

2009 Health Care Reform Analysis :: S.391(Wyden)

The following analysis of Senator Wyden's "Healthy Americans Act" (S.391) is based on priorities aimed at increasing early and uninterrupted access to affordable, comprehensive, and quality health care for persons living with HIV/AIDS. The bill language is unclear with respect to some significant provisions—in these cases 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: Expanding Medicaid 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 ("FPL").

Additionally, HHCAGW strongly supports the Early Treatment for HIV Act ("ETHA") as a critical tool to increase access to care for persons living with HIV. ETHA will help provide early access to care by giving 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 whose income is 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.

What the bill does: Eliminates traditional Medicaid coverage and establishes a system for universal, mandated coverage through private health plans. All individuals would be required to purchase private health insurance through state-level group plans, called "HAPI plans" (Healthy Americans Private Insurance plans). (S.391, Title I Subtitle A § 102(a)). The bill provides for full premium subsidies for individuals and families with income at or below 100 percent of the federal poverty level and sliding-scale premium subsidies for low-income individuals and families with income up to 400% of the federal poverty level. (S.391, Title I Subtitle C § 121(a),(b)).

The bill's subsidies for low-income individuals and families are critical to keeping health care affordable for all consumers in a privatized system. But HHCAGW is concerned that the subsidies as described in the current bill language could fail to protect low-income consumers with complicated or chronic health conditions, because the subsidies would be based on the average premium cost of the two cheapest plans in each state. (S.391, Title I Subtitle C § 121(c)). Such plans would likely be high-deductible, low-premium plans that cater to healthy individuals. Furthermore, premium subsidies are not available for any portion of premiums attributable to additional benefits, items or services (S.391, Title I Subtitle B § 111(a)).

HHCAGW is also concerned that low-income consumers would be unduly burdened by language currently in the bill that establishes regressive penalties for late enrollment. The penalty is calculated by the monthly premiums missed and an addition 15% of that sum. (S.391 Title I Subtitle A § 102(b)). An alternative approach with late penalties scaled to income would avoid disproportionately penalizing low income consumers.

Unclear: Under this bill, it appears that individuals with very low income who would technically be eligible for a "full subsidy"—but whose intense health care needs demand more expensive insurance plans—could still have to pay out-of-pocket for premiums of plans with the coverage they need. (S.391, Title I Subtitle C § 121(c)). Under the current bill language, it is also possible that even individuals who are eligible for Medicaid would have to pay out of pocket for higher-premium plans. We hope that the bill's current textual ambiguity on this matter will be interpreted to offer greater financial protection and access to care for low-income individuals with intense health care needs. In addition to the full standard subsidy, it is essential that low-income individuals with intense health care needs receive a Medicaid wrap-around to cover more expensive plans' premiums and all other costs not covered by their new private plans.

Currently in the U.S., many people who live 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 access to 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.

S.391's actual progress toward access to care for persons living with HIV/AIDS is also unclear. On one hand, the bill requires HAPI plans to provide benefits for disease prevention, early detection and management of chronic conditions. (S.391 Title I Subtitle B § 111(b)(1)(F)). But the structure of these benefits is not specified; a minimum benefits level in these areas is left to the Secretary of Health and Human Services to determine within a year of the bill's passage. (S.391 Subtitle B (b)(2)). In addition, the bill laudably seeks to promote early access to care by prohibiting cost-sharing for early detection and disease management services. (S.391 Title I Subtitle B § 111 (b)(1)(G)(i),(ii), (c)(1)(A)(i),(2)). In contradiction, language elsewhere in the bill merely *encourages* states to design chronic care performance standards to disallow cost-sharing for disease management services. (Title VI Subtitle C § 621(d)(3)).

With the goal of promoting access to voluntary HIV screening, counseling and long-term treatment, we hope that these ambiguities and apparent discrepancies in the bill will be resolved in favor of establishing mandatory, full coverage for voluntary HIV testing, counseling, and treatment as part of disease prevention, detection and management benefits.

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 and includes the full range of services needed to successfully treat and manage HIV disease—including *prescription drugs*. 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—as under the Wyden bill—transitions to a secondary insurer role.

What the bill does: Provides for wrap-around coverage, paid for by Medicaid, for services that children, the elderly and disabled individuals would have received under traditional Medicaid in their state of residence but that aren't covered under their new HAPI plan. (S.391 Title III, Subtitle A § 301(a)). The apparent goal of this provision—to avoid cuts in services for those for whom comprehensive care is most needed—is laudable, but the bill text overlooks the wide variability in states' existing Medicaid packages. Limiting wrap-around coverage to existing Medicaid benefits simply isn't enough to protect these vulnerable populations. The bill should be strengthened by establishing a uniform minimum Medicaid benefits package that covers the comprehensive, quality care that the elderly and individuals with disabilities need to be healthy.

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.

Unclear: The bill's emphasis on prevention and medical homes is laudable, but its effectiveness is unclear. Currently, the bill requires each individual designate a health care provider as a 'health home' and for the health home to determine a care plan. (S.391 Title I, Subtitle B §111(b)) If interpreted to include HIV testing and comprehensive healthcare for treatment of HIV disease in the concept of a care plan, this provision could be a powerful tool to improve meaningful access to care.

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: Eliminates traditional Medicaid coverage and requires all individuals to purchase private health insurance through state-level group plans (called "HAPI plans"). Under this new, privatized structure, the bill requires states to provide full subsidies for cost-sharing expenses for individuals with income at or below the federal poverty level and partial (not defined) subsidies for cost-sharing expenses for low income individuals with income above the federal poverty level (no upper limit is provided). (S.391 Title I Subtitle C § 122(a),(b)). This provision seeks to ensure that individuals who would under the current

health care system be eligible for traditional Medicaid will be eligible for secondary Medicaid insurance under the new system. Under this scheme, Medicaid would cover expenses such as copays and cost-sharing associated with private insurance to the extent those costs exceed existing current Medicaid cost-sharing limits. However, it appears that this secondary coverage would not be automatic, and the bill therefore inadequately protects low-income individuals and families from unaffordable out-of-pocket expenses.

The bill also seeks to increase affordability by providing that premiums and co-pays can be reduced with participation in Wellness programs (S.391, Title I, Subtitle D § 131(b)) that can be tailored to an individual's medical needs. (S.391, Title I, Subtitle D § 131(b)(2)(D)).

Additionally, the bill provides that Medicare beneficiaries who currently receive financial assistance from their state of residence toward Medicare cost-sharing expenses would continue to receive such subsidies, and that the federal government would reimburse states for these costs. (S.391 Title XI Subtitle G § 673(b)).

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: Requires that, after switching to the new HAPI system, states to continue to spend at least the same amount that they previously did through their state-funded Medicaid programs and other public health programs (the "maintenance-of-effort" requirement). (S.391 Title XI, Subtitle D § 631(c)). This provision protects states from spiraling health care costs in the long run. Furthermore, states would likely realize some financial relief from the elimination of expenses associated with providing emergency care to uninsured individuals.

Unclear: While we strongly support the maintenance-of-effort requirement, we are concerned that the bill as currently written does not prevent states from attempting to cut costs by reducing their Medicaid programs in anticipation of the requirement being implemented. To protect access to critical health care and services for people with low and intense health needs, it is essential that the bill be amended to require states to maintain eligibility rules and benefits at, or restore to, July 2008 levels.

Priority 5. Cover routine, voluntary 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.

What the bill does: Promotes screening by prohibiting cost-sharing in HAPI plans for preventive and early detection services, which presumably includes testing for infectious diseases such as HIV. (S.391 Title I Subtitle B § 111(b)(1)(G)(i),(ii)).

Unclear: Clarification should be sought to ensure that HIV counseling would be included in this provision. It also is unclear if *all* state-approved private group plans (i.e., HAPI actuarially-equivalent plans) would have to cover screening without cost-sharing. (S.391 Title I Subtitle B § 111(c)(1)(A)(i),(2)). Clarification should be sought on this provision as well. If interpreted to require coverage for voluntary screening and counseling in all private health plans, this bill would represent significant progress in the fight against the HIV epidemic.

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. HHCAG strongly supports eliminating the 2-year waiting period for people with disabilities.

What the bill does: The bill is silent on this issue.

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 directs that savings realized by the Secretary's new authority to negotiate Part D drug prices with manufacturers be applied to reducing the coverage gap. (S.391, Title IV, Subtitle D § 431(a)). It is unclear how much this would ease the burden on Medicare beneficiaries who are in the donut hole. The bill further provides that beneficiaries entering the coverage gap but who have not reached the annual out of pocket threshold would be able to switch to a Part D plan that includes insurance for prescription drugs during the coverage gap. (S.391, Title IV, Subtitle D § 432). The bill would also allow for individuals in a PDP region without a prescription drug plan that provides some coverage of brand name covered part D drugs to enroll in a prescription drug plan that provides such coverage in another region (S.391, Title IV, Subtitle D § 432(b)).

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 it 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 does not specifically address this issue. However, the bill does contain two notable provisions regarding provider issues. First, it establishes a new, school-based system of providing primary health care services to children. (S.391 Title II, Subtitle B § 212(a)(4)(A)). The bill also seeks to expand long-term care services, including home and community based services. (S.391, Title III, Subtitle B § 311(c)(2)). These provisions represent positive steps toward increasing investment in clinical work, a critical aspect of ensuring access to quality health care for all people.

Priority 9. Improve access to private health insurance.

What we support: To ensure equitable health protection, HHCAGW strongly supports consistent regulation of broader clinical performance standards, loss ratios, and insurer accountability. While the bill contains modest provisions on these matters, we feel it could be significantly strengthened in these areas by authorizing the Secretary of Health and Human Services to set relevant standards, rather than leaving this responsibility to the states. State-by-state standard-setting could lead to a race to the bottom, for instance, in terms of setting loss ratios for insurance issuers.

What the bill does: Shifts the national health care delivery system to one based on near-universal private health insurance coverage. Within this new, privatized health insurance structure, the bill prevents health insurance issuers from considering age, gender, industry, health status, or health insurance claims history in determining premiums, instead forcing them to use a community rating. (S.391 Title I Subtitle B § 111(d)(4)). The bill continues existing rules (generally those under HIPPA) limiting the use of preexisting condition exclusions and prohibiting discrimination based on health status. (S.391 Title I Subtitle B § 112(a)(1),(4)).

The bill gives a nod to accountability for insurance carriers by requiring states to develop clinical performance standards with respect to insurers' chronic care programs and setting reporting requirements vis-à-vis those performance standards. (S.391 Title VI Subtitle C § 621(d)(3),(4)). It also requires states to set loss ratios for insurance carriers—presumably with the goal of maximizing dollars spent on the actual delivery of health care as opposed to administrative costs—but defers the determination of loss ratios to the states. (S.391 Title VI Subtitle C § 621(e)).

Unclear: The bill's inclusion of provisions to prevent private insurance issuers from discriminating with respect to eligibility or premiums is laudable. But its reliance in large part on existing anti-discrimination laws makes its likely effectiveness in promoting affordable access to comprehensive, quality care highly

uncertain. For low income individuals, meaningful access to private health insurance under current law is often prevented by a variety of financial and structural barriers, such as annual or lifetime coverage limits, preexisting condition exclusions, and high premiums. Until disincentives for covering individuals with costly health care needs are removed, it is unlikely that private health insurance issuers will consistently remove such barriers. By continuing current law on these matters, S.391 is unlikely to affect progress in this area.

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 is silent on this issue.

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Additional notes: S.391 contains several other important provisions that do not directly relate to the policy priorities described above. We feel that advocates should be aware of these additional provisions:

- Prohibits the Dept. of Homeland Security from adjusting, extending, or renewing an alien's eligibility for legal residency status in the U.S. if that person owes a HAPI plan premium payment or penalty. (S.391 Subtitle C § 122(e)). (pp.35-36)
- Authorizes appropriations to ensure coverage for children in families up to 300% poverty. (S.391 Title II, Subtitle A, Sec.201(b)).
- Provides for wrap-around coverage, paid for by Medicaid, for services for children that they would have gotten under traditional Medicaid but can't get under their HAPI plan, including EPSDT services. (S.391 Title II, Subtitle A § 202(a)).
- Sets a 5-year aggregate cap on federal funding for long-term care in connection with an optional program intended to improve long-term care choices. (S.391 Title III, Subtitle B).
- Establishes a Medicare Chronic Care program to provide chronic care to Medicare beneficiaries, but limits this program to the five most prevalent chronic diseases among Medicare beneficiaries. (S.391 Title IV, Subtitle C).
- Requires only one health consumer on the 15–person Healthy America Advisory Committee. This represents inadequate consumer representation on body that is charged with making recommendations to Congress about the benefits, items and services required under HAPI plans. (S.391 Title I, Subtitle B § 113(b)).

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 (HHCAGW). 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.

