

# HIV Health Care Access Working Group

## 2009 Health Care Reform Analysis :: HELP Committee

### Chairman's Mark

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The following analysis of the Senate Health, Education, Labor and Pensions Committee Chairman's Mark ("Affordable Health Choices Act") is based on priorities aimed at increasing early and uninterrupted access to affordable, comprehensive, and quality health care for persons living with HIV/AIDS. It is important to note that the Finance Committee has jurisdiction over the Medicaid and Medicare programs; consequently, this bill largely does not address major reforms to these programs.

#### 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"). HHCAWG strongly supports eliminating the categorical eligibility requirement for individuals with very low income, but maintains that limiting access to Medicaid coverage to those with income below 100% of the federal poverty level (\$10,000 per year for an individual and \$20,000 per year for a family of four) continues to prevent access to lifesaving treatment and care for individuals with low income above the federal poverty level.

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.

An additional, key aspect of increasing access to care for persons living with HIV is enacting the proposed Early Treatment for HIV Act (ETHA). ETHA would give states the flexibility to provide comprehensive healthcare to low and middle-income pre-disabled people living with HIV.

**What the bill does:** The bill does not address expansion of Medicaid coverage. It also does not address promoting increased access to care for people with HIV through ETHA. We recognize that these matters lie primarily within the jurisdiction of the Finance Committee in the Senate and Ways and Means in the House, and urge those committees to address them as they develop their respective plans for national health care reform.

#### 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 irrespective of race, ethnicity, gender, gender identification, sexual orientation, actual or perceived disability, age, primary language, immigration status, or geography. It is essential that all people have access to health care when they need it.

**What the bill does:** While the bill sets out minimum benefits requirements for insurance plans offered through state-level exchanges (See Sec. 3103 of §142), it does not establish a comprehensive, mandatory minimum benefits package for Medicaid. HHCAWG is concerned that Congress will miss an opportunity to enact this critical reform to the Medicaid program if it is not included in broader health care reform legislation. Again, we recognize that this matter lies primarily within the jurisdiction of the Finance Committee in the Senate and Ways and Means in the House.

#### 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.

**What the bill does:** The bill does not address cost sharing in Medicaid or Medicare or expand the LIS program. Again, these matters relate more to the jurisdictions of the Senate Finance Committee and the House Ways and Means Committee, and HHCAWG hopes to see those committees include cost-sharing limits and an expanded LIS program in their respective plans for national health care reform.

#### **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. HHCAWG suggests using indicators such as unemployment rates and other factors to create an economic hardship-based temporary FMAP increase provision.

**What the bill does:** The bill does not address implementation of an economic hardship-based temporary FMAP increase.

#### **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. The grave problems for 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.

**What the bill does:** Requires issuers of group and individual health care insurance plans to provide coverage for items with an 'A' or 'B' rating in the recommendations of the United States Preventive Service Task Force (Sec. 2708(a)(1) of §101) and immunizations recommended by the CDC Advisory Committee. This would include coverage for HIV screenings for adults and adolescents—but only those identified as being at increased risk of HIV infection. The bill therefore falls well short of the goal of requiring insurers to cover routine, voluntary screenings for all individuals ages 13-64.

The bill makes other investments in the area of prevention by requiring issuers of group and individual health care insurance plans to cover (with no or minimal cost-sharing) preventive care and screenings for all children and adolescents according to Health Resources and Services Administration guidelines (Sec. 2708(a)(3) of §101). Furthermore, the bill emphasizes preventive care more generally by creating a National Prevention, Health Promotion, and Public Health Council, which is tasked with formulating a long-term national preventive care strategy (§301(a)). The bill also allocates at least \$10 billion annually to a Prevention and Public Health Investment Fund that will fund wellness programs including health screenings (§302).

#### **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 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. HHCAWG strongly supports eliminating the 2-year waiting period for people with disabilities.

**What the bill does:** The bill does not discuss this issue. HHCAGW recognizes that this matter falls primarily under the jurisdictions of the Senate Committee on Finance and the House Ways and Means Committee. We will review and report on those committees' respective strategies, if any, to address the 2-year waiting period when their health reform bills are available.

**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. HHCAGW believes that any serious plan for national health care reform—must include these provisions.

**What the bill does:** The bill does not address this issue. HHCAGW recognizes that this is another matter falling primarily under the jurisdictions of the Senate Committee on Finance and the House Ways and Means Committee. We will review and report on those committees' respective strategies, if any, to address the prescription drug coverage gap in Medicare Part D when their health reform bills are available.

**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 HIV medical providers and Ryan White-funded clinics as designated sites.

**What the bill does:** The bill does not address provider reimbursement rates in the Medicaid and Medicare programs. HHCAGW recognizes that this matter lies primarily within the jurisdiction of the Committee on Finance in the Senate and the Committee on Ways and Means in the House. We will review and report on those committees' respective strategies for improving reimbursement structures in the public programs once their health care reform bills are available. The bill requires the development of reimbursement incentives for supporting comprehensive, coordinated care delivery systems, such as medical homes.

The bill makes substantial investments in the clinical workforce by funding a wide variety of both 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 (*See generally* §§401 *et seq.*). A few notable examples include:

- creating new loan repayment programs for pediatric subspecialists and public health professionals (§§421-425);
- increases in funding for Federally Qualified Health Centers, which must be accessible to medically-underserved populations (§171);
- increases in funding for the National Health Service Corps (§§173, 427);
- funding the development and deployment of nurse-managed health clinics in medically-underserved communities (§ 428);

- 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 (Sec. 747(b)(3)(E) of §431); 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. (Sec. 748(c)(5) of §433).

**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, not charge exorbitant premiums for coverage, cap total out-of-pocket spending, and eliminate the practices of not covering pre-existing conditions and imposing annual or lifetime caps on benefits. It is critical that coverage be portable so that persons 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 more access to comprehensive, quality health care. The goal of equitable health protection demands that any plan for health care reform must include provisions to ensure patients' privacy and that coverage, whether private or public, is comprehensive and that insurers are accountable—for example through set medical loss ratios, and community ratings.

**What the bill does:** The bill creates state-level health insurance exchanges, called “gateways,” through which individuals and businesses can compare and purchase health insurance plans (Sec. 3101(b) of §142). The bill requires gateways to screen applicants for eligibility for, and as appropriate, assist eligible individuals enroll in Medicaid, CHIP, and other Federal health care programs (Sec. 3101(b)(7)(A) of §142). Within gateways, the bill creates a risk-adjustment mechanism between health plans under which plans with lower-than-average actuarial risk pay a fee, and plans with higher-than-average actuarial risk receive a subsidy (Sec. 3101(b)(6) of §142).

Insurance companies are not required to offer plans through a gateway, nor are individuals required to elect a gateway-offered health insurance plan (Sec. 3101(k) of §142). Plans that are offered through a gateway must be certified as “qualified plans.” The draft bill proposes three coverage tiers for qualified plans that would be determined according to the cost-sharing required for services, i.e., plans with higher cost-sharing would charge lower monthly premiums. The bill leaves the criteria for qualified plan certification largely to the Secretary to determine, but does set out some criteria (Sec. 3101(l) of §142):

- plans may not use marketing techniques that effectively discourage enrollment by individuals with significant health needs or establish a benefit design that is likely to discourage enrollment by certain individuals;
- plans must ensure a “wide choice” of providers;
- plans must provide enrollees with a detailed yet easy-to-understand descriptions of plan benefits, structure, costs, etc.;
- plans must cover at least the “essential health care benefits” (ambulatory and emergency services, hospitalization, maternity & newborn care, medical & surgical care, mental health & substance abuse services, prescription drugs, rehabilitative, habilitative & laboratory services, preventative & wellness services, and pediatric services). (See Sec. 3103 of §142); and
- plans must provide for appeals of coverage determinations.

In addition to these requirements for certification as a qualified plan eligible to be offered in a gateway, the bill includes reform measure for the private insurance market generally. Under the bill, individual and group plans, among other requirements:

- are prohibited from using preexisting condition exclusions or otherwise discriminating based on health status (Secs. 2706 of §101);
- may only vary premium rates based on family structure, community rating area (the minimum size of which is to be determined by the Secretary), the actuarial benefit of the plan, and age (not to exceed 2:1) (Sec. 2701 of §101);
- must accept and renew all applicants (Sec. 2702(a), Sec. 2703 of §101);
- must pay an annual rebate to enrollees if the plan spends more than a certain percentage (to be determined) on non-claim activities (Sec. 2704(b)(1) of §101);
- are required to use reimbursement structures that promote the medical home model of delivery of services (Sec. 2707(a)(1) of §101);
- must cover (cost free or with nominal cost-sharing approved by the Secretary) certain preventive care services (Sec. 2708 of §101) (importantly, this does not include routine, voluntary HIV testing of all individuals ages 13-64); and
- may not impose annual or lifetime limits on coverage (Sec. 2710 of §101).

Furthermore, group plans are prohibited from discriminating based on salary (Sec. 2719 of §121). HHCAWG believes that these reform measures will help increase affordable access to private insurance for people living with HIV/AIDS. Annual out-of-pocket expenses would be capped at \$5,800 for an individual and \$11,600 for a family.

To help make purchasing insurance more affordable for low-income individuals and families, the bill would provide income-based subsidies on a sliding scale from 150% to 400% FPL (Sec. 3111(b)(2) of §151). The subsidy would be paid by the federal government to the gateway; the gateway would remit payment to the beneficiary's health plan (Sec. 3111(b) of §151).

The bill laudably creates a temporary reinsurance program to reimburse employers for the cost of providing health insurance to retired employees ages 55-64 (who are not yet eligible for Medicare) until a gateway is established in the employer's state (§181).

Finally, the bill creates a public plan, referred to as the "community health insurance option" (Sec. 3106 of §142). The community health insurance option will be offered in each gateway, and it must meet the same standards as the gateway qualified plans (Sec. 3106(b)(1) of §142). The option will only provide coverage for the "essential health benefits" that the Secretary of Health and Human Services determines (Sec. 3106(b)(3)(A) of §142). States may require the community health insurance option to cover additional benefits in their state, but they will need to cover the extra costs (Sec. 3106(b)(3)(B),(C) of §142). The Secretary of Health and Human Services may contract with non-profit qualified entities to administrate the community health insurance option (Sec. 3106(e) of §142).

#### **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 does not directly address this issue. However, the bill provides grants to establish "community-based multi-disciplinary, interprofessional teams" to provide multidisciplinary support services to primary care providers, and collaborate with existing community resources to coordinate chronic disease management (§212). The bill also provides grants to establish "medication management services" that will formulate medication management plans for individuals with chronic diseases and coordinate the plans with other health professionals (§213). In addition, the bill provides grants to encourage interdisciplinary, community-based linkages to help train physicians and other primary care providers to serve in underserved areas and health disparity populations (Sec. 751(b)(4)(B) of §453). HHCAGW recognizes these and numerous other related provisions in the bill as opportunities to expand the successful health care delivery models of existing Ryan White community-based programs. We encourage the HELP Committee to further capitalize on the strength of Ryan White programs by including language in the bill requiring those who offer private or group health insurance plans to include Ryan White providers in their networks (See e.g., Sec. 3101(I) of §142).

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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) and the HIV Medicine Association (HIVMA) for the HIV Health Care Access Working Group (HHCAGW). 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 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.*



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