

HIV Health Care Access Working Group

Health Care Reform Analysis

America's Affordable Health Choices Act of 2009 (H.R.3200)

The following analysis of H.R.3200 (America's Affordable Health Choices Act of 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. Further amendments are expected to the bill in September and October.

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, a 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 pre-disabled, low and middle-income people living with HIV.

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 expands coverage to childless adults up 65 years in age and extends Medicaid coverage to all families and individuals with incomes up to 133^{1/3}% of the federal poverty level (§1701(a)(1)). Under the bill, the expansion of Medicaid eligibility rules would take effect in 2013, and the federal government would pay 100% of the cost of services for beneficiaries newly eligible under the expanded eligibility rule (§1701(a)(2)).

Note: The House Committee on Energy and Commerce approved an amendment to this provision specifying that the federal contribution is 100% through 2014, but reducing the federal contribution for the cost of services for newly-eligible beneficiaries to 90% beginning in 2015.

From 2010 to 2013, the bill would allow states to provide Medicaid coverage to individuals with HIV before they are disabled—a provision modeled after existing ETHA legislation. To be eligible for Medicaid under this provision, pre-disabled individuals living with HIV would have to meet a state's existing income and asset eligibility requirements for disabled Medicaid beneficiaries (§1731(a)). The ETHA provision sunsets in 2013 when individuals eligible for Medicaid through the expanded eligibility rules will remain in Medicaid and those with incomes above 133^{1/3}% will have the option to purchase insurance coverage through the new Exchange where they will be eligible for income based subsidies.

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.

What the bill does: The bill does not establish a comprehensive, mandatory minimum benefits package for Medicaid. While the bill requires state Medicaid programs to cover some preventive care services (§1711(a),(b)), it does not create a broad mandatory package that would certify that every individual has access to comprehensive, quality care. HHCAGW is concerned that Congress will miss an opportunity to enact this critical reform to the Medicaid program if a

comprehensive, mandatory minimum benefits package is not included in broader health care reform legislation.

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 comprehensively address cost sharing in Medicaid or Medicare, although it eliminates cost sharing for certain preventive services in Medicare (§1305(b)). The bill does change the asset test for the Medicare Part D low income subsidy (LIS) program, so that full LIS will be extended to individuals with up to \$17,000 in assets (up from \$10,000) and couples with up to \$34,000 in assets (up from \$20,000) (§1201). We recommend that the LIS income test also be adjusted to help make health care more affordable for seniors and individuals with disabilities.

The bill would require drug manufacturers to provide drug rebates for dual eligibles enrolled in Part D plans (§1181(b)).

Note: An early draft of H.R.3200 provided for automatic re-enrollment in the LIS program. HHCAWG supports such a provision because automatic reenrollment helps remove procedural barriers to participation in the program—and therefore access to prescription drugs—for poor and low-income Medicare beneficiaries. This provision did not appear in the bill as introduced. We recommend that this provision be incorporated into the final House bill.

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 provides 100% FMAP for services provided to individuals who become newly eligible for Medicaid under the bill's expanded eligibility provisions (§1701(a)(2)), but it does not increase FMAP generally during times of economic crisis.

Note: An amendment to the bill reduces the FMAP to states for newly-eligibles to 90% beginning in year 2015.

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: The bill requires Medicaid plans and insurance plans issued through the Health Insurance Exchange to provide coverage for items with an 'A' or 'B' rating in the recommendations of the United States Preventive Service Task Force (§122(b)(8), §1811(a),(b)). It also requires Medicare to provide such coverage without cost sharing, subject to the Secretary of Health and Human Services's approval (§1305(a),(b)). 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 short of the goal of requiring insurers to cover routine, voluntary screenings for all individuals ages 13-64.

The bill also emphasizes preventive care more generally through the establishment of a substantial prevention and wellness trust (§3111) and through the establishment of a task force on clinical preventive services (§3131). In addition, the bill requires the Secretary of Health and Human Services to create and periodically update a national prevention and wellness strategy (§3121).

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 address Medicare's 2-year waiting period for people with disabilities. The importance of this issue depends on the robustness of the health insurance exchange and the public health insurance option. If these programs do not fully succeed in offering affordable and comprehensive coverage to every individual during the 2-year waiting period, it is critical that the 2-year waiting period be eliminated.

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. HHCAWG believes that any serious plan for national health care reform must include these provisions.

What the bill does: The bill gradually eliminates the gap in Medicare Part D coverage, so that the donut hole will be completely eliminated within 15 years (§1181(a)). This will eventually ensure that Medicare beneficiaries living with HIV/AIDS have affordable and comprehensive access to lifesaving drugs. In the meantime, the bill includes a voluntary agreement with drug manufacturers to discount the cost of certain drugs by 50% for individuals facing the donut hole gap (§1182). Under this arrangement, beneficiaries in the coverage gap would pay only 50% of the cost of a drug, but would effectively get credit for the full cost of the drug toward their TrOOP. The bill also counts ADAP contributions towards TrOOP for the purpose of triggering Medicare Part D catastrophic coverage (§1184). This will ensure that Medicare beneficiaries who receive assistance from ADAPs can escape the donut hole during the 15 year transition period in which the donut hole still exists.

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.

What the bill does: The bill gradually increases Medicaid reimbursement rates for primary care providers so that they equal Medicare reimbursement rates by 2012 (§1721(a)(1)). Furthermore, beginning in 2011, the bill increases Medicare's reimbursement rates for primary care providers by 5%, and by 10% for primary care providers serving in a health professional shortage area (§1303(a)). The bill also overhauls Medicare's Sustainable Growth Rate (SGR) physician reimbursement system to ensure that physicians will not face substantially lower reimbursement rates in 2011 (§1121).

Additionally, the bill increases funding for community health centers (§2101). It establishes loan repayment programs for individuals who agree to practice primary care in health professional needs areas (Sec. 340I of §2211), and prioritizes capacity-building grants to dentistry programs that conduct teaching programs targeted at vulnerable populations (Sec. 749 of §2215). The bill gives grants to medical schools for programs designed to improve clinical teaching, with preference given to programs that emphasize primary care, care for vulnerable populations, and programs that train large percentages of individuals from minority groups or disadvantaged backgrounds (§2213). Furthermore, the bill creates new grants for nursing education programs (§§2221, 2531). Lastly, the bill establishes a scholarship for individuals who agree to serve as public health professionals (Sec. 340M of §2231).

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, 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 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 access to comprehensive, quality health care. The goal of equitable health protection demands that any plan for health care reform must include provisions to require insurer accountability, protect patients' privacy, and ensure that coverage--whether private or public--is comprehensive.

What the bill does: The bill creates a national health insurance exchange with a public health insurance option (§§201,221). All plans offered through the exchange—including the public plan—and other qualified plans must provide essential health care benefits, which include hospitalization, outpatient care, physician services, prescription drugs, rehabilitative care, mental health care, substance abuse care, preventive services, maternity care, and well baby and well child care (§122(b)). The public health insurance option is required to offer basic,

enhanced, and premium plans, which differ based on their cost sharing requirements (§221(b)(3)(A)). However, the public plan may or may not offer premium plus plans, which are the only plans that offer additional benefits including vision and dental coverage (§221(b)(3)(B)). The bill requires that all qualified health plans offer culturally and linguistically appropriate care (§204(b)(7)). The bill forbids rescissions, except in cases of clear fraud (§162). The bill also forbids qualified health plans from imposing pre-existing condition exclusions or otherwise limit coverage based on health status (§111), and it forbids lifetime or annual limits on essential health coverage (§122(a)(3)). The bill requires qualified health plans to guarantee availability and renewability for every individual (§112). Also, by requiring plans to contract with 340B providers for outpatient services, the bill takes an important step toward integrating Ryan White providers into the broader health care system (§204(b)(6)).

H.R.3200 promotes affordability for individuals buying health insurance through the national exchange in five important ways: premium assistance, cost-sharing assistance, a cost-sharing cap, assisting workers facing high group plan premiums, and eliminating cost-sharing for certain essential health care services.

First, the bill provides premium payment assistance on an income-based sliding scale to individuals and families with income between 133% and 400% of the federal poverty level ("FPL") (§§243, 244). Consumers' out-of-pocket payments for premiums will be limited to 1.5%-11% of income, with the remainder covered by an "affordable premium credit" (§243). *Note: The House Energy and Commerce Committee approved an amendment to the affordable premium credit sliding scale provision that increases the percentage of family income paid toward the cost of premiums to 12% instead of 11% for individuals and families at 400% FPL.*

Second, cost sharing will be limited to 3%-30% of medical bills according to the same income-based sliding scale of 133%-400% FPL, with the remainder paid for by an "affordable cost-sharing credit" (§244).

Third, the bill sets annual cost sharing caps for essential benefits at \$5,000 for individuals and \$10,000 for families, regardless of income (§122(c)(2)(B)).

Fourth, individuals who have employee group plan insurance through the Exchange can receive affordability credits if their share of the premium is greater than 11% of their family income. *Note: The Energy and Commerce Committee approved an amendment raising the eligibility requirement for employees to receive affordable premium credits to 12% of family income instead of 11%.*

Fifth, H.R.3200 eliminates all cost sharing for preventive services covered in the essential benefits package (§122(c)(1)).

The bill directs the Health Choices Commissioner to impose limits on cost sharing for plans in the exchange, depending on the type of plan – basic, enhanced, premium, or premium plus (§203(c)(6)).

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 requires basic plans sold through the health insurance exchange to contract with “essential community providers,” including Ryan White programs (§204(b)(6)). This is an important provision that will increase the strength of Ryan White programs. We recommend that the federal government also provides Ryan White programs with cost-based reimbursement and ensures that Ryan White Programs are fit into Medicaid programs.

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Additional Notes – Ending Health Disparities

H.R. 3200 contains numerous provisions to address health disparities. As noted above, for example, it provides compensation bonuses within the Medicare reimbursement system for primary care providers in underserved areas—a provision that would carry over into the Medicaid program as Medicaid reimbursement rates are gradually increased to match Medicare rates. Other measures that would address health disparities include grant programs for scholarships and training programs for nurses, dental care providers, and other health workers that give priority to programs that focus on culturally- and linguistically-appropriate care as well as the provision of services in underserved areas or to underserved or vulnerable populations. HHCAGW strongly supports these and other measures to address health disparities in the House health care reform bill.

Key measures to end existing health disparities that are *not* included in this version of the House bill include (1) ending the 5-year waiting period for legal immigrants to obtain Medicaid coverage, and (2) lifting the appropriations cap on federal funding for Medicaid programs to the territories and implementing instead the same federal matching rate as applies in the states. These measures are essential if health care reform legislation is to effectively end existing health disparities.

This report was prepared by staff of the WilmerHale Legal Services Center of Harvard Law School, the Treatment Access Expansion Project (TAEP), the HIV Medicine Association (HIVMA), and Project Inform 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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