

HIV Health Care Access Working Group

Health Care Reform Analysis

Senate Bill H.R. 3950 Patient Protection and Affordable Care Act

The following analysis of the Senate's merged health care reform bill, released on November 18, 2009, is based on priorities aimed at increasing early and uninterrupted access to affordable, comprehensive, and quality health care for persons living with HIV/AIDS.

Priority 1. Increase access to health care by broadening Medicaid eligibility:

What we support: Eliminating the categorical eligibility requirement for individuals with incomes up to 200% of the federal poverty level ("FPL").

In addition, enacting the proposed Early Treatment for HIV Act (ETHA) is key to increasing access to care for persons living with HIV. ETHA gives states the flexibility and financial support needed to provide comprehensive healthcare to pre-disabled, low and middle-income people living with HIV disease.

In the bill: The Senate bill modifies Medicaid eligibility rules by eliminating the categorical eligibility requirement and setting a nationwide income eligibility cap at 133% FPL beginning on January 1, 2014 (§2001(a)). There will be no asset test for those newly eligible under the expanded rules (§2002). States are given the option to begin this expansion as early as 2011 (§2001(d)), and are required to maintain eligibility levels at least at enactment-date levels until the expansion takes effect nationally (§2001(b)).

The bill does not include ETHA.

The federal government will pay 100% of the cost of providing services to those newly eligible for Medicaid under the expanded rules in 2014-2016. After that, the federal matching rate will vary by state, with a cap of 95% (§2001).

The bill includes a provision geared toward reducing procedural and administrative barriers to Medicaid enrollment for vulnerable populations, including individuals with HIV/AIDS (§2002).

The bill also establishes an optional Medicaid program that states can elect to provide to cover in-home or community-based support services to individuals up to 150% FPL (§2401).

Priority 2. Ensure access to quality health care by establishing a mandatory minimum Medicaid benefits package available in all states.

What we support: Promoting access to affordable comprehensive, quality health care by establishing a uniform mandatory minimum Medicaid benefits package that is available in every state. Access to quality care should not depend on geography. This measure must be included in any plan for national health care reform.

In the bill: Under the bill, expansion beneficiaries (those individuals only eligible for Medicaid under the expanded eligibility rules) will receive a so-called benchmark benefits package that covers the same essential health benefits as will be required in the exchanges (§§2001(a)(2),(c)). While those benefits appear to include some benefits that are not mandatory benefits under traditional Medicaid, such as prescription drug coverage and chronic disease management, it is unclear exactly what level of coverage will be required in the benchmark package. The bill does not establish a comprehensive benefits package under traditional Medicaid, either; it leaves in place the current system under which coverage varies significantly state-by-state.

Health care reform can and must **address existing disparities** in access to care, continuity of care, and quality of care. It is essential that all people have access to health care when they need it—irrespective of race, ethnicity, actual or perceived disability, gender, gender identification, sexual orientation, age, primary language, immigration status, or geography.

Priority 3. Make health care affordable by limiting Medicaid and Medicare cost sharing.

What we support: Increasing access to care and prescription drugs by setting nominal monthly caps on out-of-pocket expenses for co-pays and cost sharing, and by extending the full Medicare Low Income Subsidy ("LIS") to individuals with incomes below 200% of poverty and partial LIS to individuals with income below 300% of the federal poverty level.

In the bill: The proposal does not comprehensively address cost sharing in Medicaid or Medicare.

Priority 4. Increase the federal matching rate to states in economic crisis.

What we support: Increasing the federal medical assistance percentage ("FMAP") to 65–89% from 50–83% during periods of economic crisis to help states avoid cutting their Medicaid budgets and making it even more difficult for people living with HIV/AIDS to access essential health care services. HHCAGW suggests using indicators such as unemployment rates and other factors to create an economic hardship-based temporary FMAP increase provision.

In the bill: The bill contains no general FMAP increase for states in economic crisis. However, the bill provides an FMAP increase for states recovering from a major disaster (§2006). The "disaster-recovery FMAP adjustment" is a 50% increase in the first year after the disaster, and a 25% increase in the second year.

Priority 5. Implement routine HIV screening in public and private health systems.

What we support: Mandating coverage of routine, voluntary HIV screening and counseling for all individuals ages 13-64 who receive care in both private and public health care systems. Late diagnosis of HIV has serious implications for both individual and public health. Nationally, 39% of people newly diagnosed with HIV receive an AIDS diagnosis within a year. More than 20% of individuals in the U.S. infected with HIV are unaware of their infection. Infected individuals who remain undiagnosed are responsible for 56% of all new HIV infections. Successful individual treatment and protecting the public health demand that both public and private health systems be required to cover cost-free HIV screening. The federal government should mandate that Medicaid and Medicare programs as well as private insurers—and any public plan(s), if created through national health care reform—cover routine, voluntary HIV screening and counseling.

In the bill: The bill would not require public programs or private insurance plans to cover cost-free, routine and voluntary HIV screening.

Priority 6. Eliminate the 2-year Medicare waiting period for people with disabilities.

What we support: Eliminating the current requirement that individuals with disabilities wait two years before becoming eligible for Medicare. For people living with HIV, this can jeopardize access to lifesaving care and treatment. Without reliable and continuous access to care during the waiting period, individuals can become sicker and require more intensive, more costly medical interventions when they do finally qualify for coverage.

In the bill: The bill does not address Medicare's 2-year waiting period for people with disabilities.

Priority 7. Protect vulnerable Medicare beneficiaries facing donut hole coverage gaps.

What we support: Counting state AIDS Drug Assistance Program (ADAP) expenditures toward consumers' true out-of-pocket spending requirements ("TrOOP") under Medicare Part D and deploying a mandatory, enhanced Medicare Part D plan option. Both of these measures are critically needed to preserve access to life-saving treatment and care for individuals living with HIV/AIDS whose out-of-pocket costs can easily reach the gap in Medicare Part D coverage.

In the bill: While the bill does not require the availability of an enhanced Part D plan, it helps Medicare beneficiaries facing the coverage gap by increasing the initial coverage limit by \$500 (§3315), implementing a 50% discount on brand-name drugs and biologics for those in the donut hole (§3301), and counting ADAP and Indian Health Services (IHS) payments toward TrOOP (§3314).

Priority 8. Promote stability by investing in the clinical workforce.

What we support: Throughout the country, health care institutions that serve Medicaid patients are struggling financially because reimbursement rates and payment mechanisms do not support the cost of providing care. This is particularly true in the case of health care for complex, chronic conditions such as HIV disease. Consequently, the problem presents a growing barrier to access for Medicaid beneficiaries living with chronic conditions. The federal government should ensure that the reimbursement systems under Medicaid, Medicare and private insurance reflect the true cost of care and mandate that providers receive adequate payment promptly.

To further strengthen the clinical workforce of HIV providers, it is critical that any plan for health care reform address HIV medical provider workforce needs by expanding federal loan forgiveness programs, such as the National Health Service Corps, to include as designated sites HIV medical providers and Ryan White-funded clinics.

In the bill: The bill avoids the impending cut in Medicare physician payment rates for one year (§3101), and makes substantial investments in the clinical and public health workforce. The legislation funds a wide variety of existing and new programs to train and retain health workers—with a focus on primary care providers—in the provision of culturally- and linguistically-competent care to medically-underserved populations. A few notable examples include:

- creating new loan repayment, grant and training programs for pediatric subspecialists, public health professionals, nurses, and primary care providers (among others) (§§5201-5206, §§5301-5315, and §§5401-5405);
- increases in funding for Federally Qualified Health Centers, which must be accessible to medically-underserved populations (§5502, 5601);
- increases in funding for the National Health Service Corps (§5207);
- funding the development and deployment of nurse-managed health clinics in medically-underserved communities (§5208);
- establishing a grant program to fund training for primary care providers in the care of vulnerable populations—with grant preference given to HIV programs and others targeted at other vulnerable populations (§5301(B)(3)(e)); and
- establishing a grant program to fund general dentistry training programs that provide training in the care of vulnerable populations—with grant preference given to HIV/AIDS programs. (§5303(c)(5)).

The legislation also incorporates two useful elements of the Finance Committee bill. It creates a National Health Care Workforce Commission to report annually on the state of the nations health care workforce and make recommendations for improvements (§5101). The legislation would also redistribute unused graduate medical education (GME) slots and include ambulatory and outpatient care settings as DGME-eligible training sites to increase access to primary care and generalist physicians in underserved areas and populations (§5504).

» **Of concern:** The plan does not address Medicaid provider reimbursement rates. As many providers are unable to support the basic cost of care under current rates, this oversight will leave many Medicaid beneficiaries with coverage but without access to providers or health care.

Priority 9. Improve access to both public and private health insurance.

What we support: For many persons living with HIV, access to private market health insurance is prohibitively expensive, and provisions against covering pre-existing conditions render most policies meaningless. For persons living with chronic, complex health conditions to have real access to private health insurance, federal policy must require insurers to: provide coverage regardless of health status, charge affordable premiums for coverage, cap *total* out-of-pocket spending (including premiums and cost-sharing), and eliminate the practices of not covering pre-existing conditions, excluding HIV care providers from their networks, and imposing annual or lifetime caps on benefits.

It is critical that coverage be portable so that those living with HIV do not lose coverage or have to re-build their care networks when they change jobs.

In addition to improving access to useful private health insurance, the federal government should implement a public insurance plan option so that people living with HIV/AIDS have access to comprehensive, quality health care. The goal of equitable health protection demands that health care reform must require insurer accountability, protect patients' privacy, and ensure that both private and public coverage is comprehensive.

Having **meaningful health insurance** means more than just having a health insurance plan. It means having a plan that provides enough coverage that the medical care you need is affordable to you. The Commonwealth Fund defines being "**under-insured**" as having out-of-pocket medical expenses (excluding premiums) that exceed ten percent of income for people with income over 200% of poverty—and for people with income below 200% of poverty, having expenses that exceed five percent of income.

In the bill: The bill addresses access to private health insurance by expanding Medicaid eligibility (see Priorities 1 & 2, above); establishing state-level health insurance exchanges through which individuals can compare and buy health insurance plans; creating a national public plan option to be available in any state that does not prohibit it; reforming certain aspects of the private insurance market; and providing financial assistance for premiums and cost-sharing to poor and low-income individuals and families.

Exchanges: Essentially portals for consumers (individuals and small businesses) to compare and buy health plans, exchanges would be set up and administered by state governments. Health plans must be certified as "qualified" to be offered within exchanges, but the bill explicitly states that insurers are not required to offer plans in exchanges—they can still sell insurance plans outside exchanges. The Secretary of Health and Human Services would set out the requirements for certification of qualified health plans, including the minimum benefits package that must be offered. While the details of the minimum benefits package are up to the Secretary, the bill lays out so-called "essential health benefits" that must be included: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services (including oral and vision care) (§2707, referring to listing at §1302(a)). Individual states are allowed, under the bill, to require additional benefits of health plans in their exchanges—but states choosing to do so would bear any associated increase in subsidy costs (§1311(d)).

» **Of concern:** The mandatory benefits of plans offered through exchanges do not include vision and dental services for adults (§1302(a)). These are critical health services for people living with HIV/AIDS disease, and coverage for these services must be mandatory if access to private health plans is to mean access to meaningful, comprehensive health care. Furthermore, only plans offered through state exchanges must cover the essential health benefits—this leaves employees of large businesses without guaranteed access to comprehensive coverage.

» **Of concern:** The plan would create multiple, state-based exchanges rather than one national exchange. A state-based system will perpetuate existing geographic disparities and result in a system that is unnecessarily complex and difficult to navigate (for example, when moving across state lines). The bill directs the Secretary to establish standard definitions for common insurance and medical terms. HHCAWG believes that at a minimum, the Secretary should also standardize the policies and regulations governing state-based exchanges.

Public Plan: The merged Senate bill includes the HELP Committee bill's concept of nationally-based "community health plans" in each state exchange (§1323). States are allowed to opt out of having the public plan in their exchange by passing legislation prohibiting it. The bill also includes the Finance Committee bill's concept of state or regional health care co-ops (§1322).

» **Of concern:** By allowing states to opt out of offering a public plan in their exchanges, the bill undermines the ability of the national public plan to bring down overall health care costs by competing on as broad a market as possible.

Private Market Reforms: The proposal includes provisions that would increase access to private health insurance by reforming the private market, for example, by eliminating pre-existing condition exclusions (§2704), lifetime limits and "unreasonable" annual limits (§2711), and the rescission of coverage (§2712). The plan calls for risk sharing through risk-adjustment, reinsurance and risk corridors (§§1341-1343). The bill limits variation in premium rating to the following four factors: family size, geographic area, age (up to 3:1), and tobacco use (up to 1.5:1) (§2701(a)).

» *Of concern:* The bill does not apply reform measures uniformly in the private market; most apply only to individual and small group plans, and some requirements apply only to plans certified to be offered in state exchanges. Failure to level the regulatory playing field will perpetuate barriers to care and frustrate the goal of reducing the nation's overall health care spending.

Affordability provisions: The bill contains subsidies financial assistance for poor and low-income individuals and families who purchase insurance in the individual market. Separate, income-based subsidies are set out for premiums and cost-sharing. Individuals and families with income between 100% and 400% of the federal poverty level (FPL) would be eligible for premium subsidies in the form of a tax credit, capping their out-of-pocket share of premiums at between 2% and 9.8% of their annual income. The percentage would be determined by a sliding scale using their exact incomes (§1401). Individuals and families between 100% and 200% of FPL would also be eligible for cost-sharing subsidies (helping pay for deductibles, copayments, etc.) as follows: for individuals with incomes between 100% and 150% of FPL, the subsidies would pay for 90% of the cost of health care services, leaving the individual to pay only 10%; for individuals between 150% and 200% of FPL, the subsidy would pay 80% and the individual share would be 20% (§1402(c)).

The proposal would also cap out-of-pocket cost-sharing expenses at the following levels: \$1,667/\$3,333 (individual/family) for income between 100% and 200% of FPL; \$2,500/\$5,000 for income between 200% and 300% of FPL; and \$3,333/\$6,667 for income between 300% and 400% of FPL (§1402(c)). Above 400% of FPL, the bill sets a universal cap of \$5,000/\$10,000. These caps will be adjusted annually for all income levels (§1302(c)(1)).

Individual & Employer Mandates: The bill would require all individuals to carry health insurance (§1501). Individuals face penalties for not complying with the mandate: \$750 per individual per year, phased in as follows: \$95 in 2014, \$350 in 2015, \$750 in 2016. After 2016, the penalty will be increased each year based on the cost-of-living adjustment (§1501). Exemptions from the penalty are provided in instances of religious conscience objections, financial hardship, and coverage gaps of less than three months, as well as for individuals with income below 100% FPL, members of Indian tribes, and those who are prohibited from receiving subsidies under the bill (undocumented immigrants and incarcerated individuals) and "hardship" (§1501).

Employers with more than 50 employees that do not offer coverage would be required to pay a fee for each full time employee who is enrolled in a state exchange and receives a tax credit (§1513). The fee per individual would be a flat dollar amount equal to the national average tax credit, with total payments capped at \$400 (or \$600 where there are longer waiting lists) multiplied by the total number of employees at the firm (§1513).

Priority 10. Expand the role of Ryan White community-based programs.

What we support: Preserving and expanding the role of Ryan White community-based health care delivery systems. The Ryan White program is vital in supporting the delivery of care, treatment and important social services for individuals living with HIV/AIDS through community-based organizations and clinics. Ryan White programs help build the capacity of minority communities to provide primary medical care and other critical services to underserved populations. The federal government can strengthen these important programs by providing cost-based reimbursement and ensuring that Medicaid programs and private insurers build these providers into their networks.

In the bill: The bill does not directly address this issue. However, qualified health plans on the state Exchanges are required to include "essential community providers" that serve low-income, medically

underserved individuals, including providers defined in Public Health Service Act §340B(a)(4)—which includes ADAP and other Ryan White providers (§1311(c)(1)(C)).

The bill includes several provisions that will expand the successful health care delivery models of existing Ryan White community-based programs. For instance, the bill provides grants and contracts to promote “community health teams” that are interdisciplinary and inter-professional, and address the needs of individuals with chronic conditions (§3502). The bill also provides grants to support medication management in the treatment of chronic disease (§3501), as well as funding an “Independence at Home” demonstration program for Medicare beneficiaries with 2 or more chronic illnesses and two or more functional dependencies (§3024).

In addition, the bill creates a Center for Medicaid and Medicare Innovation (CMI) that will test health service models, which includes coordinating care for “multiple chronic conditions.” (§3021(b)(2)(B)(iii))

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Additional Notes

» *Of concern:* Measures key to ending existing health disparities **absent** from the proposal include (1) ending the 5-year waiting period for legal immigrants to obtain Medicaid coverage, and (2) lifting the appropriations cap for territories' Medicaid programs and implementing instead the same federal matching rate as applies in the states. The proposal does increase territories' Medicaid spending caps by 30 percent, and raises the FMAP from 50% to 55% (§2005).

» *Of concern:* The bill includes the Hatch Amendment appropriating \$50 million annually through FY 2014 for abstinence education—effective upon enactment. This language restores funding for abstinence-only education after the Obama Administration, responding to evidence of the failure of such programs to effectively reduce teen pregnancy and STD infections, zeroed out the funding.

Dual-Eligibles: The bill establishes a Federal Coordinated Care Office within CMS that is tasked with improving coordination between Medicaid and Medicare for individuals who are dually-eligible (§2602). Goals of the new office include achieving full enrollment, improving quality of care, eliminating regulatory conflicts, and improving continuity of care.

Prevention/Wellness: The bill establishes a Prevention and Public Health Fund (§4002), and allocates \$500 million in 2010, increasing to \$2 billion in 2015 and subsequent years for the fund. HHCAWG applauds action to invest in public health and disease prevention; we note, however, that the funding provided in the merged Senate bill is one fifth of what was set out in earlier versions of the legislation. Other relevant provisions in the bill include the creation of a Preventive Services Task Force and a Community Preventive Services Task Force (§4003), as well as the creation of a \$500 million public-private preventive benefits education and outreach campaign (§4004).

Home-Based Chronic Care Management Program: The proposal includes a provision establishing a chronic care coordination pilot program to bring in-home primary care services to Medicare beneficiaries with multiple chronic conditions and functional limitations (§3034).

This report was prepared by staff of the WilmerHale Legal Services Center of Harvard Law School & the Treatment Access Expansion Project (TAEP) for the HIV Health Care Access Working Group (HHCAWG). The Working Group is a coalition of over one hundred national and community-based AIDS service organizations representing HIV medical providers, advocates and people living with HIV/AIDS and providing HIV-related health care and support services. For more information, contact co-chairs Laura Hanen, of the National Alliance of State and Territorial AIDS Directors, at 202.434.8091, or Robert Greenwald, of the Treatment Access Expansion Project, at 617.390.2584.



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