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"Painless" Administrative Ways For States To Preserve or Even Increase ADAP Funding

by Thomas P. McCormack (revised 3/16/12)

1. *Proactively* Asking About and Paying Added Premiums for Offered, But Un-Taken-up, Dependent Coverage in Employer Health Plans of Working Spouses and Domestic Partners of Clients

a. Working Spouses

While many if not most of those eligible for ADAP programs are single, divorced or widowed, some *are* currently married. This therefore means that *married* clients who have working age spouses---even though they may well be small minority of the caseload---need detailed attention to uncover possible un-taken-up dependent coverage in spouses' job health plans.

A number of key studies of health insurance enrollment show conclusively that lower income workers are highly unlikely to enroll their dependents in their job health plans. (Some of these studies are available on request; however, they are long, detailed, technical and hard to plow through!) This is because, for almost all employer-based plans, *the employee must bear a costly premium surcharge to enroll his dependents.* For most of those making, say, $10 an hour or less (e.g., WalMart clerks, etc.) this is simply unaffordable---*even if they have seriously ill dependents.* After all, food and shelter come first at this income level.

For example, in a survey released in September,2003, the Kaiser Family Foundation found that only 33% of employees chose to take family coverage

through their company in 2003, down from 39% in 2001. In addition, the percentage of companies that fully subsidize family health premiums decreased to 15% in 2003 from 27% in 2001, the survey found. Premiums for family coverage rose 49% since 2000---with much of the surcharge to add coverage of dependent family members being deducted out of employee paychecks, except for the most progressive employers. The Bureau of Labor Statistics reported that same month that employees must pay an average of over $228 monthly as payroll deductions to secure dependent coverage. And in August, 2005, a U.S. Agency for Healthcare Research and Quality report found that in 2003 an average employee paid $2,283 yearly for family coverage in an employer plan, up from $1,275 since 1996. And in a 2004-05 survey of over 300 employers, www.salary.com found that over 14% of firms actually *pay* their employees not to enroll themselves and their dependents in company health plans. This means that a large percentage of spouses eligible to get dependent coverage in a working spouse's job health plan quite often just don't get enrolled by their employed spouse.

So this phenomenon means that---even if the ADAP program asks about other possible health insurance (e.g., which covers drugs) on its application forms---*such patients will* (somewhat misleadingly) *answer that they have* **no** *such coverage* (because they're not enrolled now, because they've forgotten a prior decision not to enroll and/or because the employed spouse didn't share the decision to non-enroll with the spouse on the public health program). So, to find out if an employer plan with offered dependent coverage **is** available from a working spouse's employer will require careful and precise telephoned or mailed questions to the program applicant, his or her spouse and even to the spouse's employer's benefits office.

One way to begin to deal with this might be to have the program's enrollment/eligibility/systems staff produce a list of those cases with spouses who've reported earned income. (In all states, for programs determining eligibility on family income, some data is kept on who has what sort of income). Such cases might then receive a mailing asking for the name and telephone number of the working spouse's employer---with follow up correspondence to the employer to inquire if there's a health plan, the premium surcharge amount, the date of the next Open Season and the plan's benefit package. Where a pre-existing condition waiting period has to be "waited out"---and, of course, this is far more rare than before thanks to the HIPPA legislation---cases would have to be monitored/diaried. And all cases requiring premium payments and related monitoring/diarying would obviously entail some added administrative effort.

However, such an extra effort to uncover non-election of offered employer health insurance should prove well worthwhile: The figures cited in the studies mentioned above all suggest that not just a large number--but **an**

absolute majority-- of couples with a working spouse in ADAP's income range have declined offered dependent coverage in health plans due to cost.

b. **Health Insurance As Dependent of Working Domestic Partner**

For ADAP, but not Medicaid, there's still another group of dependents of workers whose health insurance premiums can be paid by state Ryan White programs as a tool to stretch limited funds. These are those clients living with domestic partners who are working for employers which permit enrollment of such partners in the employer health plan. These are mostly gay couples; but there are probably numbers of straight unmarried couples too.

At www.hrc.org , at the "worknet" and then the "domestic partner" icons, are listed the 9 states, 136 or more localities and many but not all of those enlightened private employers that offer their employees the right to enroll their domestic partners in employer group health plans. There's even a query function to find out about particular employers as well as a "2002: State of the Workplace" report offering even more updated information about domestic partner health insurance offerings by progressive employers. Also see the list at http://www.buddybuddy.com/d-p-1.html , dated 9/ 2002.

As with traditional working spouses, lower-paid domestic partners may not have been able to afford to enroll their HIV+ partners (i.e., ADAP clients) in the workplace health plan. But even higher income ones may not have been aware that the benefit is available---or simply viewed enrolling in ADAP (at a big cost to ADAP's budget but **not their own !**) as more convenient for them than enrolling in the employer plan.

Obviously, screening an ADAP caseload and new applicants for this type of possible alternate coverage will be even more labor-intensive than screening those with traditional working spouses. ADAP enrollees and applicants must be asked whether they have live-in domestic partners; if such partners are working; where they're working; whether the employer offers domestic partner health coverage; and what the plan premiums, coverage and enrollment details are. As with traditional employed spouses, this information might well also require directly contacting partners' job benefits offices to secure details and arrange premium payment and enrollment. In some cases, partners' sensitivities to contacting the workplace must be accommodated too.

Since ADAP enrollees and applicants with live-in domestic partners probably outnumber those with traditional (straight) working spouses, this will be a new a new---even if hard-to-develop---alternate health coverage source.

c. Figures on dependent enrollment for low income workers (see highlighted figures below)

US	**All US Adults, Access Through Other Than Own Employer**								
US	**ALL RACES**	Total	No Access	With Access Thru Any Fam Member	With Access Other Than Thru Own Employer	No Employer Coverage	With Coverage, But Not Thru Own-Employer	Non-Own-Er Take-Up Rate	Check Diff
US	TOTAL	158,747,266	44,184,350	114,562,916	42,537,081	13,100,216	29,436,865	69.2%	
US	ROW PCT	100.0%	27.8%	72.2%	26.8%	8.3%	18.5%	69.2%	
US	Gross Family Income as % FPG	Total	No Access	With Access Thru Any Fam Member	With Access Other Than Thru Own Employer	No Employer Coverage	With Coverage, But Not Thru Own-Employer	Non-Own-Er Take-Up Rate	
US	< 100%	22,565,735	17,664,512	4,901,224	2,810,532	1,987,418	823,114	29.3%	0.0000
US	100% - 132%	8,325,965	4,785,260	3,540,705	1,615,353	1,073,170	542,184	33.6%	0.0000
US	133% - 199%	18,481,084	6,494,353	11,986,731	4,946,417	2,531,558	2,414,859	48.8%	(0.0000)
US	200% - 249%	12,684,809	3,116,622	9,568,187	3,753,184	1,385,700	2,367,484	63.1%	0.0000
US	250% - 399%	39,167,139	6,034,138	33,133,001	11,500,455	3,205,224	8,295,231	72.1%	0.0000
US	400% +	57,522,533	6,089,465	51,433,068	17,911,139	2,917,147	14,993,992	83.7%	0.0000
US	Check Diff	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000		
US	Gross Family Income as % FPG	Total	No Access	With Access Thru Any Fam Member	With Access Other Than Thru Own Employer	No Employer Coverage	With Coverage, But Not Thru Own-Employer	Non-Own-Er Take-Up Rate	
US	< 100%	100.0%	78.3%	21.7%	12.5%	8.8%	3.6%	29.3%	

US	100% - 132%	100.0%	57.5%	42.5%	19.4%	12.9%	6.5%	33.6%	
US	133% - 199%	100.0%	35.1%	64.9%	26.8%	13.7%	13.1%	48.8%	
US	200% - 249%	100.0%	24.6%	75.4%	29.6%	10.9%	18.7%	63.1%	
US	250% - 399%	100.0%	15.4%	84.6%	29.4%	8.2%	21.2%	72.1%	
US	400% +	100.0%	10.6%	89.4%	31.1%	5.1%	26.1%	83.7%	
US	ROW PCT	100.0%	27.8%	72.2%	26.8%	8.3%	18.5%	69.2%	
US	Gross Family Income as % FPG	Total	No Access	With Access Thru Any Fam Member	With Access Other Than Thru Own Employer	No Employer Coverage	With Coverage, But Not Thru Own-Employer	Non-Own-Er Take-Up Rate	
US	< 100%	14.2%	40.0%	4.3%	6.6%	15.2%	2.8%		
US	100% - 132%	5.2%	10.8%	3.1%	3.8%	8.2%	1.8%		
US	133% - 199%	11.6%	14.7%	10.5%	11.6%	19.3%	8.2%		
US	200% - 249%	8.0%	7.1%	8.4%	8.8%	10.6%	8.0%		
US	250% - 399%	24.7%	13.7%	28.9%	27.0%	24.5%	28.2%		
US	400% +	36.2%	13.8%	44.9%	42.1%	22.3%	50.9%		
US	COL PCT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
US	Gross Family Income as % FPG	Total	No Access	With Access Thru Any Fam Member	With Access Other Than Thru Own Employer	No Employer Coverage	With Coverage, But Not Thru Own-Employer	Non-Own-Er Take-Up Rate	
US	< 100%	14.2%	11.1%	3.1%	1.8%	1.3%	0.5%	29.3%	
US	100% - 132%	5.2%	3.0%	2.2%	1.0%	0.7%	0.3%	33.6%	

`US	133% - 199%	11.6%	4.1%	7.6%	3.1%	1.6%	1.5%	48.8%	
US	200% - 249%	8.0%	2.0%	6.0%	2.4%	0.9%	1.5%	63.1%	
US	250% - 399%	24.7%	3.8%	20.9%	7.2%	2.0%	5.2%	72.1%	
US	400% +	36.2%	3.8%	32.4%	11.3%	1.8%	9.4%	83.7%	
US	CORNER PCT	100.0%	27.8%	72.2%	26.8%	8.3%	18.5%	69.2%	

Source: late 1990s MEPS data, as reformatted by Ed Neuschler, Institute of Health Policy Solutions (2002) *eneuschler@IHPS.org* ***(202) 789-1491***

2. ***Proactively*** **Identify Those Women Under 65 on ADAP or Medicaid with Breast or Cervical Cancer or Precursor Conditions; Refer/Enroll Them in Medicaid Category with 15% Higher Matching Rate**

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 offers states the 15% higher CHIP matching rate to give Medicaid coverage to uninsured women under age 65---***no matter how high*** *their incomes or assets ,and even if they do* ***not*** *have children or are* ***not*** *disabled !*---if they're screened positive for breast or cervical cancers or precursor conditions by Centers for Disease Control (CDC) –funded state health programs and referred for treatment (other than routine, superficial monitoring) by their screening or other physicians. *All states (but, except for DC and the US territories) cover this optional eligibility group.*

The CDC-funded state health screening program *itself* has an income eligibility level of 250% of poverty, or $2268.75 monthly for one in 2011 (but Medicaid, as noted, has no upper income or asset eligibility levels of its own for those referred after the screenings). Although CMS' Medicaid eligibility regulations policy do not, and will not, elaborate on what constitutes "qualifying" precursor conditions for cervical cancer, the medical literature universally and conclusively considers any invasive cervical anomalies, conditions and infections--including infection with, or a history of, human papilloma virus (HPV)-- to be cervical cancer precursors; there's also some notable weight in the medical literature for considering severe or recurrent pelvic inflammatory disease (PID) and even chlamydia as precursors.

(CDC policy addresses the question of what are to be considered precursor conditions by ducking it and simply giving governing deference to the findings of, and any consequent referrals to care by, a woman's screening or other physician. CMS' Medicaid eligibility policy likewise ducks the question and instead gives the same dispositive deference to such physician referrals to satisfy its eligibility rule that such women must first have been screened and referred by the CDC-funded program.)

General policy about the CDC screening program is at http://www.cdc.gov/cancer/nbccedp/about.htm#introduction **and state program contacts are**

listed at http://www.cdc.gov/cancer/nbccedp/contactlist.htm **. For Medicaid coverage policies, use your Internet browser to locate & read CMS' January 4, 2000 letter to state Medicaid Directors & its Technical Policy Questions and Answers at** http://cms.hhs.gov/bccpt/ **.**

Note on what are considered precursor conditions to cervical cancer by consensus of the medical community:

The *2001 Consensus Guidelines for the Management of Women With Cervical Cytological Anomalies,* published April 24, 2002 in the *Journal of the American Medical Association,* Vol. 287, No. 16, p. 2123, at http://jama-ama-assn.org/Egi/content/full/287/16/2120 **(subscription required) states "Immunosuppressed Women: Referral for colposcopy [a cervical cancer screening procedure] is recommended for all immunosuppressed patients…includ[ing]..all women infected with …HIV, *irrespective of CD4 cell count, HIV viral load or [any active] anti-retroviral therapy* [emphasis supplied]".**

Moreover, the U.S. Preventive Services Task Force (http://ahrq.gov/clinic/3rdusfstf/cervcan/cervcanrr.htm **) states that "Infections with high risk strains of *human papilloma virus (HPV)*, generally acquired sexually, is *the most important risk factor for cervical cancer* [emphasis supplied]…HPV is a necessary but insufficient precursor of squamous cell carcinoma of the cervix…".**

***Human Papillomavirus Types in Invasive Cervical Cancer Worldwide* [G.M Clifford *et. al.*], published January 13, 2003 in the *British Journal of Cancer*, Vol. 88, No. 1, pp.63-73, at** http://www.nature.com/cgi-taf/DynaPage.taf/file=/bjc/journal/v88/n1/full/66000688a.html **states that " Epidemiological studies have clearly established human papilloma-virus (HPV) infection as the central cause of invasive cervical cancer (ICC)."; that "Approximately 40 distinct HPV types are known to infect the genital tract and epidemiological studies to date suggest that at least 14 of these, called oncogenic or high-risk (HR) types, are significantly associated with progression to ICC [invasive cervical cancer]." and that "…HPV is considered a virtually necessary cause of ICC [invasive cervical cancer].."**

See the *American Cancer Society Guidelines Regarding Screening for the Early Detection of Cervical Neoplasia and Cancer* at http://caonline.amercancersoc.org/cgi/content/full/5216/342#ABS **and those of the National Cancer Institute at** http://www.cancer.gov/newscenter/pressreleases/cervicalscceen **.**

The American College of Obstetricians and Gynecologists revised its guidelines for cervical cancer screening on July 31, 2003, re-emphasizing the needs for frequent screening of HIV+ and other immunosuppressed women because of their heightened cervical cancer risk; a summary appears at http://www.acog.org/from_home/publications/press_releases/nr07-31-03-1.cfm **.** Also, see **t**he report, "Cost-Effectiveness of Human Papillomavirus DNA Testing for Cervical Cancer Screening in Women Aged 30 Years or More" (P. 619-631) and the editorial, "Human Papillomavirus DNA Testing as an Adjunct in Primary Screening: Is It Prime Time?" (P. 617-618) in *Obstetrics & Gynecology* (2004;103(4)). Finally, a survey of over 12,000 persons found the chlamydia (and related gonorrheal) genital infection rate among women of different ethnic

groups to be 2.5 percent among whites; 4.4 percent among Latinas; 14 percent among blacks; 3.3 percent among Asian Americans; and 13.3 percent among Native Americans; see "Prevalence of Chlamydial and Gonococcal Infections Among Young Adults in the United States" in the *Journal of the American Medical Association* (2004;291(18):2229-2236).

States wishing to maximize enhanced, 15% higher federal Medicaid matching funds to care for such patients (and not just for the cancer care; *they're eligible for the full breadth of Medicaid services*) can proactively screen their ADAP and Medicaid patient claims data bases to identify uninsured women under 65 receiving treatments or drugs indicative of breast or cervical cancer or their precursors. *But states can and should be proactive and go further: All women known to be HIV-positive on Medicaid, ADAP or other state health programs should be referred to the CDC screening program because HPV, PID and other qualifying precursor conditions are well-documented to be highly co-morbid with HIV. Since HPV, PID and other gynecological anomalies are almost as prevalent among low income "underclass" women in general as they are in HIV+ women in particular, states also should seriously consider referring all (or at least carefully targeted groups of) women under age 65 and teenage girls already on ordinary Medicaid too, TANF and SSI as well.* **Then states can begin to arrange to determine (or re-determine) their Medicaid eligibility in the new breast-and-cervical cancer eligibility category--- and claim the enhanced 15% higher federal match for their future care.**

However, the federal requirement that there must first *be a CDC-funded state health program screening and referral to care has to be met: This means that the many women who will be identified as* already *getting Medicaid-. ADAP- or other state-funded breast or cervical cancer treatment must be sent to the state's CDC-funded program* first *for screening and referral---and only* then *enrolled in this Medicaid eligibility category***.**

So, some challenging, but not insuperable, case management procedures and logistics must be dealt with for states to claim the enhanced matching funds for these patients.

3. **Identify and enroll ADAP recipients on Medicare too who have incomes under 135% --and also those under 150%-- of poverty and enroll them in Medicare's Part D prescription drug coverage by signing them up for QMB, SLMB and QI**

Promoting enrollment for the Medicare Savings Programs run by state welfare offices to pay Medicare premiums and some other cost-sharing for limited-income Medicare Savings Program (MSP) patients on QMB, SLMB and QI who are slightly "too rich" for full, *regular* Medicaid are now also eligible for *full* subsidy, Extra Help *comprehensive*, premium-free, no-deductible, low-copay enrollment in a Medicare Part D drug plan (with no "donut hole" of non-coverage).

The Centers for Medicare and Medicaid Services (CMS), with state Medicaid agencies, has already arranged to certify those Medicaid eligibles who are also on Medicare ("*full*" dual eligibles), plus QMB, SLMB and QI eligibles, for *full* Low Income Subsidy (LIS)/"Extra Help" Part D drug coverage.

It's therefore important that state ADAP programs at once **begin to identify those of their *current* recipients---as well as *new* applicants---who are on Medicare *or whose two year***

Medicare waiting periods are coming up **and have countable incomes under 135% of poverty (in 2012, $1256.53 annually for one person**—after subtracting the $20 and other income disregards used by QMB, SLMB and QI)--- and with modest assets*.

Such clients now can be referred to state welfare offices to apply for QMB, SLMB and QI --- which will thereby facilitate their enrollment for the above-described **federal** ***Medicare prescription drug plans, which can significantly reduce the hard-pressed states' ADAP and pharmacy assistance costs.***

All Medicare patients with countable incomes under *150%* (in 2012, that's $1396.25 monthly for one person, and with slightly higher modest assets*, are ***also*** **eligible to enroll** (through the Medicare 800 number, welfare offices *or* Social Security offices) for *partial* low income subsidized/"Extra Help" Medicare Part D drug coverage with a ***very*** **low premium, *very* low deductible and a 15%-of-price coinsurance (with no "donut hole")**.

Enrollment in QMB, SLMB and QI now can ensure full Part D enrollment for ADAP clients. This can result in greatly decreased state ADAP budgets.

- Allowable asset levels for full LIS Extra Help are $11,500 per person, $23,000 for two, plus one lived-in home of any value; *any* number of vehicles of *any* value; and life insurance policies---no matter how much their cash surrender value or death benefit amounts are; and household goods. The QMB, SLMB and QI allowed assets are the same, except that the dollar amounts for liquid and non-home assets are only $4,000 for singles and $6,000 for couples (plus $1500 per person in designated burial accounts); only *one* vehicle of any value per person or couple is allowed; but many states can and often do allow even more.

4. Getting Medicaid coverage for disabled clients with ordinarily "excess" income by encouraging/arranging for their full-time. part-time or even token, nominal employment

At least 19 states now have little-known and rarely-used Medicaid eligibility provisions that allow disabled persons with incomes far, far higher than their state's ordinary Medicaid income level (with earnings up to $46,000 or more) to get Medicaid if they become "employed"---even for only a few hours or dollars a month and even as self-employed in such easy-to-work-in occupations as baby-sitting and lawn-mowing.

The 1999 Ticket to Work and Work Incentives Improvement Act (TWWIIA) has provisions that offer state Medicaid programs the option of allowing employed disabled persons (who are ordinarily "over-income" for Medicaid in their states) the right to "buy in" to Medicaid at very small premiums if they're working. Companion provisions in that law also offer states the right to cover those disabled workers who recover from their disabilities while working and those workers who have serious illnesses that could lead to disability; in addition, the 1997 Balanced Budget Act had earlier also offered states the right to cover the working disabled.

A useful disability advocacy website, www.barrierbreakers.com , at the icon "Medicaid buy in: Huge loophole" contains very helpful information about how to use the Medicaid buy in for the working disabled---and above all makes the quite accurate and vital point that states' Medicaid buy in programs cannot condition eligibility on the number of hours worked, minimum earning levels of clients or whether the work is as self-employed: The TWIIAA law's *only* requirement is that, where required, such employed disabled persons be paying any applicable income and FICA taxes. This website also offers detailed (indeed, probably overly-literal-minded) instructions for those clients who cannot secure traditional, regular paid work to easily become self-employed---even if only on a part-time basis--- so as to properly qualify as "employed".

Email tomxix@ix.netcom.com for "2003 MedBuyIn"; it charts the eligibility and enrollment criteria used by states which have taken the Medicaid buy in option for the working disabled. The following states' Medicaid buy in eligibility criteria would allow any disabled clients with SSDI or other "unearned" income over the state's regular Medicaid disabled level to qualify so long as they work and earn at least *some* money subject to FICA and income taxes, no matter how little! (Virtually no federal and state income taxes are due where earnings are very low--- even though, theoretically, such earnings could be subject to such taxes; see www.barrierbreakers.com .):

AZ, CA, CT, IL, IA, KS, LA, MA, MN, MS, NV, NH, NY, ND, OR, PA, UT, VT, VA, WA and WI.

But the following states, while they *do* have Medicaid buy in programs for the working disabled, unfortunately have chosen to impose an *additional eligibility test which limits the actual availability of the coverage*. They require that clients---to begin with and before they even commence work---have SSDI and other "unearned" income below the state's SSI or Medicaid level---which thus prevents eligibility for almost anyone with SSDI or other countable income over about $674 or $930 monthly:

AK, AR, IN, ME, MI, NE, NJ, NM, NC, SC, WV and WY.

Of course, even the second group of states' Medicaid buy-ins could be made more widely accessible if advocates convinced their state Medicaid eligibility policy staffs to drop their low "unearned" income thresholds that so severely limit eligibility. (And in most cases, such detailed eligibility criteria will have been promulgated via malleable administrative rules rather than harder-to-change statute.)

States not appearing in either listing above may have not yet elected to cover

the working disabled at all (but check with the local Medicaid eligibility staff to be sure).

Assisting clients with accessing Medicaid through the working disabled buy in----even those who can't manage or find full-time work and even those who secure only self-employed "chore"-type work--- can bring invaluable Medicaid coverage (including drug and other medical benefits) to clients who are ordinarily "too rich" for Medicaid in their states.

5. A Quick & Easy Method of Screening for Medicaid Eligibility under the Pickle Amendment (for the 2012 information/calculation sheet to determine eligibility under this provision, email tomxix@ix.netcom.com)

(The Pickle Amendment can make many fully disabled persons with current SSDI income above their state's present Medicaid income level eligible for Medicaid by deducting all the SSDI cost-of-living increases they received since---and if—they were originally on SSI, however briefly, when they were first found disabled by Social Security.

(The person need not literally receive both SSI and Social Security checks in the same month, but need only be *entitled* to both for the same month. There is a one-month lag in OASDI payments, which are not disbursed until the month after entitlement, while SSI payments are paid in the month of entitlement. It is common for a person to receive SSI while awaiting receipt of OASDI payments. Once her monthly OASDI begins, if it exceeds the SSI rate, she receives just OASDI thereafter. In such circumstances, even though the person never actually received simultaneous payments from both programs in a single month, she meets the first Pickle requirement. This is true even if income from a retroactive OASDI payment exceeds the SSI benefit level for all months in which SSI was received. For this reason, you should ask not just if the person received both SSI and Social Security in the same month, but did he receive SSI immediately before his Social Security payments began. See 42 C.F.R. §435.135 and 51 Fed. Reg. 12326 (April 10, 1986). For more information, see "Medicaid Eligibility in a Time Warp", 22 *Clearinghouse Review* 120 [June 1988].)

(Due to Social Security's rounding rules, the adjustment factors in the table produce an approximate, rather than exact, figure. Because a discrepancy of one cent may mean the difference between Medicaid eligibility as a Pickle case and no meaningful access to health care, advocates should obtain exact information from the Social Security Administration if the figure produced by the screening method results in a determination that the client is over the eligibility limit by a small amount (i.e., $20 or less).

6. PROPER SCREENING FOR VA MEDICAL ELIGIBILITY

1998 Census data, as re-tabulated by the Department of Veterans' Affairs (VA), suggests that state drug assistance programs may be bearing some medical costs for patients actually eligible for free or low-fee VA medical care.

State programs have long been rightfully viewed as last resorts. Those eligible for medical care and drugs from other programs should use that coverage before turning to the state. Thus, medical care coverage available from the VA should—unless there are exceptional circumstances—be turned to before limited state monies are spent.

But virtually all members of the public, many state officials and even most veterans themselves ***wrongly*** assume that one must be a combat or wartime veteran or have been injured or become sick on active duty to get VA medical care. As a result, some states don't bother to screen at all

for VA medical care eligibility. Or, just as worse, they ask veterans themselves whether they're eligible for VA medical care. And—not surprisingly, since even veterans themselves don't know the correct eligibility rules—few applicants indicate that they're VA-eligible!

To be eligible for VA medical care, a veteran must have served at least 180 days active duty and have an honorable or general discharge. Those with service-connected disabilities, former prisoners of war and *any* veteran whose served in a combat zone within the last two years are *guaranteed* high-priority, copayment-free care. However, veterans who first enlisted after September 7, 1980, must also have served at least two years; see the note below for details about, and exceptions to, that rule .* But, in general, veterans do ***not*** need to have served in combat or in wartime; have been injured or become ill while on duty; be disabled; or even have been overseas.

VA Health Care Priority Groups, Service-Connected Veterans and Co-Payment Rules

Except for genuine emergencies, the VA prioritizes access, waiting times and availability of medical services for elective and other non-emergency care, using eight priority groups:

1. 50% or more service-connected disabled veterans
2. 30% and 40% service-connected disabled veterans
3. 10% and 20% service-connected disabled veterans; former prisoners of war; Purple Heart recipients
4. Veterans found by the VA to be "catastrophically disabled", even from a *non*-service-connected cause (see below) or who get pension or compensation add-ons for Aid and Attendance or as Housebound; those who served in combat zones within last 2 years
5. Non-service-connected veterans considered "poor" under VA income/asset rules (see below)
6. Vietnam War (1962-75) Agent Orange victims; First Gulf War (1990-91) and Iraq War (1998-) veterans with Gulf War Syndrome; World War I (1917-21) and Mexican Border War (1916-17) veterans
7. Non-service-connected veterans considered "near poor" under VA income/asset rules (see below)
8. Non-service-connected veterans *not* considered poor under VA income/asset rules (see below; new enrollments in this category were suspended as of 1/03)

Service-connected veterans *always* get free care, without even the $8 prescription co-payment, for their *service-connected* conditions---no matter how high their income or assets. If they have private health insurance it is *never* billed for treatment of service-connected conditions.

2011 VA Medical Care Income/Asset Eligibility Levels and Copayments For Poor *Priority 5* Veterans

To get ***free care*** (except for a $8 co-payment per prescription), a "Priority Group 5" veteran can have up to $80,000 in assets, not counting household goods, a lived-in home and one vehicle of any value (but recently the VA has become very flexible is applying this $80,000 asset test).. In addition, in 2011, monthly income can't exceed the following:

Single veteran……..……...$2,450.25

Veteran with one dependent…….. …$490.16 more

For each additional dependent…..……$168.33 more

However, if the "Priority Group 5" veteran does have some private health insurance the VA will bill and collect what it can from the private insurance. It will then give the veteran "credit" towards whatever prescription copayments he owes for the insurance money it collects.

(In 2012, the first $9750 yearly in wages *actually earned* by a child under age 18 are not counted. *Actually received* child support and spouses' incomes are fully counted, though.)

2011 Income & Asset Levels and Copayments For Wealthier, "Priority 7" Veterans

To get ***very heavily discounted care***, veterans can have even more than $2450.25 in monthly income (it ranges, by region, up to a ceiling of about $35,000 to $50,000 yearly, depending on where they live) or $80,000 in assets (counted very flexibly, and not counting household goods, a lived-in home of any value and one vehicle of any value). . They'd still qualify as "Priority Group 7" veterans and get care when *space is available* (it usually is, except in the most overcrowded hospitals). But they also must pay the following small copayments for care in 2011:

$9 per prescription

$15 to $50 per doctor, clinic or emergency room visit

$2 per day for each inpatient hospitalization

$226.40 more for the first inpatient hospitalization per year

$113.20 more for most subsequent hospitalizations per year

However, if the "Priority Group 7" veteran does have some private health insurance the VA will bill and collect what it can from the private insurance. It will then give the veteran "credit" towards whatever copayments he owes for the insurance money it collects.

(In 2012, the first $9750 yearly in wages *actually earned* by a child under age 18 are not counted. *Actually received* child support and spouses' incomes are fully counted, though.)

2011 Income and Asset Levels *with Even Bigger Copays* for *Still Wealthier* Priority Group 8 Veterans

On October 1, 2002, the VA created a new Priority Group 8 for health care eligibility to implement the VA Health Care Programs Enhancement Act, which was enacted in January, 2002. Priority 8 patients are those non-service-connected veterans with assets over the levels allowed for Priority 7 *or income* ***over*** *the levels used by HUD as the upper limits for housing*

assistance eligibility. The HUD levels vary state-by-state, and by Standard Metropolitan Statistical Areas (SMSAs) within states, depending upon regional costs-of-living (for one person, they generally range from about $35,000 yearly to about $50,000, depending on the area). See the sidebar below to calculate local area Priority 8 income levels.

The family-sized upper income limit for housing assistance in a locality is now the maximum Priority 7 income allowed for Priority 7. Non-service-connected veterans' with income ABOVE this income level are now in Priority Group 8 !

In 2011, Priority 8 patients must pay the copayments of $9 per prescription, $15 to $50 per outpatient encounter, $1,132 plus $10 per night for the first inpatient hospital stay in a year and $556 plus $10 per night for most subsequent hospitalizations in a year**.**

However, if the "Priority Group 8" veteran does have some private health insurance the VA will bill and collect what it can from the private insurance. It will then give the veteran "credit" towards whatever copayments he owes for the insurance money it collects.

(In 2012, the first $9750 yearly in wages *actually earned* by a child under age 18 are not counted. *Actually received* child support and spouses' incomes are fully counted, though.)

Moreover, on January 17, 2003, the VA published Interim Final Regulations in the ***Federal Register*** (Vol. 68, No. 12, pp.2669-2673) **immediately suspending further enrollment of Priority 8 veterans.** But those veterans now classified as Priority 8 who are *already enrolled* --- plus those already who originally qualified as Priority Group 5 or 7 but whose income or assets *only later* rise into the Priority Group 8 range---are "grandfathered-in".

VA Medical Care Eligibility and Enrollment Procedures

Veterans typically begin the enrollment process with interviews at VA medical facilities, bringing discharge papers (DD214s)*, documentation of any *private* health insurance and, for those of limited income seeking Priority Group 5 or 7 care, proof of dependents, income and "net worth" (assets). Enrollment is completed once veterans are assigned to a Primary Care Team (often denoted by colors: "red', "green", etc.) and are scheduled for Team intake examinations--- after which referral to specific departments and clinics for ongoing care is arranged.

But, anytime, those presenting themselves at the emergency room for *genuine* emergencies--- *even those who haven't yet completed the regular enrollment process!*--- are seen with the same

* Most veterans keep copies on hand of their discharge forms (DD214s); but those who've lost them can request copies by writing to the National Personnel Records Center (Military Personnel Records), 9700 Page Avenue, St. Louis, MO 63132 – 5100. One can also request military medical care and other records from this facility. Requests can be made with an ordinary written letter, or on a SF 180 form, downloadable at http://usmilitary.about.com/library/blsf180htm or at www.VA.gov . Provide one's full name, date of birth, military service number, Social Security number, branch of service, dates of service, military rank at discharge and current address. Women who served before marriage should provide their maiden names. Getting a response can take several months---and a catastrophic fire in 1973 destroyed the only known copies of many records from the World War II and early Cold War years.

medical triaging, waiting, processing, physician treatment and necessary prescription issuances as are used at *any* hospital emergency room.

But again, ***even*** *those who are still awaiting intake examinations can present themselves* ***anytime*** *at VA hospital ERs for necessary, emergent care (including necessary prescription issuance).*

Congress has appropriated massive increases in recent years for the VA health budget and will continue to do so to handle the crowding. Higher VA health budgets are popular with Congress: Until the GOP House presented its 2012 austerity budget (which had few VA cuts in any case), Republicans had always strongly favored it as a sort of "military" expense; while liberals know well that the VA cares for the poor, the disabled and the elderly.

Upgrading Bad Conduct, Dishonorable, Less-Than-Honorable and Undesirable Discharges; Having Discharge Reclassified To Being For Disability or Hardship

Bad conduct, dishonorable, less-than-honorable or undesirable military discharges---and often unexplained, early discharges that need to be rewritten to reflect that they were actually for hardship or disability reasons---which now prevent eligibility for VA medical care, pensions, compensation and other benefits can be changed by applying to appropriate military discharge review boards. The website www.usmilitary.about.com offers clear and concise explanations and instructions, with relevant forms and addresses. For attorneys and other professional-level advocates who need more exhaustive information, the National Veterans Legal Services Program (www.nvlsp.org) sells a comprehensive manual for about $100.

What About Those Veterans Who Seek Only VA Prescription Drugs But Want To Retain Their Own Civilian Doctors?

Some veterans may argue that enrolling in VA medical care (for example, to get expensive prescription drugs costs from the VA rather than the state) might require their giving up their own civilian doctors (whom they see through Medicare or as patients in various low income clinic prorgams). Actually, this isn't so. There's *no rule* to deny VA eligibles the right to also see civilian doctors---and, in fact, a surprising number do so. As mentioned in the previous paragraphs, VA facilities are now crowded *precisely because* many older veterans use their Medicare to see *civilian doctors* ***but subsequently use their VA eligibility to (redundantly) then see VA doctors to have the prescriptions they need ordered and written on VA prescription forms--- which they then fill at the VA at $8 or $9 each!***

The VA's rules still require that its prescription drugs can only be issued when the prescriptions are written by VA doctors for patients they actually see. So, to get VA-covered drugs, many, many older patients go through the motions of seeing a VA doctor to get him to write the same prescriptions their civilian doctors ordered----but now on VA prescription forms. VA doctors know this and are quite used to it---they quickly assess the patient's state of health and what prescriptions the civilian doctor ordered. If everything seems reasonable and necessary they then write the very same (or equivalent) desired prescriptions on VA forms, send patients on their way and rapidly move on to the next waiting patient.

Of course, even abbreviated, “pro forma” VA patient visits like these *are* wasteful of VA resources (and the time of patients, who resent having to be seen by a second doctor just to get VA drugs). But under current rules, the VA requires that its own doctors be responsible for decisions to issue prescriptions. Some veterans, members of the public, Congressmen and the General Accounting Office have called for considering abandoning the “see a VA doctor first” prescription rule and the VA has begun to study doing so.

The VA will allow *some* eligible veterans with *already*-issued prescriptions from *private, non-VA* doctors---those who've signed up for VA care but still awaiting their post-enrollment "intake" exams for at least 30 days as of 7/25/03---to fill them via its mail-order system to ease the current backlog of veterans waiting to be in-processed to the VA system.

Only those privately-prescribed drugs that are otherwise VA-covered, that are non-narcotic, that don't have to be injected and that can be mailed out can be offered by this temporary stop-gap for those veterans queued-up in the backlog as of July 25, 2003. But those who only become "backlogged" *in the future* aren't eligible for this temporary, stopgap coverage unless VA rules are again changed.

The VA still maintains its requirement that, in general, VA-issued drugs can only be written by VA physicians for those veterans they actually see after full intake. Nevertheless, the GAO, many Members of Congress and some veterans' organizations still want *regular, ongoing* access to VA-issued drugs for those who remain in treatment with private doctors---and the VA has said it is still considering such a permanent change in policy.

A press release on the temporary new policy is at
http://www.va.gov/opa/pressrel/PressArtInternet.cfm?id=639
The text of the temporary interim is printed in the 7/25/03 *Federal Register* at
http://a257.g.akamaitech.net/7/257/2422/14mar20010800/edocket.access.gpo.gov/2003/03-19011.htm

More On VA Prescriptions

VA prescriptions are issued by the prescribing doctor on a VA prescription form, where he usually indicates how many refills are to be allowed. Patients then drop them off at in-house VA pharmacies---where, typically, dozens of patients are waiting at any given time. With often-long waits that usually exceed those at commercial pharmacies, patients are given their prescriptions after they pay their $8 co-payments. Those non-service-connected veterans claiming exemption from co-payments because they can’t afford them (see below) at this point can encounter time-consuming red tape that might well require an hour or two *more* of processing (and only then if the finance and pharmacy offices are open for such business).

Service-connected veterans are *not* charged co-payments for care related to their disabilities. And, yes, in practice the difficulties VA staff face in distinguishing, Solomon-like, between care for service-connected conditions and other conditions can, and often does, result in some service-connected veterans getting co-payment exemptions for care for their *non*-service-connected conditions.

Patients can---and, where it's medically possible, many do---choose *not* to wait on-site for prescriptions to be filled: They can instead opt for mail delivery service to their homes. Yet this can, and often does, take a week or more; shipments are often late or lost in the mail; and medications that are narcotics or are heat- or refrigeration-sensitive can't be mailed in any case. On the other hand, patients choosing mail service can thereby avoid having to make on-the-spot cash co-payments at the VA pharmacy window. Instead they're mailed bills for the co-payments, which they can later pay by mailed checks or money orders. But those who become seriously delinquent may well then be required to make on-site, up-front cash co-payments for future prescriptions.

The VA is not subject to applicable state medication prescribing laws. Hence, patients generally must accept what the VA physician orders; for example, they can't (without convincing the prescribing doctor) ask for a generic or invoke other substitution options that might be available under state law at commercial pharmacies. On the other hand, the VA permits registered nurses and physician assistants to prescribe in many cases---even where state law wouldn't permit this.

Moreover, the VA can, and often does, allow prescriptions to be refilled more times than is allowed at "civilian" pharmacies. Patents can request this when first given prescriptions and as they drop them off at the VA's on-site pharmacies. Refills can be scheduled/diaried for "automatic" mail refill or can be specifically re-ordered via telephoned- in computerized systems. Those who don't wish to wait at the VA for their prescriptions---if they're willing and able to pay cash themselves-- can fill those signed by a *physician* at commercial pharmacies.

An important advantage of the VA system is that it issues "prescriptions" (and at the often-attractive "bargain price" of only $8!) for a wide variety of "over-the-counter" items---bandages, dressings, braces, lotions, salves, cough medicines, digestive remedies, patent medicines, crutches, canes, walkers, adult diapers and many other first aid supplies---that aren't legally considered "prescriptions" and that civilians simply pay cash for. Thus, asking VA doctors for prescriptions for such items can result in some savings.

Suspending *All* Prescription Co-pays for the *Very Neediest* Veterans

In 2012, Priority Group 2 through 6 veterans' prescription co-payments can be suspended for the rest of the year once they incur $960 of such charges—as is also true for any applicable prescription copayments that might otherwise be required of 40%-or-less service-connected disabled veterans or for treatment of a service-connected disabled veteran's *non*-service-connected condition. In addition, ***all* veterans with incomes under the prior year's basic family-sized pension level (so for 2012, that would be 2011's $1031 monthly for a single veteran) are exempt from *any* prescription copayments at all.** When first enrolling for VA care, those under this income level should be sure to insist that their enrollment file specify that they're copayment-exempt and those who originally enrolled at higher income levels---but whose income later falls to within the exemption low income range---should re-visit the VA hospital or clinic's enrollment/eligibility office with revised, current proofs of income to request that their records be corrected to exempt them from drug copayments. Debts owed the VA for any copayments can be waived on grounds of "equity and good conscience" by hospital fiscal officers (see amendment to 38CFR17.05 in the April 20, 2004 *Federal Register*).

Special Rules For VA-Paid Care from Non-VA Medical Providers

Note that (except for rare, arranged-in-advance purchases of specialty care at non-VA hospitals) the VA *does not pay* for care at non-VA facilities, with three exceptions:

First, with advance permission, some veterans—usually, *only* those who get *service-connected* compensation benefits -- can be treated by non-VA medical staff or facilities in Colorado, Wyoming, Utah, Montana, Idaho and parts of central Florida under special, limited pilot programs.

Secondly, *service-connected* compensationers--but *not* other veterans—can with advance permission be treated by approved foreign medical providers and, on a space-available basis, at foreign US military medical facilities, for emergencies when overseas. Contact the Medical Administration Service (136), Foreign and Insular Affairs Unit, VA Medical Center, 50 Irving Street, NW, Washington, DC 20422, telephone (202) 745-8242. There are numerous authorization and billing forms which are required. Request a copy of the pamphlet "Department of Veterans Affairs Foreign Medical Services Program". Nevertheless, in spite of the restriction of care at overseas US military medical facilities to service-connected compensationers who have secured advance permission, there are anecdotal reports that *other* veterans with VA patient identity cards *have* secured emergency care at those facilities. This is because clerks there understandably have trouble mastering the VA's complex rules. Hence, they often fail to distinguish between the classes of eligible and ineligible VA patient identity cardholders.

Lastly, otherwise eligible veterans----***only if*** *they have already enrolled for VA health benefits* ***and*** *have actually received some VA treatment*----can receive emergency care paid for by the VA at a non-VA hospital in the US when 1) such a hospital is nearer than a VA one and 2) delaying care to reach a more distant VA facility (under a "prudent person" standard) would seriously endanger life or health. Ambulance and related emergency in-hospital medical services which seem necessary (also under a "prudent layperson" standard) can be covered too In cases of inpatient admission, the veteran, his family, legal representative or the non-VA facility must get authorization from the veteran's regular VA clinical staff within 48 hours. That VA staff also decides when the patient is medically ready to transfer to a VA facility---after which VA liability for payment for care at a non-VA facility ends.

2011 Priority Group 5 Copays; Co-pay Credit for Private Insurance Payments

In 2011` single veterans with incomes below $2,450.25 monthly ----known as Priority Group 5---- are eligible for free care (except for a $8 co-payment per prescription), after those with service-connected disabilities, former prisoners of war and certain other priority classes are served. ($490.16 *more* monthly is allowed for one dependent, and $168.33 *more* monthly for additional ones; here, too, the first $9750 yearly of a *child's* earnings is not counted.) Allowable assets per family include household goods, a lived-in home of any value, one vehicle of any value, and $80,000 in very flexibly counted "net worth" (automobiles, bank accounts, other property , investments, etc.). If a Priority 5 veteran has private health insurance, the VA will bill the plan for what it can, but it will not bill the veteran if he or she has income below this level, except for the $8 prescription co-payment.

Arranging/Subsidizing Transportation To Distant VA Hospitals & Clinics

In metropolitan areas with good, economical public transit, getting to VA medical care via buses or subways costs relatively little and is reasonably available. But many patients living in rural or far-out suburban areas lack a family automobile, have little or no income to pay for their gas or reimburse others for rides or live in areas that aren't served by *any* reliable or frequent-enough public transit or even long distance bus service (e. g., Greyhound).

In addition, the Disabled American Veterans (www.DAV.org), a nationwide non-profit organization provides daily, free door-to-door van transport service to disabled and indigent veterans who otherwise can't get to VA medical appointments. On its website, the key terms "transportation network", "hospital coordinator" and "volunteer services" refer one to a hospital-by-hospital listing of, and telephone numbers for, those DAV workers who supervise the van transport system serving that hospital. They can provide details about local van service, scheduling, reservations and priorities. Almost all DAV van drivers---and even some of the hospital-based coordinators---are unpaid middle-aged and older veteran volunteers.

Case Management and Patient Advocacy for VA Patients

Because the VA is a classical large, often-impersonal bureaucracy, patients' needs can sometimes be overlooked or forgotten: Mail-ordered prescriptions may not come on time or at all; mail-order and other prescriptions may expire, with their expiration perhaps being overlooked by busy physicians; and vulnerable, less self-proactive patients may not get the detailed case management and treatment/drug regimen training that they need.

While the VA benefits system does offer an appeals and hearings for those who are aggrieved, it is attuned almost exclusively to the needs of those seeking money Pension and Compensation payments rather than timely, quality medical care and related supportive services. Veterans have one year after the denial of a benefit, or being given a substandard service, to appeal in writing to their servicing VA Regional Office, using VA forms available at www.VA.gov or even by simply writing a letter. The appeals system is clogged with hundreds of thousands of overdue appeals, and getting decisions often takes two or more years. Hence, it is not timely enough to be useful for medical care complaints.

More vulnerable veterans—those who are frail, are intellectually-challenged, have limited education, are confused or intimidated by the massive, complex VA system or otherwise need detailed case management, guidance and assistance with appointment schedules, treatment orders or drug therapy regimens--- can seek help from, or be referred to: the "service representatives" (middle-aged and older veteran volunteers from groups like the American Legion, the Veterans of Foreign Wars, etc., who work from offices in VA hospitals—although what skills they have are more often focused on Pension and Compensation questions); Patient Advocates and Ombudsmen (on staff in VA hospitals just as they are in civilian hospitals---with skills in handling patient complaints about treatment and quality of care); and---above all !—the VA hospitals' own medical Social Work departments (which offer treatment-related supportive counseling and services to *all* VA patients, including even those treated by *out*patient clinical departments).

The VA medical care system, at least theoretically, requires one to secure unscheduled or between-appointments medical care through the Emergency Room. But that can take many hours' wait, and then only to be seen by a generalist physician unfamiliar with the patients' individual care. He can (at most) offer temporary care solutions and impermanent, stopgap prescriptions for expired, lost-in-the-mail or about-to-expire medications. Some more proactive patients successfully deal with this inevitable eventuality by chatting up acquaintance-ships with their main treating clinical department's receptionists, clerks, nurses and social workers. These contacts can then squeeze them in for an unanticipated appointment or arrange to have a physician renew an expiring prescription or write a stopgap for one lost or delayed in the mail.

Techniques For States To Promote VA Care as a Prior, Alternate Resource

To get the most out of VA medical care as an alternative, states might consider altering application forms to ask ***not just whether an applicant is eligible for VA medical care: after all, many veterans wrongly think they're NOT eligible!*** Instead, application forms could ask about the *key, underlying eligibility factors:* "Did you serve on active duty for over 180 days, or over two years, with the Army, Navy, Air Force, Marines, Coast Guard or, if you were activated in the National Guard or Reserves, for the full activation tour of duty?" "Did you receive an Honorable or General discharge?" "Please attach a copy of your DD214 (discharge papers)."

State officials should also know that the state's Medicaid eligibility electronic enrollment file staff (with whom they've likely already worked) can advise them about access to and use of federally-provided electronic data bases which might possibly check for veterans' status and other key income and eligibility data matches through the "PARIS" program.

VA medical care is often unfairly looked down upon because so many of its patients are poor, minority and working class men. As a result, some veterans who are state clients may be reluctant to use (or even reveal) their VA medical care entitlement—preferring, instead, to receive their expensive care at state expense.

But unless state eligibility procedures guard against this, expensive medical care (which the VA is responsible for) will be shifted unfairly to the state budget. This could limit access, drug formularies, or both in state programs.

To implement a VA eligibility-screening program, states might wish to consider other, supplementary policies as well:

- Using state funds to pay copayments of those of the "Priority Group 7" veterans (the "near-poor" ones) who cannot afford them. (But states *should note* that the VA does *not* require the veteran to front cash for care; it will bill later.)

- Using state funds to pay the $8 per prescription copayments due from the "Priority Group 5" (lower income) patients.

- Installing procedures to continue to provide care to those Priority Group 7 or 8 patients whom the VA turns away for care when space is *not* available. (But even here, states might

wish to refer patients to at *other* area VA facilities to see if *they* have space available, before granting unfettered access to state benefits.)

- *Prohibiting* use of state funds to pay for any prescription written on a VA prescription form. (This would prevent VA patients wishing to avoid their VA co-payments from using their *state* coverage to secure lower copayment prescriptions—which, of course, results in shifting heavy expenses from the VA to the state.. But here, too, individual override procedures need to be developed for when a particular drug happens to be out of stock at a VA hospital.)

- Using state funds for ambulance, taxi, bus or car mileage payments for transportation to distant VA hospitals for care for those who cannot afford the travel if VA-reimbursed or free DAV transport is unavailable.

- Exemption procedures need to be developed for patients who live so very far away from VA facilities that only state coverage, using local civilian resources, would be cost effective or humane.

Screening/Referring For VA Medical Care Brings Veterans *Total* Medical Coverage (Not Just Drugs) and Helps Them Access Other VA Benefits Too

States can somewhat sugarcoat the imposition of these strict referral rules by bearing in mind and pointing out to veterans that the VA offers them *not just prescription drugs* ***but also comprehensive, total medical care---including physician, care, specialists' care, clinic care, hospital services, laboratory services and sometimes even eyeglasses, hearing aids and dental care.*** In addition, by screening for VA medical eligibility, states can also serve veterans by at least preliminarily screening them for the VA's disabled wartime veteran's "pension". This welfare program pays up to the monthly amounts shown below. It is available to fully disabled veterans—whether or not their disability arose from their time in service, and whether or not they actually served in a war zone or overseas, ***unless*** **their service fell *wholly* within these dates**: January 1, 1946-June 27, 1950; February 1, 1955-August 4, 1964; and May 8, 1975-September 1, 1990.* For a pension, family assets (counted very flexibly) can include up to $80,000, not counting household goods, a lived-in home of any value and one vehicle of any value.

The 2011 monthly payment rates for VA pensions are $985.83 for a single veteran; $305.25 more with one dependent; and $168.33 more for each additional dependent, plus a $658.83 Aid and Attendance increment for those found to be invalids, *after deducting other family income like Social Security, wages or pensions.* (Thus, as with all welfare programs, *other, non-welfare* income reduces the VA pension dollar-for-dollar; where *total* family income exceeds the pension level, the family isn't eligible at all. As with medical care, though, in 2011 the first $9350 yearly of a child's earnings aren't counted.) Screening for this program, while checking for VA medical care coverage, will enable states to ensure that eligible clients get the income they need.

Special Rules For Those Who First Enlisted After September 7, 1980

*Those first enlisting after September 7, 1980 must, in addition, serve at least 24 months' total active service *unless:*

1. They were activated Reservists or National Guardsmen who served out their full activated tour, even if it was less than 24 months (for a pension, the 90 days' active service and one-day-of-wartime rules also apply; but medical care only requires the 180 days' active service time minimum *or* being found service-connected disabled).
2. They got early honorable or general discharges before 24 months because of hardship or disability (again, the 90 days' active service minimum and one-day-of-wartime rules still apply for pensions; but medical care only requires the 180 days' active service time minimum *or* being found service-connected disabled).

STATE VETERANS BENEFITS ADVOCACY AGENCIES

*(These **state—not federal--** agencies provide **free, expert** help to state residents in applying for---or appealing denials of--- VA compensation, pensions, medical care and other benefits. These are state headquarters offices; in all but the smallest states, there are branch offices to assist veterans in local communities. Some larger states offer in-state 800-number service; ask your information operator to check under the **state—not federal—**listings. For a complete, nationwide and updated listing of addresses, telephone numbers, websites and email addresses see* www.NASDVA.com **,** *the website of the National Association of State Directors of Veterans Affairs.).*

Sidebar:

New Regional Priority Group 8 Income Levels

Priority Group 8 income levels---by family size, by county, within each state---are listed at http://va.gov/healtheligibility/Library/pubs/GMTincomeThresholds/ . If this link doesn't work, patient if difficult research on the VA health eligibility pages can also locate this chart. (Be very sure to take great care not to incorrectly identify, and then consult, the maximum Priority Group *5* income levels by mistaking them for those of Priority Group *8*: Unfortunately, without one's vigilant attention to detail, the VA website's flawed configuration and its referring information icons can refer one to what are. in fact, the much lower Priority Group *5* levels—and *not* the sought-for Priority Group *8* levels!)

Sidebar:

What Conditions Qualify as "Catastrophically Disabled"?

(Veterans with certain specified, gravely-disabling conditions---*even if they're **non**-service-connected* **and no matter how high their income or assets**—*can apply and qualify for **Priority Group 4 status**.* And under recent legislation they have no co-payments at all---not even for drugs! Email tomxix@ix.netcom.com for a copy of the listed conditions, *which unfortunately does* **not** *as yet include HIV*).

RECOMMENDED QUESTIONS ON VETERAN STATUS FOR STATE DRUG ASSISTANCE PROGRAM APPLICATION/RENEWAL FORMS

One can't determine the facts about possible VA eligibility with one or even two questions---VA eligibility is too complex to capture that way.

And remember, we're dealing with a situation where a good number of veterans *themselves* don't know the VA health eligibility rules---or, worse, may be attempting to conceal their eligibility in order to get state drug assistance which, for them, may be more "convenient" than going to the VA. Thus, state drug aid programs have to get the underlying facts to see who has VA health care eligibility---the clients' own opinions may well be unreliable!

RECOMMENDED QUESTIONS FOR ADAP APPLICATION/RENEWAL FORMS

Did you ever serve in the Air Force, Army, Coast Guard, Marines or Navy?
Yes_____No_____

If yes, was your discharge:
honorable___
general___
dishonorable___
bad conduct___
undesirable___
disability___
hardship___
other___
Explain_____
__

Did you first enlist after September 7, 1980? Yes___No___

How long did you serve on active duty?
Over 6 months_____Less than 6 months_____
Over two years_____Less than two years_____

Did you ever serve in the Reserves or National Guard?
Yes_____No_____
If so, were you ever called up for activated service?
Yes___No____
If yes, for how long?_____
If yes, did you yourself complete service for the full time your unit's activation orders called for?
Yes____No_____

Were you discharged early because of disability or hardship? Yes_____No_____
If no, were you discharged early for another reason? Yes___No___
If yes, what reason?_____
How much earlier than your scheduled discharge or end of activation call-up were you discharged?_____
What dates did you serve on active duty in the Army, Air Force, Coast Guard, Navy, Marines or activated Reserves or National Guard?

From_____To_____

Please attach your DD214 or similar discharge/deactivation document or orders.

VERIFICATIONS OF VETERANS' STATUS AND CHARACTER OF DISCHARGE IN SCREENING FOR VA MEDICAL ELIGIBILITY: USING THE FREE VA- STATE "PARIS" COMPUTER MATCHING SYSTEM

The VA maintains two electronic data bases: **Vetsnet**, which includes ***only*** those veterans (and dependents and survivors receiving---or who have received, or initially applied but failed to complete applications for ---veteran pensions and compensation payments; and "**BIRLS**, or Beneficiary Identification and Records Locator System" of ***all*** veterans---*including* activated National Guardsmen and Reservists---who have ever been issued a DD214 (or predecessor discharge paper) since the Civil War, ***even if they or their dependents or survivors never applied for VA pensions or compensation payments***.

By law, data files submitted ***only by state "PARIS" coordinators*** can be run for data matches and "hits" against this system---***if*** the state PARIS coordinator and the VA determines the submitting agency has an "appropriate" purpose (like helping those clients who may be qualified veterans learn of and access their health care rights, which is what state agencies requesting computer matches should tell the VA is their purpose---which it is).

There are some computer file formatting constraints which need to be followed up on. (it may be necessary to have states re-format, or seek HHS assistance to re-format, some ADAP files).

Identifiers used by the VA files are:

Names
VA claim numbers (the same as SSNs, but only since sometime in the late 1960s; there was a separate numbering system before then).
Dates of birth
Social Security Numbers---almost universally captured since late 1960s, but scattershot for discharges before that
Addresses to which discharged and address from which enlisted (and thus not of current value)
Character of discharge---almost, but not quite, universally captured (only honorable and general discharges are eligible for VA care)
Length of active duty service—almost always captured (only those who served over 6 months, for pre-8/80 enlistees, and 2 years, for post-8/80 enlistees are eligible for VA health care)
Use by veterans of benefits (health care, pensions, compensation, education, mortgages, etc.)

One can get output only for those with "hits" who meet the above parameters.

Some drawbacks possible from using the VA's data base:

Where there is no SSN in the VA files, there may well be duplicate hits for those with same name---and even for some with same name and DOB.

There may be, for some files, an inability to determine character of discharge or length of service
Female veterans who've later changed their names upon marriage won't necessarily be captured.
It is possible that the VA may charge the requesting agency money to do this
The VA or HHS may have formatting, file length or frequency-of-runs constraints
Requesting agencies that only have paper files---or non-centralized files of any kind that cannot be easily merged and formatted uniformly---will probably be unable to access this system
Where requesting agencies have *not* captured the SSN in their own files---or even worse, haven't captured the DOB—file comparisons are not at all likely to output useful data.

The biggest current drawback to fully exploiting the potentials of a VA-ADAP computer match via the PARIS system is that it now uses only the VA's "Vetsnet" computer file (which lists* ONLY *those who receive, or who once received, or who failed to complete an application for, VA pensions or compensation---rather than the VA's "BIRLS" list, which includes ALL those who EVER served on active duty (even if they've never sought VA benefits). Fortunately, the PARIS national program chairman is now actively urging the eventual use the "BIRLS" rather than the more limited "Vetsnet" list, and has even spoken of beginning to plan a pilot project using the "BIRLS" list in at least one state in the near future.

ADAPs can seek assistance from ***their "State [PARIS] Administrative Representatives" who are listed under "State Information" by entering www.acf.hhs.gov in your Internet browser and then typing "PARIS" in the "Search" box. At the national level, PARIS is coordinated by George.Patterson@cms.hhs.gov (410-786-4609) for Medicaid, Thomas.Miller@acf.hhs.gov (202-401-7237) for HHS and all other federally-aided assistance programs (which would therefore include Ryan White and ADAP programs that choose to, and are accepted to, participate)***.

Members of Congress who serve on House or Senate Veterans' Committees, or House or Senate Veterans' Appropriations Subcommittees, are listed and accessible through www.thomas.gov. Facilitation through them---and, if necessary, also from those Members from your state on committees and subcommittees handling TANF legislation and appropriations--- can speed state and federal PARIS officials' decision to include ADAP files in their quarterly state-federal computer matching runs. Have your Senator's or US Representative's staff members handling state welfare and VA issues contact the state PARIS coordinator and the HHS and VA officials named above to facilitate an ADAP-VA "BIRLS"---not just "Vetsnet"--computer file match to identify those who should be using VA care---but for some reason aren't-- rather than wasting scare ADAP funds.