

# HIV Health Care Access Working Group

## Health Care Reform Analysis

### Chairman's Mark, Senate Finance Committee (modified 9/22/09)

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*The following analysis of the Chairman's Mark submitted by Senator Max Baucus (D-MT), Chairman of the Senate Finance Committee, is based on priorities aimed at increasing early and uninterrupted access to affordable, comprehensive, and quality health care for persons living with HIV/AIDS. Amendments are expected to the bill in during Committee markup the week of September 21<sup>st</sup>).*

#### **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 Chairman's mark:** The proposal modifies Medicaid eligibility rules in two stages. First, the proposal would allow states to provide Medicaid coverage to childless adults (up to income levels determined by the states) beginning in 2011 (p.42). This would give states flexibility to extend coverage to pre-disabled individuals living with HIV. But it does not accomplish the goals of ETHA, as the proposal does not include additional federal funding (an "enhanced FMAP") to make electing this option financially feasible for states. Without providing additional federal funding, it is extremely unlikely that states will opt to extend coverage to non-disabled, childless adults—including pre-disabled individuals living with HIV disease.

Second, the proposal eliminates the categorical eligibility requirement and sets a nationwide income eligibility cap at 133% FPL beginning in 2014 (p.42). Additionally, states could elect to provide coverage to people at higher incomes through traditional Medicaid or in the form of supplemental wrap benefits (9/22/09 Modifications, p. 9). Individuals with MAGI above 133% FPL who receive only a benefit wrap may be eligible for tax credits in the state exchange as well (9/22/09 Modifications, p. 9).

Notably, the proposal also includes provisions geared toward reducing procedural and administrative barriers to Medicaid enrollment for vulnerable populations, including individuals with HIV/AIDS (9/22/09 Modifications, p.11).

» **Of concern:** Under the proposal, a "benchmark benefit package" will be available to newly-eligible beneficiaries under the expanded Medicaid eligibility rules (p.42). We are concerned that the benchmark package would represent less than the full state benefits package, and urges the Committee to make the full Medicaid benefits package available to all Medicaid beneficiaries. Medicaid is tailored to meet the medical needs of low income individuals who—because of their limited resources and circumstances—often require additional support such as transportation and case management to access medical care.

» **Of concern:** The proposal would use modified adjusted gross income (MAGI) to determine financial eligibility for Medicaid, and would eliminate all current income disregards for most Medicaid applicants (p.42). The MAGI is based on factors relevant to higher-income individuals and ignores the financial realities facing working-class families. For instance, MAGI does not take into account public benefits, child support or medical/work-related expenses. Using MAGI in this context would therefore unfairly and artificially reduce eligibility for Medicaid. A fairer, more appropriate income determination standard is that used by the Supplemental Nutrition Assistance Program (food stamps).

Currently in the U.S., many persons living with HIV/AIDS **lack medical care** due to significant financial and programmatic barriers 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.

»*Of concern*: The proposal does not fully fund the cost of benefits & services for individuals newly eligible under the expanded rules, except in the case of “high-needs states” (defined as states that (1) have total Medicaid enrollment below the national average for Medicaid enrollment as a percent of state population as of the date of enactment, and (2) had seasonally-adjusted unemployment rates of 12% or higher for August 2009) (9/22/09 Modifications, p. 10). Full federal funding for newly-eligible beneficiaries in these states would last for five years (9/22/09 Modifications, p. 10). Without full federal financing for so-called “expansion beneficiaries,” states are likely to find cost-savings that limit beneficiaries’ access to care—for instance, by cutting or limiting benefits or lowering provider reimbursement rates—to accommodate the cost of higher enrollment.

**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.

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.

**In the Chairman’s mark:** The proposal laudably eliminates existing exclusions on 11 classes of drugs (p.52), but does not create a mandatory benefits package that would ensure that all Medicaid enrollees have access to comprehensive, quality care regardless of their state of residence.

**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 Chairman’s mark:** The proposal does not comprehensively address cost sharing in Medicaid or Medicare. But it eliminates cost sharing for certain preventive services in Medicare (p.70), and creates incentives for states to eliminate cost sharing for preventive services in their Medicaid programs (p.73). The proposal would not increase the income or asset limits for the LIS program.

**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 Chairman’s mark:** The proposal contains no general FMAP increase for states in economic crisis. However, the proposal provides assistance to certain “high needs states” to fully fund the cost of providing medical assistance to newly eligible beneficiaries from 2014-2018 (9/22/09 Modifications, p. 10). “High needs states” are defined as states that (1) have total Medicaid enrollment below the national average for Medicaid enrollment as a percent of state population as of the date of enactment, and (2) had seasonally-adjusted unemployment rates of 12% or higher for August 2009 (9/22/09 Modifications, p. 10).

»*Of concern*: The proposal expands Medicaid eligibility rules, but does not fully fund the cost of Medicaid benefits & services for individuals newly eligible under the expanded rules (except as described above). Without full federal financing for so-called “expansion beneficiaries,” states are likely to find cost-savings that limit beneficiaries’ access to care—for instance, by cutting or limiting benefits or lowering provider reimbursement rates—to accommodate the cost of higher enrollment.

**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 Chairman's mark:** The proposal 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 Chairman's mark:** 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 Chairman's mark:** The proposal would neither count ADAP expenditures toward TrOOP nor create an enhanced Medicare Part D plan option. Rather, the proposal calls for a 50% discount off the Medicare-negotiated price of Part D-covered drugs for certain enrollees in the coverage gap (p.121). Under this provision, an enrollee in the donut hole would pay only 50% of the price of a drug—but 100% of the price of the drug would be counted toward the enrollee's TrOOP. This provision would only apply to Part D enrollees who do not qualify for the Low Income Subsidy program and whose annual income is less than Part B thresholds (currently \$85,000 for individuals and \$170,000 for couples). The Finance Committee rejected an amendment to gradually eliminate the Part D coverage gap during markup proceedings.

**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 Chairman's mark:*** The proposal contains several provisions that represent investments in the clinical workforce. The plan would provide a five-year, ten percent bonus in Medicare payment rates to primary care practitioners who practice family, internal, geriatric, or pediatric medicine in medically-underserved areas (p.101). The plan includes a provision to avoid an impending 21% decrease in the Medicare sustainable growth rate (p.110).

The plan would also redistribute unused graduate medical education (GME) slots (p.102) and include ambulatory & outpatient care settings as DGME-eligible training sites (p.103) to increase access to primary care and generalist physicians in underserved areas and populations.

Chairman Baucus's proposal provides for the development of a National Workforce Strategy to examine issues such as health care workforce supply and demand, education training capacity, implications of federal policies on the clinical workforce, the workforce needs specific to minority populations, rural and urban populations, and other medically-underserved populations (p.107).

In addition, the proposal establishes demonstration grants to provide financial aid and support services (including child care, case management & supportive services) to low-income individuals—including recipients of assistance under state TANF programs—to obtain education and training for occupations in the health care field (p.108).

» ***Of concern:*** HIV care is highly complex; many HIV providers are unable to support the basic cost of care under current rates. The plan does not address Medicaid provider reimbursement rates, and 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.

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 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 coverage—whether private or public—is comprehensive.

***In the Chairman's mark:*** The proposal includes provisions that would increase access to private health insurance by reforming the private market, for example by eliminating pre-existing conditions exclusions (p.2), annual benefits limits (p.18) and lifetime coverage limits (p.18) and the rescission of coverage (p.2). The plan calls for risk-sharing through risk adjustment, reinsurance and risk corridors (pp.8-10). The proposal would require plans offered through exchanges to cover the following health benefits: preventive and primary care, emergency services, hospitalization, physician services, outpatient services, day surgery & related anesthesia, diagnostic imaging & screenings (including X-rays), maternity & newborn care, pediatric services (including vision and dental), medical/surgical care, prescription drugs, radiation & chemotherapy, and mental health & substance abuse services (p.17). Modifications to the proposal would eliminate lifetime limits for all plans participating in state

exchanges and preclude group health plans from imposing "unreasonable" annual or lifetime limits on coverage (9/22/09 Modifications, p. 5).

» *Of concern:* The proposal allows health insurance companies to dramatically vary premiums based on tobacco use and age—a policy that would perpetuate financial barriers to access to health care.

» *Of concern:* The mandatory benefits of plans offered through exchanges do not include vision and dental services (p.17). These are critical health services for people living with HIV/AIDS disease, and must be mandatory if access to private health plans is to mean access to meaningful, comprehensive health care.

» *Of concern:* Plans may discourage enrollment of people with HIV by not including HIV medical providers in their provider networks. We urge that plans be required to contract with safety-net providers, such as 340B programs, including Ryan White-funded programs.

» *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). At a minimum, the Secretary should standardize the policies and regulations governing state-based exchanges.

The proposal also contains an individual mandate to purchase health care coverage (p. 28). Individuals face penalties for not complying with the mandate: \$750 per year for individuals with income between 100-300% FPL, with a cap of \$1,500; and \$950 per year for individuals with income above 300% FPL, with a cap of \$1,900 (p.29, 9/23/09 Modifications, p. 7). Exemptions from the penalty are made for individuals with income below 100% FPL or for whom the full premium of the lowest cost option available to them exceeds ten percent of their AGI (p. 29).

In order to make health care more affordable, the Chairman's mark contains subsidies for low-income individuals and families who purchase health 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 tax credits) that would cap their out-of-pocket premium expenses at 2% to 12% of their annual income (9/22/09 Modifications, p.6). Individuals and families with income between 100% and 200% of FPL would be eligible for cost-sharing subsidies as follows: for individuals between 100% and 150% of FPL, the subsidy reduces out-of-pocket cost-sharing for health care services to 10%; for individuals between 150% and 200% FPL, the subsidy reduces out-of-pocket cost-sharing for health care services to 20%. The proposal would also cap out-of-pocket cost-sharing expenses at the following levels: \$1,933.33/\$3,866.66 (individual/family) for income between 100% and 200% of FPL; \$2,900/\$5,800 (individual/family) for income between 200% and 300% of FPL; and \$3,866.67/\$7,733.33 (individual/family) for income between 300%-400% of FPL.

Under the proposal, individuals who are offered employer-sponsored health insurance (ESI) are generally ineligible for premium subsidies (p. 31). But individuals would qualify for the premium subsidy if the ESI premium cost to the individual exceeds 10% of income (indexed to the growth in premiums) (9/22/09 Modifications, p. 7).

» *Of concern:* Modifications to the proposal would allow states to apply for a waiver of the market reform portion of the proposed bill (9/22/09 Modifications, p. 2). We are concerned that such waivers would perpetuate geographic health disparities.

» *Of concern:* The proposal uses modified adjusted gross income (MAGI) to determine eligibility for premium and cost-sharing assistance (p.42). The MAGI is based on factors relevant to higher-income individuals—not the financial realities facing working-class families. For instance, MAGI does not take into account public benefits, child support or medical/work-related expenses. Using MAGI in this context would therefore unfairly and artificially reduce eligibility for financial assistance. A fairer, more appropriate income determination standard is that currently used by the Supplemental Nutrition Assistance Program (food stamps).

» *Of concern*: By separating the provisions on premium cost and cost-sharing, the proposal hides the total out-of-pocket cost of health care for low-income individuals and families.

**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 Chairman's mark:** The bill does not address this issue.

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**Additional Notes**

**Ending Health Disparities:** The Chairman's mark contains provisions that would help address existing health disparities. For instance, it would prohibit cost-sharing (including premiums, deductibles, co-payments, co-insurance, etc.) for all American Indians and Alaska Natives with incomes at or below 300% FPL for state exchange plans and public programs (p.62). It also directs CMS to collect data on race and ethnicity, gender, primary language, and disability (pp.65, 66). This provision should be further strengthened by requiring data on gender identity and sexual orientation.

» *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 (though the proposal does increase spending caps 30% and raises the FMAP from 50% to 55% for territories, p.45).

**Dual-Eligibles:** The proposal would address the unique needs of people dually eligible for Medicaid and Medicare by improving coordination through demonstration projects and a dedicated office at CMS (p.58). Nearly 80,000 people with HIV are dually-eligible category and, due to inadequate coordination, are particularly vulnerable to falling through cracks in the health care system.

**Prevention/Wellness:** The proposal creates an "Incentives for Healthy Lifestyles" grant program to support states to develop comprehensive, evidence-based programs that meet the unique health needs of Medicaid beneficiaries and have demonstrated success in helping beneficiaries control cholesterol & blood pressure, lose weight, quit smoking and/or manage or prevent diabetes. (p.73)

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*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 84 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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