

2009 Health Care Reform Analysis :: S.703 (Sanders)

The following analysis of Senator Sanders's "American Health Security Act of 2009" (S.703) is based on priorities aimed at increasing early and uninterrupted access to affordable, comprehensive, and quality health care for persons living with HIV/AIDS. In areas where the bill language is unclear we have noted potential pitfalls and opportunities for interpreting the text.

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

What we support: Strengthening the existing Medicaid program—expand coverage for individuals with low income by eliminating the categorical eligibility requirement for individuals with incomes up to 200% of poverty. This critical measure would increase access to lifesaving treatment and care for individuals with low income above the federal poverty level.

Additionally, HHCWG strongly supports increasing access to care for persons living with HIV/AIDS through passing the Early Treatment for HIV Act ("ETHA"). ETHA is a critical tool to providing early access to care, as it gives states the flexibility to provide comprehensive health care to low and middle-income pre-disabled people living with HIV. Under ETHA, states could extend Medicaid coverage to individuals living with HIV but with incomes above the federal Medicaid income eligibility limit, should it be determined that these individuals' health needs are best met through a Medicaid benefits package and cost-sharing system.

Currently in the U.S., many persons living with HIV/AIDS lack medical care due to significant financial and programmatic barriers to access in both publicly-funded and private health care systems. Barriers to care that prevent or delay treatment have devastating consequences for the lives of individuals living with HIV and present major obstacles to addressing the HIV epidemic and protecting the public health.

What the bill does: The bill dismantles Medicaid, Medicare, and SCHIP (§106) as well as private primary insurance (§201(c)), and replaces them with state-run health insurance programs funded primarily through the federal government. Under this new health insurance paradigm, the bill increases access to health care by qualifying all residents of the United States who are citizens or lawful resident aliens for health care coverage (§102(a)). The bill calls for automatic enrollment in a State health security program at the time of birth in or immigration to the United States, or as of January 1, 2011 (§103(a)).

Additionally, the bill provides flexibility to the American Health Security Standards Board (created under the bill) to make certain other classes of aliens and individuals eligible for benefits as necessary to preserve public health. This provision is intended to prevent adverse financial and medical consequences of uncompensated care (§102(b),(c)), and the bill would provide compensation to States for the additional financial burden presented by this expanded coverage.

Priority 2. Promote early access to quality health care by establishing a standardized 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, and applies whether Medicaid remains a primary insurer for low income individuals and families or transitions to a secondary insurer role.

What the bill does: Although it would dismantle Medicaid, the bill addresses this priority by establishing a list of comprehensive benefits for which a State health security program must pay, including preventative services, prescription drugs, and benefits for long-term care (§201). States may make additional benefits available under their health security programs, but additional benefits would be solely state-funded (§201(d)).

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 affordable, quality, comprehensive health care when they need it—irrespective of race, ethnicity, gender, gender identification, sexual orientation, actual or perceived disability, age, primary language, immigration status, or geography.

Priority 3. Make health care more affordable by limiting cost-sharing.

What we support: Within the existing Medicaid and Medicare programs, making health care more affordable for individuals and families with low income and 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 to individuals with incomes below 200% of poverty and partial LIS to individuals below 300% of poverty.

What the bill does: The text of the bill is unclear as to cost-sharing and co-pay arrangements for comprehensive services; however, Section 631 prohibits balance billing and provides that payments for benefits made under the bill shall constitute payment in full. Providers may not accept any payment or impose any charge for any service other than accepting payment from the State health security program in accordance with the bill. Further, Section 735, which authorizes grants for the operation of school health service sites, prohibits those sites from collection of any cost-sharing for services under the comprehensive benefit package.

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

What we support: Strengthening the existing state-based Medicaid program by increasing the FMAP to 65–89% from 50–83% 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.

What the bill does: The program is primarily federally funded, but administered through the States. Thus, the FMAP is no longer applicable. However, §604 outlines the federal payments to States with a federal contribution percentage of between 81-91%. In determining the federal contribution percentage in each State, the American Health Security Standards Board shall take into consideration a State's per capita income, revenue capacity, and other economic indicators.

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

What we support: Mandating coverage of routine, voluntary HIV screening and counseling in both private and public health care systems for all individuals ages 13-64.

What the bill does: While certain cancer screenings are included under comprehensive services, it is unclear whether HIV screenings are included as covered preventive care as well (§202(b)(2)). As the details of this bill are spelled out, it is critical that this provision be revised to specifically include routine, voluntary HIV screening as part of comprehensive preventive care services.

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

What we support: Current law requires individuals with disabilities to wait two years before becoming eligible for Medicare. For many persons living with HIV, this requirement jeopardizes their access to lifesaving care and treatment. Without reliable and continuous access to care during the two-year waiting period, individuals can become sicker and require more intensive and more costly medical interventions when they do finally qualify for coverage. HHCAWG strongly supports eliminating the 2-year waiting period for people with disabilities.

What the bill does: Because the bill ends Medicare, this principle does not apply. However, the bill mandates that States impose no waiting periods or residence requirements greater than three months before residents of the State are eligible for benefits under the program (§104(a)). Additionally, the bill provides that a State shall continue to provide coverage for individuals who have moved out of that State for the duration of any waiting period imposed in the State of new residency (§104(b)).

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

What we support: Counting ADAP expenditures toward 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. HHCAWG believes that any serious plan for national health care reform must include these provisions.

What the bill does: This priority is not directly addressed because the bill ends Medicare (§106). Section 615, however, provides limited information regarding payments for prescription drugs. Specifically, §615 outlines that the American Health Security Standards Board will establish a list of approved prescription

drugs and biologicals, and set maximum prices for the items on the list. Section 615 does not include any information regarding co-pay arrangements; however, §631, which prohibits balance billing and provides that payments for benefits made under the bill shall constitute payment in full, presumably applies to payments made under this Section as well.

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

What we support: Strengthening the primary care and HIV specialist clinical workforce by expanding federal loan forgiveness programs such as the National Health Service Corps to include HIV medical providers and Ryan White-funded clinics as designated sites. Additionally, within the existing Medicaid system, inadequate Medicaid payment rates currently straining hospitals and other Medicaid providers must be addressed, as this presents a growing barrier to access for Medicaid beneficiaries, including individuals living with chronic, complex diseases such as HIV/AIDS.

What the bill does: The bill focuses on an investment in the clinical workforce by more than doubling the funds allocated to the National Health Service Corps programs in fiscal years 2010, 2011, and 2012 (§703). The bill also provides for allocations growing from nearly \$700,000,000 in FY 2013 to \$1.15 billion in FY 2015 (§703). Additionally, the bill establishes a set of primary care output goals (§701), and an advisory committee on health professional education to oversee the attainment of those goals (§702).

Further, the bill allows for direct payment under global budgets for institutional and facility-based care (§611). The budgets are to be established through negotiations between the institution or facility and a panel of individuals appointed by the Governor (§611(b)(1)). Payments to independent health care practitioners may be based on global fee methodologies as well (§612(a)(2)). Payment for services must be made within 60 days of the date of submission of the claim (§632).

Priority 9. Improve access to private health insurance.

What we support: To ensure equitable health protection, HHCWG strongly supports consistent regulation of broader clinical performance standards, loss ratios, and insurer accountability in both public and private health insurance systems. The Secretary of Health and Human Services should set relevant standards, rather than leaving this responsibility to the states.

What the bill does: §201(c) of the bill forbids the sale of any health insurance in a State under which payment would duplicate payment by the State health security program for any items or services. It is unclear how this bill affects insurance for items and services not covered under the bill. The overall effect of the bill is to move the nation's health care system away from private primary insurance.

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 should stabilize and strengthen these important programs by providing them with cost-based reimbursement and ensuring that Medicaid programs and private insurers build these providers into their networks.

What the bill does: The bill provides that grants shall be made for HIV health care services under parts A, B, and C of title XXVI of the Public Health Service Act (§711(a)(7)). The amount of these grants is unspecified.

This report was prepared by staff of the WilmerHale Legal Services Center of Harvard Law School and the Treatment Access Expansion Project for the HIV Health Care Access Working Group (HHCWG). The Working Group is a coalition of nearly 100 national and community-based AIDS service organizations representing HIV medical providers, advocates and people living with HIV/AIDS and providing critical 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.

