Ohio Administrative Code

Rule 3701-43-16.1 Adult hemophilia insurance premium payment program.

Effective: January 30, 2004

(A) As used in this rule:

(1) "Adjusted family income" means a balance after credits for child care expenses or educational expenses not reimbursed by a third party, estimated annual expenditures for health insurance not reimbursed by a third party, and service level are subtracted from family income.

(2) "Assistance" means reimbursement to the eligible participant or legal representative for premiums paid by the eligible participant or legal representative for health insurance coverage for the eligible participant. Assistance may include payments for premiums for an eligible participant's single coverage under a health insurance plan or payments for premiums for the dependent portion of an insurance plan when the eligible participant is one of a group of dependents who is covered under a health insurance plan.

(3) "Eligible participant" means a person twenty-one years of age or older with hemophilia or a related bleeding disorder, who is under the care of a BCMH approved hemophilia treatment center, and who also meets the conditions for eligibility for insurance premium payment assistance set forth in paragraph (B) or (C) of this rule.

(4) "Estimated annual expenditure for health insurance" means the estimated amount for which a family unit spends on insurance premiums.

(5) "Family income" means the current year's projected adjusted gross earnings based on current gross earnings as reported on pay stubs and/or the sum of the annual adjusted gross incomes, as reported to the United States internal revenue service for federal income tax purposes for the previous year, of the eligible participant.

Family income shall not include educational scholarships, loans, and grants; amounts spent by the family unit for child care expenses; amounts spent by the family unit for respite care (with

appropriate verification from a qualified respite care provider); and lump-sum death benefits.

(6) "Family unit" means the group consisting of the following persons:

(a) The eligible participant;

(b) The eligible participant's spouse, if married;

(c) The eligible participant's parents, if participant is considered a dependent by parents for federal income tax purposes;

(d) Other persons who, for federal income tax purposes are considered dependents of the eligible participant.

(7) "Service level" means a credit against the family income as determined by the director based upon the eligible participant's need for treatment services. Service level credits are the following:

(a) Service level one is based on the eligible participant's need for routine physician visits or routine outpatient hospital care. The service level credit for this service level is five hundred dollars.

(b) Service level two is based on the eligible participant's need for brief hospitalizations, minor surgical procedures, medications, durable equipment, or medical supplies. The service level credit for this service level is one thousand dollars.

(c) Service level three is based on the eligible participant's documented need for medication and supplies costing more than five hundred dollars per month. The service level credit for this service is two thousand dollars.

(B) The director may authorize assistance to an applicant who meets the definition of an eligible participant under paragraph (A) of this rule, has health insurance coverage and meets all the following criteria:

(1) The applicant's adjusted family income is less than or equal to the income guidelines as defined

in paragraph (A)(1) of rule 3701-43-16 of the Administrative Code.

(2) The cost of the applicant's or family unit's annual health insurance premiums exceed seven and one half per cent of the family unit's gross annual earnings and assistance with the premiums is cost-effective as determined by the director; and

(3) There are funds available in the hemophilia insurance premium program encumbrance to cover the eligible participant.

(C) If an applicant is found ineligible for assistance under paragraph (B) of this rule, the director may deem the applicant eligible if the applicant meets the definition of an eligible participant under paragraph (A) of this rule, has health insurance coverage and meets all the following criteria:

(1) The applicant's annual health insurance premiums exceed fifteen per cent of the family unit's gross annual earnings and assistance with the premiums is cost-effective as determined by the director;

(2) The applicant's adjusted family income does not exceed three hundred per cent of the federal poverty level;

(3) The director determines that the cost of the annual premiums constitutes a hardship to the applicant; and

(4) There are funds available in the hemophilia insurance premium program encumbrance to cover the eligible participant.

(D) The director shall require that the following written documentation be submitted to determine the applicant's eligibility for assistance:

(1) The BCMH medical application form signed by the applicant or legal representative, and the treating physician or authorized representative of the BCMH approved hemophilia treatment center.

(2) Combined program application and supporting documentation to determine financial eligibility;

(3) Documentation showing the annual insurance premium amount;

(4) Documentation of annual health care costs of the applicant that has been covered by the insurance; and

(5) Any other documentation requested by the director.

(E) The director shall notify the applicant in writing of his decision to provide assistance within thirty days of the receipt of all the required documentation. Assistance with health insurance premium payments will not begin prior to the first day of the month in which all the required documentation is received.

(F) The director shall establish an initial period of eligibility for assistance not to exceed twelve months. The director may renew the eligibility on an annual basis as long as the requirements of paragraph (B) or (C) of this rule is met and funds are available.

(G) The eligible participant or legal representative shall submit, within thirty days of the date of the change, documentation of any changes to income that result in an increase in annual gross earnings, changes to the eligible participant's medical condition or treatment thereof, changes to the eligible participant's health insurance coverage, or documentation of any other changes that would affect the eligible participant's eligibility for assistance.

(H) The director may discontinue assistance or change the terms of assistance if:

(1) The eligible participant or legal representative fails to meet the requirements set forth in paragraphs (B) and (C) of this rule: or

(2) The eligible participant or legal representative fails to pay the health insurance premiums; or

(3) The funding for the hemophilia insurance premium payment program has been expended.

(I) The director shall provide the eligible participant or legal representative written notice of the

decision to discontinue or change the terms of assistance. Any such discontinuation or change will become effective no sooner than thirty calendar days from the date of the written notice.