Office of AIDS – Health Insurance Premium Payment Program (OA-HIPP)

Requirements and Enrollment Process Overview

OA-HIPP

- OA-HIPP pays health insurance premiums for eligible CA residents living with HIV
- Clients can remain enrolled as long as they continue to meet all eligibility requirements

OA-HIPP Eligibility Requirements

MUST

- Be enrolled in **ADAP**:
  - Have an HIV or AIDS diagnosis
  - Be 18 years of age or older
  - Effective June 24th, 2015 client's must have a Modified Adjusted Gross Income (MAGI) that does not exceed 500% Federal Poverty Level based on family size and household income.
  - Be a **California resident**

MUST NOT

- Have comprehensive employer-based health insurance premium that is less than 9.66 percent of annual household income
- Be enrolled in Medicare, Full-Scope Medi-Cal, or Medi-Cal Expansion

How the Program Works

- The monthly premium payment threshold that OA-HIPP will pay is **$1,938**
- Payments are made ***directly*** to the insurance company or Consolidated Omnibus Budget Reconciliation Act (COBRA) administrator
- Payments ***are not*** sent to clients
- Payments are made the month that the complete application was received

Employer-Based Insurance

- Individuals with employer-based health insurance premiums **above 9.66 percent of their annual household income** may enroll in OA-HIPP after obtaining coverage in a Covered California health plan.

Employer-Based Insurance Required Documents

- Applicants must submit the following documents to Office of AIDS (OA) as part of their OA-HIPP application packet for review:
  1. Latest tax return and
  2. Documentation showing the individual's portion of the employer-based premium that he/she is responsible for (i.e. copy of their paystub)
     1. ***Please note:*** This does not guarantee that the application will be approved. OA will have to review the documents and if OA determines that the individual's portion of the employer-based premium is less than 9.66 percent of their annual household income, the individual will not be eligible for OA-HIPP.

Dental and Vision Policies

- The OA-HIPP program will assist eligible clients with dental and vision plans only if the client is enrolled in a health plan. However, OA-HIPP will not pay for stand-alone vision policies; the vision plan must be included with the medical or dental plan.

- To request for dental and vision premium assistance that is paid separate from your medical health plan:
  - A separate OA-HIPP application packet must be submitted along with the corresponding billing statement.

- Only one OA-HIPP application packet is required if the premium amount includes the medical, dental, and vision premiums combined. (IAS Memo 2014-01)

OA-HIPP Application Package

Required Documents

1) OA-HIPP Program Application (must be signed and dated)
2) Insurance Assistance Consent Form (must be signed and dated)
3) Most recent health insurance policy billing statement
4) Dependent supporting document(s) if more than one person is on the policy:
    1) We accept a government issued marriage certificate, proof of California registered domestic partnership, and/or the most recent Internal Revenue Service tax return that denotes each dependent child with each OA-HIPP application. If a dependent child is not included on the most recent tax return, alternative documentation may be submitted such as a birth certificate or adoption paperwork.
5) Covered California Plans Only: Covered CA renewal, Covered CA welcome letter, or coverage summary page
6) COBRA Plans Only: COBRA Continuation Form, and initial billing statement with a valid account number

Required Documents

OA-HIPP applicants co-enrolled in a Covered CA plan:

- Must take the full monthly federal premium assistance amount Advanced Premium Tax Credit(APTC) and submit documentation verifying the APTC amount (e.g. Welcome Letter, Plan Enrollment Summary Page).
- Must be prepared to submit their 2015 Federal tax return, IRS Form 8962, and IRS Form1095-A for their first re-enrollment or recertification after April 15, 2016.

1. OA-HIPP Program Application

Section 1

Section 2

Section 3

Section 4

Section 5

State of California - Health and Human Services Agency

California Department of Public Health

HEALTH INSURANCE PREMIUM PAYMENT PROGRAM APPLICATION

California Department of PublicHealth

I. Eligibility Criteria

1. Are you currently receiving or eligible to receive employer-based health insurance? ◯ Yes ◯ No
2. Are you currently enrolled in Medicare or Full-Scope (free) Medi-Cal? ◯ Yes ◯ No
3. Are you currently enrolled in Medicare Part D? ◯ Yes ◯ No
4. Are you currently enrolled in a COBRA or Cal-COBRA policy? ◯ Yes ◯ No
   a. If yes, when does it expire?

II. Applicant Information

Applicant's Name (First, MI, Last)	Social Security Number		Mother's Maiden Name	
Home Address (Number, Street, Apt #)	City	County	State	Zip Code
Mailing Address (if different than home)	City	County	State	Zip Code
Telephone Number	Email Address		Date of Birth (mm/dd/yyyy)	

III. Demographic Information

1. Hispanic: ◯ Yes ◯ No
2. Race (check all that apply): ☐ White ☐ Black ☐ Asian ☐ American Indian or Native Alaskan ☐ Pacific Islander ☐ Other

◯ Male ◯ Transgender Male to Female ◯ Other_____
◯ Female ◯ Transgender Female to Male

IV. Current Insurance Plan Information (Your most current billing statement must be included with this application)

Payee Name	Payee Contact Name	Payee Phone Number	
Payee Address (Number, Street, or P.O. Box)	City	State	Zip Code
Type of Policy (Individual, Small Group, Large Group)	Member ID/Policy Number	Monthly Premium Amount ($)	

V. Please answer these questions ONLY if you obtained coverage through Covered California (otherwise leave blank)

1. What is your annual household income reported to Covered California? Policy effective date:
2. What is your household size (Includes self, spouse, registered domestic partner, and/or dependent children)?
3. How much of the monthly tax credit (APTC) are you eligible for? How much will you be taking?
4. What type of plan did you enroll in? ◯ Bronze ◯ Silver ◯ Gold ◯ Platinum

IMPORTANT: Please note that the information on this form is being collected to determine eligibility for benefits under the Ryan White Treatment Extension Act of 2009 (Public Law 111-87) and is required by the California Department of Public Health (CDPH). *Provision of the Social Security Number is voluntary. The information may be used to contact insurance companies, Consolidated Omnibus Budget Reconciliation Act (COBRA) administrators, employers and employer administered health insurance plans, enrollment workers, providers of health care services, and other governmental or public agencies as necessary to determine the extent of available health insurance and eligibility for insurance assistance and for the purpose of administering the program. Failure to provide the mandatory information may result in the application not being processed. You have the right to review the information maintained by CDPH unless access is exempt by law. To access the information contact CDPH Insurance Assistance Section, MS 7704, P.O. Box 997426, Sacramento, CA 95899-7426, or by phone at (844) 421-7050.

AUTHORIZATION: I authorize insurance companies, COBRA administrators, employers and employer administered health insurance plans, enrollment workers, providers of health care services, and other governmental or public agencies to release information to CDPH with regard to health insurance premiums, benefits and health care services provided to me. I authorize payment of refunds to CDPH for premiums paid by the program.

DECLARATION: I agree to re-enroll annually and re-certify as required by the HIPP Program. I certify that the answers I have given in this application and the documents provided are true and correct to the best of my knowledge. I understand that failure to provide accurate information may result in termination of insurance premium assistance. I understand that it is my responsibility to immediately notify my Enrollment Worker of changes to my policy including: increases to my monthly premium; change in billing address; or enrolled in employer-based health insurance, Medicare, or Full-Scope (free) Medi-Cal.

_____ Signature of Applicant _____ Date

CDPH 8522 (1/15)

OA-HIPP Program Application

Section I

I. Eligibility Criteria	
1. Are you currently receiving or eligible to receive employer-based health insurance?	Yes No
2. Are you currently enrolled in Medicare or Full-Scope (free) Medi-Cal?	Yes No
3. Are you currently enrolled in Medicare Part D?	Yes No
4. Are you currently enrolled in a COBRA or Cal-COBRA policy?	Yes No
a. If yes, when does it expire?	

- Complete all questions in Section I
- ***If yes to Question 4, must include the policy expiration date***

OA-HIPP Program Application

Section 2

II. Applicant Information				
Applicant's Name (First, MI, Last)	Social Security Number		Mother's Maiden Name	
Home Address (Number, Street, Apt #)	City	County	State	Zip Code
Mailing Address (if different than home)	City	County	State	Zip Code
Telephone Number	Email Address		Date of Birth (mm/dd/yyyy)	

- Complete all fields, excluding mailing address if not applicable

OA-HIPP Program Application

Section 3

III. Demographic Information

1. Hispanic: ◯ Yes ◯ No
2. Race (check all that apply): ☐ White ☐ Black ☐ Asian ☐ American Indian or Native Alaskan ☐ Pacific Islander ☐ Other

◯ Male ◯ Transgender Male to Female ◯ Other_____
◯ Female ◯ Transgender Female to Male

- Complete all demographic questions by checking the applicable fields

OA-HIPP Program Application

Section 4

IV. Current Insurance Plan Information (Your most current billing statement must be included with this application)			
Payee Name	Payee Contact Name	Payee Phone Number	
Payee Address (Number, Street, or P.O. Box)	City	State	Zip Code
Type of Policy (Individual, Small Group, Large Group)	Member ID/Policy Number	Monthly Premium Amount ($)	

- Please provide health insurance plan information located in the payment instructions on your most recent billing statement to fill out section 4

OA-HIPP Program Application

Section 4

- Payee = health insurance plan or COBRA Administrator
- Payee address = billing address
- The Member ID/Policy Number is used to post payments to the client's account
- If the payee requires a coupon code to be included with payments, please provide that code in the "Member ID/Policy Number" field

OA-HIPP Program Application

(Only to be completed by **Covered CA** clients)

Section 5

V. Please answer these questions ONLY if you obtained coverage through Covered California (otherwise leave blank)				
1. What is your annual household income reported to Covered California?		Policy effective date:		
2. What is your household size (Includes self, spouse, registered domestic partner, and/or dependent children)?				
3. How much of the monthly tax credit (APTC) are you eligible for?		How much will you be taking?		
4. What type of plan did you enroll in?	◯ Bronze	◯ Silver	◯ Gold	◯ Platinum

- The information in question 3 documents that the client has elected to take 100% of the APTC
- The APTC amount must match what is listed on the included Covered CA supporting documentation

OA-HIPP Program Application

IMPORTANT: Please note that the information on this form is being collected to determine eligibility for benefits under the Ryan White Treatment Extension Act of 2009 (Public Law 111-87) and is required by the California Department of Public Health (CDPH). *Provision of the Social Security Number is voluntary. The information may be used to contact insurance companies, Consolidated Omnibus Budget Reconciliation Act (COBRA) administrators, employers and employer administered health insurance plans, enrollment workers, providers of health care services, and other governmental or public agencies as necessary to determine the extent of available health insurance and eligibility for insurance assistance and for the purpose of administering the program. Failure to provide the mandatory information may result in the application not being processed. You have the right to review the information maintained by CDPH unless access is exempt by law. To access the information contact CDPH Insurance Assistance Section, MS 7704, P.O. Box 997426, Sacramento, CA 95899-7426, or by phone at (844) 421-7050.

AUTHORIZATION: I authorize insurance companies, COBRA administrators, employers and employer administered health insurance plans, enrollment workers, providers of health care services, and other governmental or public agencies to release information to CDPH with regard to health insurance premiums, benefits and health care services provided to me. I authorize payment of refunds to CDPH for premiums paid by the program.

DECLARATION: I agree to re-enroll annually and re-certify as required by the HIPP Program. I certify that the answers I have given in this application and the documents provided are true and correct to the best of my knowledge. I understand that failure to provide accurate information may result in termination of insurance premium assistance. I understand that it is my responsibility to immediately notify my Enrollment Worker of changes to my policy including: increases to my monthly premium; change in billing address; or enrolled in employer-based health insurance, Medicare, or Full-Scope (free) Medi-Cal.

Signature of Applicant _____ Date _____

**** Clients MUST sign and date the form ****

2. Insurance Assistance Consent Form

State of California – Health and Human Services Agency

California Department of Public Health

INSURANCE ASSISTANCE CONSENT FORM

Consent to Participate and Consent to Release Personal and Medical Information

The California Department of Public Health (CDPH), Insurance Assistance Programs provide health insurance premium payment assistance to low-income individuals living with human immunodeficiency virus (HIV). Individuals applying for these services must meet eligibility standards. Services are only available to individuals living with HIV/AIDS, who reside in California, are at least 18 years old, and have a modified adjusted gross income that does not exceed 500 percent of the federal poverty level per year based on family size and household income.

To verify eligibility for this program, CDPH, or its agents may be required to obtain personal information from other agencies or health care providers. If you agree to take part in a CDPH insurance assistance program, the enrolling agency will collect personal information including your name, date of birth, address, Social Security Number, medical history, and financial eligibility for the program. The information will be considered confidential, but may be released to CDPH, enrollment workers, Consolidated Omnibus Budget Reconciliation Act (COBRA) administrators, health insurance companies, employers and employer administered health insurance plans, health care professionals who provide services to you, CDPH contractors associated with the administration of the program, and other governmental or public agencies as necessary to determine your eligibility and for the purpose of administering the program.

Information that you provide for your application may be made available to your local health department for statistical purposes. This information includes, but is not limited to, gender, ethnicity, zip code, diagnosis status, and date of birth. This information may also be used for professional writings under strict assurances that all identifying information including name and Social Security Number is deleted. Any professional or research reports that may be published will not use your name nor any personal identifying information.

I, _____, consent to release of personal and medical information as described above to CDPH, enrollment workers, COBRA administrators, health insurance companies, employers and employer administered health insurance plans, health care professionals who provide services to me, CDPH contractors associated with the administration of the program and other governmental or public agencies as necessary to determine my eligibility for services and to administer the program. This consent shall remain in effect for two years from the date of my signature below unless revoked by me in writing. A photocopy of this consent shall be considered as valid as the original.

_____ _____
Applicant's Signature Date

_____ _____
Enrollment Worker's Signature Date

Enrollment Site Name	Enrollment Worker Name		
Enrollment Site Address (Number, Street, Suite #)	City	State	Zip Code
Enrollment Site Telephone Number	Enrollment Worker Email Address		

CDPH 8685 (07/15)

- Provides authorization for Office of AIDS (OA) to share information with enrollment workers, insurance companies, COBRA administrators, employers and other healthcare professionals for purposes of administering the program
- Client must sign and date
- Enrollment worker sign, date and complete bottom section

3. Billing Statement

- Client must provide a copy of the most recent health insurance policy billing statement.
- The billing statement is used by OA to verify who the policy holder is, member ID/policy number, billing address, and the current premium amount.

4. Covered CA Supporting Documentation
(Covered CA plans ONLY)

EXAMPLE

Covered California
PO Box 989725
West Sacramento, CA 95798-9725

COVERED CALIFORNIA

Your destination for affordable healthcare, including Medi-Cal

Important news about your health benefits

October 16, 2013 Case Number:

Dear

Thank you for applying for health insurance through Covered California for you and your household members. We used the information you gave us and state and federal data to make this decision:

Congratulations!

You qualify for health insurance through Covered California.

You also qualify for up to $114 per month in premium assistance to help pay for your health insurance coverage.

You do not qualify for Enhanced Silver Plan because:

Your income is above 250% of the federal poverty level which is higher than the Enhanced Silver Plan limits.

We have evaluated you for Medi-Cal. You do not qualify for Medi-Cal health coverage because your income is above the Medi-Cal limit.

It's time to choose a plan. Your coverage starts after you choose a plan and pay your first premium (monthly cost).

Go to **www.CoveredCA.com** and log into your account to compare plans and choose a plan.

About premium assistance
The Covered California website shows how much your premium assistance lowers your premium. Your premium assistance is based on our records and the income you put on your application that you expect this year. If you take the full premium assistance to pay the premium, and your income is

CCOE100 1

- Acceptable documents: "Welcome Letter," coverage summary page, or screenshots of online account
- The documentation is used to verify premium, APTC, effective date, health plan, and policy holder

Initial Application Process and OA-HIPP Payment Timeline

Initial Application Processing

- Prospective clients should expect to pay their monthly insurance premiums until it has been confirmed that their application has been approved and payment has been submitted to the health plan.
- OA will **NOT** reimburse **clients**. The client may pursue a refund from the health plan for any months that the client paid out of pocket and that OA also paid for.
  - *Except for Blue Shield Covered CA and Anthem Blue Cross Covered CA clients please contact your OA-HIPP analyst for reimbursement from plan.*

Initial Application Processing Timeline

- New, complete applications will be processed within six weeks of receipt
- Incomplete applications will delay processing
  - Incomplete applications will be followed-up by e-mail or phone call to the client and/or EW
  - Required Documents:
    - OA-HIPP Program Application (must be signed and dated)
    - Insurance Assistance Consent Form (must be signed and dated)
    - Most Recent Health Insurance Policy Billing Statement
    - Dependent supporting document(s) if more than one person is on the policy:
      - We accept a government issued marriage certificate, proof of California registered domestic partnership, and/or the most recent Internal Revenue Service tax return that denotes each dependent child with each OA-HIPP application. If a dependent child is not included on the most recent tax return, alternative documentation may be submitted such as a birth certificate or adoption paperwork.
    - Covered CA Clients Only: Covered CA Welcome Letter and/or coverage summary page
    - COBRA Plans Only: COBRA Continuation Form, and initial billing statement with a valid account number

Initial Payment for Covered CA Applications

- For complete applications received on or before the end of February with new Covered CA health plans for 2016, OA will pay retroactively back to the month coverage was effective and 3 months thereafter.
  - Ex: If OA received and approved an application in February and the policy effective date begins January 1, 2016, then OA would pay January through April.

Initial Payment for Covered CA Applications

- For complete applications received after the end of February with new Covered CA health plans for 2016, OA will begin making payments starting the month that the completed application is received.
  - Ex: If OA received an application in May 2016 and the policy effective date was January 1, 2016, because the application was received after February 29, 2016 – OA will pay May-July.

Initial Payment for Off-Exchange (non-Covered CA) Applications

- OA will pay for the month(s) the completed application was received and approved, and three months thereafter. This policy is for clients who have private insurance, COBRA or Cal-COBRA.

  Ex: If OA received and approved an application in January, then OA would pay January through April.

  Ex: If OA received an application in January, but it was not processed until February, then OA would pay January through May.

Payee Data Record

- If the client's health insurance company or COBRA administrator is not on file with CDPH Accounting Office, it can take up to an additional 3 months to process.

- In these cases OA staff will notify the EW or client if self-enrolling, within a week after the application has been received, so that the client knows to continue to pay their health insurance premiums.

Payee Data Record

- OA must have the health insurance company or COBRA administrator complete the Payee Data Record.

- OA staff will work directly with the COBRA administrator, health insurance company, or employer to obtain this information in order to process a payment to the provider.

Payee Data Record

PAYEE DATA RECORD
(Required when receiving payment from the State of California in lieu of IRS W-9)
STD. 204 (Rev. 6-2003)

1

INSTRUCTIONS: Complete all information on this form. Sign, date, and return to the State agency (department/office) address shown at the bottom of this page. Prompt return of this **fully completed** form will prevent delays when processing payments. Information provided in this form will be used by State agencies to prepare Information Returns (1099). See reverse side for more information and Privacy Statement.
NOTE: Governmental entities, federal, State, and local (including school districts), are not required to submit this form.

2

PAYEE'S LEGAL BUSINESS NAME (Type or Print)

SOLE PROPRIETOR – ENTER NAME AS SHOWN ON SSN (Last, First, M.I.) | E-MAIL ADDRESS

MAILING ADDRESS | BUSINESS ADDRESS

CITY, STATE, ZIP CODE | CITY, STATE, ZIP CODE

3

PAYEE ENTITY TYPE

CHECK ONE BOX ONLY

ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): ___ - _____

☐ PARTNERSHIP

☐ ESTATE OR TRUST

CORPORATION:
- ☐ MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.)
- ☐ LEGAL (e.g., attorney services)
- ☐ EXEMPT (nonprofit)
- ☐ ALL OTHERS

☐ INDIVIDUAL OR SOLE PROPRIETOR
ENTER SOCIAL SECURITY NUMBER: ___ - __ - ____
(SSN required by authority of California Revenue and Tax Code Section 18646)

NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.

4

PAYEE RESIDENCY STATUS

☐ California resident - Qualified to do business in California or maintains a permanent place of business in California.

☐ California nonresident (see reverse side) - Payments to nonresidents for services may be subject to State income tax withholding.
- ☐ No services performed in California.
- ☐ Copy of Franchise Tax Board waiver of State withholding attached.

5

I hereby certify under penalty of perjury that the information provided on this document is true and correct. Should my residency status change, I will promptly notify the State agency below.

AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print) | TITLE

SIGNATURE | DATE | TELEPHONE ( )

6

Please return completed form to:

Department/Office: California Department of Public Health
Unit/Section: Office of AIDS/ADAP Section MS 7704
Mailing Address: P.O. Box 997426
City/State/Zip: Sacramento, CA 95899-7426
Telephone: ( ) _____ Fax: (916) 449-5860
E-mail Address: _____

- Public entities are exempt from completing this form

Quarterly Payments

- If the client remains eligible for the program and complies with the program's requirements, his/her health insurance premiums will be paid quarterly.
- OA staff begin processing quarterly payments 45 days prior to payment due date.
- These payments must be submitted to the department's Accounting Office 30 days before the next premium is due.
  - Ex: If a client's initial payment was 1/1/15 – 4/30/15
  - The next quarterly payment will pay for 5/1/15 – 8/31/15
  - Staff will process the quarterly payments up to 3/15/15

Premium Changes

- Clients must notify OA of premium changes at least 45 days before the next quarterly payment is due, otherwise the client will be responsible for paying the balance owed.

  - Ex: Client's premium increased from $500 to $600 effective 5/1/15 but OA was notified on 4/1/15

    1. Client pays the $100 difference in premium amounts. $100 (difference between new premiums and old premiums) x 4 (quarterly cycle) = $400.
    2. The next quarterly payment made by OA would total to $2100. $600 (new premium amount) x 4 (quarterly cycle) = $2400 + $300 (difference between new premiums and old premiums) = $2700
    3. Client will then request for a refund in the amount of $400 after the next quarterly payment has been received by their health plan.

OA-HIPP Re-enrollment and Recertification Process

OA-HIPP Re-Enrollment

- All OA-HIPP clients are required to re-enroll during their birth month every year
- If documents are not received on time, it may effect payment to their health plan
- Required Documents:
  1) New OA-HIPP Application (must be signed and dated)
  2) Insurance Assistance Consent Form (must be signed and dated)
  3) Most recent health insurance policy billing statement

Covered California Plans Only: Clients must also submit a copy of their most recent Federal Tax Return (only if it was not submitted during recertification).

OA-HIPP Recertification

- Recertification is required 6 months after re-enrollment

- If documents are not received timely, it may affect OA-HIPP eligibility and payments will not be processed to their health plan

- Required Documents:
  1) OA-HIPP Program Application (must be signed and dated)
  2) Most recent health insurance policy billing statement

Covered California Plans Only: Clients must also submit a copy of their most recent Federal Tax Return (only if it was not submitted during Re-enrollment).

OA-HIPP Client Responsibilities

Client Responsibilities

- Clients must be made aware that they need continue to pay their monthly premiums until they have received confirmation from their EW or OA, that their application has been approved and a premium payment has been made.
- If clients do not comply with OA-HIPP's policies, then this will delay processing of the application and payment
- Clients must be enrolled in ADAP
- Clients must <u>immediately</u> communicate any changes regarding their health insurance policy to their EW, or OA such as:
  - Change in monthly premium
  - Change in health insurance policy
  - Change in billing address
  - Returned to work and obtained employer based health insurance
  - Enrolled in Medicare and/or Full-Scope Medi-Cal

OA-HIPP Client Responsibilities Form

OA-HIPP

OA-HIPP Client Responsibilities

You have successfully completed your OA-HIPP application which will be reviewed by the California Department of Public Health. Until you have received notice from your Enrollment Worker that your application has been approved and payment has been sent to your health plan, you must continue to pay your monthly insurance premiums.

After your application is approved, you will be expected to immediately inform your Enrollment Worker of the following changes:

- To your contact information (i.e. address, telephone number).
- To your policy, such as:
  - Monthly premium amount;
  - Payee contact information (i.e. address, telephone number); and/or
  - Policy expiration dates.
- In your coverage, such as if you:
  - Move from COBRA to Cal-COBRA;
  - Obtain or become eligible for employer-based health insurance; or
  - Enroll in Medicare or Full-Scope (free) Medi-Cal, to ensure that OA-HIPP is the payer of last resort.

Re-enroll and recertify in OA-HIPP at the same time you do for ADAP.
Required forms are noted in the table below:

Document Type	Re-Enrollment Due on: __/__/____	Recertification Due on: __/__/____	Covered CA Renewal Due: Every Open Enrollment Period
1. OA-HIPP Application	X	X	X
2. Most Recent Health Insurance Billing Statement	X	X	X
3. IAS Consent Form	X		
Covered California Plans Only: 4. Most Recent Tax Return	X (Whichever comes first after you receive your tax return.)	X	
5. Renewal or Summary Page			X

Failure to submit the documents by the above due dates may result in a delay in payment made on your behalf to your health plan or a potential loss of health insurance.

I understand and acknowledge my responsibilities as an OA-HIPP Client:

Signature: _____ Date: _____

- Explains the clients' responsibilities
- Must be discussed with each client, signed, handed to client for reference, and a copy kept in the file

Client Responsibilities

Frequently Asked Questions:

1. How long will it take for my application to be processed?
Application processing may take a minimum of 6 weeks from the date it is received. You must submit a complete application packet with no missing information and/or documents. Keep in mind that if your health plan is not currently in the OA-HIPP accounting database, OA-HIPP would need to obtain necessary documents from your health plan, which could take extra time.

2. What is the status of my OA-HIPP application?
You may speak with your enrollment worker regarding OA-HIPP determination or enrollment. Please keep in mind application processing time frame (see #1). Your enrollment worker will be notified once a check has been sent to your health plan on your behalf.

3. Why am I still receiving billing statements from my health plan if OA-HIPP is paying for my premiums?
You will continue to receive billing statements as long as you are the insurance policy holder. Your health plan sends an automated statement to inform you of your premiums. If there is any change in your premium rate, you must inform your enrollment worker immediately.

4. An OA-HIPP payment has been sent to my health plan but payment is still not received or posted to my account, why?
It may take a few days to a few weeks for payment to be processed and posted to your account, depending on your health plan. If it has been at least 3-4 weeks since the payment was sent and it is still not posted, please follow-up with your enrollment worker.

5. Once my OA-HIPP application is approved, will I get a refund for premiums I paid on my own?
Please contact your health plan to request reimbursement for any months you've paid out of pocket that OA-HIPP has also covered. If you are with Covered California's Anthem Blue Cross plan, please do not contact the health plan. A refund will be issued automatically.

Covered California Health Plan Members:

Continuity of Care:

If you are experiencing issues with your Covered California health plan that adversely affects your continuity of care, first contact your plan and request continuity of care services. If your request is denied or there is a delay in response, you may file a formal grievance or complaint with the health insurance company. If your issue does not get resolved to your satisfaction, you may contact the California Department of Managed Health Care's Help Center at (888) 466-2219 for help. For assistance with payment issues, medication requests, or help with working with your health insurance company, you may contact The Health Consumer Alliance at (888) 804-3536 or visit *www.healthconsumer.org*.

Covered California Renewal:

You will need to renew your Covered California health plan every year during open enrollment and subsequently submit documents to OA-HIPP (please see the chart on the fist page). If you have given consent to Covered California to obtain your tax data from the Internal Revenue Service (IRS) to verify income, the re-determination of your health plan and subsidies will occur automatically during every open enrollment period. Otherwise, you will have to actively renew your plan on the Covered California website in order to take the full Advanced Premium Tax (APTC), if applicable. You may give Covered California consent to obtain your tax data from the IRS at any time during the year by calling (800) 300-1506 or visiting *www.coveredca.com*.

Additional Resources:

- For additional guidance regarding Covered California and OA-HIPP, please visit:
  http://hbex.coveredca.com/toolkit/PDFs-Collateral/people%20living%20with%20hiv-aids.pdf
- Office of AIDS' Health Insurance Premium Payment (OA-HIPP) program enrollment:
  www.cdph.ca.gov/programs/aids/Pages/OAIAS.aspx
- Qualifying circumstances for continuity of care:
  www.dmhc.ca.gov/dmhc_consumer/br/br_continuity.aspx

- Documents frequently asked questions
- Provides additional resources

Changing Policies

- If OA sends a payment and the client subsequently cancels the policy and/or enrolls in a new policy, OA will not make a payment to the new payee until the client returns any credit remaining with their previous policy provider.

- The client should make the initial payment to their new payee to secure enrollment:
  - Ex: OA paid company A from 1/1/15 – 3/31/15 and the client subsequently cancels and enrolls with company B effective 2/1/15. OA will only pay company B 2/1/15 – 3/31/15 until the equivalent of two months premiums from company A is returned to OA.

Partial Payment – Client's Portion

- If a client's monthly premium exceeds the threshold of $1,938 or if the client is enrolled in a group policy that does not offer individual billing, the client must enter into a Partial Payment Agreement.
- Client must sign the Partial Payment Agreement Form.
- Client must send a cashier's check or money order for the difference or amount owed per the due dates outlined in their Partial Payment Agreement Form.
- Check needs to be made payable to the client's COBRA administrator, health insurance company or employer and sent to: CDPH Insurance Assistance Section, MS 7704, P.O. Box 997426, Sacramento, CA 95899-7426.
- OA will send two checks to the payee (OA's check and client's check).

Partial Payment

1) Ex: If Client has a premium of $1,958 they would need to pay $60 to cover the difference:
($1,958 - $1,938 = $20) per quarter ($20 x 3 = $60)
   - OA will send a check totaling $5814

   ($1938 x 3 = $5814) and the client's check totaling $60 simultaneously

2) Ex: If Client is on a group policy with two other people and each of their premiums is $500, the client would need to send a $3000 payment:
($500 x 2 = $1000) per quarter ($1000 x 3 = $3000)
   - OA will send a check totaling $1500 ($500 x 3 = $1500) and the client's check totaling $3000 simultaneously

Partial Payment Agreement Form

State of California – Health and Human Services Agency | California Department of Public Health

PARTIAL PAYMENT AGREEMENT
OA-HIPP PROGRAM

The following information is required for applicants whose health insurance premiums exceed the OA-HIPP Program payment limits.

I. Applicant Information

Applicant's Name (First, MI, Last)	Date of Birth (mm/dd/yyyy)	Mother's Maiden Name		
Home Address (Number, Street, Apt #)	City	County	State	Zip Code
Mailing Address (if different than home)	City	County	State	Zip Code
Telephone Number (Home)	Telephone Number (Alternate)			

II. Current Insurance Plan Information (must attach a copy of your member ID card and billing statement)

Payee Name	Payee Contact Name	Payee Telephone Number	
Payee Address (Number, Street, or P.O. Box)	City	State	Zip Code
Payee's Federal Tax ID Number	Member ID/Policy Number	Monthly Premium Amount $	
Monthly Program Threshold $	Monthly Difference $	Quarterly Amount Due (Monthly Difference x 3) $	

Please note that the information on this form is being collected to determine eligibility for benefits under the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) and is required by the California Department of Public Health (CDPH), Office of AIDS. The information may be used to determine eligibility for insurance assistance. Failure to provide the mandatory information may result in the application not being processed. You have the right to review the information maintained by CDPH unless access is exempt by law. To access the information, contact CDPH Insurance Assistance Section, MS 7704, P.O. Box 997426, Sacramento, CA 95899-7426, or by phone at (800) 367-2437.

☐ I understand that I am an applicant with a monthly health insurance premium that exceeds the Office of AIDS Health Insurance Premium Payment (OA-HIPP) program limits and that I am financially responsible to pay the difference between the monthly premium amount and the program threshold.

☐ I understand that I must submit a money order to OA with this form, made payable to the Payee Name listed above, for the amount equivalent of three months of the difference owed between the monthly premium amount and the program threshold. I will submit additional money orders for that amount for each future quarter, due on the first of the following month(s), _____, _____. In the event that the premium amount increases, I will notify OA of the additional amount I owe and I will pay the adjusted amount.

☐ I understand that I will be terminated from the OA-HIPP Program and I will no longer be eligible to receive OA-HIPP services if I fail to pay the portion of the premium that I am responsible for.

☐ I certify that the information provided on this form is true and correct to the best of my knowledge.

_____ _____
Applicant's Signature Date

CDPH 8722 (09/11)

- OA staff will complete this form and send to the EW/client
- Documents when and how much the client must pay
- Client must sign and date

Refunds

- If the client and OA paid for the same month(s), the client must contact the COBRA administrator, health insurance company or employer and request a refund.

** **OA will not reimburse clients**

- If the client receives a refund for premiums that were paid by OA, the client must immediately return the money to OA. Personal checks are not accepted. The client must send a cashier's check or money order that is made payable to the **California Department of Public Health** and mail to:

CDPH, Insurance Assistance Section,
MS 7704, P.O. Box 997426
Sacramento, CA 95899-7426

Enrollment Worker Responsibilities

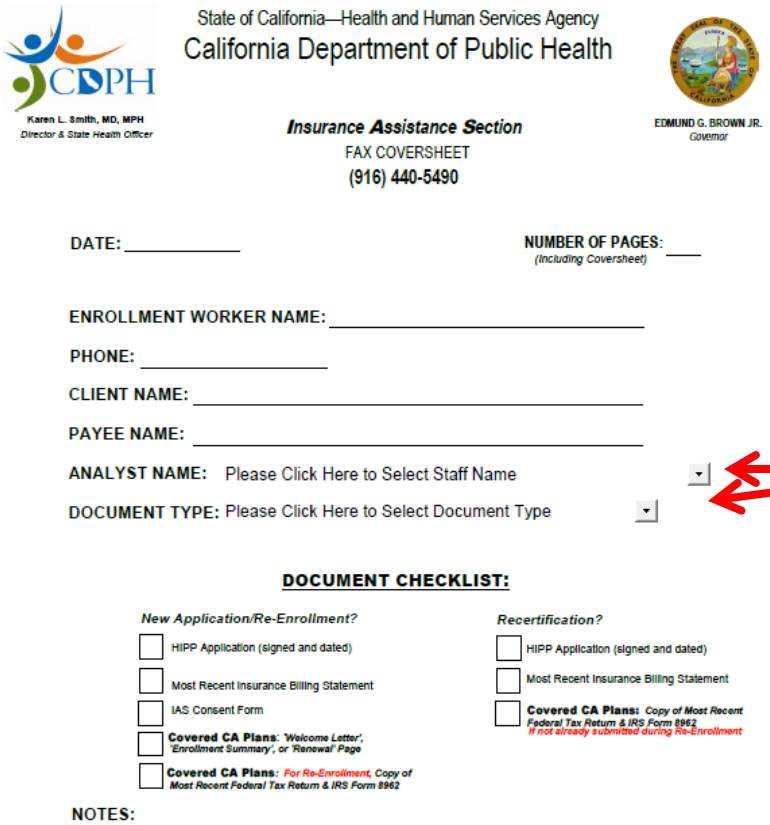
EW Responsibilities

- EWs are the liaison between the client and OA-HIPP
- EWs are responsible for the following:
  1) Ensuring all client-level information is stored and transmitted securely
  2) Helping the client enroll and stay enrolled in the program
  3) Answering questions from OA staff and the client
  4) Ensuring that the client recertifies and re-enrolls in accordance within expected timeframes
  5) Immediately notifying OA of changes to the client's account and/or eligibility information

Emails

- All emails that contain protected health information, such as client name, social security number, or date of birth ***must*** be sent via secure or encrypted email
- Please follow your organization's protocols for sending secure emails
- When sending client information via secure email, **do not** include patient information in the subject line

IAS Fax Coversheet



State of California—Health and Human Services Agency
California Department of Public Health

Karen L. Smith, MD, MPH
Director & State Health Officer

EDMUND G. BROWN JR.
Governor

Insurance Assistance Section
FAX COVERSHEET
(916) 440-5490

DATE: _____

NUMBER OF PAGES: ____
(Including Coversheet)

ENROLLMENT WORKER NAME: _____

PHONE: _____

CLIENT NAME: _____

PAYEE NAME: _____

ANALYST NAME: Please Click Here to Select Staff Name

DOCUMENT TYPE: Please Click Here to Select Document Type

DOCUMENT CHECKLIST:

New Application/Re-Enrollment?

- ☐ HIPP Application (signed and dated)
- ☐ Most Recent Insurance Billing Statement
- ☐ IAS Consent Form
- ☐ **Covered CA Plans**: *'Welcome Letter', 'Enrollment Summary', or 'Renewal' Page*
- ☐ **Covered CA Plans**: *For Re-Enrollment, Copy of Most Recent Federal Tax Return & IRS Form 8962*

Recertification?

- ☐ HIPP Application (signed and dated)
- ☐ Most Recent Insurance Billing Statement
- ☐ **Covered CA Plans:** *Copy of Most Recent Federal Tax Return & IRS Form 8962 If not already submitted during Re-Enrollment*

NOTES:

THIS COVERSHEET MUST ACCOMPANY ALL FAXES GOING TO CDPH/IAS. ALL DOCUMENTS SUBMITTED WITHOUT THIS COVERSHEET WILL BE DISCARDED.

- Coversheet must be submitted with all faxed documents
- Fill out the appropriate information
- Use the drop down box to choose the analyst's name and Document Type

Affordable Care Act (ACA)

Affordable Care Act (ACA)

- Two key provisions of ACA that impact ADAP and OA-HIPP are:
  - Medi-Cal Expansion
  - Covered CA

Medi-Cal Expansion (MCE)

- Medi-Cal has expanded to cover people between 19 to 64 years old
  - Eligibility solely based on income (less than 138 % Federal Poverty Level [FPL])
  - Includes individuals with or without disabilities
  - Full-scope (no healthcare expenses)

- Due to OA Payer of Last Resort requirements, OA-HIPP and ADAP clients eligible for MCE must apply for MCE.

Medi-Cal Expansion

- All ADAP clients who earn less than 138 % FPL ($16,395) for the year of 2016, **must** apply for Medi-Cal Expansion (MCE):
  - Current OA-HIPP clients who qualify for MCE will need to submit proof to OA via their enrollment workers that they have applied to MCE
  - Once proof has been provided, they will have a 45 day determination grace period (subject to change based on determination)
  - If enrolled into MCE, clients will be disenrolled from ADAP and OA-HIPP

- ADAP will continue to serve clients enrolled:
  - In standard Medi-Cal with a share of cost
  - Medicare/Medi-Cal (medi-medi) clients with a share-of-cost, who need drug co-payment assistance
  - Medi-Cal HIPP who need co-payment assistance

Medi-Cal Expansion Enrollment

- Eligible individuals can enroll in Medi-Cal Expansion at any time
- When applying for Medi-Cal Expansion, you are submitting one application for both Medi-Cal Expansion and Covered CA
- Ways to apply:
  - Online: www.CoveredCA.com
  - Telephone: 800-300-1506
  - In person
    - List of Trained Representatives at www.CoveredCA.com or by calling 888-975-1142
  - Paper application
    - Send in by fax: 888-329-3700
    - Covered California, P.O. Box 989725, West Sacramento, CA 95798-9725

Covered California

- In California, documented residents can obtain private health coverage through the statewide marketplace, a.k.a., Covered California
- For legal CA residents earning more than 138 % FPL
  - Provides comprehensive health coverage
- Four coverage options available: **Bronze, Silver, Gold, and Platinum**
  - **Platinum** has **highest premiums** but **lowest out-of-pocket cost**
  - **Silver** has **lower premiums** and **lower out-of-pocket cost**
  - **Bronze** has **lowest premiums** but **highest out-of-pocket cost**
- Two primary benefits
  - Premium assistance
  - Cost sharing subsidies

Covered CA Premium Assistance

- Also known as Advanced Premium Tax Credit (APTC)
- Available for individuals with income 138 % to 500 % FPL
- Sent directly to health plan by federal government and applied to client's monthly premium
- Decreases the clients portion of the monthly premium
- To maintain OA-HIPP eligibility, clients must elect to take 100% of Premium Assistance (if applicable)

Report Changes to Covered CA

- It is critical that individuals report changes to Covered CA throughout the year to avoid underpayment or overpayment of APTC.
- A client should notify Covered CA if he/she:
  - Gets married or divorced
  - Gains or loses a dependent
  - Has a change in income, or
  - Experiences other changes that may affect the household income or household size.
- Clients should report changes within 30 days of change by calling Covered CA at (800) 300-1506.
  - *Clients must also report changes to OA after notifying Covered CA.*

Covered CA Cost Sharing Subsidies

- If an individual earns 138 % to 200 % FPL (approx. $16,395 - $23,760), we advise individuals to select an Enhanced Silver Plan for the lowest possible out-of-pocket health care expenses including copays and deductibles

FPL (%)	Primary Visit Co-Pay
138-150	$3
151-200	$15
201-250	$40
Standard Silver	$45

Client Out-of-Pocket Cost

- If an individual earns between 201% to 500% FPL (Approx. $23,879- $59,400) we advise they select a Platinum plan for the lowest possible out-of-pocket health care expenses including copays and deductibles

FPL (%)	Primary Visit Co-Pay
138-150	$3
151-200	$15
201-250	$40
Platinum	$20

Covered CA Open Enrollment

- Open enrollment for 2017 is November 1, 2016 through January 31, 2017.

Covered CA Special Enrollment

- Special Enrollment period
  - Occurs within 60 days of a Qualifying Event:
    - Becoming a new California resident
    - Becoming a legal resident
    - Loss of job / health insurance
    - Birth of child
    - Death of spouse
    - Income increases, disqualifying the client for Medi-Cal Expansion

Covered CA Enrollment Application

- Eligible individuals can enroll into Covered CA during open enrollment or Special Enrollment
- When applying for Covered CA, you are submitting one application for both Medi-Cal Expansion and Covered CA
- Ways to apply:
  - Online: www.CoveredCA.com
  - Telephone: 800-300-1506
  - In person
    - List of Trained Representatives at www.CoveredCA.com or by calling 888-975-1142
  - Paper application
    - Send in by fax: 888-329-3700
    - Covered California, P.O. Box 989725, West Sacramento, CA 95798-9725

OA-HIPP Office Information

Security and Confidentiality

- California law and Federal law (HIPAA) protect the confidentiality of ADAP client information (i.e., HIV public health records)
- California law includes specific requirements such as signing OA's HIV/AIDS confidentiality agreement and restricting who and for what purpose ADAP client information can be shared by EW's (Click link for more information)
- If ADAP client information is shared without the authority of law then, California law carries the following penalties:
  1) Person may be liable up to $5,000, plus courts costs, for the negligent disclosure of ADAP client information.
  2) Penalties significantly increase for "willful or malicious disclosure"- not less than $5,000 and not more then $25,000 plus court cost.
  3) Disclosure that leads to economic, bodily or psychological harm can lead to imprisonment in a county jail and/or a fine up to $25,000 plus court cost.

Record Retention and Disposal

- OA-HIPP and ADAP files can be filed together
- OA-HIPP and ADAP client files must be retained for a period of four years (current year + three prior years)
- OA-HIPP and ADAP client files are stored in a locked filing cabinet in a secured office
- OA-HIPP and ADAP hard copy files must be shredded when disposed
- Electronic files will need to be destroyed securely based on the ADAP site IT protocols

Contact Information

- All forms noted in this training are available on the following webpage: http://www.cdph.ca.gov/programs/aids/Pages/OAHIPPForms.aspx
- General toll-free phone number is: (844) 421-7050
- All forms and required documents must be submitted via the Ramsell website

Or

- Faxed to: (916) 440-5490

Or

- Mailed to:

California Department of Public Health
Insurance Assistance Section
MS 7704 P.O. Box 997426
Sacramento, CA 95899-7426

Thank you!