

# Impact of Health Care Reform on Care and Treatment for People with HIV



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# The Promise: Significant Expansion of Access to Care and Treatment for People with HIV



- Most uninsured people with HIV will be covered under either an expanded Medicaid program or a health insurance exchange
  - Some have estimated that as many as 70% of uninsured people with HIV may be served under Medicaid after 2014
- If people are served in the exchange, they are eligible for tax credits, subsidies, and out of pocket cost caps to make insurance more affordable
- The worst of insurance company discrimination, such as refusing coverage to those with pre-existing conditions, rescinding coverage, gender and age discrimination will be prohibited or restricted
- Creates a new standard for benefits in the exchange and in the Medicaid expansion program

# A Big Step Forward; Not a Magic Bullet



## **Care coverage:**

- No vision or dental health coverage
- Abortion services are seriously limited
- Undocumented people are left out of health care reform entirely
- Legal immigrants continue to have a five year waiting period for Medicaid
- Full federal funding for Medicaid expansion is temporary, although it continues at 90%, higher than the best current match
- No new mandatory minimum benefits package for Medicaid
  - Must still offer “essential benefits” to expansion population
  - Could also scale back non-expansion benefits

## **Provider reimbursement:**

- Inadequate Medicaid provider rates are not really addressed

# Not a Magic Bullet



## **State Differences:**

- No national plan. State-based exchanges. State disparities could continue to exist

## **Affordability:**

- No public option.
- Very little in the plan that clearly addresses health care costs; people who get their coverage through their employer could continue to see significant cost increases
- Tax credits, subsidies, and out-of-pocket caps to address premiums and out-of-pocket costs; may be insufficient for some living with HIV
- Tax credits on premium stop at 400% FPL. Out-of-pocket subsidies stop at 250% of FPL, and reduced out-of-pocket caps stop at 400% FPL. Affordability could still be a barrier for PLWHA and others with chronic conditions at slightly above 400%FPL.
- Medicare, including Part D cost-sharing, still too high for some.

# Making it work for people with HIV



- Documented residents will be required to carry insurance, file for an exemption from the mandate, or face a penalty
- Most uninsured people living with HIV currently served by Ryan White programs will be entering new systems of care and treatment but many will likely still need some RW services as well
- Most will have access to more comprehensive medical care and a broader formulary of medications
- Undocumented people will continue to depend on Ryan White and other public health services, leaves them very vulnerable to discretionary funding changes and political whim
- Enormous amount of advocacy, education, technical assistance and resources necessary to prepare for and ensure a smooth transition to new systems of service – we need resources to make it work!

# Integrating the HIV Care System



- **Ryan White has funded an alternative care system for people with HIV, often a model for both HIV and chronic care**
  - Excellent infrastructure, expertise, and care and treatment models have developed through the years
  - Opportunity: To bring new models of chronic care delivery to larger systems
  - Risk: Transition could be challenging and it's possible to lose hard won infrastructure
- **RW care system will have to integrate with the larger care systems**
  - Clinics will have to be able to contract, bill, and interact with private and public care systems, including managed care
  - If up to 70% of uninsured people with HIV will be covered by Medicaid, strategies will have to be formulated to provide sufficient reimbursement for the delivery of quality care

# Integration



- Ryan White programs will need to ensure that they can pick up unaffordable out-of-pocket and premium costs associated with insurance, both public and private
- RW programs will also need to be able to reimburse for care not delivered under HCR, such as vision and dental, and support services that may not be covered under traditional insurance such as care linkages, support to engage in and continue care, medical navigators, and adherence support

## **Advocacy:**

- NHAS states that people with HIV and their health care providers will need to be involved with the development of new systems and integration in order to be successful
  - The work of securing the promise of health care reform will take place at federal and the state level, but as with most health care many of the quality details will fall to the state level, i.e. Medicaid and exchange advocacy
  - Challenges advocating with Medicaid and Private Insurance systems, developing alliances and partnership, inclusion in critical processes