

2009 Health Care Reform Analysis :: S.1099 (Coburn)

The following analysis of Senator Coburn's "Patients' Choice Act" (S.1099) is based on priorities aimed at increasing early and uninterrupted access to affordable, comprehensive, and quality health care for persons living with HIV/AIDS. Notably, S.1099 does not contain a universal coverage mandate or include a public plan option.

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, HHCAWG 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: Limits access to Medicaid coverage to individuals who meet categorical eligibility criteria (blind, disabled, breast or cervical cancer, TB). Eliminates coverage for low-income families and pregnant women, and does not provide access to Medicaid for non-disabled childless adults (Sec. 1903(a) of S.1099 §401, See also §411). The bill leaves the determination of income and asset eligibility requirements to states (Sec. 1903(a)(1)(B) of S.1099 §401). The bill does not incorporate ETHA language or otherwise provide access to Medicaid for non-disabled low-income people living with HIV.

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.

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. Access to quality care should not depend on geography. This measure must be included in any plan for national health care reform.

What the bill does: The bill does not establish a comprehensive mandatory minimum Medicaid benefits package. Rather, S.1099 restructures Medicaid as a two-component system: acute care services ("Part A") and long-term care ("Part B"). Acute care services under the bill largely resemble today's Medicaid, retaining essentially the same mandatory and optional benefits (with addition of inpatient psychiatric treatment for individuals over the age of 21 as a mandatory, not optional benefit) (Sec. 1903(b)(1) of S.1099 §401). Prescription drug coverage, dental services, optical care, mental health services and substance abuse treatment remain optional services (Sec.

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.

1903(b)(2) of S.1099 §401). Part A generally retains the funding and administrative structure of today's Medicaid (Sec. 1905(b) of S.1099 §401). Long-term care services under Part B programs, however, would be funded as block grants (Secs. 1913, 1915 of S.1099 §401), and the bill explicitly states that Part B services are not entitlement benefits (Sec. 1911(b) of S.1099 §401). States can cap enrollment in their Part B programs and change eligibility rules to reduce enrollment without the Secretary's approval (Sec. 1917(a) of S.1099 §401).

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: Within Medicaid, seeks to limit consumers' out-of-pocket expenses by directing that premiums or cost-sharing, if required by Medicaid state plans for acute or long term care services, be set on a sliding scale based on family income. Under the bill, premium and cost-sharing expenses cannot exceed 5% of annual income for families with income between 150% and 250% of poverty. For families with income above 250% of poverty, premium and cost-sharing expenses are limited to no more than 7.5% of annual income (Sec. 1952(a) of S.1099 §401). This implies that states may not require any premiums or cost sharing of individuals with annual income less than 150% of poverty. Absent an explicit statement to this effect, though, clarification is needed. The bill seeks to further protect poor and low-income beneficiaries by providing that states may not require prepayment of premiums or cost-sharing, and by providing a 60-day grace period for payment as well as establishing an undue hardship exception (Sec. 1952(a) of S.1099 §401).

The bill also seeks to increase affordability by establishing a financial assistance program for low-income families under which value-assigned debit cards would be provided to eligible families for exclusive use toward health care expenses (S. 1099 §411). Eligibility for the program is limited to low-income families with children (Sec. 340A-1(b)(1) of S.1099 §411) and individuals who are eligible for Medicaid or SCHIP as disabled, elderly or a special population (Sec. 340A-1(f) of S.1099 §411). Dollar amounts up to \$5,000 per year per family would be allotted to enrollees in this program on a sliding scale for income up to 200% of poverty (Sec. 340A-1 of S.1099 §411). Notably, Medicaid-eligible individuals' income is to be excluded from the family income determination (Sec. 340A-1(b)(2) of S.1099 §411). The debit card may be used for cost-sharing expenses in addition to the direct purchase of health care services and supplies (Sec. 340A-1(c) of S.1099 §411). The program appears to facilitate the purchase of private health insurance for card-holders, but the bill excludes from eligibility for the debit card program any family of which any member carries private health insurance (Sec. 340A-1(b) of S.1099 §411). This conflict in the bill text requires clarification. Finally, while the language establishing the supplemental debit card program does not indicate that enrollment could be capped, the bill prescribes discrete annual funding for the program (Sec. 340A-1(i)(2) of S.1099 §411). It is unclear how enrollment determinations would be made should eligibility outpace funding.

Within Medicare, the bill does not address increasing the income eligibility standard for the LIS program or set nominal caps on out-of-pocket expenses for low income Medicare beneficiaries. S.1099 allows the Secretary to adjust premiums based on individuals' enrollment in prevention and wellness programs (S.1099 §504). While this provision offers beneficiaries potential savings, its benefit is undermined by the requirement that any premium adjustments be cost-neutral—implying that individuals not enrolled in prevention/wellness programs could be penalized in their premiums (S.1099 §504).

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: Maintains the current FMAP for services provided under Part A state plans (acute care services) (Sec. 1905(b) of S.1099 §401) and establishes annual allotments for services provided under Part B state plans (long term care services) (Secs. 1913, 1915 of S.1099 §401). The bill does not provide for increasing the Part A FMAP or Part B annual allotments in response to economic crises.

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.

What the bill does: The bill does not directly 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 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. HHCAGW 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 is silent on this issue.

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 establish a pilot program to provide grants for coordinated health care delivery programs (“accountable care organizations”) under Medicare (S.1099 §502). By providing grant money and bonuses to groups of providers delivering quality, coordinated care to Medicare fee-for-service beneficiaries, this provision represents a positive step toward increasing investment in coordinated clinical work. On the other hand, the bill eliminates the existing Disproportionate-

Share Hospital (DSH) program under Medicaid that provides financial assistance to hospitals that serve a disproportionate share of low-income patients with special needs (Sec.1953(1)(K) of S.1099 §401(a)). Without the DSH program, these providers could be forced to close their doors to Medicaid beneficiaries and other uninsured and underinsured patients.

Priority 9. Improve access to public and private health insurance.

What we support: To ensure equitable health protection, HHCAG 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: S. 1099 does not create a public health insurance option. In the private market, the bill provides for the creation of state-level health insurance exchanges through which individuals could purchase private health insurance plans. Notably, the bill does not require all individuals to purchase health insurance (S.1099 §202(c)(5)). It is unclear what major improvements, if any, would be made in the context of increasing meaningful private health care choices for low-income individuals living with HIV/AIDS under S.1099. For instance, the bill contains language providing for “limitation on *exorbitant* premiums” for plans offered through state exchanges that instructs directors of state exchanges to employ mechanisms to “protect enrollees from the imposition of *excessive* premiums, to reduce adverse selection, and to share risk” (S.1099 §202(d) (*emphasis added*)). Conceptually, these are laudable approaches to keeping private health coverage affordable, but the bill language contains no detail and consequently provides no meaningful protections. Furthermore, states are actually prohibited from setting premiums or cost-sharing levels for plans offered through the exchange (S.1099 §202(a)(4)), and may not set any requirements relating to benefits packages beyond what is required of plans that are offered to members of Congress. The bill continues existing rules (generally those applicable to group plans under the tax code) limiting the use of preexisting condition exclusions in plans offered through state exchanges. (S.1099 §202(c)(4)).

We are concerned that the bill's proposed structure for state health insurance exchanges 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.1099 is unlikely to affect progress in this area.

The bill provides for the creation of a health credit tax refund for individuals and families who purchase “qualified” private health insurance (S.1099 §301). The maximum (not minimum, as described in the bill sponsors' "Section-by-Section summary) credit would be \$2,290 for adults and \$1,710 for children, with a family maximum credit of \$5,710 (which represents only 1 adult and 2 child credits) (Sec. 25E(a),(b) of S.1099 §301). Medicaid and Medicare beneficiaries are not eligible for the credit (Sec. 25E(e)(2) of S.1099 §301) (again directly contradicting the bill sponsors' "Section-by-Section" summary). To qualify as “qualified,” a health insurance plan must be judged by the Secretary as having “reasonable” annual and lifetime benefit limits, and provide coverage for inpatient, outpatient and emergency care as well as physician services (Sec. 25E(f) of S.1099 §301). Prescription drug coverage is not required. Notably, only consumers in group health plans are eligible for advance payment of the health tax credit (Sec.7527A(a) of S.1099 §301).

HHCAGW is concerned that the requirements for exchange-participating plans and health credit-eligible insurance are inadequate to ensure that consumers living with complex, chronic disease have affordable access to meaningful coverage choices in the private health insurance market. Annual- or lifetime-limited coverage does not work for people who have ongoing, serious health care needs. Premiums based on risk determinations that include consumers' diagnoses (S.1099 §202(d)(2)(A)) are likely to remain unaffordable to low-income people living with complex, chronic disease. By taking a hands-off approach to regulating the private insurance market, S.1099 represents hollow reform 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.

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. 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 (National Alliance of State and Territorial AIDS Directors) at 202.434.8091, or Robert Greenwald (Treatment Access Expansion Project) at 617.390.2584.

