Affordable Care Act and Ryan White Program Considerations for People Living with HIV & HCV: An Overview of Where We Are & Where We Are Going

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Where We Are: U.S. Lags Behind in Health Outcomes

The Status Quo Isn’t Working

In all other industrialized democratic countries health care costs are low and every citizen is guaranteed access to health care.

The Pre-ACA Status Quo = Access to HIV/HCV Care Crisis

Medicaid/ Medicare are lifelines to care, but disability standard means they are very limited

Demand for Ryan White Program care and services greatly exceeds available funding

Few insured through employer system and pre-ACA nearly impossible to obtain individual health insurance

29% of people with HIV and 33% with HCV uninsured (More than 2X national 14%)

The Current Crisis
Over 50% of people with HIV and over 70% with HCV are not in regular care
Ryan White Program Not Keeping Pace with Increased Need

Number of People Living with AIDS in the US vs. Ryan White Funding (adjusted for inflation)


ACA Implementation Must Address Engagement and Retention in Quality HIV Care

National HIV/AIDS Strategy calls for:

- Increasing HIV screening and improving linkages to care
- Increasing retention in care rates
- Closing the gap between those who need antiretrovirals (ARVs) and those who are on ARVs
- Providing needed care and support services to increase treatment adherence and number of persons with undetectable viral load rates

Engagement in Selected Stages of HIV Care

Engagement in Selected Stages of HIV Care: NY Outcomes vs. National Outcomes

HCV Engagement and Retention in Care

Viral Hepatitis Action Plan calls for:
• Educating providers and communities to reduce health disparities
• Improving testing, care, and treatment to prevent liver disease and cancer
• Strengthening surveillance
• Eliminating transmission
• Reducing cases caused by drug-use behaviors
• Protecting patients and workers from healthcare-associated viral hepatitis

WHERE WE ARE GOING
ACA Reforms Include New Responsibilities

Mandates
- Individual Mandate Penalty 2016 and Beyond - $695 per adult and $347.50 per child (up to $2,085 for a family) or 2.5% of income, whichever is greater (with some hardship exemptions)
- Employer Mandate Penalty – Employers (ER) with more than 50 employees (EE) who don’t provide insurance and who have any EE receiving an exchange subsidy subject to $2,000 penalty per full-time EE beyond the first 30 EEs

Taxes
- Tax credits for small businesses
- 0.9% increase for individuals with income > $200,000 and couples > $250,000 (plus a 3.8% additional tax on unearned income)
- Cadillac Tax of 40% of value of plan if the plan costs more than $10,200 for individual and $27,500 for families

Sources: Center on Budget Policies and Priorities, The Number of Uninsured Americans is at an All-Time High (2006), Kaiser Family Foundation, The Uninsured: A Primer (2010); Kaiser Health News, Census: Uninsured Numbers Decline as More Young Adults Gain Coverage
ACA Reforms to Private Insurance

- Health plans cannot drop people from coverage when they get sick
- Cannot be denied insurance because of pre-existing health condition, even if you don’t currently have coverage
- No annual or lifetime limits on coverage
- Allows young adults to stay on their parents’ health care plan until age 26

ACA Increases Access to Subsidized Private Insurance through new Marketplaces

- Consumer-friendly Marketplaces to compare plans based on cost and coverage and to purchase insurance
- Marketplaces must include patient-centered outreach and navigation programs to assist consumers in finding the right coverage – “No wrong door”
- Plans can’t charge higher premium based on health status or gender
- Plans must include Essential Health Benefits and essential community providers, including Ryan White providers
- Federal subsidies with income between 100-400% FPL
  - (Up to $46,680 for an individual/$95,400 for family of four)
Impact of ACA Private Insurance Reforms on Immigrants

- Undocumented adults and children are not eligible for subsidies in the Marketplace; they are even barred from purchasing unsubsidized coverage through the exchanges
  - The ACA provides no increased access to private health insurance for undocumented adults and children

- Qualified non-citizens (legal immigrants, if you will) are eligible for exchange subsidies, regardless of how long they have been in the U.S and their access to the exchanges and available subsidies are the same as for citizens
  - this represents a substantial increase in the affordability of insurance for low and moderate income immigrants

State Decisions for Creating Insurance Marketplaces
(As of March 26, 2014)

Essential Health Benefits Package Addresses Many HIV and HCV Health Care Needs

- Ambulatory services
- Emergency services
- Hospitalization
- Maternity/newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services

Ryan White Program (RWP) Needed to Address Gaps in Coverage: Core RWP Services vs. EHB

### Ryan White Core Services
- Ambulatory and outpatient care
- AIDS pharmaceutical assistance
- Mental health services
- Substance abuse outpatient care
  - Home health care
  - Medical nutrition therapy
  - Hospice services
  - Home and community-based health services
  - Medical case management, including treatment adherence services
  - Oral health care (not an EHB)

### ACA "Essential Health Benefits"
- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Red = covered by both ACA and RWP
Black = covered by ACA only
Blue = covered by RWP only
RWP Needed to Address Gaps in Affordability

- Even with ACA private insurance premium credits and subsidies the costs are too high for many people with HIV and HCV

**At 100% FPL ($11,670) = ~ $2,500 for a single individual**

<table>
<thead>
<tr>
<th>INCOME</th>
<th>PREMIUM (% of income)</th>
<th>COST SHARING</th>
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<td>$2,250 single/ $4,500 family of 4</td>
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<tr>
<td>200-250% FPL</td>
<td>6.3-8.05%</td>
<td>$5,200 single/ $10,300 family of 4</td>
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</table>

ACA Increases Access to Medicare Drug Coverage & Preventive Services

- Part D “donut hole” phased-out by 2020
- 50% discount on all brand-name prescription drugs
- ADAP Counts toward TrOOP
Standard Medicare Prescription Drug Benefit, 2020
Before and After Health Reform

Before Health Reform
- Enrollee pays 5%
- 15% paid by plan; 80% paid by Medicare
- The Donut Hole: 100% paid by enrollee
- Initial coverage limit: 25% paid by enrollee
- Catastrophic coverage: 75% paid by plan
- Deductible: 100% paid by enrollee

After Health Reform (2020)
- Enrollee pays 5%
- 15% paid by plan; 80% paid by Medicare
- Brands: 50% discount
- Generics: 75% paid by plan
- Coverage gap: 25% paid by enrollee
- Initial coverage limit: 25% paid by enrollee
- Deductible: 100% paid by enrollee

Source: Kaiser Family Foundation illustration of standard Medicare drug benefit in 2020 under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

ACA Creates An Opportunity to Expand and Improve Medicaid
(Optional Based on Supreme Court Decision)

- Expands Eligibility to Medicaid by eliminating the disability requirement for those with income up to 138% FPL (~$16,105 for an individual/~$32,913 for family of four)
  - Every low-income U.S. citizen and legal immigrant (after 5 years in U.S.) is now automatically eligible
- Federal government pays 100% through 2016 and then 90%
- Includes Essential Health Benefits
- Based on Supreme Court decision federal government can’t withhold all federal Medicaid funds if states refuse to implement Medicaid expansion

Medicaid expansion is optional and will be decided state-by-state
Status of State Decisions to Expand Medicaid

- 27 (26 states plus DC) moving forward with Medicaid expansion (NH recent addition)
- 26 states participated in Medicaid’s first year (1966)
- Three states are expanding under waivers (AR, IA, MI)
- Two states are pursuing waivers (IN, PA)
- Active expansion debate in others (MO, UT, VA)


The Importance of Medicaid Expansion for Ensuring Health Care Coverage of People with HIV

Figure 5
Health Insurance Coverage Options Under the ACA for Uninsured Adults with HIV in Care

All States Expand Medicaid
- Medicaid 57% (46,310)
- Subsidized Marketplace 39% (33,200)
- >400% FPL Unsubsidized Marketplace 4% (3,120)

Total = 69,720

26 States Expand Medicaid
- Medicaid 82% (25,400)
- Subsidized Marketplace 15% (3,140)
- >400% FPL Unsubsidized Marketplace 3% (940)

Total = 69,720

RWP Essential for Low-income, Uninsured People Left Outside of Medicaid Expansion and Other ACA Reforms

- In addition to addressing gaps in care and affordability, the RWP will remain the primary health care program for ~18,000 low-income people with HIV in non-Medicaid expansion states (as well as those living with HCV and other chronic health conditions)

- Also, lawfully residing low-income immigrant adults who have been in the country five years or less remain ineligible for Medicaid coverage

- ACA makes no progress in providing health care to undocumented immigrants as they remain ineligible for Medicaid and for Marketplace private health insurance

ACA Includes Other Medicaid Improvements: Supports Primary Care Providers, Medicaid Health Home, and Free Preventive Services

- Improves reimbursement rates for primary care providers (up to Medicare reimbursement rate) for 2013 and 2014

- Gives state the **option** to provide free preventive services in traditional Medicaid program (mandatory for Marketplace plans and Medicaid expansion; by secretary approval for Medicare)

- Gives states the **option** to provide cost-effective, coordinated and enhanced care and services to people living with chronic medical conditions through Medicaid Health Home Program*

* HIV and HCV not on original list of covered chronic health conditions, but now on the list as a result of successful advocacy
Spotlight on NY:
Opting Into Medicaid Free Preventive Care

- NY was among the first three states to expand their Medicaid coverage of preventive services
- By agreeing to cover all services graded A or B by the U.S. Preventive Services Task, NY receives a one percent increase in the matching rate that CMS contributes to their Medicaid program to pay for those services
- The new program makes approximately 5.5 million Medicaid beneficiaries in NY eligible to receive free preventive services

Free Preventive Services Include Broad–Based Screening Related to Sexual Health & Disease Prevention

- STI prevention counseling (high risk adults only; sexually active adolescents)
- Herpes vaccination (all adults)
- HPV vaccination (all women)
- Syphilis screening (high risk adults and pregnant women)
- HIV screening (one time for age 15-65; more often for those at risk)
- Hepatitis C screening (for high risk adults and baby-boomers)
- Hepatitis B Screening (pregnant women)
- Chlamydia screening (young and high risk women)
- Gonorrhea screening (high risk and pregnant women)
- Gonorrhea preventive Rx (all newborns)
- HPV DNA testing (30+ women)
- Tobacco cessation counseling

Additional Free Preventive Care for Women

- Well-woman visits
- Gestational diabetes screening
- Cervical cancer screening
- Cervical dysplasia screening (sexually active adolescents)
- Mammography every 1-2 years (age 40+)
- BRCA screening and counseling (high risk)
- Breast cancer chemoprevention counseling (high risk)
- Anemia screening (pregnant women)
- Urinary tract infection screening (pregnant women)
- RH incompatibility screening (pregnant women)
- Folic acid supplements (women who may become pregnant)
- Breastfeeding support, supplies, and counseling
- Domestic violence screening and counseling
- FDA-approved contraception methods and contraceptive counseling
- Vasectomies are not covered

Note: A religious employer is not obligated to provide contraceptive care; instead the insurance company is required to offer it to her.

Supports Enhanced & Coordinated Care Through Medicaid Health Home Program

- Gives states the option to provide cost-effective, coordinated and enhanced care and services to people living with chronic medical conditions*
- States are eligible for planning grants and increased federal support – 90% FMAP for first two years of the program
- Goals are to reduce inpatient and emergency room costs while improving health outcomes through both enhanced care coordination and service integration
  - high intensity care/service management, integrated physical and behavioral health services, health promotion, patient and family support, and prioritized housing

* Successful advocacy led to inclusion of people living with HIV/AIDS and HCV
Spotlight:
New York’s Medicaid Health Home Program

• New York was one of the first states to take advantage of the Medicaid Health Home option, and include all individuals living with HIV on Medicaid

• The program is a work in process - as among other issues, the process of identifying eligible individuals and contracting with community-based providers has been challenging

• But, the bottom line is that NY is taking steps towards integrating HIV care models of whole person care into larger healthcare infrastructures, and taking advantage of increased federal reimbursement for essential case management and care coordination services

Spotlight:
New York’s Basic Health Plan

• NY will be among the first states to implement a Basic Health Plan (BHP)

• Starting in 2015, BHP will provide more affordable coverage for low-income individuals and families with income between 133-200% FPL

• BHP can help to smooth transitions for those with incomes between 133-200% FPL, where incomes are most volatile, by establishing a health plan that builds off of the state’s Family Health Plus program and Medicaid expansion program

• Attractive as more affordable option for low-income individuals than Marketplace coverage; limits “churning” between Medicaid and Marketplace; and allows use of federal funds for legal immigrants and a higher federal match for people currently enrolled in Medicaid waiver

Recent NY studies predict BHP will promote access to insurance, increase continuity of care, and result in savings of $954 million to state

See CMS, Basic Health Program Final Rule, 79 FR 14111, March 12, 2014
Spotlight: New York Medicaid’s Supportive Housing & Food and Nutrition Services Initiatives

- The Supportive Housing Initiative
  - Capital investments for construction of new supportive housing units
  - Rental subsidies and service supports
  - Health Homes Supportive Housing Pilot

- The Food and Nutrition Services Initiative
  - Nutritional counseling and home-delivered meals through Managed Care and Long-Term Care Plans (MLTCs)

*Great examples of a state Medicaid program addressing social determinants of health by integrating housing and food/nutrition services into larger coordinated health care efforts!*

ACA Includes Strong Overarching Anti-Discrimination Provisions

- ACA prohibits discrimination based upon race, color, national origin, disability, age, sex, sexual orientation, or gender identity

- Cannot be denied participation in, denied benefits of, or be subjected to discrimination in the provision of health care under any health program or activity established under the ACA

- Plans cannot be designed in a way that discourages enrollment by people living with HIV and other chronic illnesses

*The good news:* Includes strong anti-discrimination language

*The bad news:* Increasing state flexibility undermines strong, fair federal standards and leaves enforcement of protections to states and relatively unclear grievance processes
Challenges in New Health Insurance Plans: Systemic Issues with Enrollment and Access to Benefits

Transparency
• Lack of transparency with respect to formularies and mail-order/specialty pharmacy requirements

Coverage
• Random exclusions of HIV medications and inadequate coverage of single-tablet regimens tablets (STRs)

Cost/Affordability
• Placing all HIV/AIDS drugs on the highest cost-sharing tiers
• QHPs and employer-based plans refusing to accept third-party payments from Ryan White Programs/ADAPs

Challenges Due to Lack of Transparency on Marketplace

• ACA transparency rules must ensure the ability of consumers to review plans, compare them and make informed decisions. However, several trends undermine transparency objectives:
  – Inadequate Drug Coverage or Essential Provider Information on Plan Website
  – Failure to Include Adequate Information as to the Cost of Covered Medications on Plan Website
  – Lack of Standardization of Plan Formulary Information
  – Inconsistencies between Marketplace and Insurer Websites
  – Changing Plan Design and Cost-Sharing Subsequent to Enrollment
Formulary Accessibility: Average Scores of Analyzed Plans by State

PLAN FORMULARY ACCESSIBILITY, AVERAGE PLAN SCORE FOR FEDERAL AND STATE EXCHANGE STATES

<table>
<thead>
<tr>
<th>State</th>
<th>Average Score</th>
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<td>RI</td>
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<tr>
<td>WA</td>
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Methodological note: In order to quantify a state average, Avalere graded plans with no available formularies with a score of “10”.
* Analyzed Federally-Facilitated Marketplace states. FFMs states also denoted in red.
** Note that, in each state, we analyzed a total of five plans offered by the number of different carriers shown below each state on the graph.

Provider Directory Accessibility: Average Scores of Analyzed Plans by State

PROVIDER DIRECTORY ACCESSIBILITY, AVERAGE PLAN SCORE FOR FEDERAL AND STATE EXCHANGE STATES

<table>
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* Analyzed Federally-Facilitated Marketplace states. FFMs states also denoted in red.
** Note that, in each state, we analyzed a total of five plans offered by the number of different carriers shown below each state on the graph.
**Recommendations for Addressing Transparency**

- Require all Marketplace plans to provide complete, accurate and accessible formulary information in a standard format, including the actual out-of-pocket costs that will be imposed on enrollees
- Limit the ability of plans to change benefits and costs after close of open enrollment period
- Allow beneficiaries to change plans under the “qualifying event” provisions if coverage or costs change in such a way as to deny access to care and treatment needed

**Challenges Related to Coverage**

- Despite early advocacy efforts, we continue to see plans that do not cover HIV medications including single tablet regimens (STRs)
  - Plans in many states seem to be covering fewer Protease Inhibitors than required by EHB
  - 28% of all HIV drugs not covered*
  - 19% of single tablet regimens (STRs) not covered*
- There is also evidence of increased use of utilization management techniques such as prior authorization and step therapy, which reduce access to needed medications

*Based on an assessment of 15 states QHPs conducted by Avalere
Recommendation for Addressing Coverage

- Amend the Essential Health Benefits (EHB) rule to require coverage of specialty drugs (where no generic alternative exists) that are widely accepted in treatment guidelines or best practices
  - For example, this would require coverage of all HIV antiretroviral drugs, including fixed-dose combinations and single tablet regimens, in accordance with the federal HIV treatment guidelines
- Promulgate regulations defining the protections provided under the non-discrimination provisions to ensure that design of formularies and utilization management do not discriminate against people living with HIV, HCV and other chronic health conditions

Challenges Related to Cost of Medications

- Some Marketplace insurance plans have refused to accept 3rd party payments that are used to help cover costs of coverage
- Many plans are placing all HIV medications on formulary tiers with very high levels of cost-sharing
  - 50% of HIV/AIDS drugs covered on plans eligible for tax credits and subsidies in Marketplaces are subject to an average of 36% co-insurance
  - Some plans are placing all HIV and HCV medications on 50% co-insurance
Recommendations for Addressing Cost of Medications

- Clarify that all Marketplace insurance plans must accept public and private co-payment assistance for brand name medications without a generic equivalent

- Amend the EHB rule to prohibit excessive coinsurance for specialty drugs (where no generic equivalent exists) that are widely accepted in treatment guidelines or best practices

When You See Discrimination Related to Transparency, Coverage, Cost or Any Other Issue: SPEAK UP!!!

- A team of national and state partners has established “SPEAK UP” to monitor, assess and document barriers to HIV care

- Through SPEAK UP we see patterns of discrimination emerging that need to be addressed, educate state and federal officials about what’s happening on the ground, advocate for change, and report back to the community

- We need to help inform and shape state and federal policy to ensure the needs of people living with HIV are addressed as the ACA is implemented

To SPEAK UP, visit:
http://www.hivhealthreform.org/speakup/
Action Needed to Ensure Success:

Step 1: Evaluate Initial Open Enrollment & Plan for October 2014

• What was successful in initial open enrollment and what needs to be done differently this fall?
• Transparency in Qualified Health Plans:
  o Were clients able to see which providers were included in plan networks?
  o Formularies:
    • Were plan formularies clear and accessible, and inclusive of HIV medications?
    • Did formularies include the cost of the drugs so that enrollees could calculate any co-insurance requirements?
    • Were all HIV medications on the highest cost-sharing tiers?
• State departments of insurance and marketplaces need to hear from you!

Action Needed to Ensure Success:

Step 2. Monitor ACA Implementation and Access to Care

Many individuals living with HIV gained access to new health insurance coverage, but are they able to access the care and treatment services they need?

• We must monitor potential discrimination:
  o Provider networks - have HIV providers been included?
  o Plan formularies - are they covering all necessary medications?
  o Affordability:
    • Are all HIV medications on the highest cost-sharing tiers?
    • Are premiums and cost-sharing really affordable?
  o Utilization management: are plans implementing excessive prior-authorization, step-therapy or other barriers?
  o Are appeal processes working?
  o Have there been disruptions in care as a result?

• Again, report problems to SPEAK UP and state insurance departments need to hear from you!
Step 3: Get Involved in Ryan White Planning & Advocacy

- Advocate that it is premature to discuss cost-offsets or destabilization of HIV care and disease management services
- Work to position Ryan White to cover services not offered or to address service limitations under new care delivery systems
- Plan to provide insurance premium and co-pay assistance
- Plan to assist populations left out of health reform
- In short, plan to realign the Ryan White Program and to advocate for ongoing funding and support

Resources

- [www.hivhealthreform.org](http://www.hivhealthreform.org)
- [www.statereforum.org](http://www.statereforum.org)
- Center for Budget and Policy Priorities - [www.cbpp.org](http://www.cbpp.org)
- Center for Health Law and Policy Innovation - [www.chlpi.org](http://www.chlpi.org)
- Families USA - [www.familiesusa.org](http://www.familiesusa.org)
- National Health Law Program – [www.nhelp.org](http://www.nhelp.org)