

HIV Health Care Access Working Group

2009 Health Care Reform Analysis :: H.R.3400

The following analysis of the Republican Study Committee Bill ("Empowering Patients First 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.

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") and enacting the proposed Early Treatment for HIV Act (ETHA). Eliminating the categorical eligibility requirement and raising the income eligibility standard for Medicaid coverage would make major progress to decreasing the number of uninsured people in the U.S. 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 does not address this issue.

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: The bill does not address this issue.

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 this issue.

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.

What the bill does: The bill does not address this issue.

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 does not address this issue.

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, individuals can become sicker and require more intensive, more costly medical interventions when they 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 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.

What the bill does: The bill does not address this issue.

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: H.R.3400 overhauls Medicare's Sustainable Growth Rate (SGR) physician reimbursement system so that physicians will not face substantially lower reimbursement rates in 2011 (§1001). The bill creates a new federally-supported student loan program for medical students (§1101); repayment of loans granted through this program may be deferred until residencies and/or fellowships are concluded (Sec. 730(c) of §1101). The bill also creates a loan forgiveness program for primary care physicians. Physicians practicing primary care medicine for at least 5 years will receive up to \$50,000 in loan forgiveness (§1111).

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. To achieve the goal of equitable health protection, health care reform legislation must include provisions to ensure patients' privacy and require that coverage, whether private or public, is comprehensive and that insurers are accountable.

What the bill does: The bill creates an internet portal system to provide consumers with information regarding health insurance plans and healthcare providers (§901).

The bill gives tax credits to low income individuals to help cover the cost of health insurance. Under H.R.3400, individuals would have the option of having the tax credits paid in advance to qualified health insurance providers (Sec. 7529 of §102). The tax credit will be the lesser of aggregate premium costs and the set limits of \$2,000 for an individual, \$4,000 for joint filers, and \$5,000 for a family of four (Sec. 36B(b)(2) of §101). The full tax credit would be available to individuals with income up to 200% FPL; for individuals with higher income, the credit would be reduced by 1% for every \$1,000 above 200% FPL (Sec. 36B(b)(3) of §101). The bill provides that individuals who are eligible for Medicare, Medicaid, SCHIP, or other eligible health programs may opt to receive the tax credit in lieu of program benefits (§103). Credits would only be available in states that implement a high risk pool or reinsurance pool that provides health coverage for high risk individuals (§201). Block grants divided between states would help pay for the implementation of these pools.

The bill allows insurance companies to continue imposing coverage exclusions based on preexisting conditions, but provides a tax exemption to employers that contribute to health plans forbidding preexisting condition exclusions for conditions diagnosed prior to 6 months before the individual's enrollment in a health plan (§106).

Based on the [bill summary posted on the Republican Study Committee's website](#), it appears that the bill's authors intend the bill to allow residents of states in which insurance premiums exceed the national average by at least 10% to purchase health insurance in other states (based on the bill summary posted on the RSC website). But the current bill language actually prohibits such individuals from purchasing insurance in other states (Sec. 2798 of §301).

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 address this issue.

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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