

ACA in 2015: Continuing to Advocate for Medicaid Expansion, Reporting Discrimination, Gearing up for Open Enrollment

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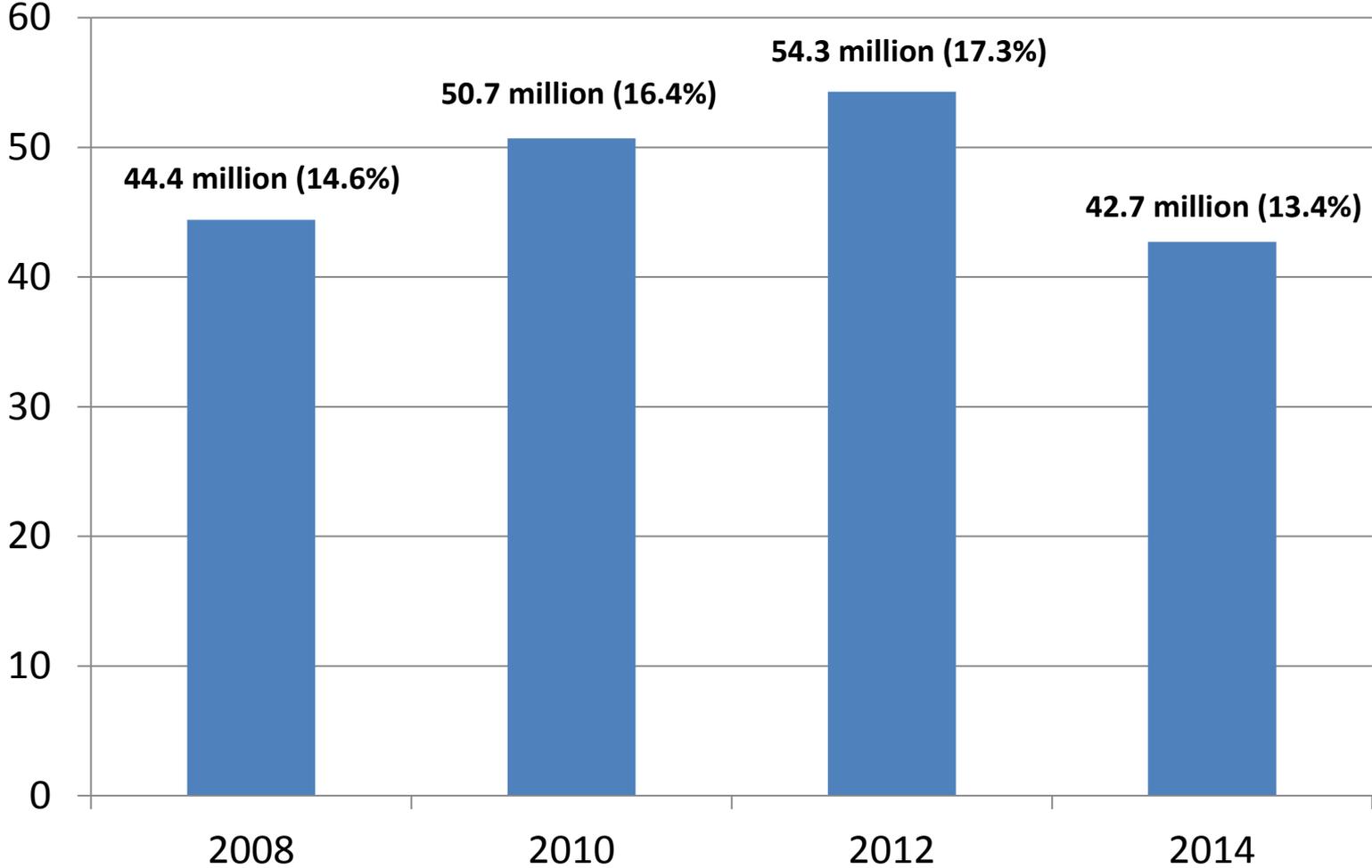
Agenda

1. ACA Refresher
2. Evidence that ACA Works
3. SpeakUp – Identifying & Reporting Discrimination
4. Gearing up for Open Enrollment

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Number of Uninsured Americans



Sources: Jenna Levy, US Uninsured Rate Drops to 13.4%, Gallup (Aug. 14, 2014); US Population by Year, S&P

National Uninsured Rate is at Record Low

Percentage Uninsured in the U.S., by Quarter

Do you have health insurance coverage?

Among adults aged 18 and older

■ % Uninsured



Quarter 1 2008-April 30, 2014

Gallup-Healthways Well-Being Index

ACA Insurance Reforms

- Health plans cannot drop people from coverage when they get sick
- No lifetime or annual caps on coverage
- Cannot be denied insurance because of pre-existing health conditions, even if you don't currently have coverage (10.6 million Texans have a pre-existing condition)
- Plans cannot charge higher premiums based on gender or health status

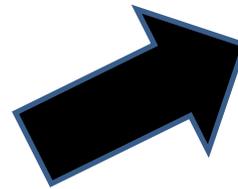
ACA Promotes Access to Subsidized Private Insurance through Exchanges

- Consumer-friendly Marketplace to purchase private insurance in a competitive market
- Federal subsidies for people with income between 100-400% FPL
- Plans must include Essential Health Benefits

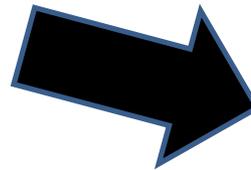
ACA Includes a Comprehensive Essential Health Benefits Package

ACA Essential Health Benefits

- 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



For All Newly Eligible Medicaid Beneficiaries



For Most New Individual and Small Group Private Insurance Beneficiaries

ACA is Reducing Health Disparities

	Uninsured in US (age 18+)		
	December 2013	April 2014	Net change
All adults > 18	17.1%	13.4%	-3.7%
Adults 18-25	23.5%	19%	-4.5%
Adults 26-34	28.2%	24.5%	-3.7%
Adults 35-64	18%	13.2%	-4.8%
Adults > 65	2%	2.2%	+0.2%
White	11.9%	9%	-2.9%
Black	20.9%	13.8%	-7.1%
Hispanic	38.7%	33.2%	-5.5%
Households < \$36 k	30.7%	25.2%	-5.5%
Households \$36 k – \$89,999	11.7%	9%	-2.7%
Households > \$90 k	5.8%	3.2%	-2.6%

Threat to Subsidies on Federal Marketplaces

- *Halbig v Burwell* – DC Circuit (federal court) ruled that federal subsidies could only be used in state-based Marketplaces
- Court will hear the case again on appeal
- What if court upholds the ruling?
- Worst case scenario:
 - No subsidies available in federal Marketplaces
 - \$5.6 billion federal dollars spent on subsidies in Texas
 - Over 1.4 million Texans (eligible)
 - Domino effect of people leaving Marketplace – healthy people most likely to drop coverage first, risk pool shrinks, premiums increase more

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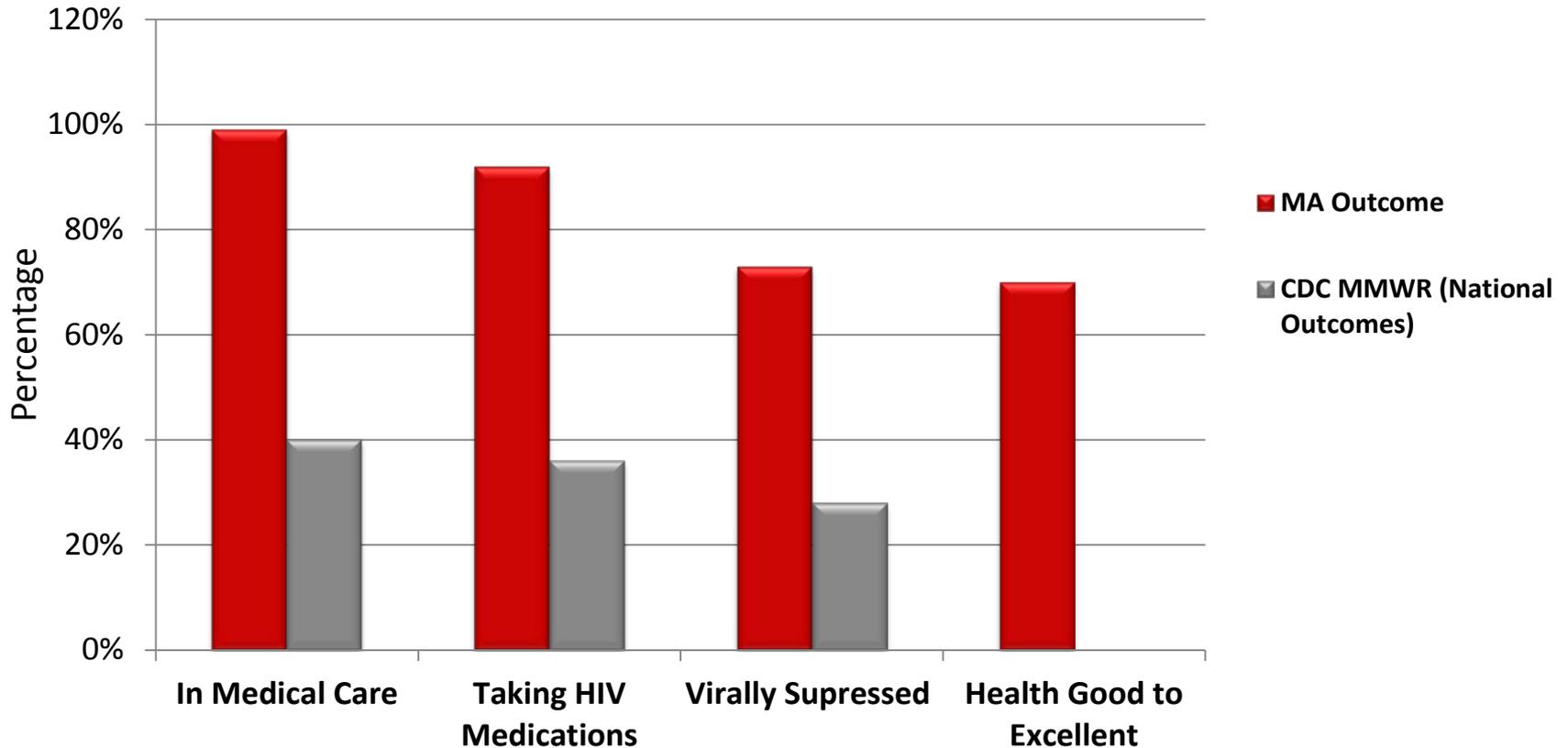
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Evidence of Efficacy of Expanding Coverage: Massachusetts

- Expanded Medicaid coverage to pre-disabled people living with HIV with an income up to 200% FPL (2001)
- Enacted private health insurance reform with a heavily subsidized insurance plan for those with income up to 300% FPL (2006)
- Insurance mandate

Improved Outcomes

MA Outcomes v. National Outcomes

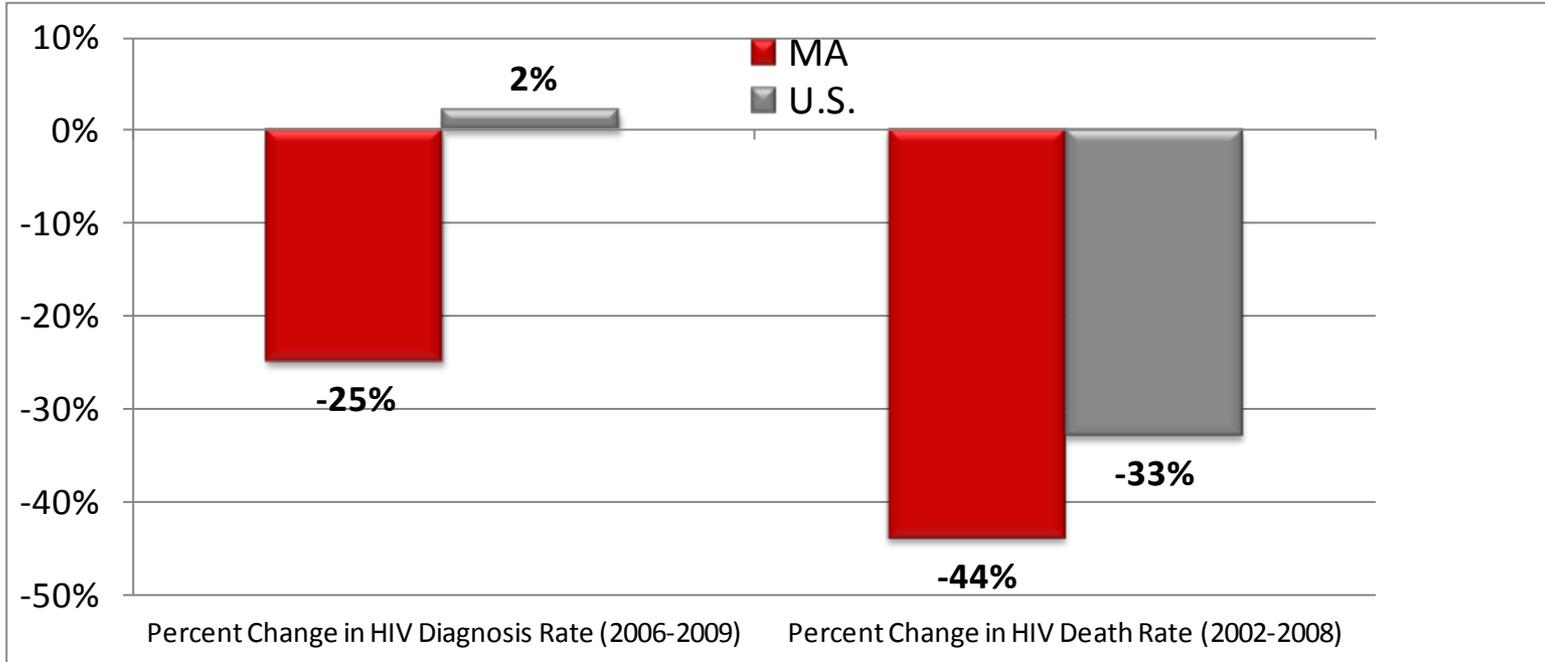


MA outcomes are based on *Massachusetts and Southern New Hampshire HIV/AIDS Consumer Study Final Report*, December 2011, JSI Research and Training, Inc.; National outcomes are based on Cohen, Stacy M., et. al., *Vital Signs: HIV Prevention Through Care and Treatment — United States*, CDC MMWR, 60(47);1618-1623 (December 2, 2011);

For both MA and the US, the percentages used are taken from a baseline of those who have already been diagnosed, not the total number of individuals living with HIV/AIDS. The definition of “In Medical Care” may differ slightly between the MA data and the MMWR. There was no comparable data category in the MMWR report for “health good to excellent.”

Fewer New Infections and Reduced Mortality

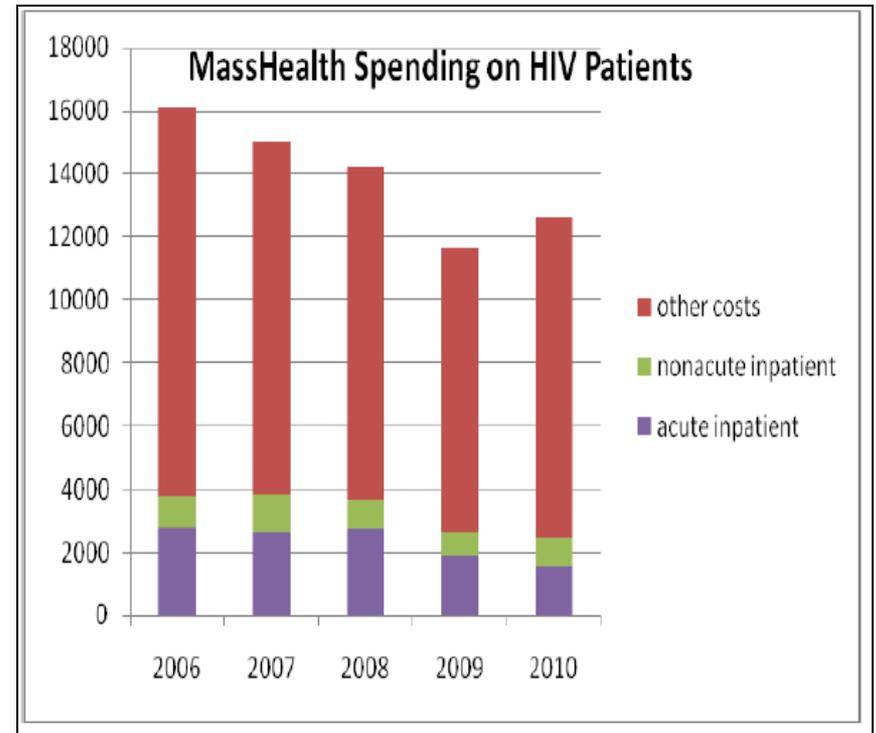
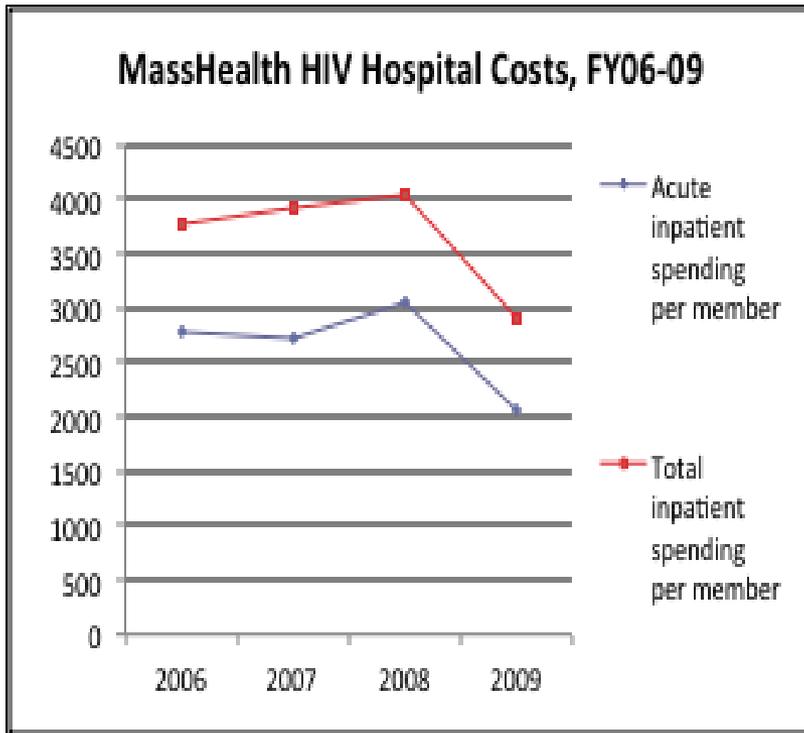
Percent Change in HIV Diagnoses and Death Rates (MA v. U.S.)



- Between 2006 & 2009, Massachusetts' new HIV diagnoses rate fell by 25% compared to a 2% national increase
- **Current MA new HIV diagnoses rate has fallen by 46%**
- Between 2002 & 2008, Massachusetts AIDS mortality rate 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*.

Reduced Spending



- 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 in past 10 years

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SPEAK UP: Identifying ACA Challenges for Individuals Living with HIV

- With support from the M-A-C AIDS Fund, a team of national and state partners has established “SPEAK UP” to monitor, assess and document ACA implementation success and 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
- Ongoing monitoring and documentation is critical 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/>



Lack of Transparency on Marketplace

- Failure to include adequate information as to the cost of covered medications on marketplace and/or plan websites
- Lack of standardization of plan formulary information
- Inadequate drug coverage and/or essential provider Information on plan websites
- Inconsistencies between marketplace and plan websites
- Changes to plan design and formulary tiering/cost-sharing structures after enrollment

Transparency Improvements in 2015

- Plans now are required to provide direct links from the marketplace to their formularies and provider networks and make clear which formularies and networks apply to particular QHPs

stronger requirements are still needed:

- Plans that require co-insurance for medications should provide the actual cost of each drug
- Plans should make clear if there are any requirements with respect to mail order and/or specialty pharmacy for all or some medications
- Plans should not be allowed to increase costs-sharing for medications by changing tiering structures after the close of open enrollment period (unless enrollees are allowed to switch plans in between open enrollment seasons)

Improving Transparency

- Advocate for federal and/or state regulations that address transparency issues.
 - E.g., NV Department of Insurance (DOI) proposed a [regulation](#) that would limit the ability of plans to reclassify drugs in a formulary to make a different deductible, copayment or coinsurance amount applicable to the drug.
- If a consumer has experienced a plan changing a tiering structure in a formulary after enrolment, request a special enrollment period
- File complaints with QHPs, marketplaces, and DOIs
- Ensure consumers are aware of what other kinds of information to ask for when selecting a QHP (e.g. drug pricing and specialty tiers; mail order pharmacy requirements)
- Share information and best practices

Inadequate Coverage of HIV Medications

- many plans do not cover all HIV medications including single tablet regimens (STRs)
 - Plans in many states are covering fewer Protease Inhibitors than required by EHB
 - 28% of all HIV drugs not covered*
 - 19% of single tablet regimens (STRs) not covered*
- Also seeing increased utilization management requirements, such as prior authorization and step therapy

*Based on an assessment of 15 states QHPs conducted by Avalere

Improving Drug 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
- This would require coverage of all HIV antiretroviral drugs, including fixed-dose combinations and single tablet regimens, in line with federal HIV treatment guidelines (<http://aidsinfo.nih.gov/guidelines>)

Examples of Progress

- Community partners (AIDS Foundation of Chicago, AIDS Legal Council of Chicago, Jenner & Block) sent a [complaint](#) to the IL DOI which included specific examples of harmful coverage exclusions, burdensome prior authorization processes, and other practices in IL health plans
- The IL DOI responded with a [bulletin](#) to insurers suggesting that plans which fail to cover all HIV drugs as recommended by HHS, and/or plans who institute burdensome and redundant prior authorization requirements may be found to be discriminatory

Unaffordable Cost-sharing Structures

- 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 have average of 36% co-insurance
- increased cost-sharing for HIV medications in employer-sponsored insurance plans
- Placement of HIV medications on tiers requiring specialty or mail-order pharmacies

Assisting Consumers With Access and Affordability Issues

- Patient Access Network Foundation provides some assistance with paying for medications (individuals living <500% FPL): panfoundation.org/hiv-aids
- Patients can appeal adverse decisions by insurance companies (as well as Medicaid and Medicare) and request exceptions when medically necessary drugs aren't available on formularies

Watch for and Report Potential Discrimination

Examples of non-discrimination protections in the ACA:

- *QHPs* must not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs
- A plan does not meet *Essential Health Benefits (EHB)* Requirements if:
 - It discriminates on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation
 - Its benefit design, or the implementation of its benefit design, discriminates based on an individual's ... predicted disability ... or other health conditions
- ACA applies already existing civil rights laws and protections to health insurance

Reporting Discrimination

- **File complaints with state departments of insurance (DOIs)**
- **File complaints with the Office of Civil Rights (OCR) (federal)**
 - the AIDS Institute (& the National Health Law Program (NHeLP) filed a [complaint](#) alleging that Florida health plans (Coventry, Cigna, Humana, Preferred Medical) discriminated against individuals with HIV by placing all HIV medications in highest cost sharing tiers (40-50% coinsurance)
 - Asked OCR to cancel the plans and impose fines to pay for excess costs imposed on enrollees, cost of drug resistance due to non-adherence to treatment, and cost of hospitalizations from interrupted treatment, among other things
- **File complaints in courts**
 - Lambda Legal filed [lawsuit](#) alleging discrimination by BCBS Louisiana for refusing to who accept premiums from 3rd parties (e.g., Ryan White) ... CMS now requires QHPs to accept 3rd party payments from government programs
 - A lawsuit alleging discrimination by health plans that required individuals living with HIV to obtain their medications through mail order pharmacies filed in California ... insurers now must offer an alternative to mail order

Advocate for Better Laws Regulating Marketplace

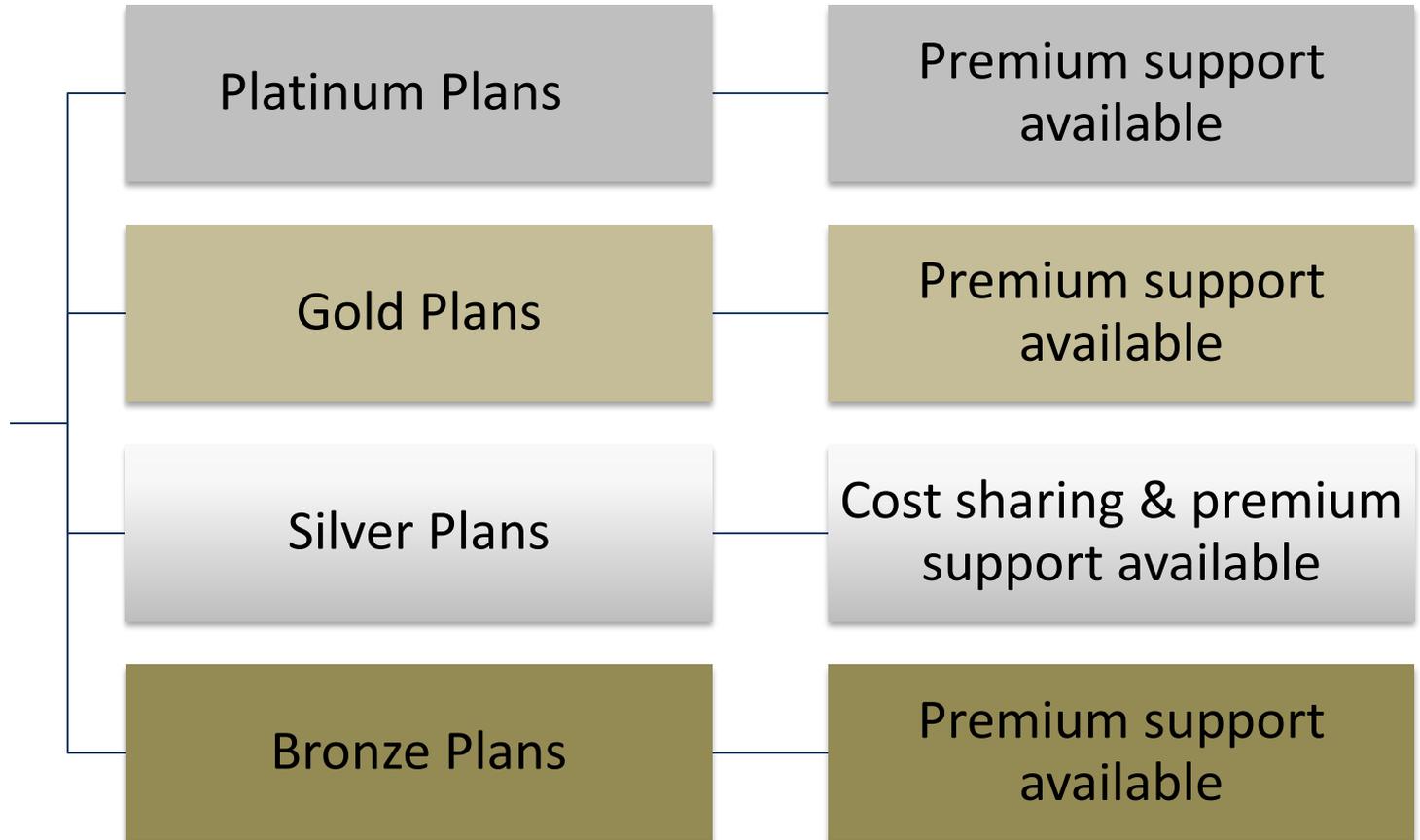
- Federal EHB rule could prohibit excessive coinsurance for specialty drugs where no generic equivalent exists
- Examples of State laws:
 - Copay for specialty drug (30 days) cannot exceed \$150
 - Must allow provider to appeal for coverage of non-formulary drug if medically appropriate
 - Cannot place all drugs in a given class on a specialty tier
 - Texas – plans cannot make substantial formulary changes outside of open enrollment & must give 60 days notice to enrollees (includes moving drug into more expensive tier; adding PA or step therapy requirements)

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Federal Cost-sharing and Premium Support Available to your Clients

4 Coverage Levels



4 Categories of Marketplace Plans

average % of care covered

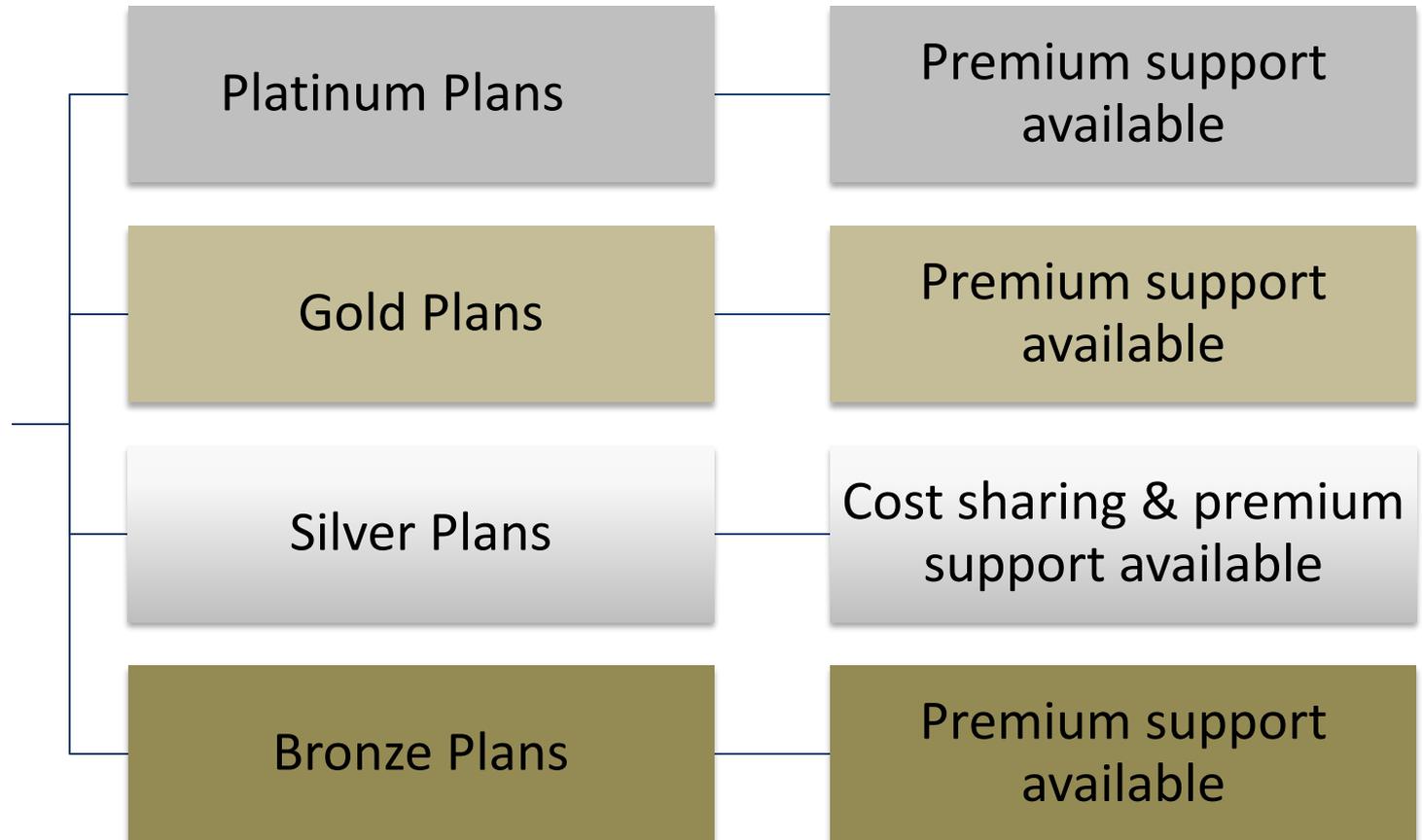
by plan

		Patient Premiums	Patient Cost-Sharing
	Platinum (90%)	\$\$\$\$	\$
	Gold (80%)	\$\$\$	\$\$
	Silver (70%)	\$\$	\$\$\$
	Bronze (60%)	\$	\$\$\$\$

Premium Support

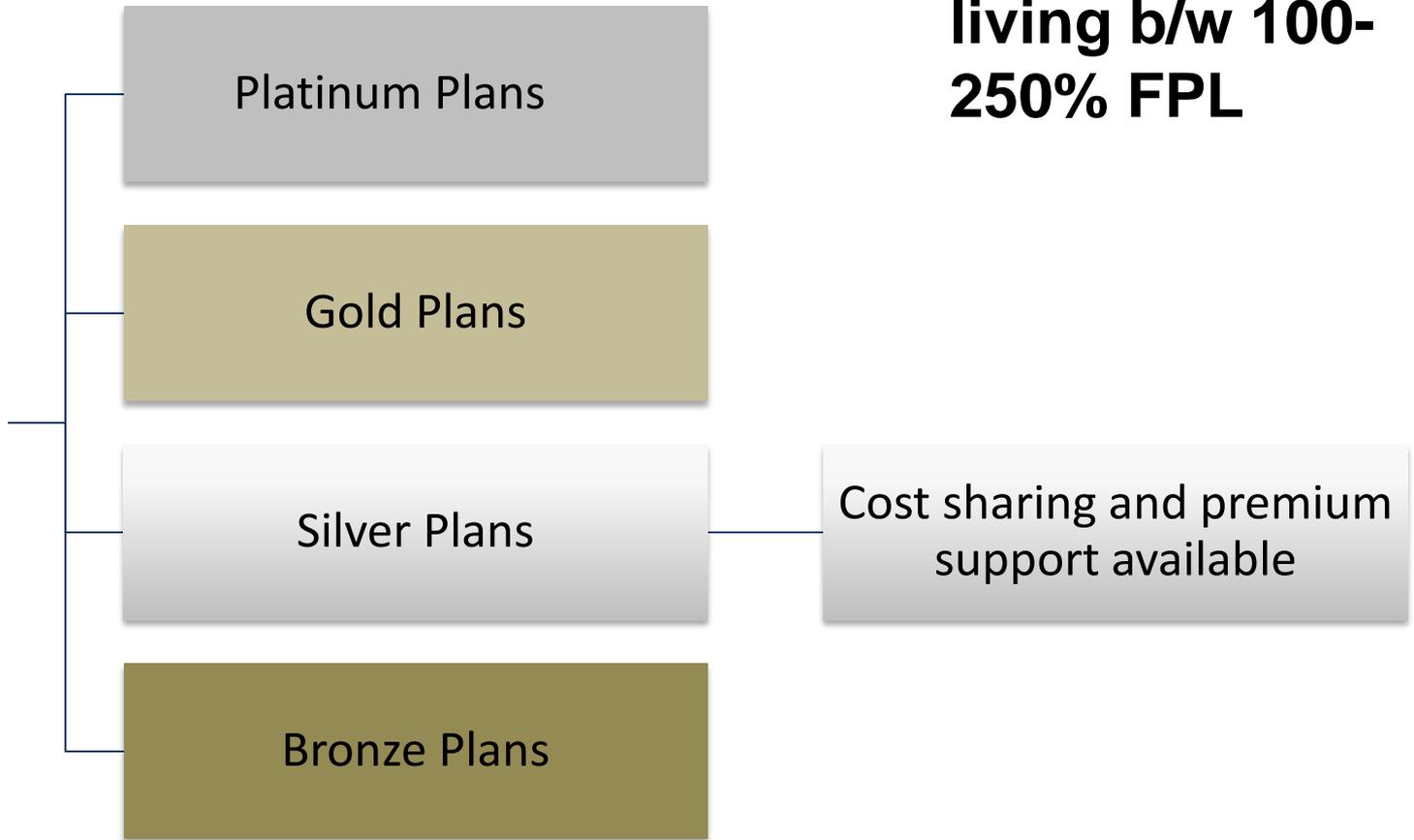
**For clients living
b/w 100-400% FPL
(~ \$11,490 - \$45,960)**

4 Coverage Levels

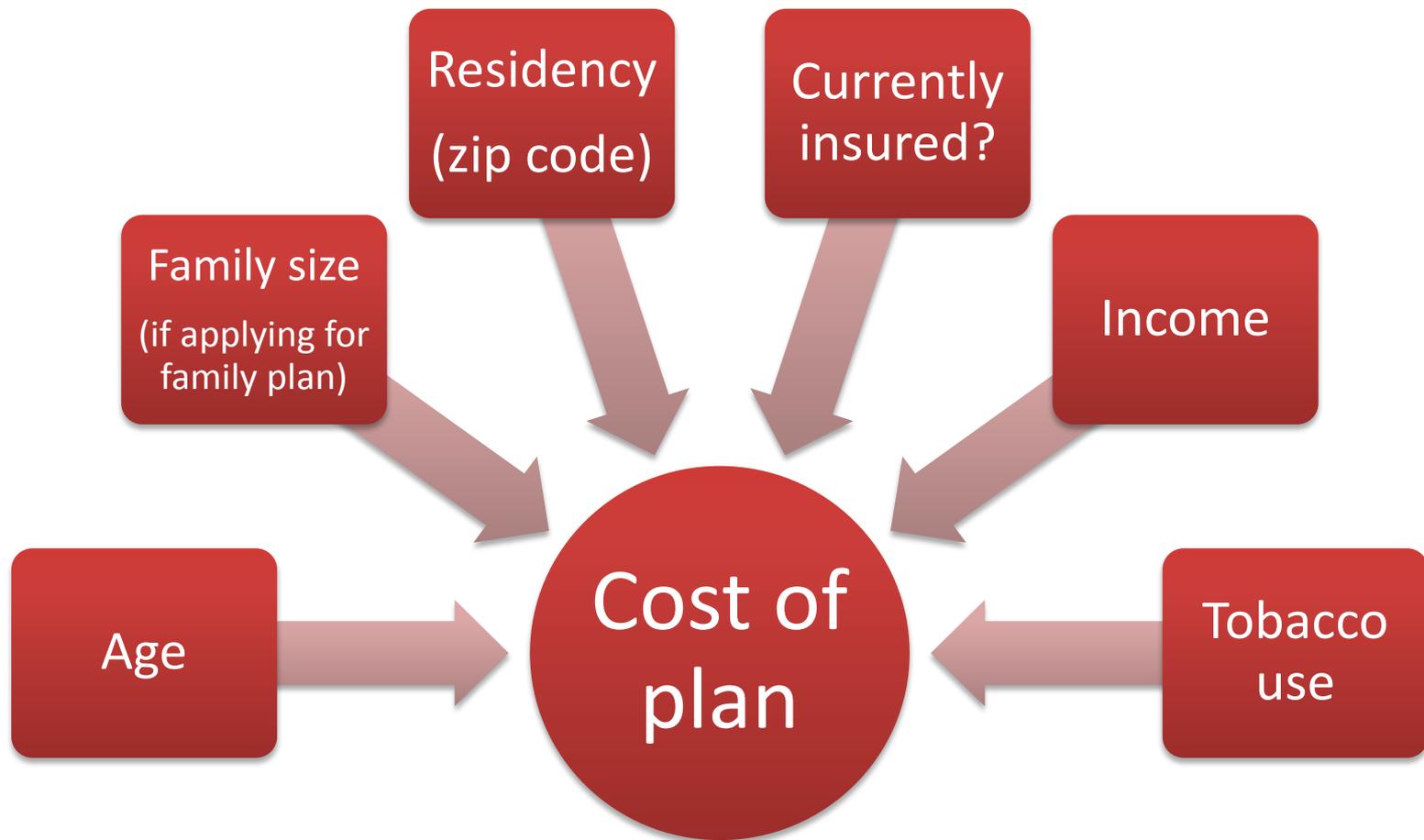


Cost-Sharing Support (co-pays, co-insurance)

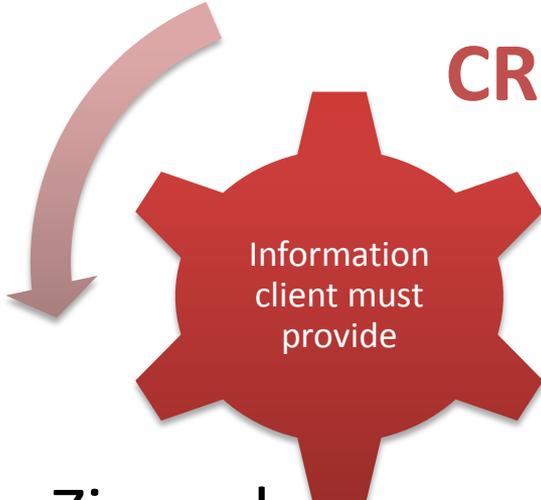
4 Coverage Levels



Factors Affecting Premium



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



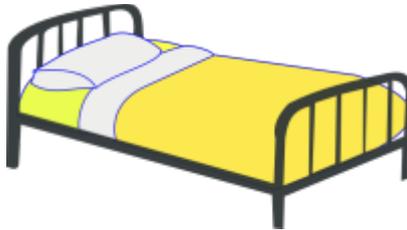
Case management



Referral requirements for specialists

Cost sharing

Limits on specialty or inpatient care



Nutritional counseling

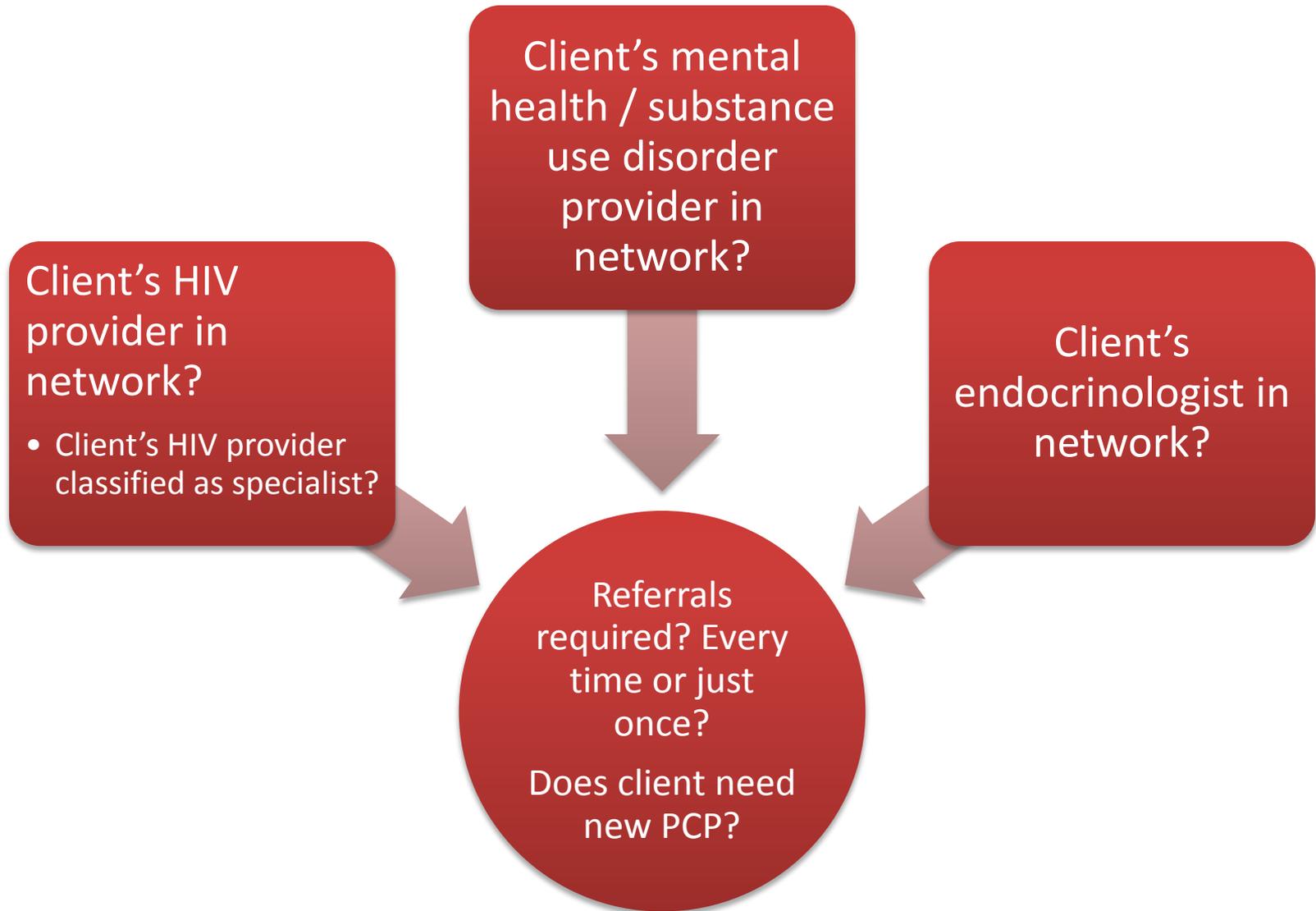


Pharmacy locations



Drug formularies

Provider Networks & Referrals for Specialists



Mental Health & Substance Use Disorder Care

- Limits on outpatient visits?
- Limits on inpatient days?
- Treatment exclusions? (e.g., methadone, suboxone; eating disorders often excluded)
- close monitoring and reporting is crucial

Diabetic Care

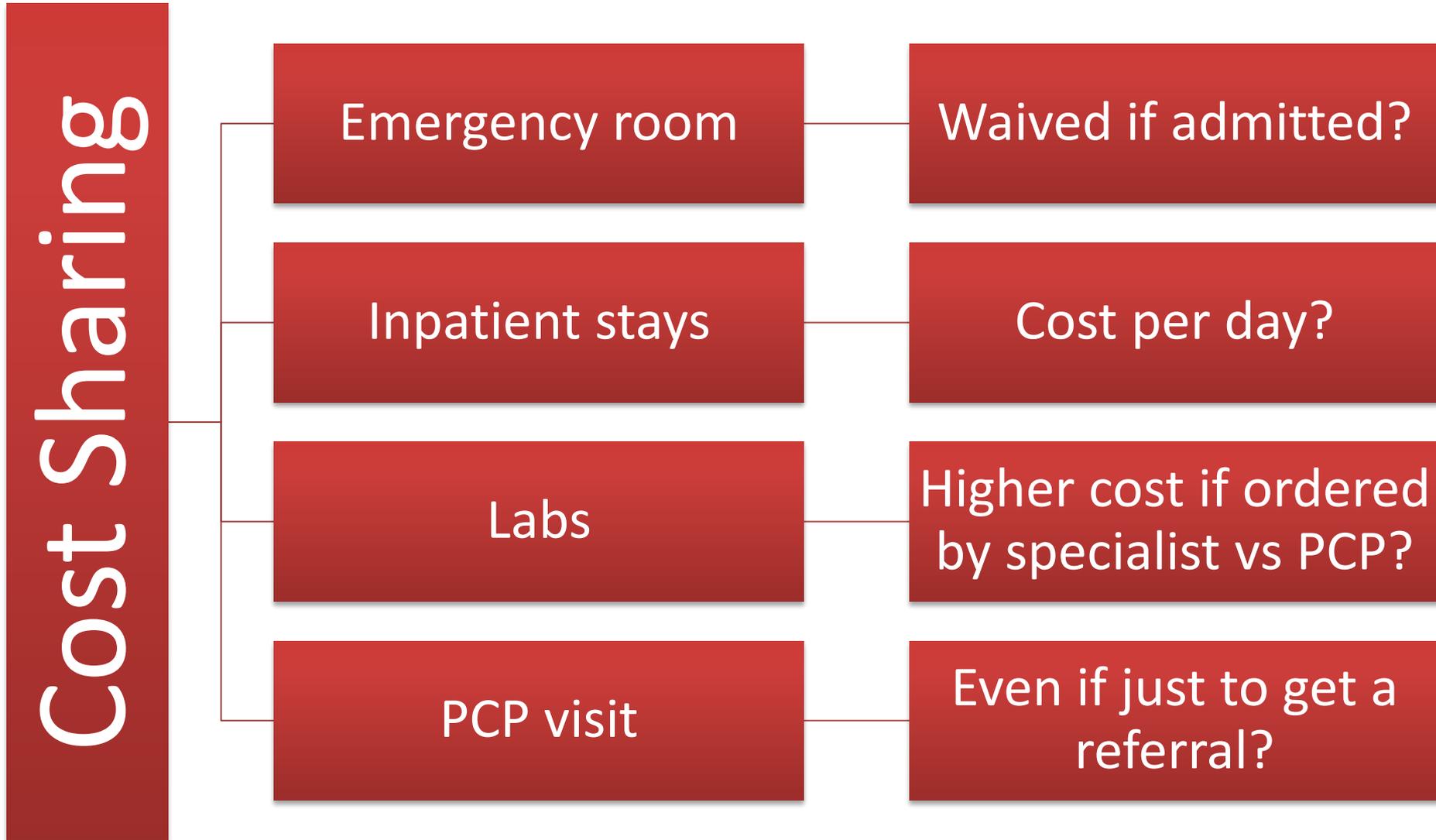
- Glucose monitors
- Syringes
- Glucose testing strips
- Glucose tablets
- Lancets



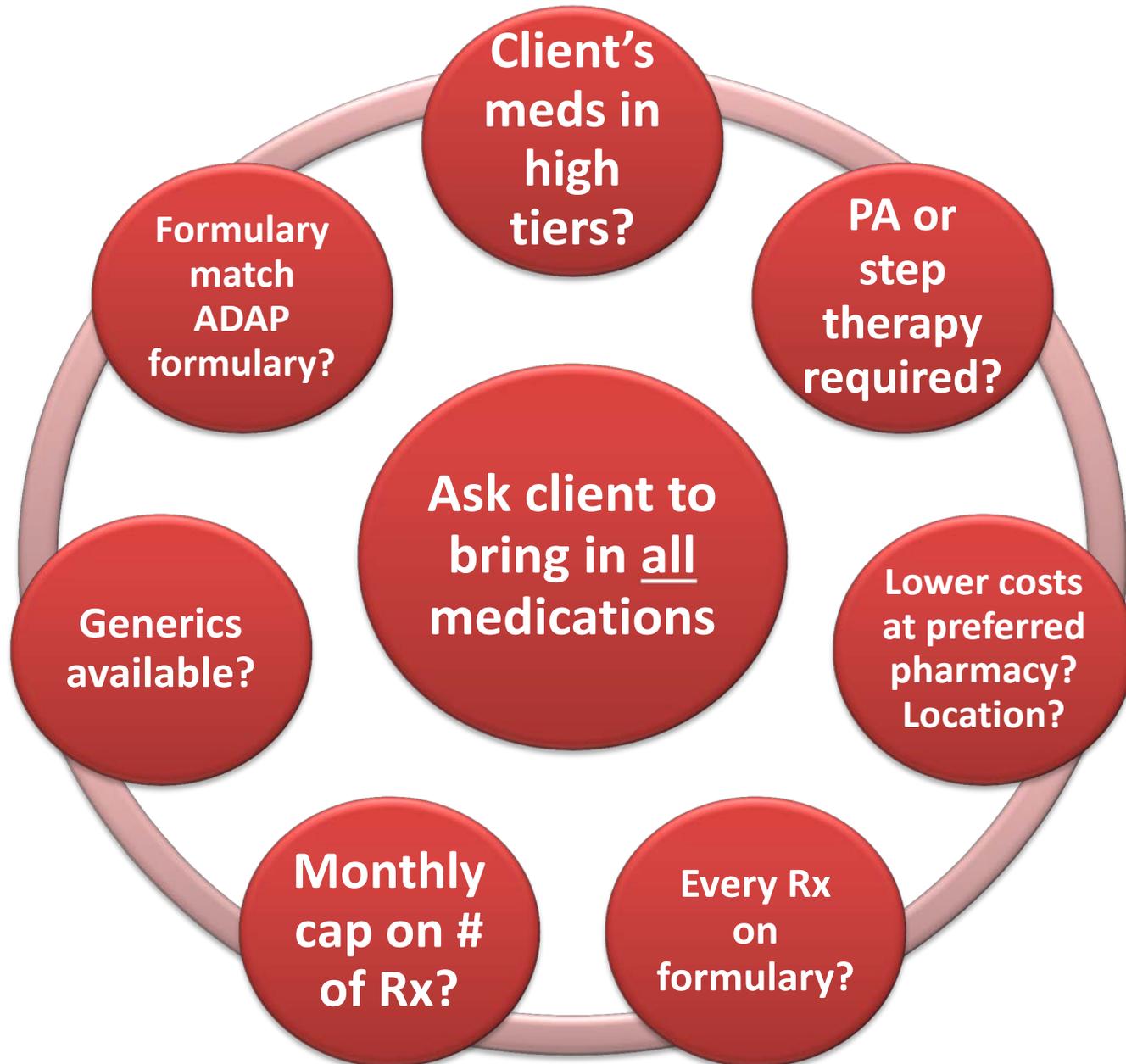
- Insulin
- Metformin / glucophage



Co-pays; Co-insurance; Deductibles



Comparing Drug Formularies



Other Specialty Services

Hospice care

Vision

Oral health

Chiropractic care

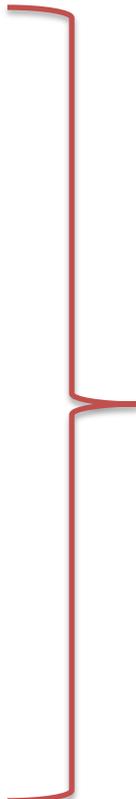
X-ray / imaging services

Home health visits

Durable medical equipment

Rehabilitation

Dialysis



**Consider client
needs and plan
limitations or
exclusions**

Assisting with Enrollment

DO NOT:

Ask for financial information (help client enter his/her info only if requested)

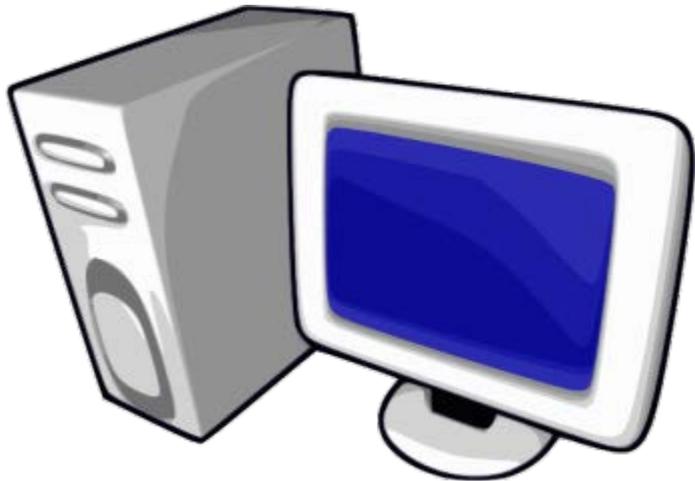
Make copies or keep any financial information

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

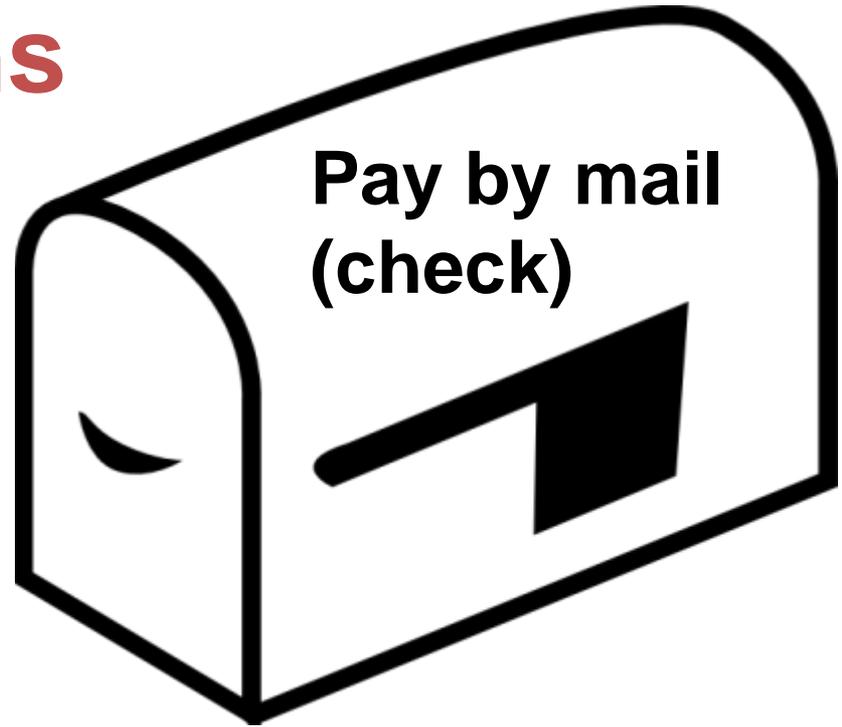


Request paper
application
800.318.2596



Apply by fax

Paying Premiums



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



**Pay in cash,
cashier's
check,
money order**

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)

Priority Checklist

Current Providers in Network?



All Pharmaceuticals Client Needs



Labs – PCP or specialist ordered?



MH / SUD – quantitative limits; rescission of coverage for non-compliance?



Finding the Best Plan for Your Client

Joe

- Earns \$16,000/year - about 140% FPL
- HIV – takes atripla
- Depression & anxiety – takes zoloft and klonopin
- Schizophrenia – takes risperidone
- Was in 30 day detox facility once for heroin addiction; has been sober for 6 months
- Currently has labs taken by his RW provider – doesn't already have a PCP



Priority Checklist

Current Providers in Network?



Pharmaceuticals – Atripla, klonopin,
zoloft, risperidone



Labs – cheaper if he starts going
through PCP? Does he need a PCP for
a referral?



MH / SUD – outpatient visit limits?
Inpatient detox limits? rescission for
non-compliance?



Questions?



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