)***

The third scenario is perhaps the most straightforward as it does not involve any revenue generation. Instead, in this scenario, the RWHAP insurance assistance program is *only* paying for client cost-sharing, including medical and prescription drug cost-sharing. In this scenario, programs should assess the costs of the insurance assistance program and identify other sources of funding to cover these costs.

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| **Program Spending** | **Program funding** | **Program revenue** |
| Prescription drug cost-sharing | ADAP federal award, ADAP Emergency Relief Funds, Part B base or supplemental awarded to ADAP, state or local funds allocated to ADAP, rebates generated by ADAP    Health Insurance Premium and Cost-Sharing Assistance (RWHAP Parts A, B, C, and D)  Program income (across RWHAP Parts A, B, C and D) | Not applicable |
| Medical cost-sharing |
| Vendor contracts |
| Staffing   * Payment oversight * Enrollment oversight * Contract oversight |
| Infrastructure   * Data/systems |

1. ***340B Coordination Across RWHAP Parts***

The 340B Drug Pricing Program is a federal program that requires drug manufacturers to provide steep discounts to certain safety net providers (including RWHAP recipients and subrecipients) that meet program requirements. The program only allows one entity to receive the 340B price for eligible patients and prescriptions. This can get complicated when more than one RWHAP recipient or subrecipient is eligible for the 340B discounted price. Take the following example:

*An ADAP purchases health insurance for and provides prescription drug cost-sharing assistance to a client and is eligible to receive a 340B partial pay rebate for each drug cost-sharing claim. A RWHAP Part C recipient provides care and treatment to the same client, and the client meets the 340B definition of “patient” of the RWHAP Part C recipient, making the RWHAP Part C recipient eligible to purchase the drugs prescribed to the RWHAP client at the 340B discounted price. Both the ADAP and RWHAP Part C recipient are eligible for the 340B discount, but only one may claim it.*

The Office of Pharmacy Affairs, who administers the 340B Drug Pricing Program at HRSA, provides the following guidance on this issue, “To the extent that an individual qualifies as a patient of both covered entities, HRSA expects the entities to resolve the issue in good faith. In cases where a covered entity purchased and dispensed a 340B drug to an individual, no other covered entity is permitted to replenish or otherwise assert credit.” Whatever approach is taken, transparency and communication is critical to ensure that all RWHAP clients have access to comprehensive HIV care and treatment and that only one 340B entity is claiming the 340B discount.

**APPENDIX A: Resources**

The following are national resources to help RWHAP recipients navigate the complex world of health insurance enrollment and assistance.

* [The Access, Care, and Engagement Technical Assistance (ACE TA) Center](https://navigatorguide.georgetown.edu/new-homepage) is funded through a HRSA HAB cooperative agreement and builds the capacity of the RWHAP community to navigate the changing health care landscape and help people with HIV access and use their health care coverage to improve health outcomes. The ACE TA Center provides technical assistance, including practical tools and resources, to support health care coverage engagement, education, enrollment, and renewal activities for people with HIV. Resources include information on Marketplace, Medicare and Medicaid enrollment, health insurance literacy, and shareable print, social media and video resources for consumer engagement.
* NASTAD (National Alliance of State & Territorial AIDS Directors) holds a HRSA HAB technical assistance cooperative agreement to provide technical assistance to RWHAP Part B and ADAPs, including on insurance purchasing and health insurance navigation. Resources developed by NASTAD through this cooperative agreement include financial forecasting and insurance cost-effectiveness tools and are available on the [TargetHIV](https://targethiv.org/) website.

**APPENDIX B: Glossary**

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| Essential Health Benefits (EHB) | The ACA requires most private insurance plans to cover ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care). |
| **Insurance Benefits Manager (IBM)** | A vendor that provides support for administration of RWHAP premium assistance programs. |
| **Medical Benefits Manager (MBM)** | A vendor that provides support for administration of RWHAP medical cost-sharing assistance programs. |
| **Pharmacy Benefits Manager (PBM)** | A vendor that provides support for administration of RWHAP prescription drug programs, including drug procurement, pharmacy network management, and administration of prescription co-payments. |
| **Premium Tax Credit (PTC)** | PTCs are available to consumers purchasing Marketplace coverage to offset premium costs. They are available on a sliding scale based on income, and consumers may apply for them in advance to reduce their premiums as soon as they enroll in coverage or can claim these tax credits as a refund at tax time. |
| **Cost-sharing reductions (CSRs)** | CSRs reduce the amount of out-of-pocket costs (such as coinsurance, co-payments, and deductibles) that consumers have to pay. They are based on income and are only available with silver level Marketplace plans. |
| **Out-of-pocket (OOP) maximum** | The OOP maximum is the most a consumer will pay in co-insurance, co-payments, and deductibles for covered services during a health insurance plan year. |
| **Federal Employee Health Benefit (FEHB) program** | FEHB is the health insurance program for individuals employed by the federal government. |
| **Rebate** | A rebate is a return of a part of a payment (e.g., an entity purchases medications at a price higher than 340B price may submit a rebate to the manufacturer down to the 340B price). See [PCN 15-04](https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-15-04-pharmaceutical-rebates.pdf)  for more information. |
| **Program income** | Program income is gross income earned that is directly generated by a supported activity or earned as a result of the federal award (e.g., an entity purchases medications at 340B discounted price and is reimbursed by insurer at higher “usual and customary price”). See [PCN 15-03](https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-15-03-program-income.pdf) for more information. |
| **Special Enrollment Period (SEP)** | An SEP is a period of time outside the annual Open Enrollment Period when a consumer may sign up for or change health insurance. The Marketplace has specific rules for when a consumer qualifies for an SEP. |
| **Qualified Health Plan** | An insurance plan that is certified by the Health Insurance Marketplace, provides EHB, follows federal limits on cost-sharing, and meets other requirements under the ACA. |

1. HRSA HAB, Ryan White HIV/AIDS Program Annual Client Level Data Report, 2020, available at [Ryan White HIV/AIDS Program Annual Client-Level Data Report 2020 (hrsa.gov)](https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/data/rwhap-annual-client-level-data-report-2020.pdf) [↑](#footnote-ref-1)
2. NASTAD, National ADAP/Part B Annual Monitoring Project Report, <http://publications.partbadap-2020.nastad.org/> [↑](#footnote-ref-2)
3. [PCN 18-01: Clarifications Regarding the Use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost-sharing Assistance (hrsa.gov)](https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/18-01-use-rwhap-funds-premium-cost-sharing-assistance.pdf) [↑](#footnote-ref-3)
4. The Plan Cost Effectiveness Review Tool was created through HRSA HAB’s ADAP Training and Technical Assistance cooperative agreement. [↑](#footnote-ref-4)
5. See [PCN 18-01](https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/18-01-use-rwhap-funds-premium-cost-sharing-assistance.pdf) for more information on what components of Medicare can be covered through the RWHAP. [↑](#footnote-ref-5)
6. [PCN 16-02](https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/service-category-pcn-16-02-final.pdf) and its accompanying [FAQ](https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/faqs-dental-insurance.pdf) address RWHAP and ADAP coverage of dental insurance premiums. [↑](#footnote-ref-6)
7. <https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/dcl-rwhap-adap-long-act-arv.pdf> [↑](#footnote-ref-7)
8. [ADAP Data Sharing Agreement User Guide v1.7 Oct. 2020 (cms.gov)](https://www.cms.gov/files/document/adap-dsa-user-guide-october-2020.pdf) [↑](#footnote-ref-8)
9. A cost-effectiveness plan assessment tool with a more nuanced formula has been developed through HRSA HAB’s ADAP Training and Technical Assistance cooperative agreement. ADAPs can request the tool through NASTAD, the recipient of the cooperative agreement. [↑](#footnote-ref-9)