

The Ryan White Program, Health Care Reform and HIV Health Care Advocacy:

**An Overview of Efforts to Expand Access
to Care to People Living with HIV/AIDS**

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**Louisiana Commission on HIV/AIDS and Hepatitis C
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PART 1

- Ryan White Program Reauthorization Overview

PART 2

- Health Care Reform Overview

PART 3

- HIV Health Care Access Advocacy: Including State Healthcare Access Research Project (SHARP) Overview

PART 1: Ryan White HIV/AIDS Treatment Extension Act of 2009

- Extension signed into law by President Obama on October 30, 2009
- Authorization for four years (FY2010 – **FY2013**) and eliminates sunset provision
- Extends protection for code-based states; in FY2013 all formulas will be distributed on living HIV and AIDS cases reported to CDC
- Extends hold harmless protections
- Increases allowable unobligated balances (UOB) from two to five percent

Ryan White HIV/AIDS Treatment Extension Act of 2009

- Several Transitional Grant Areas (TGAs) will lose their TGA status in FY2011
- Allows ADAP rebate income to be deducted from unobligated amount to avoid penalty
- Re-establishes the requirement that emergency responders are notified if exposed to potentially life-threatening infectious disease
- Early Diagnosis grants were not reauthorized

Ryan White HIV/AIDS Treatment Extension Act of 2009

- Prevention provisions added to the bill:
 - 1/3 of Part A supplemental criteria will be judged on jurisdiction's ability to identify new positives and link them into care
 - States must incorporate info on approaches to testing and linkages into existing state plan
 - National testing goal of 5 million test supported by federal funds
 - HHS review of existing CDC programs to determine effectiveness

Ryan White HIV/AIDS Treatment Extension Act of 2009

MINORITY AIDS INITIATIVE:

- MAI for Part A and B returns to formula awards and synchronizes the grant year with the regular award cycle
- GAO to report on MAI activities across HHS agencies and include description of best practices in capacity-building for minority CBOs
- HHS secretary to prepare a plan for the use of MAI funds for capacity-building based on report findings

Ryan White HIV/AIDS Treatment Extension Act of 2009

REPORT LANGUAGE:

- Addresses transportation by encouraging grantees to maximize flexibility in the use of support services including finding methods of reducing costs
- Encourages Part B grantees to develop and implement pre- and post-release programs for HIV-positive inmates
- Encourages HRSA to increase capacity of grantees to deliver medical management, treatment and support services for clients co-infected with HIV and HCV/HBV

Implications of Ryan White Changes

- Changes not as impactful as in 2006 reauthorization
- UOB change to 5% may mean less money in Part A and B supplemental pots
- Loss of TGA status could lead to drastic cuts in available services in some communities (especially in Puerto Rico which is losing two)
- Year four could see larger funding shifts when all formulas based on living HIV and AIDS cases reported to CDC and hold harmless decreases to 92.5% of the previous year's funding

Ongoing Ryan White Program Concerns

- Ryan White is NOT an entitlement program
- Fiscal crisis continues to have a dramatically negative affect on Ryan White programs
- Critical support services will continue to be squeezed out as budget get tighter and 75/25 requirement for core medical services continues
- 24-month housing limit has not been readdressed

Future of Ryan White in Reformed Health System: Key Issues

- IF HCR enacted, expanded access through HCR will shift many to Medicaid
- Authorization expires in 2013
- 75/25 may be a challenge as current clients get primary care elsewhere
- Program complexity will grow
- Undocumented individuals will stand out more

PART 2

HEALTH CARE REFORM

OVERVIEW

- Private Insurance Reform
- Public Insurance, Medicaid & Medicare Reform
- New Investments
- HIV Specific Issues

HCR Improvements: Private Health Insurance

Increased Access

- Largely eliminates discrimination based on health status

Increased Coverage

- Establishes new mandatory benefits packages
- Establishes both an individual and employer mandate to maximize coverage

Increased Affordability

- Affordability includes premium credits and cost-sharing subsidies

Private Insurance: Ongoing Concerns

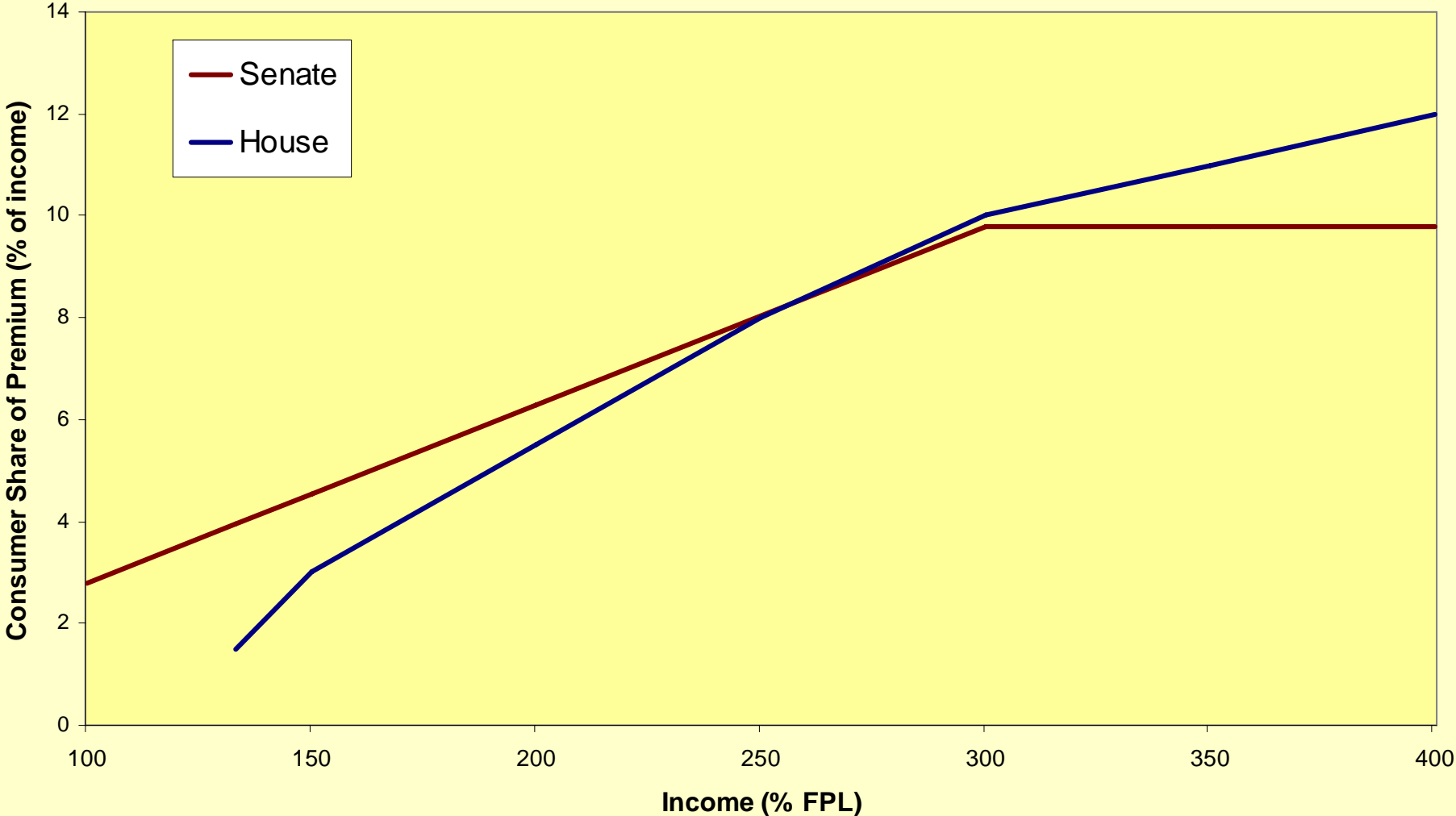
- All reforms, including premium rating rules, should apply uniformly to all insurance plans (in and out of the exchange and employer-based group plans)
(Senate bill exempts large employer-based group plans)
- Policies and regulations governing state-based exchange plans should be nationally standardized
(Senate bill allows for state variation and state opt-out)
- Premium and cost-sharing credits need to be increased (Particularly in Senate bill at lower income levels)

Affordability – Consumer Share after Premium Subsidy

- Premium Credits (as % of annual income)

	Senate (2014)	House (2013)
100% FPL	2%	
133% FPL	2.8%	1.5%
150% FPL	4.6%	3%
200% FPL	6.3%	5.5%
300% FPL	9.8%	10%
400% FPL	9.8%	12%

Affordability: Consumer Share of Insurance Premiums



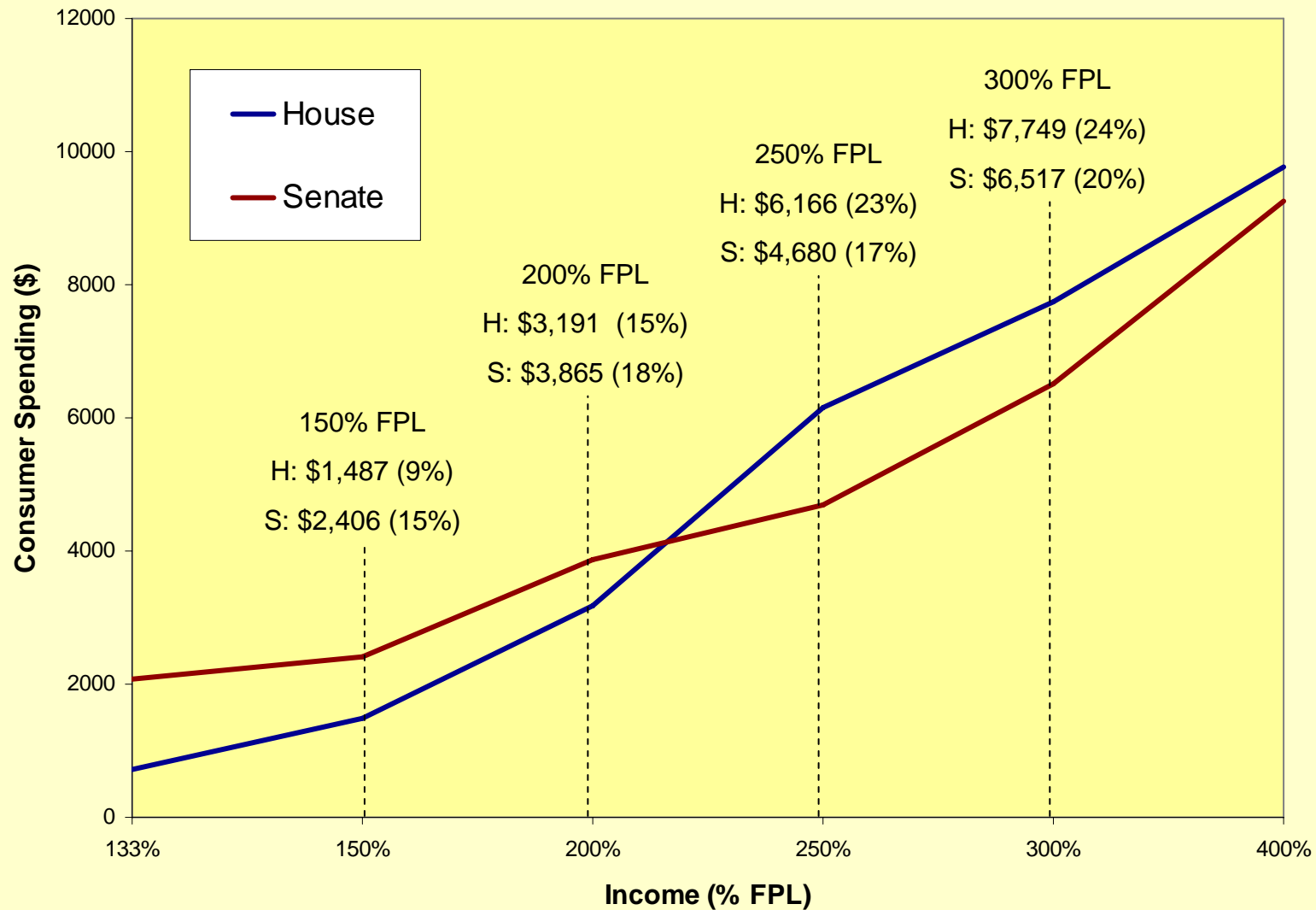
Affordability – Consumer Share after Cost-Sharing Subsidies

	Senate (2014)	House (2013)
100% FPL	10%	3%
133% FPL	10%	3%
150% FPL	20%	7%
>200% FPL	40%	15%
>250% FPL	40%	22%
>300% FPL	40%	28%
>350% FPL	40%	30%
>400% FPL	40%	30%

Affordability - Cost-Sharing Spending Caps

	Senate	House
<150% FPL	\$1,667 individual \$3,333 family	\$500 individual \$1,000 family
150-200% FPL	\$1,667 individual \$3,333 family	\$1,000 individual \$2,000 family
200-250% FPL	\$2,500 individual \$5,000 family	\$2,000 individual \$4,000 family
250-300% FPL	\$2,500 individual \$5,000 family	\$4,000 individual \$8,000 family
300-350% FPL	\$3,333 individual \$6,667 family	\$4,500 individual \$9,000 family
350-400% FPL	\$3,333 individual \$6,667 family	\$5,000 individual \$10,000 family
> 400% FPL	\$5,000 individual \$10,000 family	\$5,000 individual \$10,000 family

Total Out-Of Pocket Cost to Consumer: Premium and Cost-Sharing



HCR Improvements: Public Health Insurance

- House -- only includes a public insurance option
 - House – a national public option
 - Senate – OPM plans and Co-ops
- Both increase Medicaid eligibility*
 - Senate - below 133% FPL
 - House – below 150% FPL
- House only - Increases Medicaid primary care reimbursement rates
- Both address Medicare “donut hole” issue
 - Senate - \$500 gap reduction and 50% discount
 - House - Phases out donut hole over 10 years
- Current Medicaid restrictions based upon citizenship apply, including 5-year ban for legal immigrants

Public Health Insurance: Ongoing Concerns

- Protect and/or strengthen the public option
- Increase the income eligibility for Medicaid to 150%FPL (as in the House bill)
- Raise Medicaid rates to providers (as in House bill)
- Fully fund the Medicaid expansion
- Ensure all Medicaid beneficiaries have access to same new mandatory minimum benefits package
- Fully close the Medicare Care Part D gap quickly
- Codify protections for 6 protected classes

Other HCR Key Improvements

New Investments

- Prevention and wellness
- Health disparities
- Clinical workforce serving vulnerable populations
- Public Health Infrastructure

New Investments

Ongoing Concerns

- Insufficient investment in prevention & wellness, health disparities, public health infrastructure and public health infrastructure
- House & Senate fail to address legal immigrant 5 year exclusion
- House and Senate include restrictions on abortion funding
- Senate includes funding of abstinence-only education

HCR Improvements: HIV Specific Issues

- **Voluntary, Routine HIV Testing**
 - House - for at-risk populations
 - Senate - not addressed
- **ADAP as TrOOP in Medicare Part D**
 - In both House and Senate
- **Integration of Ryan White Providers**
 - Both House and Senate plans require integration of 340b providers
- **Early Treatment for HIV Act (ETHA)**
 - House only

HIV Specific: Ongoing Concerns

- Senate fails to include ETHA
- Neither bill includes broad private and public insurance mandate for HIV screening
- Neither bill codifies Medicare Part D coverage of all antiretrovirals

Summary: Key Reform Improvements

Private Health Insurance

- Increased Access – largely eliminates discrimination on health status
- Increased Coverage – establishes new mandatory benefits packages
- Affordability – subsidies up to 400%

Public Health Insurance

- Creation of public health insurance option (House only)
- Increased Medicaid Eligibility – Senate below 133%, House below 150%
- Increased Medicaid reimbursement rates to providers (House only)
- Phase out of Medicare Part D “donut hole” over by 2019 (House only)

HIV Specific

- HIV testing of at-risk (House), ADAP as TrOOP (House and Senate) and ETHA (House only)

Other Key Improvements

- Investments in public health infrastructure, addressing health disparities and supporting clinical workforce

Summary: What Isn't Addressed

Private Health Insurance

- Affordability –still too expensive

Public Health Insurance

- Public plan option is too weak
- No new mandated Medicaid benefits – state variation continues
- Senate fails to increase Medicaid reimbursement rates to providers
- Senate fails to phase out Medicare Part D “donut hole” and House 10 year “donut hole” phase out too long

HIV Specific

- Senate fails to include ETHA; no broad HIV Screening; no 6 protected classes

Other Shortcomings

- Insufficient investment in prevention, wellness and disparities
- House and Senate fail to address legal immigrant 5 year exclusion

Part 3: HLS/TAEP Advocacy Initiatives

HEALTHCARE REFORM ADVOCACY PROJECT



Securing the Future of Medicaid

An Action-Based Toolkit



On behalf of Treatment
Access Expansion Project &
Bristol-Myers Squibb

Bristol-Myers Squibb



Alabama State Report

An Analysis of the Successes, Challenges, and
Opportunities for Healthcare Access

Prepared by Student, Robert Greenwald, and Amy Rosenberg

THE WILMERHALE LEGAL SERVICES CENTER OF HARVARD LAW SCHOOL



On Behalf of: The Legal Services Center of Harvard Law School,
Treatment Access Expansion Project, and Bristol-Myers Squibb

Bristol-Myers Squibb



What we are Doing to Increase Access to Care

Healthcare Reform Project

- Facilitated process of identifying key principles for reform
- Built widespread community support for identified reform principles
- **Ongoing** -- evaluate all healthcare reform proposals
- **Ongoing** -- develop materials/ mechanisms to support community involvement

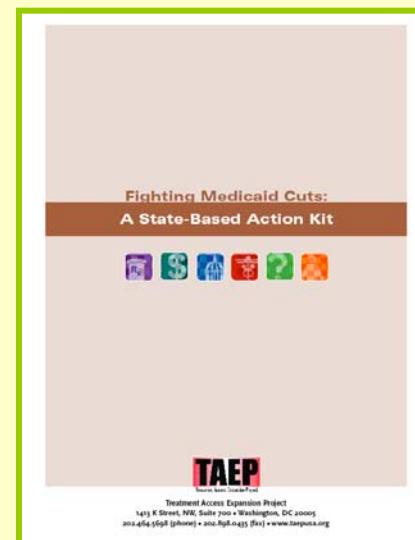
***All health care reform materials
available at www.taepusa.org***

Medicaid Advocacy Initiative

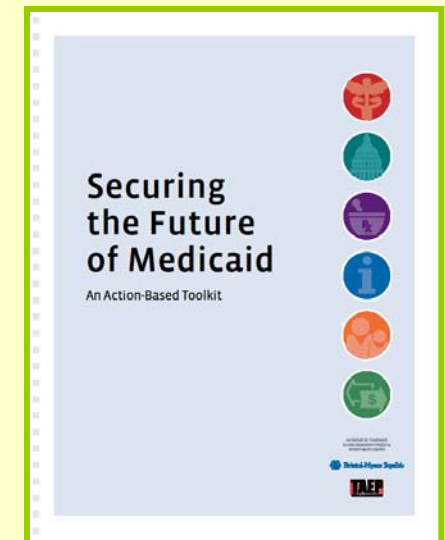
Purpose:

- **Protect Medicaid from budget cuts as states confront dire economic conditions**
- **Document cost-effectiveness of unrestricted access to HIV Rx**
- **Encourage informed and active HIV community-based Medicaid advocacy**

2004 Version



2009 Version





State Healthcare Access Research Project

PHASE 1:

- Produce SHARP reports that examine state-specific capacity to meet the care and treatment needs of PLHIV
- Collaborate with state-based partners to identify successes, challenges and opportunities for improving healthcare access and begin process of building community advocacy capacity

PHASE 2:

- Work with state partners to build stronger healthcare access advocacy coalitions
- Help to facilitate the ongoing development and implementation of SHARP Healthcare Access Advocacy Plan

