REPORT OF THE
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

STUDY OF PREMIUM ASSISTANCE PROGRAMS FOR HIV-POSITIVE INDIVIDUALS

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 35

COMMONWEALTH OF VIRGINIA
RICHMOND
1994

Table of Contents

	Page
Executive Summary	i
I. Introduction	1
II. Study Origin	1
III. Background	
Loss of Health Insurance Due to HIV Diagnosis	2
Public Resources for HIV/AIDS Health Care	3
IV. Costs of Health Care	5
V. Insurance Premium Assistance Programs	
Programs in Other States	6
Feasibility of a Virginia Program	9
Program Costs and Financing Options	12
VI. Recommendations	13
Appendices	15

STUDY OF PREMIUM ASSISTANCE PROGRAMS FOR HIV POSITIVE INDIVIDUALS

Executive Summary

Study Origin House Joint Resolution No. 663 of the 1993 General Assembly directed the Secretary of Health and Human Resources, in consultation with the Department of Medical Assistance Services and the State Corporation Commission's Bureau of Insurance, to study the cost-effectiveness of an insurance premium assistance program for Human Immunodeficiency Virus (HIV) positive persons and to develop a plan for review by the General Assembly. The study findings and recommendations are to be submitted to the Governor, the Joint Subcommittee Studying HIV and the 1994 General Assembly.

Background Ensuring adequate health coverage is a major concern for those receiving a positive diagnosis for HIV infection. Medical expenses range from $3,400 to $11,880 annually for persons with HIV and are about $33,000 for persons with Acquired Immunodeficiency Syndrome (AIDS). As with other serious, chronic illnesses, once the condition is diagnosed insurers may reject a new applicant or pre-existing condition limitations may apply to the coverage.

An additional problem may occur for those persons previously working and covered by employer group insurance. Federal and state law provide for continuation of policies for a period of time, with some qualification, if an employee leaves a job. The employee is responsible for picking up premiums. Although insurance is therefore available, the cost frequently becomes prohibitive and the individual must drop coverage. Options then are to be uninsured or to try to qualify for Medicaid.

Findings At present, 27 states have addressed this problem through premium assistance programs. These programs supplement or pay, for qualifying individuals, the premium for continuing the employer-group insurance. Requirements are that the individual be documented as HIV positive and unable to work due to the medical condition, be low income, and be eligible for such coverage.

Five states that prepared evaluations of their premium assistance programs found that the programs were cost-effective in terms of postponing or avoiding the necessity of Medicaid coverage. A 1993 federal report concluded that "potential savings to these five states, even using conservative estimates...are considerable." Additionally, it is believed that the program provides better continuity of care by allowing individuals to maintain coverage without lapses and to continue with the same providers.

States have used state funds and federal funds for AIDS programs (Title II of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990) for these programs.

About 15 states currently use the federal funds for this purpose. Virginia received $1.4 million in Ryan White Title II funds FY 1993; at present funds are being used to support community HIV consortia which provide support and medical services and to provide HIV related medications. The Department of Health believes it has not had adequate funds to support a premium assistance program but is considering such use in the future if federal funding is increased.

Although there is insufficient data at this time to estimate the number of HIV positive Virginians who could benefit from this type of program, the program size in other states has been fairly small. Few states have enrolled more than 100 participants, and most are smaller. Even so, the programs appear to be cost-effective.

Recommendations The premium assistance program represents one mechanism to cost-effectively provide health insurance coverage for those who are HIV infected and unable to work because of the illness. Based upon the findings of the study, the following recommendations are made:

Recommendation 1: A premium assistance program for HIV positive individuals should be implemented in Virginia. Based upon an estimated average participation level of 50 persons, annual costs are projected to be $170,000.

The program should have, at minimum, the following characteristics:

- **Provide for payment of health policy premiums for individuals eligible to continue their employer's group policy under COBRA 85 provisions**
- **Income limit: no more than 200 percent of the federal poverty level**
- **Cash asset limit: no more than $10,000**
- **Documentation of HIV infection and inability to work for medical reasons**
- **Exclusion of co-payment and deductible payments**
- **Coverage of family members if the HIV infected individual's policy is the sole source of health insurance**
- **Participants not eligible for Medicaid - the Health Insurance Premium Program (HIPP) already provides premium payment for Medicaid recipients when determined cost-effective**

Recommendation 2: The program should be evaluated after one year of operation. The evaluation should include information regarding the cost, utilization and cost-avoidance achieved through the program.

STUDY OF PREMIUM ASSISTANCE PROGRAMS FOR HIV POSITIVE INDIVIDUALS

I. Introduction

Ensuring adequate health coverage is a primary concern for people who receive an HIV-positive result. Interruption or loss of health care insurance may occur as a direct or indirect consequence of an HIV diagnosis. Coverage of related care can be excluded as treatment of a pre-existing condition. Or, enrollment through a new insurer can be refused because of the pre-existing condition. Even if health insurance continues to be available, the premium payments frequently become unaffordable for part-time workers and the unemployed.

To offset the affordability problem, a number of states have developed programs that subsidize premiums so that individuals may continue existing policies. Twenty-seven states currently operate premium assistance programs that benefit HIV positive individuals. These programs serve to enable individuals to continue private health insurance, thus guaranteeing access to medical care and continuity of care and providers. The programs also defer dependence upon Medicaid or other public health financing. Since as much as 30 percent of costs for persons with AIDS are covered by the Medicaid program nationally, prolonging the continuation of private health insurance can have important public cost implications.

This report describes the programs currently operating in other states and describes the feasibility and issues currently facing implementation of a premium assistance program in Virginia.

Note: The premium assistance programs discussed in this study are targeted to those individuals who already have health insurance, usually through an employer. Options to expand health coverage of HIV/AIDS diagnosed individuals also include expanding Medicaid eligibility, allowing individuals to "buy-in" to Medicaid, and coverage through state risk pools. This report focuses on extension of employer-based private health insurance through premium assistance only. The issues of providing health insurance coverage for high-risk populations and uninsured populations are beyond the scope of this report and are not addressed.

II. Study Origin and Method

House Joint Resolution (HJR) No. 663 of the 1993 General Assembly directs the Secretary of Health and Human Resources, in consultation with the Department of Medical Assistance Services (DMAS) and the State Corporation Commission's (SCC) Bureau of Insurance, to study the cost-effectiveness of an insurance premium assistance program for

HIV positive persons and to develop a plan for review by the General Assembly. The study findings and recommendations are to be submitted to the Governor, the Joint Subcommittee Studying Human Immunodeficiency Virus (HIV) and the 1994 Session of the General Assembly. The study resolution is provided in Appendix A.

The Secretary's Office worked with the assistance of staff of DMAS, the Bureau of Insurance and the state Department of Health (VDH) in researching and developing this report. Additionally, representatives of community organizations in all areas of the state that provide services to individuals with AIDS and HIV infection were invited to participate in an August 1993 meeting with study staff to explore issues concerning health insurance availability, costs and access. A summary of the meeting is provided in Appendix B.

III Background

Loss of Health Insurance Due to HIV Diagnosis

Several circumstances can create a loss of health insurance coverage once HIV infection is detected. If a job change or other circumstances lead to coverage by a new policy or insurer, the person can be denied coverage based upon the HIV diagnosis or subjected to pre-existing clauses which temporarily bar payment for related services. Most pre-existing clauses are for a twelve month period. If the condition progresses so that an individual can no longer work, insurance coverage may be lost because of inability to continue premium payments. This situation, discussed below, is the one addressed by the premium assistance programs.

For persons who have health insurance coverage through an employer's group plan, it is possible to continue the health coverage even after employment ends. Both Virginia and federal law provide for continuation of health policies for a period following the termination of employment. Specifically, federal law enacted by COBRA 1985 requires employers with over twenty employees to allow a terminated employee to continue under the group's policy for eighteen months.[1] The employee is required to pay the premium, which can be no more than 102 percent of the premium for comparable coverage through the group. A longer period of twenty-nine months is permitted under COBRA if the employee left employment due to disability. The premium may be increased after eighteen months to 150% for the last eleven months of coverage.

Virginia law requires that group policy holders, usually employers, be offered the option of either 1) allowing terminated employees to convert to an individual policy or 2) allowing terminated employees to continue group coverage for 90 days. This does not apply to self-insured plans. There is no time limit on how long the person can continue the individual

[1] COBRA applies to plans in the private sector including self-insured plans and state and local government sponsored plans. The law does not apply to plans sponsored by the federal government and certain church-related organizations.

policy. In general, a policy converted to an individual policy is considerably more expensive in terms of premium payments than a policy continued as part of a group.

Even if insurance coverage continues to be available, it frequently becomes too costly for the individual to afford. This most typically occurs when, due to the progression of the disease, an individual must stop working full-time and work either part-time or not at all. Often, insurance coverage lapses due to non-payment of premiums. Not only does the coverage cease at least temporarily, but obtaining new coverage may be difficult or impossible once the HIV diagnosis is on record. Therefore, a primary goal of the premium assistance programs is to assist individuals so that health insurance can be continued as long as possible and if transition to public programs such as Medicaid (discussed below) is necessary, it can be accomplished without interruption in health benefits.

Public Resources for HIV/AIDS Health Care

Public funds are also used for medical costs for HIV infected persons. A recent federal report stated that as many as 71 percent of the estimated one million persons with HIV infection or AIDS are dependent on public sources for access to medical care.[2] The type of health insurance coverage is frequently linked to the length of the sickness - persons with HIV who have been sick for longer periods are more likely to be using publicly financed care.

Medicaid, the federal-state financed health program for the poor, aged, blind and disabled, is the major public payor for AIDS. The Medicaid program is estimated to have the highest payments for AIDS/HIV conditions among all single payors, public and private. It is estimated that about 30 percent of health costs for AIDS nationally are paid for through the Medicaid program and that at least 40 percent of all persons with AIDS will eventually get Medicaid coverage. In Virginia, at least 487 persons[3] with HIV infection received medical care through the Medicaid program in fiscal year 1992 at a cost of $5.4 million.

To be eligible for Medicaid, a person must be in a specified eligibility category: women and children receiving welfare or below certain income levels, or persons of low-income who are aged, blind, or disabled. Persons with HIV infection who are not eligible as mothers or children must generally qualify based upon disability status. To qualify under the disability category, disability status must be established according to federal and state criteria and, importantly, the person also must meet income and asset requirements. The disabled individual must either be indigent or "spend-down" assets for medical care in order to be covered. Medicaid coverage of individuals generally will not start until a

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[2] Hager, C.J., Baitty, R.L., Young, S.R.,"Characteristics of State Health Insurance Continuation Programs for Person with HIV/AIDS", Bureau of Health Resources Development, Office of Science and Epidemiology, Division of HIV Services, Service Documentation and Quality Assurance Branch, Planning and Technical Assistance Branch, May 1993.

[3] Estimates based upon total payments for recipients using drugs typically used only for treatment of HIV related conditions - DDI and AZT at that time. In its report to the Joint Subcommittee Studying AIDS in 1992, DMAS noted that any HIV-infected persons who were not using these drugs would not be included in this cost data. Therefore, these are believed to be conservative estimates of HIV-infection related costs.

significant level of disability has occurred and also until resources are depleted.[4] An individual may or may not be able to maintain private insurance coverage during this period.

Medicare coverage, the federal health program for the elderly and disabled, is also available to certain HIV-infected individuals. However, it is not a major payor. Eligibility for persons with HIV is generally on the basis of disability; coverage begins twenty-nine months after a disability determination is made. Until this year, HIV related disability required a diagnosis of AIDS. This requirement impeded broad coverage under Medicare; the average survival time from time of AIDS diagnosis to death is twenty months and many individuals do not survive the waiting period after the disability determination. In 1993, federal regulations broadened the definition of disability to allow HIV related conditions not limited to AIDS. This may allow more coverage under Medicare than has occurred to date. Additionally, new treatment modalities may extend survival periods and the longest survivors may become eligible for Medicare. However, Medicare still is not likely to become a significant payor for HIV-infected persons.

Congress also has made direct funding available for HIV and AIDS services. Most of this funding has come to the states through Title II of the federal Ryan White Comprehensive AIDS Resources Emergency Act of 1990, more commonly known as the Ryan White CARE Act. These grants are available to states annually based upon the per capita HIV and AIDS prevalence rates. States have discretion over these funds which may be used for four broad purposes: supporting "HIV care consortia" designed to provide a comprehensive continuum of care to individuals with HIV and their families; providing community-based care services; providing medical treatments for individuals with HIV including prescription drugs; and, continuing health insurance coverage for low-income persons with HIV who previously had been covered by their employer through premium assistance to purchase coverage under the employer group health insurance or other insurance programs. Virginia received $1.35 million in 1992 and $1.43 million in 1993. To date VDH, Virginia's grantee for the funds, has opted not to use the funds for premium assistance but is considering this use in the future.

Experts suggest that disease trends in HIV and AIDS will create more demands on publicly financed health services. The incidence of HIV infection is growing most rapidly among women, children, minority populations and injecting drug users. These populations are more likely to have no or limited private health insurance, lower incomes, and loss of employment once diagnosed with HIV. Low-income women and children are also more likely to qualify for Medicaid eligibility categorically - that is in their status as dependent children and mothers rather than through disability- and perhaps receive benefits earlier in their illness.

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[4] Several states, including Virginia, do not allow Medicaid to use "presumptive eligibility" for disability determinations. Medicaid coverage will not start until the disability has been established. This process can take up to three months.

Therefore, it is likely that expanded HIV infection and AIDS among these groups will put even greater pressure on Medicaid as well as expand the number of HIV infected individuals who are without any health insurance. Other factors that may affect replacement of private insurance by Medicaid, in addition to loss of insurance and expansion of the epidemic into population groups that are less likely to have private insurance coverage, are increased longevity and more understanding of Medicaid eligibility by advocates and providers. Premium assistance programs enabling individuals to continue private health insurance allow individuals with HIV/AIDS to postpone or avoid reliance upon Medicaid. This then allows public funds to be focused on the needs of those dependent solely upon public resources.

IV. Costs of Health Care

The cost of treatment of HIV-infected persons is well beyond the means of most individuals unless adequate insurance coverage is available. A recent study[5] estimates the lifetime cost of treating a person with HIV from the time of infection until death to be approximately $119,000. This is for estimated treatment costs from time of HIV infection to development of AIDS ($50,000) and from development of AIDS until death ($69,000). The study notes the assumption in the estimates that HIV is diagnosed and treatment initiated upon infection, and therefore these numbers represent upper limits.

Annual costs are estimated to be approximately $32,088 for persons with AIDS and range from $3,384 to $11,880 for HIV infected persons depending upon the stage of the disease. Costs include inpatient hospital care, outpatient services, home health services, long-term care, and drugs. Different types of services are used depending on the disease stage. Inpatient services consume an increasing percent of the total dollars as the disease progresses. However, absolute costs for all services increase through the course of the disease.

The costs of the different types of services, including prescription drugs, are particularly relevant regarding health insurance coverage. The average costs for services by stage of disease are presented below.

Estimated Monthly Cost of Treating a Person with AIDS		
Service component	Person with AIDS	HIV Positive w/out AIDS
Inpatient	$ 1,890 (68%)	$ 54 - 456 (19 - 46%)
Outpatient	$ 380 (14%)	$ 151 - 344 (54 - 35%)
Home Health	$ 174 (6%)	$ 10 - 80 (4 - 8%)
Drug Costs	$ 265 (10%)	$ 67 - 110 (24 - 11%)
Long-term Care	$ 55 (2%)	$ 0
Total	$ 2,674 (100%)	$ 282 - 990 (100%)

Source: Hellinger, F.J., "The Lifetime Cost of Treating a Person with HIV" *JAMA* 1993

[5]Hellinger, F.J., The Lifetime Cost of Treating a Person with HIV, *JAMA*, 1993;270:474-478.

It is useful to note that the estimated cost of treating persons with AIDS has declined since the early part of the epidemic. This decline is attributed to declines in hospital admissions and lengths of stays in hospitals. Advances in technology that allow outpatient and home care, and community networks that contribute to avoided hospitalization or shortened stays are also believed to have a role. However, changes in affected populations may reverse some of these trends; for example, IV drug users are reported by one study to develop diseases less well treated by outpatient care and to be more severely ill. Increased life expectancy will also affect costs and the effect will depend upon functional status and the costs and levels of medical utilization by persons with HIV infection.

V. Insurance Premium Assistance Programs Analysis

A. Programs in Other States

Twenty-seven states currently operate HIV/AIDS health insurance premium assistance programs. Most of them are specific to the HIV diagnosis; in a few states individuals with HIV are covered by state subsidized high-risk pools. Several states transfer individuals into the Medicaid Health Insurance Premium Program (HIPP)[6] program if the individual is eligible; the income criteria for the premium assistance program (discussed below) usually are more liberal than those used by Medicaid.

Premium Assistance Programs in Other States	
Income Level	
<185%	NY
<200%	FL,GA,KS,MI, MT,NM,TX,WI
<250%	KY
>250%	CA,DC,HI,IA,MA,MD,MN,WA
Cash Assets	
<$ 5,000	LA,DC,FL,WA
<$10,000	GA,HI,IA,KY,MD,MI,MT,NM
<$25,000	MN
<200% SSI	CA
Premium Maximum (Individual)	KY,CA,LA,NM
Continue private insurance or the person will lose coverage (some states limit to COBRA extensions)	AK,CA,CT,DC,DE,FL,GA,IA,KS,KY,LA,MA, MD,MI,NM,NY,RI,WA,WI
Pt pays copay,deductible (some states will pay co-pays and deductibles for Medicaid recipients)	CA,CO,DC,NY
Maximum time of program eligibility	CA,DC,WI
Rx coverage required	CA

Source: Adapted from information provided in Hager, et al

[6] The HIPP program, legislated as part of OBRA 1990, mandates state Medicaid programs to pay group health insurance premiums, co-payments and deductibles for eligible Medicaid recipients if this is identified to be cost effective. The Virginia HIPP program was initiated on a pilot basis in several localities in Virginia in April 1993.

Programs are relatively small, typically enrolling about 100 people or fewer. All of the programs address eligibility and coverage issues. The specific designs used by the programs vary by state. Key elements of the programs are summarized below.

1) Income Level
All states require that income is at or below a specific level, or that financial need is demonstrated. Income level is generally tied to the federal poverty level, with programs requiring income not greater than 100 to 300 percent of the federal poverty level.
(The 1993 federal poverty level is $6,970 for a single person and $14,350 for a family of four.)

2) Cash Assets and Resources
Limits range from $4,500 to $25,000 for an individual. Family or couple levels are also established in some states.

3) Documentation of HIV or AIDS diagnosis
Written verification of a diagnosis of HIV infection or AIDS is required by all states, usually in the form of a physician's statement.

4) Documentation of inability to work for medical reasons
Most or all states require that the person is unable to work or is likely to become unable to work within a short period of time due to the HIV infection. Some states (e.g. Massachusetts) specify that the definition of disability used for Supplemental Security Income (SSI) and Social Security Disability (SSD) be met. Other states (e.g. Maryland) require a statement by a physician that due to illness the patient is likely to become unable to work within a certain period of time, for example within three months.

5) Limits on premium payments, limits on duration of coverage, and maximum lifetime benefits
States vary in the limits imposed on the amount of the premium payment, the duration of coverage under the programs, and maximum lifetime benefits.

6) Provisions regarding coverage of co-payments, deductibles, prescription drugs, coverage for other family members
States vary with regard to whether co-payments and deductibles will be paid. Some programs specifically cover these costs, some limit the payments to Medicare or Medicaid eligible individuals, other states require the individual to pay all co-pays and deductibles.

Coverage may be available in some states to extend coverage to other family members.

Some states require that the private insurance policy include prescription drug coverage in order to be eligible under the program.

7) Premium payments for policies continued under COBRA or purchase of individual policies
Almost all states with programs require that the person be eligible to continue a health insurance policy, usually under COBRA mandated extensions. Only three also purchase individual policies (Colorado, Louisiana, and Minnesota) through state risk pools. The Texas program covers individuals infected with HIV as well as individuals with other terminal or chronic illnesses with incomes below a certain level.

8) Limit on number of program participants
A number of states define limits of the number of persons that will be permitted to enroll in the program. Presumably this reduces funding liability particularly during the start-up periods and allows more accurate budget planning.

Program Cost and Savings
Several states have evaluated the cost-effectiveness of their programs. The consensus is that the programs are cost-effective because they defer, or eliminate in some cases, reliance upon Medicaid or other state-funded programs. A recent federal study[7] reported that in FY 1992, states reported serving a total of about 1,400 individuals with HIV/AIDS in premium assistance programs at an average cost of $1,643 per year (administrative costs are not included).

In the five states surveyed in the study, estimated monthly Medicaid payments for HIV positive individuals ranged from $1,600 to $2,779 in 1992. Last year, DMAS reported to the Joint Subcommittee Studying AIDS that annual medical expenditures averaged $9,246 in FY 1991 and $11,170 in FY 1992 for Medicaid recipients being treated for HIV/AIDS. However, these costs are not reported in a way that allows direct comparison to the states studied. It is assumed, for the purposes of this report, that Virginia's Medicaid expenditures are within the range reported by the other states.

The states estimated that the program savings ranged from $1,465 per person-month to $2,588 per case-month. The federal study of these programs states that "potential savings to these five states [reviewed in the study], even using conservative estimates ... are considerable."[8] A summary table is presented below.

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[7] Hager, et al
[8] Hager, et al

Comparison of Cost Estimates for Premium Assistance Program in Maryland, Massachusetts, Michigan, Wisconsin, and Washington (Evergreen) 1992					
	MA	MD	MI	WA	WI
Enrollees	51	64	100	161	32
Average Premium Per Month	$ 149	$ 171	$ 135	$ 157	$ 168
Medicaid Cost Per Month	$2,246	$2,749	$1,600	$2,146	$2,779
Ratio of Medicaid Cost to Premium	14.06	16.14	11.85	13.67	11.52
Annual Program Savings	$1,164,463	$1,987,584	$1,758,000	$3,843,393	$ 733,333

Source: Adapted from Hager, et al.

B. Feasibility of a Program in Virginia

Level of Need

Virginia ranked fifteenth in the nation in the cumulative number of total AIDS cases reported as of December 1992. A total of 4,057 cases of AIDS were reported as of March 1993. The state has similar trends to the national figures regarding increasing numbers of women, minorities, heterosexuals, and injecting drug users diagnosed with AIDS, with the implications for insurance coverage discussed previously.

At present the state does not have reliable data regarding the insurance status of HIV infected individuals or persons with AIDS. In 1992, using available figures, about 58 percent of the AIDS population in Virginia as estimated by the Department of Health received services as Medicaid recipients.[9] This corresponds reasonably with data reported by other states and exceeds the estimated 40 percent national level. However, these figures at best represent estimates and are not conclusive. Therefore, the national figures presented below are assumed to be representative of the experience in Virginia.

In 1991, the National Commission on AIDS reported that approximately 40 percent of persons with AIDS had Medicaid, 29 percent had private insurance, 2 percent were covered by Medicare, and 29 percent were uninsured. A 1993 study (based on 1989-1990 data) found similar results.[10] About 30 percent of the persons with AIDS had private insurance at the time of the interview; another 17 percent had lost private insurance since testing positive for HIV. The remaining 53 percent did not have private insurance either at the time of testing positive for HIV or at the time of the study; of these, 30 percent were uninsured.

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[9] Based on DMAS estimate of 457 individuals receiving treatment typically related to HIV/AIDS and the VDH estimated of 840 persons with AIDS in Virginia in 1992.

[10] Fleishman, J.A., Mor, V, Insurance Status Among People with AIDS: Relationships with Sociodemographic Characteristics and Service Use, *Inquiry* 30: 180-188, (Summer 1993)

The study found that having insurance coverage and whether it was public or private appeared to be correlated with sociodemographic factors. Coverage is likely, therefore, to be significantly affected by the current trends in HIV infection. Women, those with IV drug-user risk factors, minorities, and those with low incomes were less likely to have private insurance and more likely to receive Medicaid. Those at higher risk of losing health insurance were lower income and unemployed, and the risk of losing insurance rose with each month since the AIDS diagnosis.

Finally, access to care appears to be clearly related to insurance status. People with no insurance were significantly less likely to have inpatient care and they had shorter lengths of stay than those with public and private insurance.

Proposed Program Design

As described earlier, all premium assistance programs have certain features:

- Income and cash asset limits
- Documentation of HIV infection
- Inability to work for medical reasons, precluding the availability of health coverage through an employer (except through COBRA)
- Eligibility for insurance, usually employer-based group plans (through COBRA) or state subsidized high risk insurance programs

Additionally, programs may address the following:

- Maximum premium payment level
- Limit on duration of coverage
- Maximum lifetime benefits
- Specific rules providing for either payment or exclusion of co-payments and deductibles
- Coverage of family members
- Requirements regarding covered services, e.g. prescription drugs
- Limit program to COBRA payments versus payments of individual policies
- Limit on program participants

Following review of the programs in other states and the needs of the HIV population in Virginia, the following design is proposed. The objectives in developing this proposal are twofold: To create an equitable and cost-effective program; and, to keep to a minimum the necessary administrative requirements for both the administering agency and the client.

Income Limit: 200 percent of the Federal Poverty Level: For 1993, this amount would be $13,940 for an individual. This would be consistent with about half the states with existing programs. This level targets those who may not be impoverished and are more likely to have private insurance available. It also will permit individuals to work part-time, based on the episodic nature of the disease, without jeopardizing their eligibility.

Cash Assets: No more than $10,000: This figure is comparable to the limits used by most other state programs.

Documentation of HIV infection: Documentation provided by a physician or other appropriate source, e.g., public health clinic.

Inability to Work For Medical Reasons: Documentation provided by a physician or other appropriate source that the individual is unable, due to medical reasons, to work thereby precluding group insurance coverage except under COBRA extensions. Eligibility determinations should be permitted if documentation indicates that the individual at present or within a three month period will no longer be able to work; preliminary determination will reduce the possibility of insurance lapses.

Eligibility for Continuation of Employer-based Group Health Insurance: Premium assistance limited to individuals who are eligible for continuation of group health insurance under COBRA 85. There is no state risk pool, which other states have used, to consider as an option. Purchase or continuation of coverage as individual policies would be extremely expensive and make the costs of the program probably unfeasible.

Maximum Premium Payment Level: No maximum established. As individual policies are not covered, it is likely that group based insurance should be close to average amounts. Should broad variation occur, a limit can be re-considered once there is experience.

Limit on Duration of Coverage: Coverage will automatically be self-limiting: COBRA coverage does not exceed 29 months. Additionally, the survival periods once the disease has progressed to a significant level of disability are relatively short. Therefore, a limit on coverage duration is not determined necessary at this time.

Maximum Lifetime Benefits: Because coverage will be self-limiting, no life time maximum benefits are determined necessary at this time.

Co-payments and Deductibles: Co-payments and deductibles should be the responsibility of the client. Incorporating these payments would increase the costs of the program and make administration significantly more complicated.

Coverage of Family Members: If the family is solely dependent upon the health insurance of the HIV infected individual, premium costs should be covered for the period of coverage of the individual.

Requirements For Covered Services: No requirements established. The greatest concern in this regard is coverage of prescription drugs, which can be a significant expense. However, reviewing coverage of each proposed policy would be administratively burdensome and labor intensive. Additionally, precluding any premium assistance if certain services are not covered is probably not cost-effective in most circumstances.

Limit Program to COBRA Payments: As noted above, the program should be limited to individuals eligible to continue their employer's group policy under COBRA 85 provisions.

Limit on Program Participants: No study recommendation. The clear advantage of placing a limit is because of budget constraints and improved predictability of program costs. The study cannot address this issue. Clearly, making the program available to all who qualify is preferable, if that is feasible.

C. Program Costs and Financing Options

Program Costs:
The following estimates are based upon these assumptions:

50 clients per year (600 client months)
$200 premium payment per client month
Total annual program cost for premiums: $120,000

Administrative requirements estimated by other states reflect the variation in program sizes. Most programs require about 10 to 30 hours per week, with larger programs requiring one full time staff person to administer the program.
One Full Time Employee (salary and benefits): $50,000

Total annual program cost: $170,000

As noted previously, there is insufficient data about the Virginia HIV positive population to determine the level of insurance, level of income, and the percent with COBRA continuation options. The average number of months of premium payments per eligible individual and the number of case-months that would result is also unknown. Given these uncertainties, one option would be to initiate the program with a limit on the maximum number of participants and/or case months, based upon available funding. This would provide additional experience to use as a basis for future projections and also allow the program to stay within program budgets.

Financing Options:
The states reporting programs use state funds or Title II (Ryan White CARE) funds, or some combination of the two.

At present, 15 states are using Title II funds. Premium assistance programs represent from 2 percent to 30 percent total use of Title II funds in those states. As noted previously, the use of the funds for this purpose is optional but not mandatory. At present, these funds are used in Virginia to support health care services provided by HIV consortia and medications for HIV positive individuals.

VI. Recommendations

The premium assistance program is one mechanism to cost-effectively purchase health insurance coverage for those who are HIV infected and not able to work because of the illness. It potentially postpones or avoids dependence upon publicly financed medical programs for certain individuals, thereby preserving these funds for those in more dire need. Additionally, the program may provide continuity of care as well as ongoing access to health services.

The program, if implemented, leaves significant gaps in terms of insurance coverage for persons with HIV infection as well as other chronic diseases. The program as proposed will not address those without insurance or in very small businesses to which COBRA does not apply. It also will not assist persons who are not able to obtain coverage for treatment associated with the HIV infection because of pre-existing conditions exclusion provisions in insurance policies.

Additionally, the coverage offered by the polices that are continued may not be completely adequate. For example, prescription drug coverage is particularly important and the program will not guarantee it. However, the availability of other sources of coverage, including Title II funds, may help to cover some of these gaps. The premium assistance program, at best, can serve certain individuals in a manner that would appear to use public dollars in a cost-effective way.

Therefore, the following recommendations are made:

Recommendation 1: A premium assistance program for HIV positive individuals should be implemented in Virginia. Based upon an estimated average participation level of 50 persons, annual costs are projected to be $170,000.

The program should have, at minimum, the following characteristics:

- **Provide for payment of health policy premiums for individuals eligible to continue their employer's group policy under COBRA 85 provisions**
- **Income limit: no more than 200 percent of the federal poverty level**
- **Cash asset limit: no more than $10,000**
- **Documentation of HIV infection and inability to work for medical reasons**
- **Exclusion of co-payment and deductible payments**
- **Coverage of family members if the HIV infected individual's policy is the sole source of health insurance**
- **Participants not eligible for Medicaid - the HIPP program already provides premium payment for Medicaid recipients when determined cost-effective**

Recommendation 2. The program should be evaluated after one year of operation. The evaluation should include information regarding the cost, utilization and cost-avoidance achieved through the program.

Appendix A

HOUSE JOINT RESOLUTION NO. 663

Requesting the Secretary of Health and Human Resources, in consultation with the Department of Medical Assistance Services and the State Corporation Commission's Bureau of Insurance, to study the cost effectiveness of an insurance premium assistance program for HIV positive persons.

Agreed to by the House of Delegates, February 25, 1993
Agreed to by the Senate, February 23, 1993

WHEREAS, as of September 1992, there were 3,361 reported cases of AIDS and 4,124 reported cases of HIV infection in Virginia; and

WHEREAS, Virginia is projected to have between 79,000 and 116,000 cumulative cases of HIV infection by the year 2000 and over 14,000 cumulative AIDS cases; and

WHEREAS, the annual per patient cost of care is estimated at $5,150 for persons with HIV infection and $32,000 for persons with AIDS; and

WHEREAS, the annual cost of care for all persons living with HIV infection is estimated to increase from $81 million in 1991 to $727 million in 2000, and the annual cost of care for all persons living with AIDS is estimated to increase from $35 million in 1991 to $392 million in the year 2000; and

WHEREAS, it is likely that the number of uninsured and underinsured persons living with AIDS is higher than for the general population because persons diagnosed with AIDS eventually are unable to work; and

WHEREAS, there are likely to be savings that occur by identifying people who are likely to incur costly medical expenses before they lose private health insurance; and

WHEREAS, at least 16 states have established programs to pay insurance premiums for persons with HIV; and

WHEREAS, these programs appear to be cost effective; and

WHEREAS, more information is needed about how such a program might work in Virginia; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Secretary of Health and Human Resources, in consultation with the Department of Medical Assistance Services and the State Corporation Commission's Bureau of Insurance, be requested to study the cost effectiveness of an insurance premium assistance program for HIV positive persons and to develop a plan for review by the General Assembly. The Secretary, the Department of Medical Assistance Services, and the State Corporation Commission's Bureau of Insurance shall submit their findings and recommendations to the Governor, the Joint Subcommittee Studying Human Immunodeficiency Virus (HIV) and the 1994 Session of the General Assembly according to the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Appendix B

Summary - August 20, 1993 Meeting with Representatives of Virginia AIDS Service Organizations and HIV Consortia, 10:00 a.m. - 12:00 p.m., DMAS

Attendees: Jim Beckner, Fan Free Clinic; Fred Wilson, Central Virginia AIDS Services; Michelle Smith, No. VA Planning District Commission; David Kelly, Arlington City Department of Human Services; Jay Fisette, Phil Fornaci, Whitman-Walker Clinic of No Va; Sheila Balian, Bonnie Szeker, AIDS Support Group; Giles Norrington, Tidewater AIDS Crisis Task force; Norma Szakal, Legislative Services; Ann Colley, Bureau of Insurance; Kathryn Hafford, Department of Health; Ellen Zagorin, DMAS

Meeting Objective: To solicit input regarding the health insurance issues facing HIV/AIDS positive individuals in Virginia from community organizations directly providing support and medical services to this population. Specifically, to identify health insurance problems, the population in need, features of a premium assistance program, and what the gaps in a program may be.

Summary:
Meeting convened at 10:15 a.m. Ms. Zagorin explained the objective of the meeting and gave a brief overview of the study resolution and the report. Approaches used by other states include: premium assistance to help individuals continue employers group insurance under COBRA provisions; tie to HIV diagnosis and some measurable level of disability that precludes continuing full-time employment; tie to income level, generally 100% - 300% with 200% appearing most typical; programs generally don't address individual policies or purchasing insurance for the uninsured.

HEALTH INSURANCE PROBLEMS
In addition to payment of premiums, inability to afford copayments is a major problem. This is especially true for medications. Much of the care can be provided on an ambulatory and/or home based basis and medicine represents a major cost.

Many insurance policies exclude certain drugs from coverage, especially high cost. Or, drugs may not be covered at all. HMOs cover drug payments but may restrict drugs and also may have copayments.

Pre-existing condition clauses can prevent individuals from qualifying for insurance for at least a period of time. Northern Virginia may offer the best location in this regard - no exclusionary clauses under much of the insurance provided by employers there.

Copayments for Medicare (once disability has been established) is also a problem. Also, Medicare doesn't cover drugs.

HIV/AIDS individuals have the impression that the "system" can offer them assistance and should offer help. Often find themselves without adequate medical coverage, and few public hospitals/ medical clinics offer services.

POPULATION IN NEED
A survey of the insurance status and problems of clients of ASOs and consortia services could help define insurance status. Limited data is available, all national or studies in other states. Survey of clients or of case managers would be detailed enough for this purpose. To capture HIV/AIDS persons missed in the survey, i.e. those cared for in private medical community, may identify

through 1) physicians who participate in clinical drug trials and have sizable HIV patient base 2) through other consortia services (support groups, etc.)

Literature suggests about 29% have private insurance.

Individuals "falling through net" - the uninsured:

- small number of drugs covered by Ryan White (Dept. of Health program)
- individuals not disabled but symptomatic and requiring care - not eligible for Medicaid or Medicare
- hospital services are extremely expensive and most hospitals won't accept uninsured unless emergency

The uninsured, underinsured, those with COBRA benefits who can't afford premiums and/or copays, families of HIV/AIDS persons, those with individual policies - all identified.

POSSIBLE SOURCES OF FUNDING

Ryan White funds may be used for premium assistance and are so used by about 1/4 of the states. Virginia does not use funds for this purpose - program currently is used to cover services for those who don't have insurance or whose insurance doesn't cover drugs. Funds also used for other support and coordination services through the ASOs and consortia. Premium assistance program may be complementary rather than replacing the need for this use of funds.

FEATURES OF PREMIUM ASSISTANCE PROGRAM

Should program also cover individual policies (versus COBRA group policies)? Cost for this and for covering currently un-insured was discussed. Noted that in those few states that cover uninsured, they are covered under high-risk pool and are not specific to HIV.

Should minimum benefits be defined - e.g. some states require drug coverage. Pros include ensuring best expenditure of funds; cons include difficulty in deciding benefits requirements; hard to restrict; hospitalization is most significant expense and very few policies don't pay; administrative structure required to evaluate each policy. Could allow individuals to opt in program even if it is poor insurance coverage.

Family coverage discussed. If parent HIV infected and dies, the family still needs health coverage continued. Noted that cost can double from coverage of single individual to coverage of family.

Suggest that proposed program keep narrow focus - on individuals with insurance that can be continued - at this time can't explore other tier, i.e. the uninsured - 1) expense would be very high 2) many uninsured in Virginia with equally compelling problems 3) continuing existing coverage distributes population more evenly among insurers, individuals are already insured anyway, and are legally entitled to continuation under COBRA. Suggest recommendation should be included to revisit issue after one year and consider enlarging population served.

Features should include very streamlined qualifying and premium payment procedures, because COBRA payments must be made within time frame or insurance lapses.

In terms of process for obtaining program assistance, case-manager should facilitate with information, but ultimately the individual has the responsibility. No special program features necessary to assist individuals aside from reasonable good information and processes.

Income levels for eligibility discussed. Very restrictive income limits would reduce positive impact of program. Use of sliding scale assistance based on income, e.g. Maryland, discussed.

Use of cap on number of enrollees - Questions about how cap could be determined - level of appropriation is most likely determinant.

Duration of eligibility for program - Typically COBRA period (18 months) used by states. Need to have eligibility reconsidered at a later time, due to labile nature of disease, discussed - can not be a one time determination.

OTHER ISSUES

Cost effectiveness discussed, concept of cost-avoidance rather than savings per se.

Possible use of costs averted ("savings") through premium program to fund drug purchase assistance.

Concerns of insurance companies and their anticipated response discussed.

Trends in cost of care discussed - number of individuals increasing and length of period under care increasing but costs per case declining - attributed to reductions in drugs costs and most home based and ambulatory care.