Health Care Reform:
What Ryan White Grantees Need to Know

Ryan White HIV/AIDS
All Grantee Meeting

August 24, 2010, 8:30 am

Washington, DC

What's Ahead

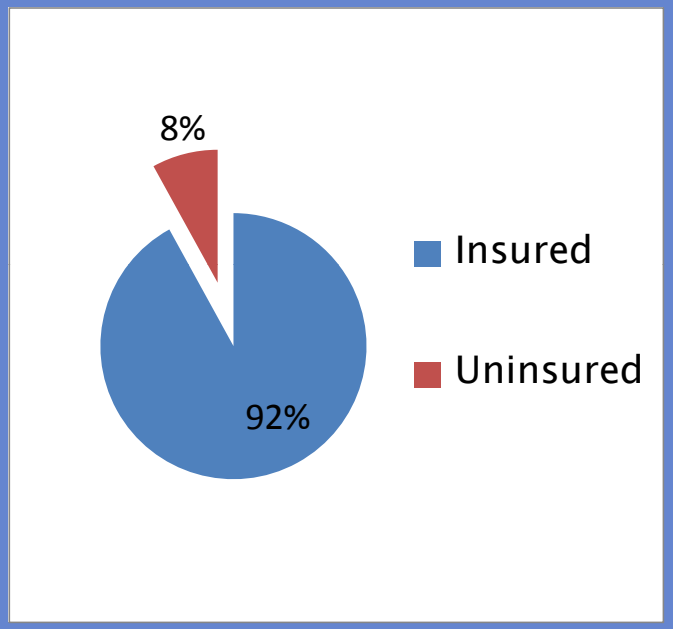
- Overview of Key Health Coverage Expansion Components
- Ryan White and Health Reform: Preparing for 2014 and Beyond
- Case Examples: What It Means to People with HIV

Overview of Key Health Coverage Expansion Components

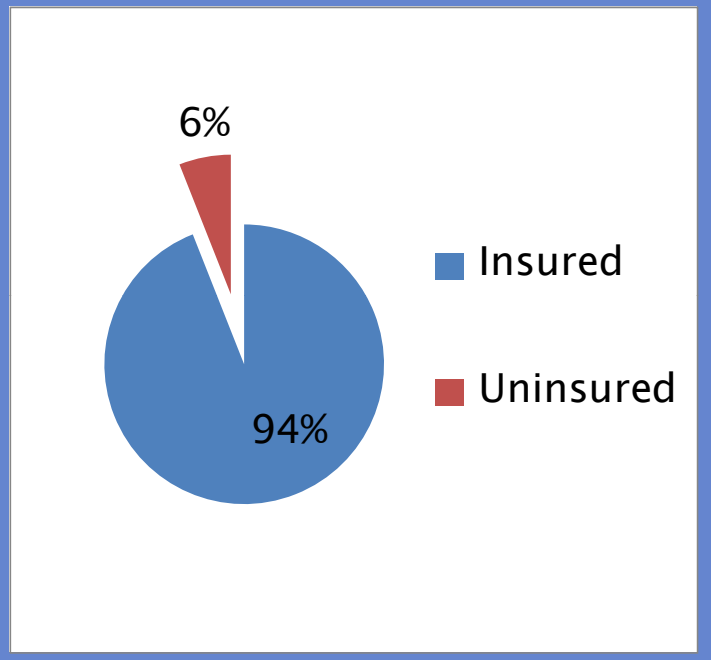
What Does the Affordable Care Act Do?

- Establishes a mandate that all U.S. Citizens and legal residents maintain health insurance coverage
  - Provides subsidies to help low income people maintain coverage and hardship exemptions
- Legislation makes significant changes/improvements to major components of our health care system:
  - Private Health Insurance
  - Medicaid
  - Medicare
- Elements phased in over the next ten years
- Coverage expansion largely begins in 2014

Extent of Coverage Expansion When Fully Implemented



Insurance Coverage All Residents by 2019



Insurance Coverage Excluding Unauthorized Immigrants by 2019

Reducing the Uninsured

Estimated 32 Million will gain coverage by 2019

Medicaid: 16 million
Income Under 133% FPL

Exchange: 24 million
Income above 133% FPL

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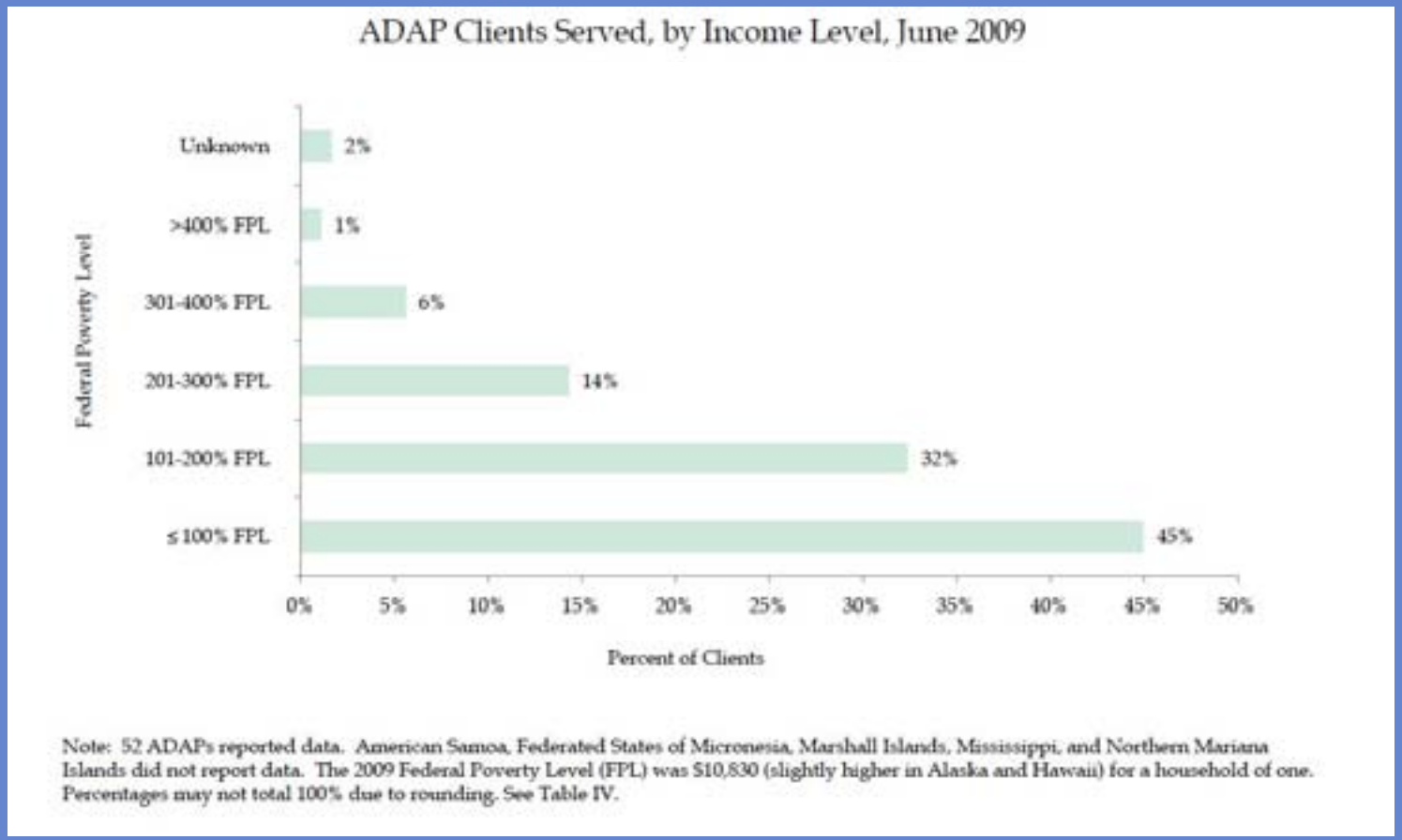
ADAP Clients Served, by Income Level, June 2009



Note: 52 ADAPs reported data. American Samoa, Federated States of Micronesia, Marshall Islands, Mississippi, and Northern Mariana Islands did not report data. The 2009 Federal Poverty Level (FPL) was $10,830 (slightly higher in Alaska and Hawaii) for a household of one. Percentages may not total 100% due to rounding. See Table IV.

Medicaid Improvements

- Expanded to all under 65 with incomes up to 133% FPL ($14,400) in 2014
  - Uniform minimum eligibility threshold across states
- State option beginning April 2010 to expand coverage
  - Connecticut
- Federal funding for Medicaid expansion begins 2014
  - 100% initially then decreasing to 90% in 2020 and beyond
- Improve coordination for duals through demos and a dedicated office at CMS
- Increases reimbursement rates to primary care providers to Medicare levels for 2013 and 2014 only

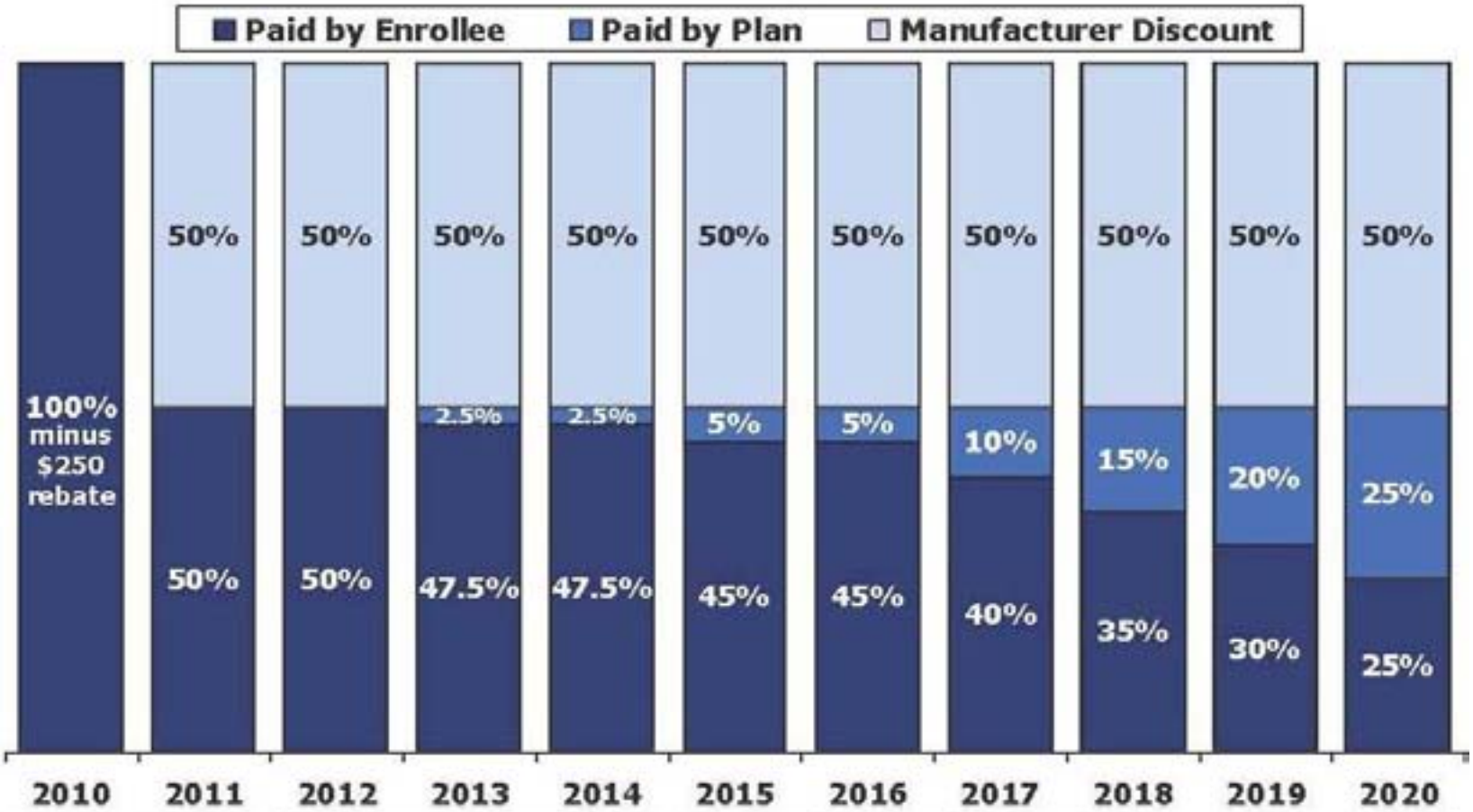
Medicaid Expansion Limitations

- No Early Treatment for HIV Act expansion
- Medicaid's 5-year exclusion on legal immigrants continues
- Increase in provider reimbursement rates limited and temporary (2013 -14)
- Full federal support for Medicaid expansion is temporary
- No new mandatory minimum benefits package for Medicaid
- States may opt to provide a more limited benefits package to expansion population

Medicare Part D: Improvements

- 2010: $250 rebate paid to individuals who enter the "Donut Hole"
- 2011: ADAP counts towards Medicare Part D "TrOOP" (the expenditure that moves a person through the donut hole)
  - 16% of ADAP clients or 17,000 clients (NASTAD)
- 2011-2019: Coverage gap gradually closed starting with 50% reduction in cost of on-formulary brand name drugs during "donut hole" with 100% of cost counting towards TrOOP
- 2020: Coverage gap closed but standard cost sharing will apply (25% co-pay on average)

Cost Sharing for Brand-Name Drugs in the Medicare Part D Coverage Gap, 2010-2020



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

Medicare Program Improvements

- Improved prevention coverage
  - 2011 – no cost sharing for A and B USPSTF preventive services
    - Covered: Targeted High Risk HIV Testing & Pregnant Women
    - See: http://www.ahrq.gov/clinic/uspstfix.htm
  - Coverage of annual personalized Medicare prevention plan
- Creates new office to better coordinate services for dually eligible individuals (Medicaid/Medicare)
- 2 year waiting period continues
- No major coverage expansion

Insurance Exchanges: Key Features

- Centralized, state-based marketplaces to purchase insurance
- Goal is to create healthy market competition
  - Better benefits package/coverage
  - Lower costs passed on to consumer
- Established with federal funds and must meet national standards

What It Means

- Open to individuals and small group employers with income over 133% FPL to purchase insurance
- More affordable and better coverage options for individuals without group coverage
- Federal premium and cost-sharing subsidies for individuals with incomes133% - 400% FPL
  - Around $19,000 to $57,616/per year for an individual based on 2010 federal poverty level

The Exchange: New Rules

- Bars discrimination based on health status
  - no longer permitted to deny coverage based on health history
  - not permitted to increase costs based on health history or gender and increases for age limited
- Establishes minimum “essential” benefit requirements
- Caps out of pocket costs for individuals and families

Essential Benefits Package

- 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

Medicaid and Insurance Exchanges: Undocumented Immigrants Left Out

- Exempt from individual mandate
  - not allowed to purchase private health insurance in the exchange
  - not eligible for subsidy
  - not eligible for Medicare
  - not eligible for non-emergency Medicaid
- Remain eligible for restricted “emergency” Medicaid
- Remain eligible for services through community health centers and/or safety net providers

Improvements to Group Insurance Coverage: 2010

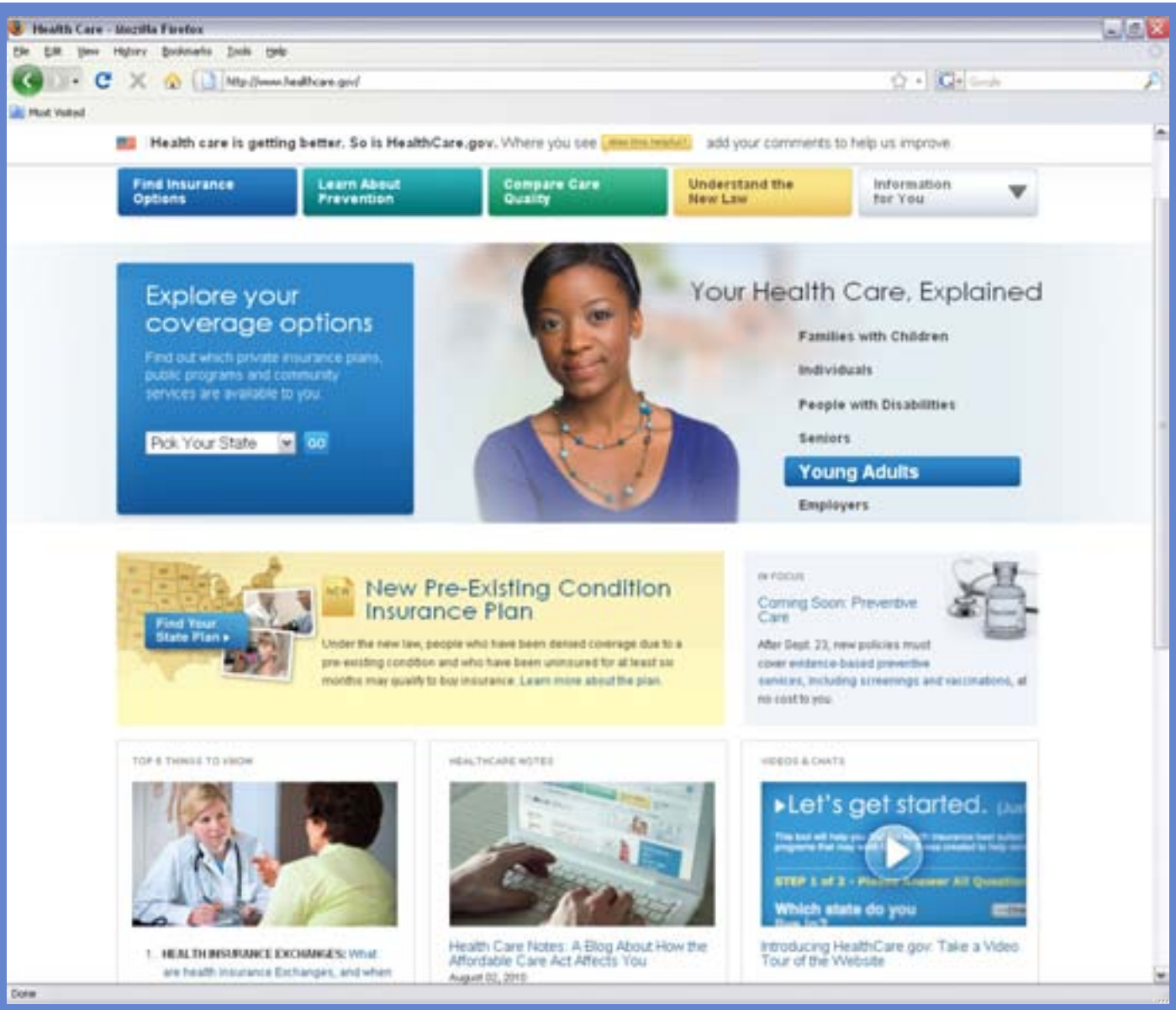
- Eliminates discrimination based on health status for children (Adults in 2014)
- Encourages employers to provide insurance coverage (small business tax credits)
- Extends dependant coverage to age 26
- Eliminates lifetime insurance caps on policies and plan rescissions
- Limits annual coverage limits to Secretary approval
- Requires new plans to cover preventive services (USPSTF – Grade A or B) with no cost sharing
- Establishes a temporary national high-risk insurance pool to cover the uninsured with pre-existing conditions (more later)

Pre-existing Condition Insurance Plan Program

- Also known as the temporary high risk pool programs
- Eligible if have a pre-existing condition and have not had creditable coverage during the previous 6 months
- $5 billion for program starting July 2010 through January 2014 when other reforms begin
- Plan covers 65% of total costs – maximum cost-35% on average
- Premiums limited to “standard rate for standard population” in the state
  - Adjusted for age only by a factor of 4

Learn What's Available in Your State

- 31 state-run high risk pools
  - State flexibility to design within minimum federal standard
  - Can designate individuals with certain conditions as eligible
  - Enrollment starting this month
- 20 "Pre-Existing Condition Insurance Plans" (PCIP) run by OPM for the "federal fallback states"
  - Individual must have written documentation of insurer rejection or denial of services related to pre-existing conditions
  - Enrollment started July; coverage started this month
- States can cap enrollment
- Will Ryan White assist with enrollment and wrap around?



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Expanded Role for Community Health Centers

- CHCs receiving $11 billion over next 5 years
- $9.5 billion is targeted to:
  - Create new CHCs in medically underserved areas
  - Expand preventive and primary health care services, including oral and behavioral health, pharmacy and enabling services at existing CHCs
- $1.5 billion for major construction and renovations
- Increased funding will allow an additional 20 million people to be seen by CHCs
- FQHC continue to receive prospective, cost-based Medicaid payments; implementing prospective Medicare payments (2014)
- Presents an opportunity to build HIV capacity at CHCs

Public Health and Prevention

- Prevention and Public Health Fund
  - $500 million in FY10 growing up to $2 billion in FY15
  - Will be $750 million in FY11
  - In FY10, $250 million for increasing the number of primary care providers
  - In FY10, $250 million for traditional prevention and public health activities
    - $126 million for Community and Clinical Prevention
      - **$30 million for HIV prevention**
    - $70 million for public health infrastructure
      - $20 million for Epi and Lab Capacity grants
    - $31 million for research and tracking
      - Surveillance, CPSTF, USPSTF
    - $23 million for public health training
      - PH workforce and PH training centers

Ryan White and Health Care Reform: Preparing for 2014 and Beyond

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National HIV/AIDS Strategy: Ryan White Will Still be Needed

"Gaps in essential care and services for people living with HV will continue to need to be addressed along with the unique biological, psychological and social effects of living with HIV. Therefore, the Ryan White HIV/AIDS Program and other Federal and State HIV-focused programs will continue to be necessary after the law is implemented."

National HIV/AIDS Strategy for the United States: July 2010 (page ix).

Patient-Centered Medical Home Care: Opportunities for Ryan White Programs

- State Medicaid plan option to allow Medicaid beneficiaries with 2 or more chronic conditions (to be defined) to designate a medical home – enhanced 90% FMAP for first two years
- Workforce training targeted to patient-centered medical home care and to physicians working with vulnerable populations, including HIV
- Community-based Collaborative Care Network: Grants from HHS to support consortiums of health providers to coordinate and integrate services (2011)
  - Possible $40 million in funding for medical home pilot
- Center for Medicare and Medicaid Innovations

Ryan White Programs: Opportunities for Contracting with the "Exchange" Plans

- Plans required to contracted with essential community providers, including "340B" programs, e.g., Ryan White-funded programs
- RW Programs be Prepared to:
  - Proactively engage with plans
  - Negotiate with plans
  - Build capacity to bill and respond to admin requirements of private plans

Role of Ryan White 2014 & Beyond

- Beginning in 2014 should see a shift of Ryan White patients to Medicaid & Private Plans
  - Ryan White can help facilitate and coordinate
- Fill medical and social service gaps left by Medicaid and exchange plan coverage, e.g., oral health care
- Assist with cost sharing
- Provide care and treatment to populations remain uninsured

Role of Ryan White 2014 & Beyond

FY11 Senate Appropriations Report Language:

- "The Committee expects HRSA to offer a plan for how to transition Ryan White benefits into a larger system of care so that Ryan White resources may be targeted to the areas of most need.
- The plan should include a year-by-year list of actions needed by the administration, the Congress and the States in order to ensure the smoothest possible transition for beneficiaries.
- The Committee expects the plan no later than 8 months after enactment of this act."

2013 Reauthorization of Ryan White

- Will have to defend future of the Ryan White Program in light of Health Reform before it is fully implemented
- Ryan White Working Group is developing a community process to address long-term
- Short-term working on Health Reform implementation & adequate funding for the entire Ryan White Program

Case Examples

Source:
Provided by Julie Cross, Benefits Consultant

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James

Current Profile: Uninsured

- Age 41
- Single, no children
- Unemployed Uninsured
- Income $220 mo county relief
- HIV Symptomatic
- Fatigue, weakness, chronic diarrhea, depression, anxiety
- Denied disability claim, SSI and Medicaid
- Health care through Ryan White funded public health clinic ADAP

2014 Health Care Reform: Medicaid Eligible

- Automatically eligible for Medicaid
- Eligibility based on income alone. Income under 133% FPL
- May need Ryan White support for services not covered under a Medicaid package

Vicky

Current Profile: Uninsured

- Age 42
- Single, one adult child
- Self-Employed, $20k
- Uninsured
- HIV Symptomatic
- Wasting syndrome, chronic sinusitis, fatigue, cardiac complications
- Community health clinic and ADAP. Unable to obtain two medications not on ADAP formulary.

2014 Health Care Reform: Private Insurance Eligible

- Eligible to purchase insurance through the insurance exchange
- Eligible for insurance subsidy (133%-400% FPL)
- Able to access medications through insurance
- Exchange rules will allow her to shop for a policy that meets her medication/health care needs RW support to pay premiums and out-of-pocket costs and get dental and vision care

Everardo

Current Profile: Uninsured

- Age 56
- Domestic Partner, No Children
- AIDS, Disabled
- SSDI $22K
- Medicare Eligible
- Enrolled in Part D drug plan. ADAP pays wrap-around costs
- Pays $300 month for non-ADAP formulary medications when stuck in donut hole 9mos year.

2014 Health Care Reform: Lower Part D Drug Costs

- Medicare eligibility will continue
- 2010: will receive $250 donut hole rebate
- 2011: ADAP will count towards TrOOP
- Everardo will not be stuck in the donut hole
- While he is in the donut hole he will receive a 50% discount on the brand name drugs he needs that aren't covered by ADAP
- His coverage will advance to the Part D catastrophic level
- Instead of paying 100% cost of drugs he will only be required to pay 5% or low co-pay.

Mario

Current Profile: Uninsured

- Age 51
- Married, one child
- Family is undocumented
- Uninsured, working part-time $15k
- AIDS, Disabled
- Community/RW Funded health clinic, ADAP.

2014 Health Care Reform: Uninsured

- Ineligible for Medicaid
- Ineligible for coverage through the insurance exchange/subsidy
- Exempt from insurance mandates
- Ongoing need for support through community health system and ADAP

Thank you!

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