Health Care Reform Update and Advocacy Priorities

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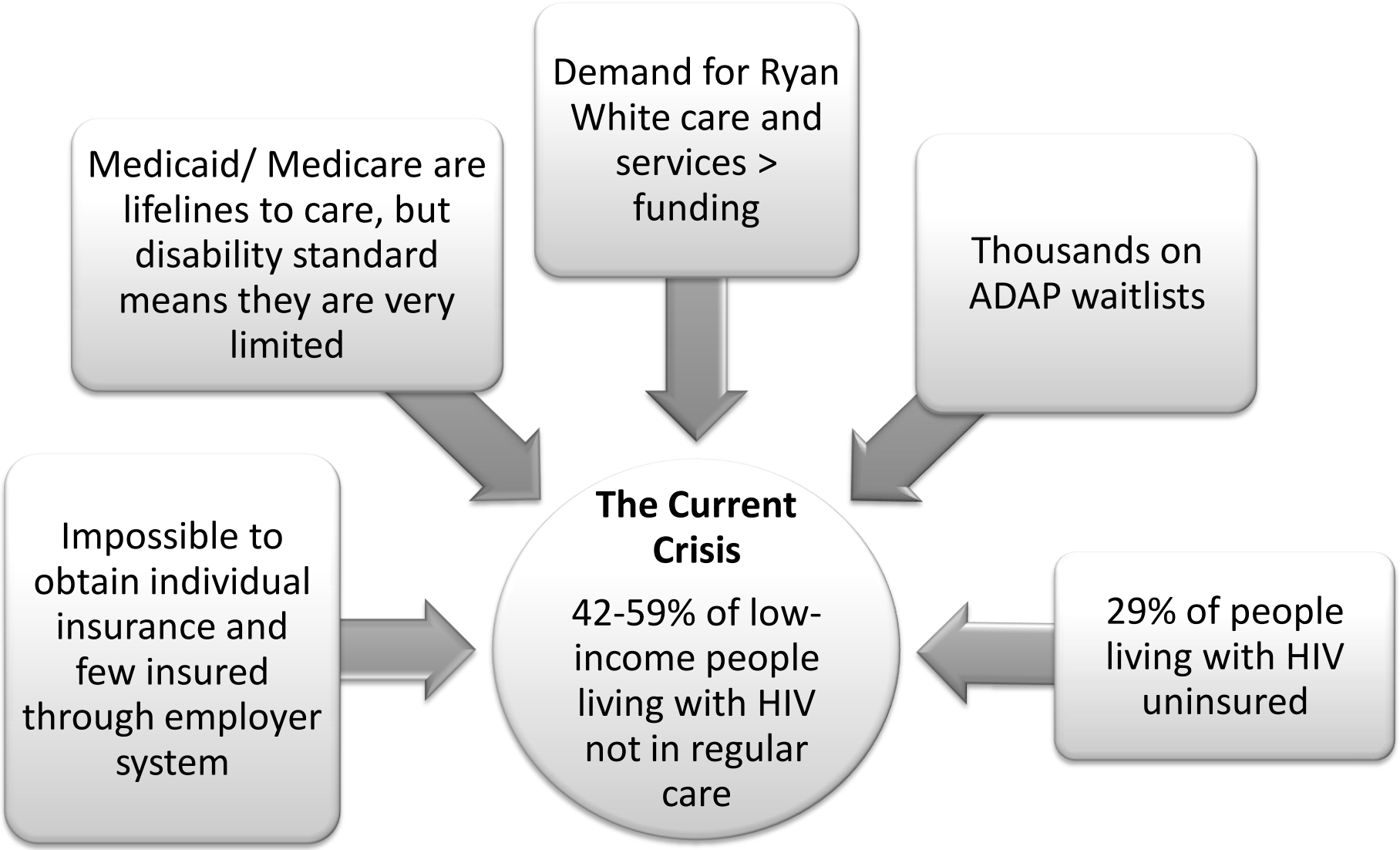
October 2012

PRESENTATION OUTLINE

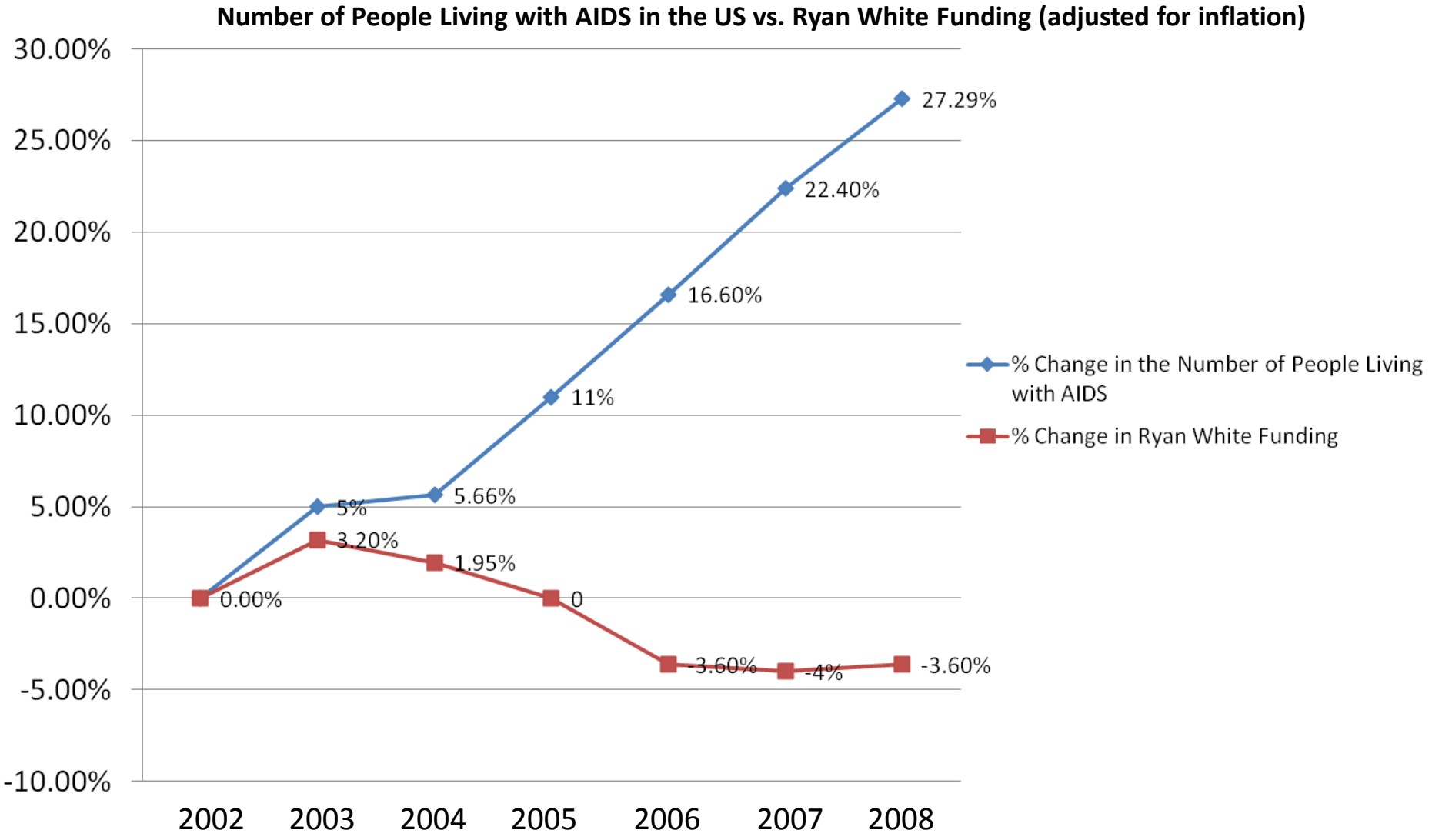
Successful Health Reforms Could End the HIV Epidemic in the U.S.

- Part 1: Massachusetts as a Case Study of Successful Health Reform Implementation
- Part 2: Key Advocacy Priorities for ACA, Medicaid and Ryan White Program
- Part 3: Steps for Ensuring the Ongoing Success of the Existing HIV/AIDS Infrastructure

Where We Are:
Status Quo = Access to Care Crisis



Ryan White Program Not Keeping Pace with Increased Need



Sources: "Estimated Number of Persons Living with AIDS," Centers for Disease Control and Prevention, http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2007report/table12.htm; Ryan White Appropriations History, Heath Resources and Services Administration, ftp://ftp.hrsa.gov/hab/fundinghis06.xls. Inflation calculated using http://www.usinflationcalculator.com; www.cdc.gov/hiv/surveillance/resources/reports/2009report/pdf/table16a.pdf; "Funding, FY2007-FY2010 Appropriations by Program, hab.hrsa.gov/reports/funding.html

Where We Are Going: Key ACA Reforms

Improves Medicaid: Expands eligibility (optional); provides essential health benefits (EHB) (varies by state); improves reimbursement for PCPs; includes health home (optional)

Creates Private Insurance Exchanges (varies by state): Provides subsidies up to 400%FPL, eliminates premiums based on health/gender, and includes EHB (varies by state)

Increases Access to Medicare Rx: 50% discount on brand-name drugs; "donut hole" phased-out; ADAP counts toward TrOOP

Reduces Discriminatory Private Insurance Practices: Eliminates pre-existing condition exclusions; lifetime and annual caps; promotes continuity of coverage

Invests in Prevention, Wellness, Workforce and Innovation: Creates Prevention and Public Health Fund; funds CHCs; provides free preventive services (optional for Medicaid)

Part 1:
Massachusetts as a Case Study of Successful Health Reform Implementation

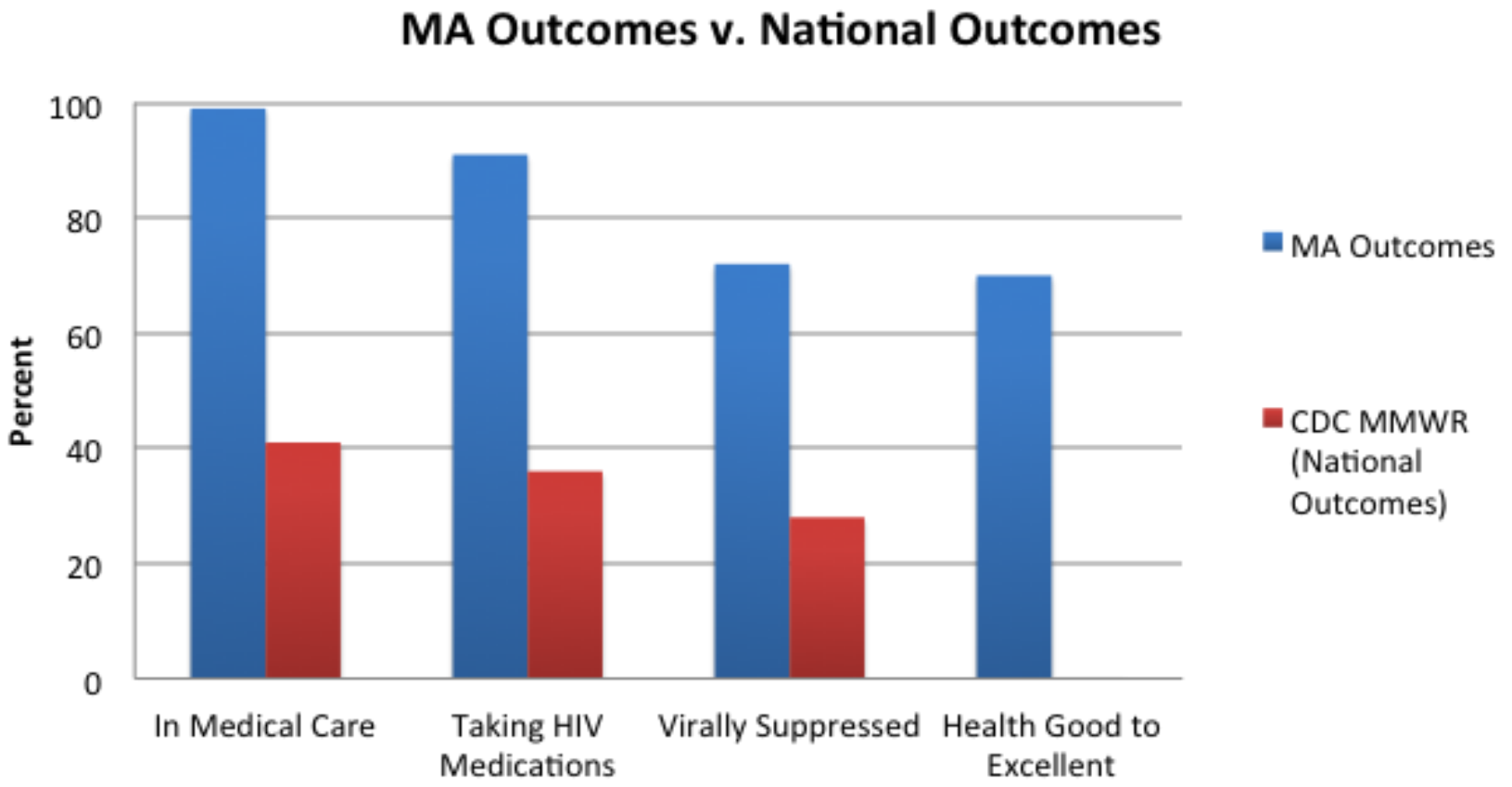
Massachusetts: A Post Health Care Reform State in a Pre-Reform Country

- Expanded Medicaid coverage to pre-disabled people living with HIV with an income up to 200% FPL (2001)
- Enacted private health insurance reform ("RomneyCare") with a heavily subsidized insurance plan for those with income up to 300% FPL (2006)
- More ADAP funding spent on insurance than on Rx, while maintaining unrestricted formulary and 500% FPL eligibility (2006)
- Waiver from Ryan White Program 75/25 rule supporting ability to provide necessary services (2007)

Massachusetts:
A Post Reform State's Utilization of ADAP

YEAR	Full Pay	Co-Pay	Premiums	Total Cost (including rebates)
FY02	$ 7,947,832	$ 648,030	$ 1,120,512	$ 9,716,375
FY03	$ 7,961,862	$ 963,205	$ 1,778,272	$ 10,703,342
FY04	**$11,174,879**	**$ 1,553,758**	**$ 3,159,200**	**$ 15,887,838**
FY05	$ 9,756,201	$ 1,839,807	$ 6,112,132	$ 17,708,142
FY06	$ 4,634,683	$ 1,893,206	$ 7,015,306	$ 13,543,197
FY07	$ 4,147,713	$ 2,071,118	$ 8,366,273	$ 14,585,106
FY08	$ 4,184,279	$ 2,083,431	$ 9,323,821	$ 15,591,533
FY09	**$ 4,695,780**	**$ 2,567,789**	**$ 8,835,835**	**$ 16,099,405**

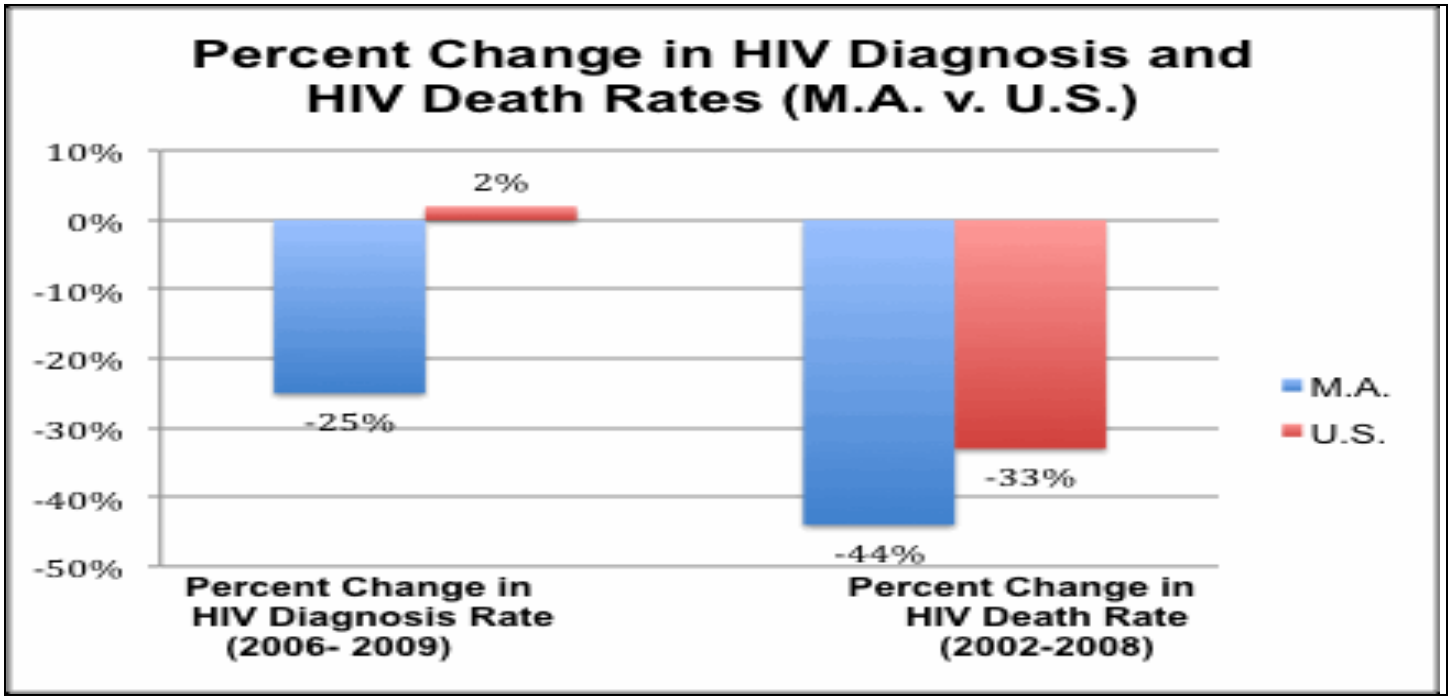
Massachusetts' Successful Reform Implementation Improves Health Outcomes and Meets NHAS Goals



Source: *Massachusetts and Southern New Hampshire HIV/AIDS Consumer Study Final Report*, December 2011, JSI Research and Training, Inc. Note: MA Outcomes N = 1,004

Source: Cohen, Stacy M., et. al., *Vital Signs: HIV Prevention Through Care and Treatment — United States*, CDC MMWR, 60(47);1618-1623 (December 2, 2011); Note: National Outcomes HIV-infected, N = 1,178,350; HIV-diagnosed, n=941,950

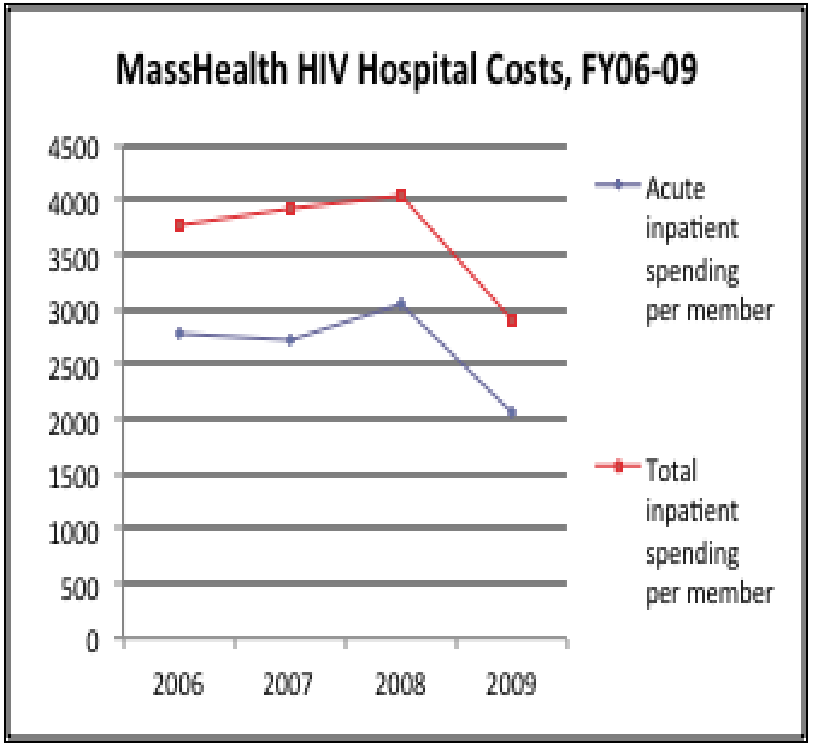
MA Reform Demonstrates Successful Implementation Reduces New Infections and AIDS Mortality

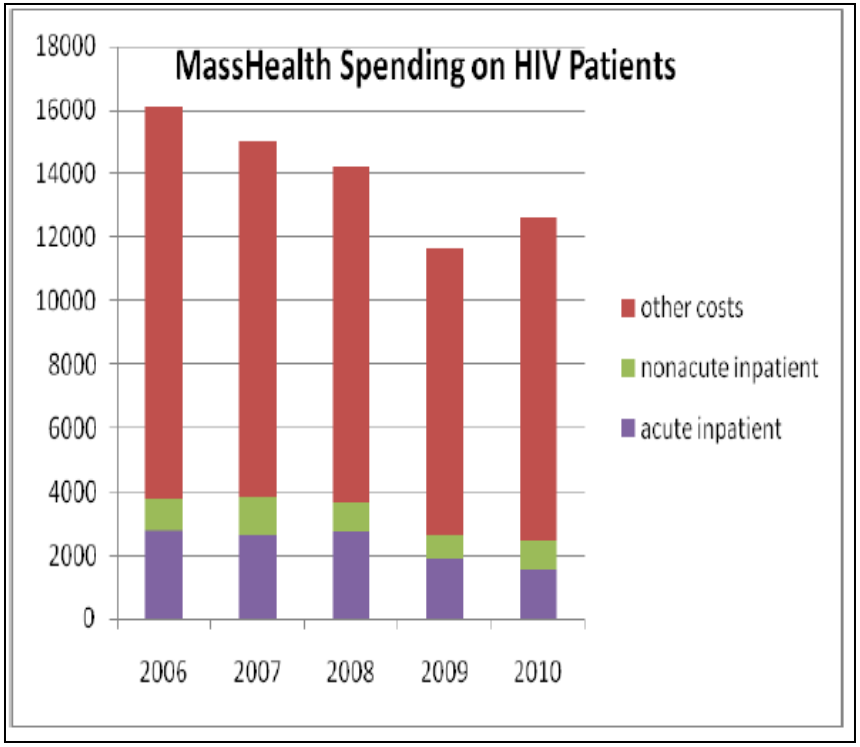


- Between 2006 & 2009, Massachusetts new HIV diagnoses rates fell by 25% compared to a 2% national increase
- Current MA new HIV diagnosis rates fell by more than 50%
- Between 2002 & 2008, Massachusetts AIDS mortality rates decreased by 44% compared to 33% nationally

Sources: *MA Dept of Public Health, Regional HIV/AIDS Epidemiologic Profile of Mass: 2011, Table 3; CDC, Diagnoses of HIV infection and AIDS in the United States and Dependent Areas, 2010, HIV Surveillance Report, Vol. 22, Table 1A; CDC, Diagnoses of HIV infection and AIDS in the United States and Dependent Areas, 2008, HIV Surveillance Report, Vol. 20, Table 1A.*

MA Reform Demonstrates Successful Implementation Reduces Costs





- Massachusetts cost per Medicaid beneficiary living with HIV has decreased, particularly the amount spent on inpatient hospital care
- Massachusetts DPH estimates reforms reduced HIV health care expenditures by ~$1.5 billion

Source: MA Office of Medicaid, data request

Part 2:
Key Priorities for Successful ACA Implementation

3 federal priorities: Strong ACA regulations, Medicaid, and RWP

+

3 state priorities: Medicaid Expansion, EHB, and State Exchanges

1. Full Federal Implementation of ACA

Overarching goals:

Transition of uninsured to uninterrupted, comprehensive care

Reduction of health disparities through strong national standards

Requires Strong Federal Regulations Addressing:

- Routine HIV testing (USPSTF) and linkage to care
- Comprehensive EHB for Medicaid and Exchanges
- Effective outreach and patient navigation, streamlined eligibility and enrollment, and access to essential community providers in Exchanges
- Anti-discrimination protections and enforceable appeals processes

ACA Statute Requires Strong Federal Oversight of Medicaid Expansion and Exchanges

ACA's Essential Health Benefits Mandates + **§ 1937 Benchmark Mandates** (applies to Medicaid) + **ACA Non-Discrimination Mandates**

= **<u>Regulations</u> that Ensure Medicaid and Exchanges Meet HIV Standard of Care**

Access to care, treatment and services that reflect national standards:

- Unlimited access to necessary medications
- Unlimited access to specialists
- Case management, care coordination, treatment adherence, & counseling
- Comprehensive mental health & substance abuse services
- Preventive & wellness services

Other Key Federal Obligations

Guidance to states:

- Expansion of Medicaid
- Medicaid, Exchanges, and RWP coordination
- Inclusion of AIDS service providers (including peers) as navigators for outreach, enrollment, and retention efforts

Technical Assistance:

- Fund ASOs to demonstrate commitment

Oversight:

- Streamlined HIV measures and reporting requirements (to monitor & manage the epidemic)

2. Medicaid: The Challenge of Proposed Federal Reforms

Spending caps	• Across-the-board caps and cuts
Block grant	• Restructure Medicaid so that federal government pays only a fixed dollar amount, with states responsible for all remaining costs
Federal Medicaid blended rate	• Replace mix of federal matching rates with one rate for each state
Repeal "Maintenance of Effort" Requirement	• Would allow states to restrict Medicaid eligibility or reduce enrollment

Impact: Shifting Medicaid Costs to States Threatens Access to HIV Care and Treatment

Currently, Medicaid is an entitlement program jointly funded by federal and state governments

(if you're eligible, you're in)

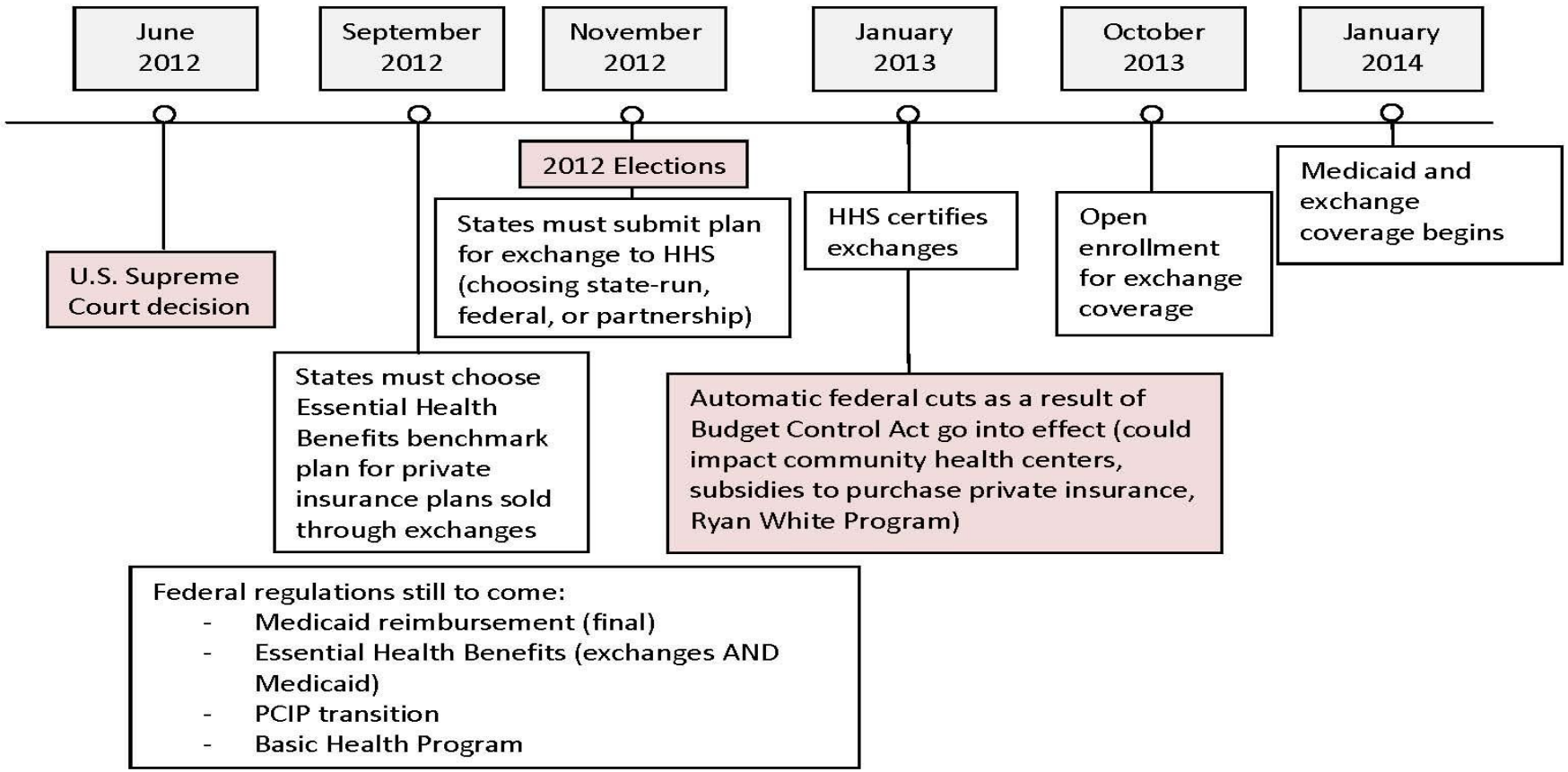
Capping federal spending for Medicaid will shift costs to already cash-strapped states

States will be unable to respond to increased need for services given current economic downturn, and would likely continue to cut services and eligibility

3. Ryan White Program Challenge: Need for Ongoing and Sufficient Funding

- Premature to discuss cost-offsets or destabilization of HIV care, treatment, and disease management services
- Ryan White will be essential even after full implementation of ACA (fill gaps in care, treatment, services, and affordability)
- Success in addressing HIV epidemic requires ongoing support of HIV-specific expertise and experience
- Post 2014, we need to evaluate ongoing ACA integration of HIV care, treatment and services and re-tool

State ACA Implementation



Source: Treatment Access Expansion Project, May 2012

1. ACA Medicaid Expansion Update

SCOTUS decisions turns the Medicaid expansion into a state-by-state advocacy issue

- CMS has said there is no deadline for states to opt in
  - But 100% federal match only applies 2014 to 2016
- States can opt out after expanding at any time
- States required to maintain eligibility & benefit levels until exchange is fully operational in 2014 ("MOE requirement")
- States are pushing for partial expansion (e.g., up to 100% FPL)
  - CMS has said it will not entertain such requests
- Many states will wait…until after the elections

Many Reasons to Opt In

- Federal government pays 100% of expansion costs for 2014-2016 and gradually reduced to 90% in 2020 and beyond
- Other reforms (e.g., DSH payment reductions) make it difficult not to expand because of the increased pressure on hospitals without increased revenue from insured patients
- Uptake may be slow, but states have generally come around to Medicaid and CHIP expansions

Will Texas want its residents' federal tax dollars supporting access to care in NY, CA and MA?

2. EHB Implementation Update

Federal guidance suggests (at least for private plans):

- Insurers may have flexibility to substitute scope and level of benefits as long as "actuarially" equivalent to benchmark plan
- Coverage of "one drug per class" could meet EHB Rx requirement
- Plans may have discretion over utilization management

Flexibility for most states likely means bare bones plans

No current mandate that EHB must meet standards of care for HIV

State variation and disparities continue

EHB will depend upon final federal regulations & state regulations to the extent the federal government falls short

Again, ACA Statute Requires Comprehensive EHB

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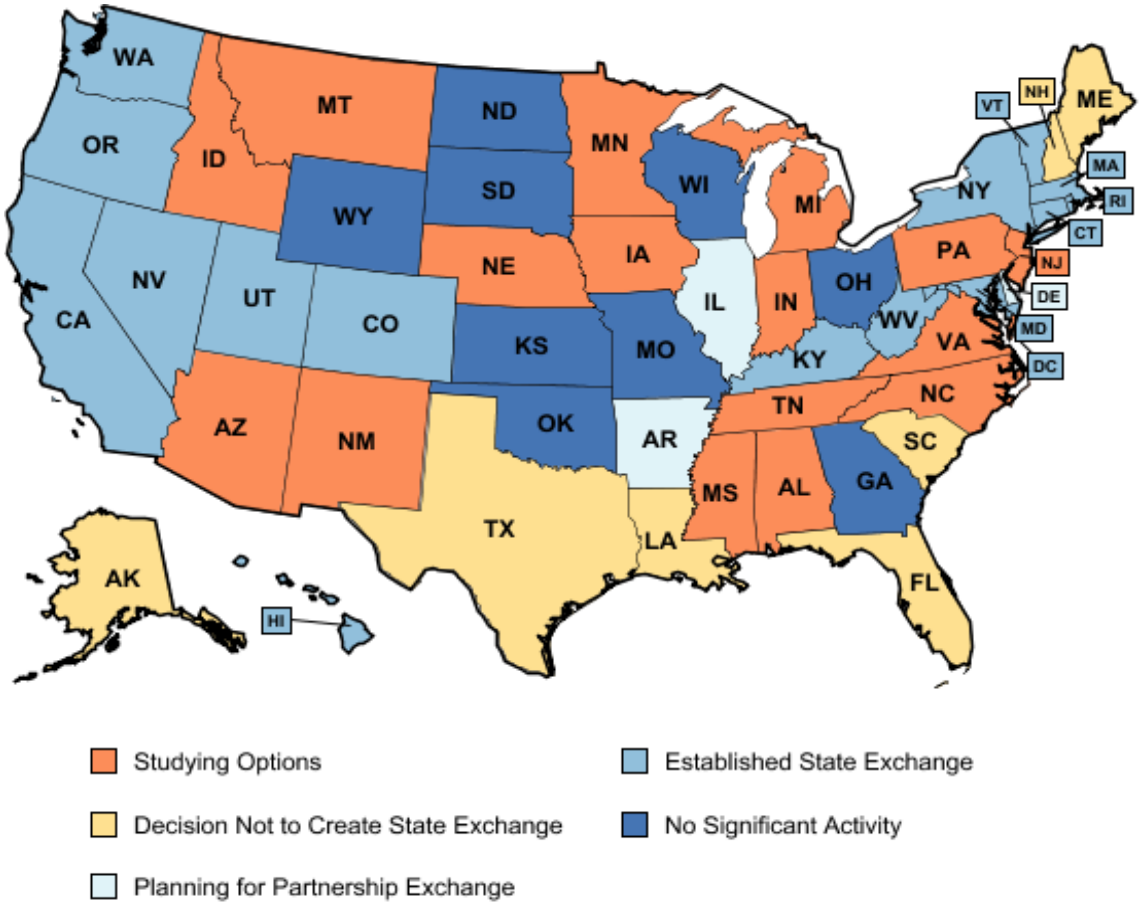
3. Exchange Update: Where the States Are



State Action Toward Creating Health Insurance Exchanges, as of August 1, 2012: Status of State Action

THE HENRY J. KAISER FAMILY FOUNDATION statehealthfacts.org
Your source for state health data

Ongoing Exchange Challenges

Difficulties in engaging in exchange process:

- HIV is small piece of larger planning issues
- The decision makers are state-specific
- Timeline is short as EHB by September; blue print by November

Successful strategies for involvement:

- State Ryan White all parts meetings to engage Medicaid and others on health reform
- Coalitions with other stakeholders

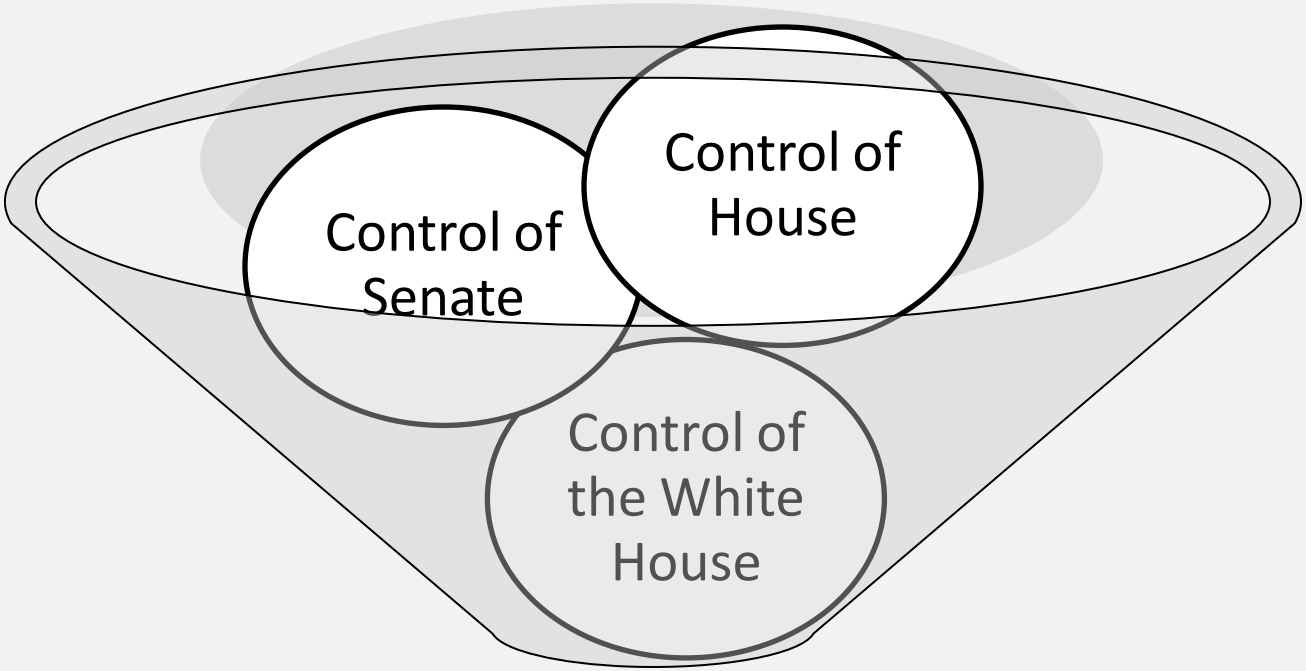
Ongoing Concerns:

- Outreach and enrollment, patient Navigator, provider network, payer of last resort compliance, and infrastructure to serve an insured population

Part 3:
Steps for Ensuring Ongoing Success

- **Advocate** for policies and programs that support your clients and your role in meeting essential care, treatment, and service needs
- **Integrate** with larger providers that have diverse portfolios of services and funding
- **Grow** to expand capacity/mission and decrease reliance on Ryan White Program that will likely not be able to provide sufficient ongoing support
- **Go** forward as is, but understand that overtime you may not be able to exist as a free-standing disease-specific organization without diversified services and funding

2012 Elections = Watershed for Health Reform



Will the ACA be fully implemented?

Will deficit reduction be achieved responsibly?

Will our health care safety nets (Medicaid, Medicare, Ryan White Program) be preserved?