The Affordable Care Act and Access to HIV/AIDS Treatment in Connecticut

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OBJECTIVES

1. Medicaid for Newly Eligibles
2. Maximizing Marketplace Enrollment for Low-income Individuals > 138% FPL
3. Identify and Report “Red Flags” in Marketplace or Medicaid Plans
4. Future of HOPWA and Ryan White Funding
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HUSKY D BENEFITS

- Preventive care
- Outpatient care
- Women’s healthcare
- Family planning services
- Maternity care
- Hospital stays
- Physical, occupational, speech therapy
- Audiology services
- Physical rehabilitation
- Dialysis
- Durable medical equipment
- Emergency Care
- Dental

- Hearing aids
- Orthotic and prosthetic devices
- Home health care
- Hospice services
- Ambulatory Surgery
- Hospital Outpatient Care
- Laboratory Tests
- X-rays / radiology
- Vision Care
- Smoking cessation (counseling & medications)
- Behavioral Health
- Pharmaceuticals
HUSKY COST-SHARING

None for HUSKY D enrollees (i.e., newly eligibles)

Prescription Drugs
• $4 preferred drugs
• $8 non-preferred drugs (<150% FPL)
• 20% for brand name drugs (>150% FPL)

Emergency Room Use
• $8 for unnecessary use of ER (<150% FPL)
• Unlimited (>150% FPL)

Outpatient Visits
• $4 (<100% FPL)
• 10% of visit (100-150% FPL)
• 20% of visit (>150% FPL)

Inpatient Stay
• $75 1st day (if <100% FPL)
• 10% of entire stay (100-150% FPL)
• 20% of entire stay (>150% FPL)

cost-sharing allowed by ACA – total cannot > 5% household income
HUSKY D FORMULARY

Only available at pharmacies participating in HUSKY (i.e., enrolled in CT Medical Assistance Program)

PA required for brand name drug if generic exists

PA required for non-preferred drug

Excluded categories of drugs:

• Experimental drugs

• Drugs treating obesity, infertility, sexual problems, cosmetic conditions

• Vaccinations provided free of cost by DPH
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CHANGE IS HERE.
SEE IF YOU QUALIFY
FOR MORE AFFORDABLE
HEALTH CARE COVERAGE.

Access Health CT is the only place you can get these savings.
What kind of coverage are you looking for?

Individuals  Families  Employees  Employers
Enrollment Timeline

Enroll by December 15 to get coverage on January 1, 2014

Open Enrollment begins October 1, 2013
Runs through March 31, 2014

Plans are active January 1, 2014
UNDERSTAND FEDERAL COST-SHARING AND PREMIUM SUPPORT AVAILABLE TO YOUR CLIENTS

4 Coverage Levels

- Platinum Plans: Premium support available
- Gold Plans: Premium support available
- Silver Plans: Cost sharing & premium support available
- Bronze Plans: Premium support available
### 4 Categories of Marketplace Plans

<table>
<thead>
<tr>
<th>Category</th>
<th>Average % of Care Covered</th>
<th>Patient Premiums</th>
<th>Patient Cost-Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Platinum</td>
<td>90%</td>
<td>$$$$$</td>
<td>$</td>
</tr>
<tr>
<td>Gold</td>
<td>80%</td>
<td>$$$$</td>
<td>$$</td>
</tr>
<tr>
<td>Silver</td>
<td>70%</td>
<td>$$</td>
<td>$$ $$</td>
</tr>
<tr>
<td>Bronze</td>
<td>60%</td>
<td>$</td>
<td>$$ $$ $$</td>
</tr>
</tbody>
</table>
PREMIUM SUPPORT

For clients living b/w 100-400% FPL (~ $11,490 - $45,960)

4 Coverage Levels

- Platinum Plans: Premium support available
- Gold Plans: Premium support available
- Silver Plans: Cost sharing & premium support available
- Bronze Plans: Premium support available

For clients living b/w 100-400% FPL (~ $11,490 - $45,960)
**PREMIUM SUPPORT EXAMPLE**

<table>
<thead>
<tr>
<th>Income</th>
<th>Premium Limit as % of Income</th>
<th>Premium Limit / Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>100-150% FPL</td>
<td>2 – 4%</td>
<td>$229.80 - $689.40</td>
</tr>
<tr>
<td>150-200% FPL</td>
<td>4 – 6.3%</td>
<td>$689.40 - $1,447.74</td>
</tr>
<tr>
<td>200-250% FPL</td>
<td>6.3 – 8.05%</td>
<td>$1,447.74 - $2,312.36</td>
</tr>
<tr>
<td>250-300% FPL</td>
<td>8.05 – 9.5%</td>
<td>$2,312.36 - $3,274.65</td>
</tr>
<tr>
<td>300-400% FPL</td>
<td>9.5%</td>
<td>$3,274.65 - $4,366.20</td>
</tr>
</tbody>
</table>

- Earns $16,000/year - about 140% FPL
- Must spend about 4% of his income on premium = $640 per year, or about $53 per month.
- Let’s say the second-cheapest Silver plan costs $500 per month.
- Client’s subsidy will be: $500 - $53 = $447 per month.
- Can get this as a tax refund or have it paid directly to insurer each month.
COST-SHARING SUPPORT (co-pays, co-insurance)

4 Coverage Levels

- Platinum Plans
- Gold Plans
- Silver Plans
- Bronze Plans

Cost sharing and premium support available

For clients living b/w 100-250% FPL
Beginning in January 2014, state and federal Marketplaces (aka exchanges) will offer a range of insurance plans called qualified health plans (QHPs). As uninsured individuals begin to enroll in these plans in October 2013, it will be critical that each is able to select a plan that includes current health care providers and affordably meets his/her healthcare needs. This workbook is designed to guide assessment of QHPs in two ways.

First, it aims to assist low-income individuals and their health and social service providers in selecting a QHP that best meets their care and treatment needs. This workbook highlights areas of a QHP that will significantly affect access to and cost of care. QHPs are available on state Marketplace websites or at www.healthcare.gov (federally run Marketplaces).

Second, this workbook is meant to build capacity among advocates in assessing the adequacy of QHPs to affordably meet the healthcare needs of individuals living with HIV/AIDS, as well as with common co-morbidities (mental illness, substance use disorder, and/or diabetes). Historically, private health plans have not met the needs of low-income individuals and families, especially those living with complex chronic health conditions or disabilities. Now that more people with lower incomes and complex health conditions will join the private market, insurance companies will need to build plans that provide access to affordable and comprehensive care. For example, although the Patient Protection and Affordable Care Act (ACA) prohibits discrimination on the basis of health status, plans may still be designed to attract the healthy consumers and deter enrollment by those in need of expensive care. Thus, advocates, case managers, and providers will need to monitor new plans to ensure adequacy for all consumers, especially those with more significant healthcare needs. This workbook highlights areas where a QHP may violate the ACA’s prohibition on discrimination based on health status, such that it may be flagged for monitoring and enforcement by the state or federal government.

This workbook is designed to guide a step-by-step analysis of the following elements in any given QHP:

1. premium and cost-sharing requirements;
2. outpatient services;
3. inpatient services;
4. provider networks; and
5. prescription drug formularies.

When used in conjunction with the Marketplace Health Plan Assessment Worksheet, it can provide individuals with a comparison of multiple plans to choose from.
The following chart accompanies the *Marketplace Health Plans Template Assessment Workbook*, which explains the importance of each category listed below. It is intended to be used in conjunction with that material to assess the adequacy of any given qualified health plan on a federally facilitated, partnership, or state run Marketplace.

<table>
<thead>
<tr>
<th></th>
<th>Plan 1</th>
<th>Plan 2</th>
<th>Plan 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issuer Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Product Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan Type</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(PPO, POS, HMO, etc)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage area (counties)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client versus Plan OOP max</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(see Workbook Table B)</td>
<td>Client: $</td>
<td>Client: $</td>
<td>Client: $</td>
</tr>
<tr>
<td>Plan: $</td>
<td>Plan: $</td>
<td>Plan: $</td>
<td></td>
</tr>
<tr>
<td>Additional state financial assistance available to client?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes / No</td>
<td>Yes / No</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Plan eligible for ADAP support?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes / No</td>
<td>Yes / No</td>
<td>Yes / No</td>
</tr>
</tbody>
</table>
FACTORS AFFECTING PREMIUM

- Age
- Family size (if applying for family plan)
- Residency (zip code)
- Currently insured?
- Income
- Tobacco use

Cost of plan
BROWSING PLAN OPTIONS BEFORE CREATING ONLINE ACCOUNT

Information client must provide

- Zip code
- Household size (if buying family coverage)
- Date(s) of birth
- Estimated income
- Current insurance status
- Tobacco use

Client can then use Marketplace to...

- View, download, print plans
- Sort plans based on premium cost, cost of specialty visit, referral requirements, ER costs
- Sort plans based on network type (HMO, PPO)
- Find plans eligible for cost-sharing subsidies
- Find plans with case management programs
BROWSING PLAN OPTIONS AFTER CREATING ONLINE ACCOUNT

Information client must provide

- Social security number
- Income (pay stub or tax return)
- Age
- Family size
- Tobacco use
- Address
- Current insurance status

Client can then use Marketplace to...

- See exact premium support and/or cost-sharing amounts he/she qualifies for
- See all costs of plan for specific client (with subsidies applied)
- See list of covered drugs (with generic, brand, specialty classifications)
- See list of providers in plan network
- Sort plans by cost, provider availability, networks
KEY BENEFITS TO COMPARE BEFORE SELECTING A PLAN

- Provider networks
- Referral requirements for specialists
- Case management
- Cost sharing
- Limits on specialty or inpatient care
- Nutritional counseling
- Pharmacy locations
- Drug formularies
PROVIDER NETWORKS & REFERRALS FOR SPECIALISTS

Client’s HIV provider in network?
• Client’s HIV provider classified as specialist?

Client’s mental health / substance use disorder provider in network?

Client’s endocrinologist in network?

Referrals required? Every time or just once?
Does client need new PCP?
MENTAL HEALTH & SUBSTANCE USE DISORDER CARE

- Limits on outpatient visits?
- Limits on inpatient days?
- Treatment exclusions? (e.g., methadone, sub-oxone; eating disorders often excluded)
- No health plans currently comply with the intent of the 2008 parity law – close monitoring and reporting is crucial
DIABETIC CARE

- Glucose monitors
- Syringes
- Glucose testing strips
- Glucose tablets
- Lancets

Anti-diabetic drugs?
- Insulin
- Metformin / glucophage

Nutritional counseling?

Case management?

Quantity Limits?
CO-PAYS; CO-INSURANCE; DEDUCTIBLES

Cost Sharing

- Emergency room
- Inpatient stays
- Labs
- PCP visit

- Waived if admitted?
- Cost per day?
- Higher cost if ordered by specialist vs PCP?
- Even if just to get a referral?
Ask client to bring in **all** medications

- Client’s meds in high tiers?
- PA or step therapy required?
- Location?
- Lower costs at preferred pharmacy? Location?
- Every Rx on formulary?
- Monthly cap on # of Rx?
- Generics available?
- Formulary match ADAP formulary?
OTHER SPECIALTY SERVICES

Hospice care
Vision
Oral health
Chiropractic care
X-ray / imaging services
Home health visits
Durable medical equipment
Rehabilitation
Dialysis

Consider client needs and plan limitations or exclusions
SUMMARY

Pick a Coverage Level

Check if providers in network

Check drug formularies

Check coverage of other healthcare needs
CT MARKETPLACE: 4 SILVER PLANS

1. ConnectiCare POS HD 3000
   • Deductible: $3,000
   • OOP Max: $6,250
   • Premium grace period: 3 months if 100-400% FPL

2. Anthem BCBS Direct Access Standard
   • Deductible: $3,000
   • OOP Max: $6,250
   • Premium grace period: 3 months if 100-400% FPL

3. Anthem BCBS Silver Direct Access
   • Deductible: $3,000
   • OOP Max: $6,250
   • Premium grace period: 3 months if 100-400% FPL

4. Healthy Partner Max 1
   • Deductible: $3,000
   • OOP Max: $6,250
   • Premium grace period: 3 months if 100-400% FPL
### COST-SHARING REDUCTIONS BASED ON INCOME

<table>
<thead>
<tr>
<th>Income</th>
<th>Max premium / year</th>
<th>Max OOP / year</th>
<th>Max Cost-sharing / year</th>
</tr>
</thead>
<tbody>
<tr>
<td>100-150% FPL</td>
<td>$229.80 - $689.40</td>
<td>$2,250</td>
<td>$2,345.80 - $2,805.40</td>
</tr>
<tr>
<td>150-200% FPL</td>
<td>$689.40 - $1,447.74</td>
<td>$2,250</td>
<td>$2,805.40 - $3,563.74</td>
</tr>
<tr>
<td>200-250% FPL</td>
<td>$1,447.74 - $2,312.36</td>
<td>$5,200</td>
<td>$4,622.74 – $5,487.36</td>
</tr>
<tr>
<td>250-300% FPL</td>
<td>$2,312.36 - $3,274.65</td>
<td>$6,350</td>
<td>$8,662.36 - $9,624.65</td>
</tr>
<tr>
<td>300-400% FPL</td>
<td>$3,724.65 - $4,366.20</td>
<td>$6,350</td>
<td>$9,624.65 - $10,716.20</td>
</tr>
<tr>
<td>Benefit</td>
<td>ConnectiCare</td>
<td>Anthem Standard</td>
<td>Anthem Silver</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------------------------</td>
<td>-----------------</td>
<td>----------------------------------------------------</td>
</tr>
<tr>
<td>PCP</td>
<td>$30 (one free annual check-up)</td>
<td>$30</td>
<td>$30 for 3 visits; deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>$45</td>
<td>$45</td>
<td>$0</td>
</tr>
<tr>
<td>MH / SUD outpatient</td>
<td>$30</td>
<td>$30</td>
<td>$0</td>
</tr>
<tr>
<td>MH / SUD inpatient</td>
<td>Deductible; $500/day or $2,000 per admit</td>
<td>$500/day or $2,000/admit</td>
<td>$0</td>
</tr>
<tr>
<td>Other inpatient</td>
<td>Deductible; $500/day or $2,000/admit (PA req’d if scheduled)</td>
<td>$500/day or $2,000/admit (PA req’d if scheduled)</td>
<td>$500/day after deductible ($2,000/yr)</td>
</tr>
<tr>
<td>ER visit</td>
<td>$150 unless admitted</td>
<td>$150 unless admitted</td>
<td>$150 unless admitted</td>
</tr>
<tr>
<td>Labs</td>
<td>$30</td>
<td>$30</td>
<td>$0</td>
</tr>
<tr>
<td>X-Rays</td>
<td>$45</td>
<td>$45</td>
<td>$0</td>
</tr>
<tr>
<td>MRI / CT / PET</td>
<td>$75 ($375/yr; $400/yr for PET)</td>
<td>$75 - $375</td>
<td>$0</td>
</tr>
<tr>
<td>Skilled nursing facility</td>
<td>$500/day or $2,000 per admit (90 days/yr)</td>
<td>$500/day or $2,000 per admit (90 days/yr)</td>
<td>$0 (90 days/yr)</td>
</tr>
<tr>
<td>Home health care</td>
<td>$0 (100 visits/yr)</td>
<td>$50 deductible; $0 (100 days/yr)</td>
<td>$50 deductible; $0 100 visits/yr</td>
</tr>
<tr>
<td>Chiropractic care</td>
<td>$45</td>
<td>$45 (20 visits/yr)</td>
<td>$0</td>
</tr>
</tbody>
</table>
## FORMULARY / COST-SHARING COMPARISON

<table>
<thead>
<tr>
<th>Tier / Retail or Mail</th>
<th>ConnectiCare</th>
<th>Anthem Standard</th>
<th>Anthem Silver</th>
<th>Healthy Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 Retail</td>
<td>$10</td>
<td>$10</td>
<td>$10</td>
<td>$10</td>
</tr>
<tr>
<td>Tier 2 Retail</td>
<td>Deductible; $25</td>
<td>$25</td>
<td>Deductible; $25</td>
<td>Deductible; $25</td>
</tr>
<tr>
<td>Tier 3 Retail</td>
<td>Deductible; $40</td>
<td>$40</td>
<td>Deductible; $40</td>
<td>Deductible; $40</td>
</tr>
<tr>
<td>Tier 4 Retail</td>
<td>Deductible; 40% co-insurance</td>
<td>40% co-insurance</td>
<td>40% co-insurance</td>
<td>Deductible; 40% co-insurance</td>
</tr>
<tr>
<td>Tier 1 Mail</td>
<td>$20</td>
<td>$20</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td>Tier 2 Mail</td>
<td>Deductible; $50</td>
<td>$62.50</td>
<td>$62.50</td>
<td>Deductible; $50</td>
</tr>
<tr>
<td>Tier 3 Mail</td>
<td>Deductible; $80</td>
<td>$100</td>
<td>$100</td>
<td>Deductible; $120</td>
</tr>
<tr>
<td>Tier 4 Mail</td>
<td>Deductible; 40% co-insurance</td>
<td>NA</td>
<td>NA</td>
<td>Deductible; 40% co-insurance</td>
</tr>
</tbody>
</table>
ASSISTING WITH ENROLLMENT

DO NOT:
Ask for financial information (help client enter his/her info only if requested)
Make copies or keep any financial information
Access a client’s account when he/she is not with you
Direct a client to enroll in any specific plan

DO: advise clients on differences between plans
APPLYING FOR A PLAN

Apply online
Healthcare.gov

Apply by phone
800.318.2596

Request paper application
800.318.2596

Apply by fax
PAYING PREMIUMS

Pay online –
credit, debit,
pre-paid debit,
electronic transfer

Pay by mail
(check)

Pay in
cash, cashier’s check, money order
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RED FLAGS IN MARKETPLACE PLANS

Plan exclusions? Exclusion lists are often non-exhaustive!

Definition of medical necessity? EVERYTHING must be “medically necessary” to be covered (utilization review physician determines this)

Grace period for failure to pay premium on time (without automatic plan termination?)

Abortion – some states prohibit ANY Marketplace plan from covering abortion (except in the case of rape, incest, endangerment of life of mother) – client must buy rider for abortion to be covered
REPORT SUSPECTED DISCRIMINATION BASED ON HEALTH STATUS

Plans cannot discriminate based on health status

Are all HIV drugs placed in higher tier than other drugs?

Is prior authorization or step therapy applied to certain categories of drugs more often than others?

Are mental health benefits more limited than physical and surgical benefits (this violates parity law as well as anti-discrimination provision)

Are provider networks adequate? Inclusion of Essential Community Providers?

Report suspected discrimination to hivhealthreform.org, DOI, HHS

(see appendix A in workbook)
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ADAP INSURANCE PURCHASING SUPPORT

Nationally – about 54% of ADAP clients will qualify for premium subsidies on Marketplaces – not all subsidies will be sufficient to make plans affordable

- Parts A or B can be used to purchase new plans or provide premium, co-pay, deductible support
- State ADAP offices must decide whether to provide insurance purchasing support on Marketplaces for individuals qualifying for subsidies and/or purchase Marketplace plans for those under 100% FPL (in non-Expansion states)
- Provide premium, co-pay and/or deductible support?
- Must ensure plan formularies match ADAP formularies – in terms of drugs and average cost
CURRENT CADAP PURCHASING ASSISTANCE

CADAP currently only provides pharmaceutical copay and deductible support

CT Insurance Premium Assistance Program (CIPA) pays up to $1500 / month in premiums for policies that:

• Match CADAP’s formulary; and

• Are comprehensive
RYAN WHITE POST ACA

Ongoing need for Ryan White:

• To cover services not required by ACA (e.g., dental, legal services, treatment adherence counseling, housing support)
• To cover populations not included in the ACA (people without documented immigration status, people under 100% FPL in non-expansion states)

Payer of last resort requirement: cannot use RW funds when “payment has been made or can reasonably be expected to be made” by another source (e.g., Medicaid)

HRSA grantees must assess clients for eligibility for other insurance coverage and facilitate enrollment

CADAP can decide to use funds for purchasing support

Ryan White Providers = **essential community providers** in Marketplace plans (10%/20% rule)
GETTING CREATIVE WITH HOUSING SUPPORT

Health homes (90% federal match for qualifying conditions) – can fund supportive housing for individuals living with HIV

- covers case management, care coordination, health promotion, comprehensive transitional care/follow-up, patient and family support, referrals to community and social support services

Look for unusual bedfellows – MCOs and ACOs may offer supportive housing funding if it lowers overall costs

Integrate with broader subsidized housing and homeless reduction programs

NY – using approximately $100 million saved via SPA redesigns for housing (no federal match granted to date)

See Josh Dawsey, New York State Rethinks Medicaid, NYTIMES (Aug. 2, 2013)
REMAINING RYAN WHITE PRIORITIES POST ACA

Support services will become more critical as individuals move onto insurance plans
Status of HRSA 75/25 mandate unknown

CT DPH 75/25 prevention split – less emphasis on testing based on EHB:
• HIV testing will be covered free of charge under all Marketplace plans & HUSKY D
• Emphasis on condoms, serodiscordant prevention, and policy initiatives remains critical
• Emphasis on cities with highest incidence remains critical (Hartford, New Haven, Bridgeport) (future of Part A versus B funding unknown)
RESOURCES TO HELP WITH ENROLLMENT

- Enrollment Navigators
- Community Health Centers
- Certified Application Counselors
- Champions for Change