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

Enrollment Worker Training

Present By: Sara Johnson, Richard Martin and Irina Banar

Learning Objectives

By the end of this presentation you will understand….

- The eligibility criteria for OA-HIPP.
- Be able to complete the appropriate forms.
- OA's application and payment processes and timelines.

What Is OA-HIPP?

- OA-HIPP pays health insurance premiums for eligible CA residents.
- Policy must provide comprehensive health insurance and prescription coverage.
- Clients can remain enrolled as long as the services are needed and they continue to meet all eligibility requirements.

How the Program Works

- The monthly program threshold is **$1,938*.**
- Payments are made ***directly*** to the insurance company or Consolidated Omnibus Budget Reconciliation Act (COBRA) administrator, health insurance company or employer each quarter.
- Payments ***will not*** be sent to individuals.

OA-HIPP
Eligibility Requirements

MUST

- Be a **California resident.**
- Be enrolled in **ADAP.**
- Have an HIV or AIDS diagnosis.
- Be 18 years of age or older.
- Have a Federal Adjusted Gross Income (FAGI) that does not exceed $50,000.

MUST NOT

- Have comprehensive employer-based health insurance.
- Be enrolled in Medicare or Full-Scope Medi-Cal.

Required Documents

1) OA-HIPP Application
2) Insurance Assistance Consent Form
3) ARIES OA-HIPP/OA-PCIP Client Consent Form
4) Most recent insurance policy billing statement

1. Program Application

Section 1

Section 2

Section 3

Section 4

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 enrolled in ADAP? ◯ Yes ◯ No
2. Are you currently enrolled in Medicare or Full-Scope (free) Medi-Cal? ◯ Yes ◯ No
3. Are you currently enrolled in the Low-Income Health Program (LIHP)? ◯ Yes ◯ No
4. Are you currently enrolled in a COBRA or Cal-COBRA policy? ◯ Yes ◯ No
   a. If yes, when does the policy expire?
   b. If no, what type of policy (i.e. Individual, Group)
5. Are you currently receiving or eligible to receive employer-based health insurance? ◯ Yes ◯ No

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

◯ HIV Positive, Disease Stage Unknown ◯ HIV Positive, Symptomatic, not AIDS ◯ CDC Defined AIDS
◯ HIV Positive, Asymptomatic ◯ HIV Positive, Disabling ◯ Disabling AIDS

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
Payee's Federal Tax ID Number	Member ID/Policy Number	Monthly Premium Amount $	

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, employers, providers of health care services, and state and county agencies to determine the extent of available health insurance and 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.

AUTHORIZATION: I authorize insurance companies, employers, enrollment workers, providers of health care services, and state and county agencies to release of information to the CDPH with regard to health insurance premiums and benefits. 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

_____ Name of Policy Holder (if different) _____ Signature of Policy Holder _____ Date

CDPH 8522 (01/13)

Program Application Continued…

Section I

I. Eligibility Criteria	
1. Are you currently enrolled in ADAP?	◯ Yes ◯ No
2. Are you currently enrolled in Medicare or Full-Scope (free) Medi-Cal?	◯ Yes ◯ No
3. Are you currently enrolled in the Low-Income Health Program (LIHP)?	◯ Yes ◯ No
4. Are you currently enrolled in a COBRA or Cal-COBRA policy?	◯ Yes ◯ No
a. If yes, when does the policy expire?	
b. If no, what type of policy (i.e. Individual, Group)	
5. Are you currently receiving or eligible to receive employer-based health insurance?	◯ Yes ◯ No

- Check the applicable boxes.
- **<u>***Question 4* is important</u>**because OA needs to know when payment should stop.

Program Application Continued…

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)	

- Fill out the appropriate information.

Program Application Continued…

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

☑ HIV Positive, Disease Stage Unknown ☐ HIV Positive, Symptomatic, not AIDS ☐ CDC Defined AIDS

☐ HIV Positive, Asymptomatic ☐ HIV Positive, Disabling ☐ Disabling AIDS

- Check applicable boxes.

Program Application Continued…

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
Payee's Federal Tax ID Number	Member ID/Policy Number	Monthly Premium Amount $	

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, employers, providers of health care services, and state and county agencies to determine the extent of available health insurance and 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.

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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	
Name of Policy Holder (if different)	Signature of Policy Holder	Date

- Payee address is the place where the payment is sent

**** Client MUST sign and date the form****

2. Insurance Assistance Section Consent Form

State of California - Health and Human Services Agency

California Department of Public Health

INSURANCE ASSISTANCE SECTION CONSENT FORM

California Department of PublicHealth

Consent to Participate and Consent to Release Personal and Medical Information for Client Eligibility

The California Department of Public Health, Insurance Assistance Section (IAS) administers programs that provide health insurance premium payment assistance to low-income individuals living with human immunodeficiency virus (HIV). Individuals applying for IAS 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 federal adjusted gross income below $50,000.

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 IAS, 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 health care providers, and CDPH staff, for the sole purpose of administering the program. Confidentiality agreements are in place, which keep client information confidential except with specific client consent or as otherwise allowed by law.

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, other health care professionals who provide services to me, and other governmental or public agencies as necessary to determine my eligibility for IAS services. 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. Any disclosure authorized by the consent form shall be made only upon agreement that the information will be kept confidential.

_____ _____
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 Site Fax Number	Enrollment Worker Email Address	

- Provides authorization for CDPH 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.

ARIES

- AIDS Regional Information and Evaluation System (ARIES) is a centralized HIV/AIDS client database.
- ARIES will be used by Enrollment Workers (EW's) to access real-time client data, including:
  - Enrollment Status
  - Insurance information
  - Premium payment history

3. ARIES OA-HIPP/OA-PCIP Client Consent Form

State of California—Health and Human Services Agency

California Department of Public Health—Office of AIDS

ARIES OA-HIPP/OA-PCIP Client Consent Form

I, _____ *(print full name)*, wish to register with the AIDS Regional Information and Evaluation System (ARIES) in order to receive services provided by the California Department of Public Health (CDPH) / Office of AIDS (OA) Health Insurance Premium Payment Program (OA-HIPP) or the OA-Pre-Existing Condition Insurance Plan Program (OA-PCIP). During registration, I will be asked to provide information about myself, including my name, race, gender, date of birth, HIV disease stage and other demographic data.

In addition to providing the above information, I must provide this form along with other program forms and documentation required by OA-HIPP/OA-PCIP. This ARIES OA-HIPP/OA-PCIP Client Consent Form is in addition to a county's or agency's ARIES Client Consent Form used to register for other (non-insurance premium payment) HIV programs or services.

SHARE: By signing below, I understand my registration information and OA-HIPP/OA-PCIP services will be shared with other agencies I receive services from that are part of ARIES. Only authorized personnel at an agency will have access to my information on a need-to-know basis. If I receive other, non-insurance services at another ARIES agency, information about those services or treatments received will also be shared with the other ARIES-using agencies that I receive services from. Mental health, alcohol/substance use, and legal information will not be shared. By stating that my information will be shared, I will usually not need to re-register (in ARIES) or provide a letter of diagnosis when I require assistance from another agency providing services funded by the Ryan White HIV/AIDS Program or the California Department of Public Health/Office of AIDS. An ARIES Consent Form will be completed again as part of the annual OA-HIPP/OA-PCIP re-enrollment process; if no re-enrollment occurs, Consent will expire two years from the date I sign this form.

I understand that the information I provide may be made available to my local health department and to the CDPH/OA for mandated care and treatment reporting requirements, and may be used for program monitoring, statistical analysis and research activities. This information includes, but is not limited to, gender, ethnicity, birth date, zip code, diagnosis status, and service data. No identifying information, such as name and social security number, will be released, published, or used against me without my consent, except as allowed by law or to ensure compliance with policy.

Additionally, as a condition of receiving insurance premium services, I consent that my local health department may disclose to my health care providers the minimum necessary of my ARIES information to assist them in complying with HIV reporting laws and regulations.

My registration in ARIES does not guarantee services from any other ARIES-using agency. Wait lists or other eligibility requirements may exclude me from services at other ARIES agencies.

By signing this form I acknowledge that I have been offered a copy of the ARIES OA-HIPP/OA-PCIP Client Consent Form and have talked about and understand my rights to confidentiality with respect to ARIES with the staff person indicated below. I understand that this form will be stored in my paper file and/or uploaded into my ARIES record.

_____ *Signature of Client or Parent/Guardian of Minor Child*

_____ *Date*

For Enrollment Site Agency Use Only

_____ *Administered By*

_____ *Agency Name/OA-HIPP/PCIP Enrollment Site*

_____ *Signature*

_____ *Date*

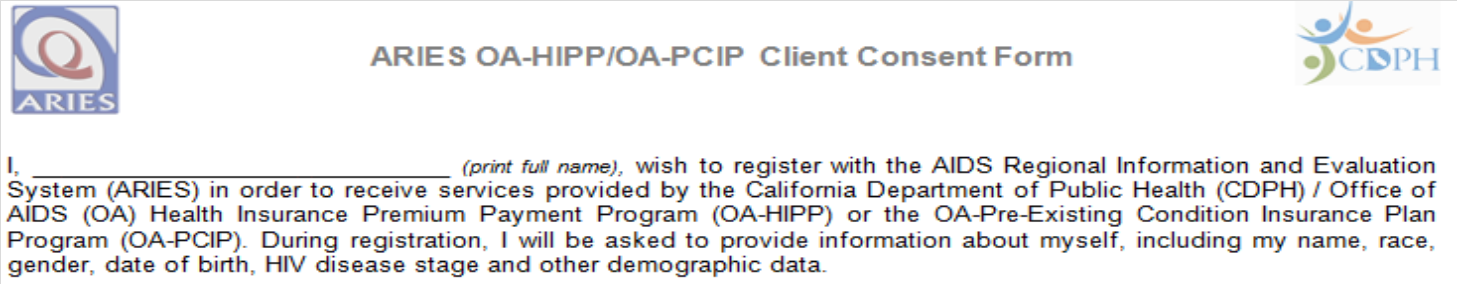
This client is a **NON-SHARE** client because: __ Unable to give consent

OA-HIPP 8454 (01/13)

EW's will only be able to view information in ARIES for the clients they serve.

3. ARIES OA-HIPP/OA-PCIP Client Consent Form

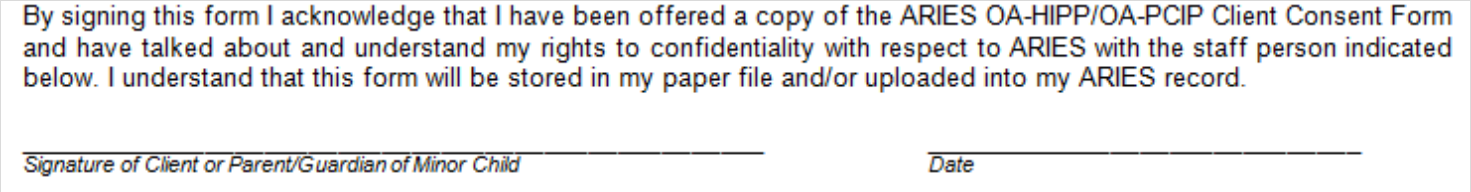
- Client must print his/her name.



ARIES OA-HIPP/OA-PCIP Client Consent Form

I, _____ *(print full name)*, wish to register with the AIDS Regional Information and Evaluation System (ARIES) in order to receive services provided by the California Department of Public Health (CDPH) / Office of AIDS (OA) Health Insurance Premium Payment Program (OA-HIPP) or the OA-Pre-Existing Condition Insurance Plan Program (OA-PCIP). During registration, I will be asked to provide information about myself, including my name, race, gender, date of birth, HIV disease stage and other demographic data.

- Client must sign & date



By signing this form I acknowledge that I have been offered a copy of the ARIES OA-HIPP/OA-PCIP Client Consent Form and have talked about and understand my rights to confidentiality with respect to ARIES with the staff person indicated below. I understand that this form will be stored in my paper file and/or uploaded into my ARIES record.

_____ _____

Signature of Client or Parent/Guardian of Minor Child *Date*

4. Billing Statement

- Client must provide a copy of their most recent insurance policy billing statement.
- OA must know the client's monthly premium amount and where to send payment to.

Initial Application Processing

- Incomplete applications will delay processing.
- Prospective OA-HIPP clients should expect to pay their monthly insurance premiums until they are notified that their application has been approved and payment has been submitted by OA.
- OA will **NOT** reimburse **clients**.

Initial Application Processing Continued

- New applications and checks will be processed and if approved, checks will be sent out within **FOUR** weeks of receipt of application.
- If the client's health insurance company or COBRA administrator is not on file with OA's Accounting Office, it can take up to an **additional** 3 months to process.
- In these cases OA staff will notify the EW within a week after the application has been received.
  - This information should be relayed to the client **immediately**, so that the client would know to continue to pay their health insurance premiums.
- OA must have the health insurance company or COBRA administrator complete the Payee Data Record.

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: _____

- OA staff will work directly with the COBRA administrator, health insurance company or employer.
- Public entities are exempt from completing this form.
- Information in box 2 must indicate who the check should be made payable to and where to send it.
- Federal Tax ID must be inputted into box 3.

Payee Data Record

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:

- Must be completed and signed by COBRA administrator, health insurance company or employer.
- Fax completed form to (916) 449-5860.

OA-HIPP Re-Enrollment

After **March 1, 2013**:

- All OA-HIPP clients will be required to re-enroll during their birthday month or at the <u>same</u> time they re-enroll in ADAP.
  - This will ensure that clients will not have separate dates of re-enrollment for OA-HIPP and ADAP.
- Required Documents:

1) New OA-HIPP Application

   ** Client will be required to sign the application. "<u>Signature on File" will no longer be permitted</u>.**

2) Insurance Assistance Section Consent Form
3) ARIES OA-HIPP/OA-PCIP Client Consent Form
4) Current billing statement

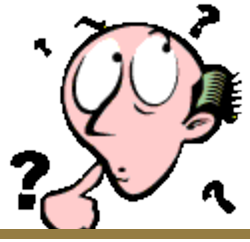
OA-HIPP Recertification

- Recertification is required 6 months after re-enrollment.

- Required Documents:
  1. New OA-HIPP Application.

     Client will be required to sign the application. "Signature on File" will no longer be permitted.
  2. Current billing statement.

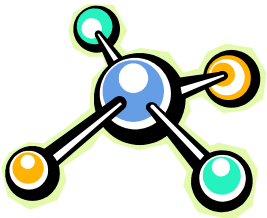
What is LIHP



- Low-Income Health Program (LIHP) is California's bridge to health care reform.
- LIHP provides healthcare coverage to legal residents who are 19-64 with incomes up to 100% federal poverty level and <u>not</u> eligible for Medi-Cal.
- Administered by the Department of Health Care Services and is established at the county-level.

LIHP Continued…

- Each county or consortia of counties have a unique name for LIHP.
  - Ex. "Healthy Way LA" is LA County's LIHP.
- LIHP will sunset after December 31, 2013.
- LIHP clients will transfer to Medi-Cal once health care reform is fully implemented on January 1, 2014.



LIHP Screening

OA-HIPP clients will be screened for LIHP when they enroll or recertify for ADAP.

- OA-HIPP clients who are potentially eligible for LIHP DO NOT have to apply for LIHP.
- OA will continue to pay OA-HIPP premiums, whether the client enrolls in LIHP or not.
- ADAP will continue to pay co-pays and deductibles for client's HIV-related medications.

Initial Payment

- OA will pay for the month the application was received, the month the application was approved (if different) and three months thereafter.

  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 approved until February, then OA would pay January through May.

- OA will no longer make retroactive payments.

Partial Payment

- If a client's monthly premium exceeds the threshold or if the client is enrolled in a group policy that does <u>not</u> offer individual billing, the client must enter into a Partial Payment Agreement.
- Client must send a cashier's check or money order for the difference or amount owed.
- Check needs to be made payable to the <u>client's COBRA administrator, health insurance company or employer</u> 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.
- Client must also sign the Partial Payment Agreement Form.

Partial Payment Continued

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.
- Documents when and how much the client must pay.
- Client must sign and date.

Quarterly Payments

- As long as the client remains eligible for the program, his/her health insurance premiums will be paid quarterly.
- OA staff begin processing quarterly payments 45 days prior to the last day a client is paid through.
- 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 1/1/13 – 4/30/13.
  - The next quarterly payment will pay for 5/1/13 – 7/31/13.
  - Staff will process the quarterly payment between 3/15/13 – 3/31/13.

Quarterly Payment Schedule

Cycle	Payment Period	Quarterly Payment Processes
1	January 1-March 31	November 15 – November 30
	April 1-June 30	February 15- February 28
	July 1-September 30	May 15- May 31
	October 1-December 31	August 15- August 31
2	February 1-April 30	December 15 - December 31
	May 1-July 31	March 15- March 31
	August 1-October 31	June 15- June 30
	November 1-January 31	September 15- September 30
3	March 1-May 31	January 15 – January 31
	June 1-August 31	April 15- April 30
	September 1-November 30	July 15- July 31
	December 1-February 28	October 15- October 31

Supplemental Payments

- OA will no longer issue supplemental payments to COBRA administrators, health insurance companies or employers.

- If OA is notified of an increase in a client's premium ***after*** the quarterly payment is processed, the client will be responsible for paying the balance owed.

- OA will then add the same amount the client paid to the next quarterly payment.

  - Ex: If a client's premium increased from $500 to $600 and the client paid $100 x 3 = $300, the next quarterly payment would total $2100 ($600 x 3 = $1800 + $300 = $2100).

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 should immediately return the money to OA.
  - Personal checks will **not** be 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.

Changing Policies

- If OA sends a payment and the client subsequently cancels the policy and enrolls in a new policy, OA will not make a full three month payment to the new payee until the client returns the overpaid funds.

  - Ex: OA paid company A from 1/1/13 – 3/31/13 and the client subsequently cancels and enrolls with company B effective 2/1/13. OA will only pay company B 2/1/13 – 3/31/13 until the equivalent of two months premiums from company A is returned to OA.

Client Responsibilities

- Clients must be aware and understand that they must continue to pay their monthly premiums until they have received confirmation from their EW that their application has been approved.

- Clients must <u>immediately</u> communicate any changes regarding their health insurance policy to their EW, 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.

EW Responsibilities

- EW's are the liaison between the client and OA-HIPP.
- EW's 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.

Record Retention and Disposal

- OA-HIPP client files must be retained for a period of four years (current year + three prior years.)
- OA-HIPP client files must be stored in a locked filing cabinet, secured office or password protected environment.
- OA-HIPP client files must be shredded when disposed.

Security and Confidentiality

- California law provides more protection than the federal law (HIPAA) when disclosing HIV information.
- California Health & Safety Code:
  1. Person may be liable up to $2,500 for the negligent disclosure of the content of a confidential health record.
  2. Penalties significantly increase for "willful or malicious disclosure."
  3. Disclosure that leads to economic, bodily or psychological harm can lead to imprisonment and/or a fine up to $25,000.

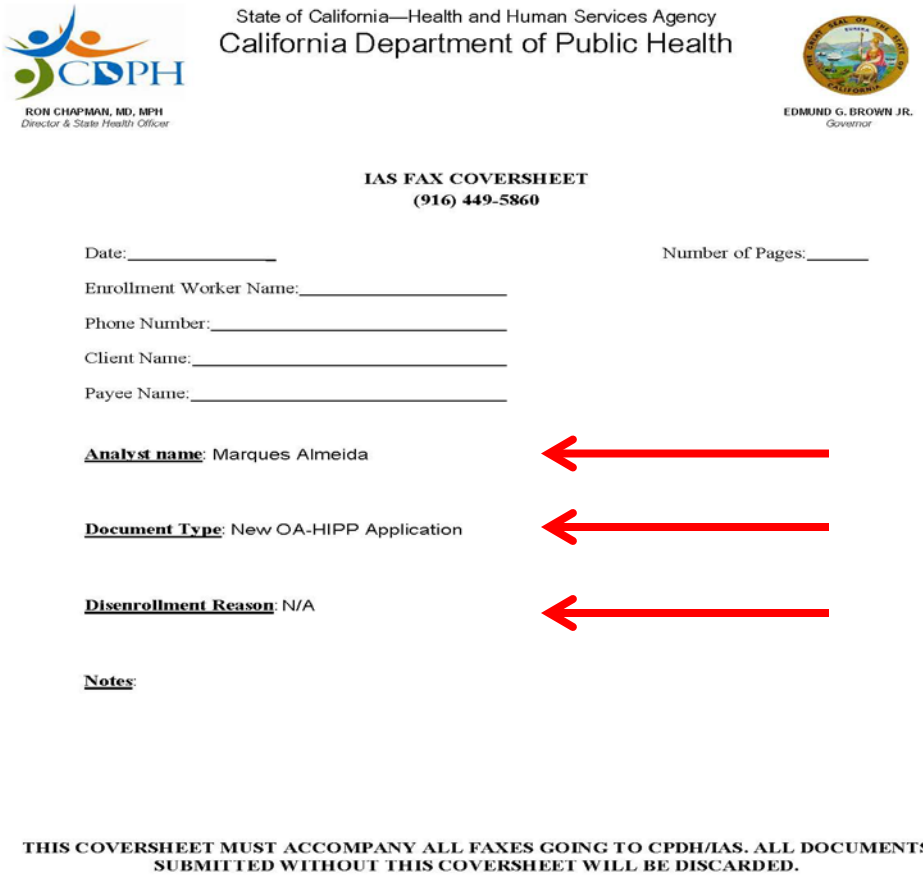
Emails

- 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.

ARIES Access

- Before EW's get access to ARIES, they must:
  1) Complete the OA-HIPP training.
     - Pass a short quiz.
     - Sign the HIV/AIDS Confidentiality Form.
  2) Complete the ARIES self-paced online training.
  3) Submit the ARIES User Registration Form.
- After steps 1-3 are complete, ARIES will be installed remotely on your computer.
- More information regarding steps 1-3 is available on the following webpage: http://www.cdph.ca.gov/programs/aids/Pages/OAIAS.aspx

IAS Fax Coversheet



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

RON CHAPMAN, MD, MPH
Director & State Health Officer

EDMUND G. BROWN JR.
Governor

IAS FAX COVERSHEET
(916) 449-5860

Date:_____ Number of Pages:_____

Enrollment Worker Name:_____

Phone Number:_____

Client Name:_____

Payee Name:_____

Analyst name: Marques Almeida

Document Type: New OA-HIPP Application

Disenrollment Reason: N/A

Notes:

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

- **Coversheet must be submitted with all documents.**
- **Fill out the appropriate information.**
- **Use the drop down box to choose the Analyst name, Document Type, & Disenrollment Reason (if applicable).**

OA-HIPP BROCHURE

- New informational brochure that is available on OA's website.
- Can be printed and handed to clients or made available in lobbies or high traffic areas.

OA-HIPP Brochure

What is OA-HIPP?

OA-HIPP is a program that pays monthly health insurance premiums. Payments are made directly to health insurance companies or COBRA administrators.

You May Qualify for OA-HIPP if:

1. You are a California resident.
2. You are at least 18 years old.
3. You are HIV positive.
4. You are currently enrolled in the AIDS Drug Assistance Program (ADAP).
5. Your annual adjusted gross income is not more than $50,000.
6. You are not enrolled in employer based health insurance, Medicare or Full-Scope Medi-Cal.

What Type of Insurance Policies Does OA-HIPP Pay?

OA-HIPP pays for policies that provide HIV-related healthcare and drug coverage, including most private plans and COBRA or Cal-COBRA plans.

OA-HIPP Client Responsibilities

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, you must continue to pay your monthly insurance premiums.

After your application is approved, you will be expected to:

1. **Immediately** inform your Enrollment Worker of changes to your contact information (i.e. address, telephone number).
2. **Immediately** inform your Enrollment Worker regarding changes to your policy, such as:
   a. Monthly premium amount;
   b. Payee contact information (i.e. address, telephone number); and/or
   c. Policy expiration dates.
3. **Immediately** inform your Enrollment Worker regarding changes in coverage, such as:
   a. Move from COBRA to Cal-COBRA;
   b. Obtain or become eligible for employer-based health insurance; or
   c. Enroll in Medicare or Full-Scope (free) Medi-Cal.
4. Re-enroll and recertify in OA-HIPP at the same time you do for ADAP. Required forms must be submitted to your Enrollment Worker and are noted in the table below:

Document Type	Re-Enrollment	Recertification
1. OA-HIPP Application	X	X
2. Most Recent Health Insurance Billing Statement	X	X
3. IAS Consent Form	X	
4. ARIES OA-HIPP/OA-PCIP Consent Form	X	

Your Enrollment Worker Can Be Reached At:

- Explains the client's responsibilities.
- Should be handed to each client.
- Input your contact information at the bottom.

OA-PCIP Update

- The federal government has suspended PCIP enrollment after March 1, 2013.
- All currently enrolled PCIP clients will continue to receive services through 2013.
- OA will continue to pay the monthly premiums for all OA-PCIP clients through 2013.

OA-PCIP Update Continued

- Please continue to immediately report any changes pertaining to an OA-PCIP client's eligibility to OA.
- OA will be developing a comprehensive outreach strategy designed to inform all the OA-PCIP clients about what coverage options will be available to them beginning January 1, 2014.

Contact Information

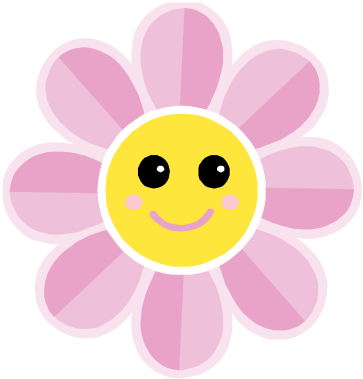
- All forms noted in this training are available on the following webpage:
  http://www.cdph.ca.gov/programs/aids/Pages/OAHIPPForms.aspx

- All forms and required documents must be faxed to:

  (916) 449-5860

  Or

- Mailed to :

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

Thank you!