



**Center for
Health Law
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Innovation**

HARVARD LAW SCHOOL

**HEALTHCARE REFORM MONITORING PROJECT
HIV/AIDS COMMUNITY UPDATE
(December 2012)**

Prepared by the Center for Health Law & Policy Innovation
of Harvard Law School

The months surrounding the November 2012 elections and the re-election of President Obama have spurred considerable momentum in the implementation of the Patient Protection and Affordable Care Act (ACA). In the months leading up to the elections, states took steps to begin to establish insurance exchanges and plan for Medicaid expansion. In the past month, federal regulations have poured out of the Department of Health and Human Services (HHS). Nonetheless, budget concerns remain a top priority in Washington, and threats of sequestration threaten strides already made to expand access to healthcare services.

Patient Protection and Affordable Care Act of 2010 (ACA): Implementation Issues

Federal Regulations and Guidance

Exchanges

HHS has provided states with an extended period for exchange planning. For those establishing partnership exchanges (with other states), plans are due February 15, 2013. States establishing their own exchanges had to notify HHS of their plans by November 16, 2012, but have until December 14, 2012 to submit an exchange blueprint.¹

- **Community Response:** HHS recently issued a Request for Information regarding Health Care Quality Exchanges.² This call for public comment gives advocates opportunity to provide input with regard to the selection of qualified health plans (those that will be sold on exchanges) and quality measures that should be applied to such plans. Comment is due December 27, 2012.

Consumer Assistance with Insurance Selection

Beginning with the most recent open enrollment period (September 2012), insurers selling plans on the individual or group markets must make available a consumer friendly “Summary of Benefits and Coverage,” modeled off of a template that requires the plan to provide basic information on deductibles and other out of pocket costs, referral requirements, exclusions from coverage, and annual limits. The summary must also include two coverage examples (of maternity care and type 2 diabetes), so that consumers may compare the cost of coverage across plans, including consumer out of pocket costs. Plans must adhere to a “Uniform Glossary” of terms (e.g., defining copayments, deductibles, covered services).³

- Community Response: Notably, the Uniform Glossary does not define case management. Ensuring that plans cover comprehensive case management services is particularly important to individuals living with HIV/AIDS to increase retention in care and enhance access to services other than antiretroviral treatment. Moreover, the coverage examples (diabetes and maternity care) simplify the costs of treatment and mask differences in coverage between plans. Advocates should push the Administration to require the Summary to include a coverage example of a more complex and high cost condition, such as HIV/AIDS.⁴

Federal funding has been granted to cover the cost of in-person assistance programs on state based or partnership exchanges. States have already begun developing consumer assistance programs and navigator programs – for example California has developed a consumer friendly website⁵ and Illinois is creating a navigator program.⁶

- Community Response: It is important to monitor state efforts to establish consumer assistance programs to ensure that they are of use to all individuals (i.e., provide multi-lingual assistance, are accessible to the disabled, and guarantee access to a sufficient number of providers to facilitate timely access to care).⁷ Similarly, navigator programs should be tailored to those most in need of assistance in identifying appropriate coverage. They should be based on needs assessments, be all-inclusive, and have the capacity to refer individuals eligible for public coverage to these programs.⁸

Essential Health Benefits

On November 20, 2012, HHS released a proposed rule detailing the scope of each of the ten essential health benefits (EHB) required to be provided by every non-grandfathered plan sold on the small and individual group markets, including all plans sold on insurance exchanges (qualified health plans).⁹ This proposed rule also included a list of every submitted benchmark plan (or the assigned default for states that failed to submit a plan). HHS is accepting public comment (due December 26, 2012) on these plans (now called base-benchmark plans), as well as on the scope of the benefits outlined in the rule. A state may change its submitted base-benchmark plan until the close of public comment.

- Community Response: Until now, the public has had very little opportunity to comment on a given state's selection. This period for public comment to HHS provides an important period to flag deficiencies in plans, especially for individuals living with HIV/AIDS. For example, every base-benchmark plan should include comprehensive coverage of antiretroviral drugs as well as medications used to treat opportunistic infections and other co-morbid conditions.

Base-benchmark plans that states submitted to HHS earlier this year, for purposes of defining EHB, must be supplemented with additional benefits if they do not already meet the requirements that HHS requires after receiving public comment and issuing a final rule (public comment is due December 26, 2012). Specific guidance was provided on the following EHB categories:

Mental Health - The proposed rule requires that the scope of the mental health and substance abuse EHB meet the requirements of the Mental Health Parity and Addiction Equity Act.¹⁰ In other words, all plans sold in the individual and small group markets must offer the same quantity of, and impose no more cost sharing for, mental health or substance abuse benefits than physical health benefits covered on the plan. This is critically important to individuals living with HIV, as mental illness and/or substance abuse are often comorbid conditions, affecting not only the individual's well being, but also the prognosis of the disease. Any limits in the benchmark plan on mental health or substance abuse treatment will not be applied to EHB unless similar limits are also placed on physical services.

Preventive Services – The proposed rule incorporates the ACA's preventive services requirements into the definition of EHB, clarifying that in order to comply with EHB, plans must include all of the preventive services required by § 2713 of the ACA (i.e., any service rated A or B by the United States Preventive Services Task Force (USPSTF), as well as specified women's preventive services). This means that routine HIV testing will be covered, free of charge to the patient, if the USPSTF's draft recommendations (issued in November) are adopted.¹¹ This also means that testing for hepatitis C will be free of cost for adults at high risk, including those with a history of injection drug use and those who received a blood transfusion prior to 1992 (B rating by the USPSTF). This marks a significant step forward in recognizing the need for increased hepatitis C testing, as well as linkage to care. However, one-time testing for those born between 1945 and 1965 received only a C from the USPSTF, meaning that cost sharing may be imposed by insurers, unless the draft recommendation is changed. This fails to match the Centers for Disease Control and Prevention's lifesaving recommendation that everyone in this birth cohort receive a one-time hepatitis C test.

- **Community Response:** Advocates have submitted written comments to the USPSTF strongly supporting its B grade recommendation for routine HIV testing of all sexually active individuals as well hepatitis C testing of adults at high risk. At the same time, advocates are strongly urging the USPSTF to change its recommended C grade for one-time hepatitis C testing of those born between 1945 and 1965 ("baby boomers") to a B grade. Public comment was due December 17, 2012.

Medicaid is not required to cover all preventive services rated A or B. However if states do cover A and B rated services without imposing cost sharing, they will receive a 1% increase in federal matching funds (as of January 1, 2013).

Habilitative Services – Habilitative services are not currently covered in most private insurance plans. The proposed rule sets forth a transitional policy for state benchmark plans that do not include this category. States may: (1) define the category; (2) impose a parity requirement on insurers, meaning that habilitative services would be covered in the same amount, duration, and scope as are rehabilitative services; or (3) allow insurers to decide which habilitative services to cover and report such coverage to HHS.

- **Community Response:** Allowing states to define the scope of habilitative services without federal oversight may be detrimental to health outcomes or disparities if some state definitions are inadequate to meet the healthcare needs of all individuals. Public

comment will be important in this regard. In addition, the Consortium for Citizens with Disabilities, in partnership with other organizations, has issued guidance to states on the appropriate design of habilitative benefit packages.¹²

Prescription drugs – The proposed rule suggests that a plan will be in compliance with the prescription drug EHB if it covers at least the greater of: (1) one drug in every category and class; or (2) the same number of drugs in each category and class as the benchmark plan submitted for purposes of defining EHB.¹³ Because most small group plans currently cover more than one drug per class,¹⁴ this proposed rule is an improvement from previous guidance. In other words, most plans would be held to the latter standard. Moreover, the proposed rule would require that multiple drugs listed be chemically distinct, meaning that covering two drugs of varying dosages, or one drug available in both brand and generic form, would not be sufficient to meet the requirement that a plan cover the same number of drugs in each category and class as the EHB-benchmark plan. HHS also proposes that plans be required to report drug lists to the exchange, and that all plans have mechanisms through which beneficiaries can request coverage of medically necessary drugs not covered by the plan.

- **Community Response** - Despite its improvement from initial guidance (issued in December, 2011), this proposed rule on prescription drug EHB is not sufficiently robust to protect individuals in need of multiple drugs per class. In the context of HIV, for example, effective viral suppression requires a combination of multiple antiretroviral drugs, many of which fall in the same class. Although advocates strongly recommended that HHS use the Medicare Part D standard for prescription drug EHB (requiring all drugs in certain disease classes to be covered and providing a robust appeals process in the case of denial of coverage), the proposed rule issued on November 20th does not take up that standard. However, the proposed rule recognizes the ACA's requirement that the scope of EHB cannot discriminate based on age, disability, or expected length of life.¹⁵ Thus, individuals living with HIV/AIDS are entitled to a drug formulary that serves their needs as sufficiently as the needs of an uninfected beneficiary. The proposed rule would preclude insurers from carrying out practices such as prior authorization and other forms of utilization management in a discriminatory manner (e.g., systematically denying coverage of a drug necessary to treat HIV). Yet close oversight and strong enforcement will be necessary to ensure that this protection is meaningful. HHS specifically welcomes public comments offering insight into making this prohibition against discrimination consequential; advocates should address this issue in submitting comment as well as continue to advocate for the Medicare Part D standard for the prescription drug EHB.

Alternative Benefit Plans

The same proposed rule regarding EHB for the private insurance market will apply to EHB available for newly eligible Medicaid beneficiaries, with some variation in order to comply with Title XIX of the Social Security Act, which establishes minimal standards for state Medicaid programs. These plans will be referred to as Alternative Benefit Plans, and may be based on: (1) the Medicaid plan already available to adults in the state; or (2) a newly designed "Alternative Benefit Plan."

States may submit State Plan Amendments (identifying an Alternative Benefit Plan), including proposed or existing contracts with managed care organizations, beginning January 2013.¹⁶ In doing so, they may choose from one of the following options, or supplement a different plan to be at least as comprehensive in coverage:

1. The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employees Health Benefit program;
2. State employee coverage that is offered and generally available to state employees;
3. The commercial HMO with the largest insured commercial non-Medicaid enrollment in the state;
4. The base-benchmark plan submitted for purposes of defining EHB on the private insurance market; or
5. Secretary-approved coverage, including the Medicaid state plan already offered in the state.

The Social Security Act also requires that states allow eligible persons in certain populations (e.g., disabled persons) to enroll in the traditional state Medicaid plan, rather than the Alternative Benefit Plan. Alternatively, states may design multiple Alternative Benefit Plans, specifically tailored to the needs of people living with a specific disease (e.g., HIV/AIDS).

All Alternative Benefit Plans must include the same scope of coverage of mental health and substance abuse services and treatment as is available for physical health care (the Mental Health Parity and Addiction Equity Act applies here just as it does to the private market). In addition, similar to the proposed rule governing the private market, states are given flexibility in defining the scope of the habilitative EHB required by the ACA.

- **Community Response:** It will be important to monitor both mental health and substance abuse parity in Alternative Benefit Plans, to ensure that adequate access to these services becomes a reality. Moreover, because the definition of habilitative services is new to most states and health plans, ensuring that robust benefits are provided under this category will be critical.

As for prescription drugs, the proposed rule outlining EHB requirements for private plans also applies to Alternative Benefit Plans. However, the Social Security Act requires that states may not exclude an FDA approved drug that has a significant clinically meaningful therapeutic advantage (in terms of safety, effectiveness, or clinical outcome) over other available drugs, except as expressly provided for in the Act (e.g., drugs used for cough relief, fertility treatments, weight loss or gain, sexual or erectile dysfunction, cosmetic purposes). Medicaid plans will continue to have the flexibility to implement prior authorization and other utilization control measures for prescription drug coverage (including quantity limits on number of drugs provided per month or refills provided per prescription).

- **Community Response:** It is important that states do not inappropriately use tactics such as prior authorization, utilization review, and/or quantity limits to restrict access to care. Advocates should act as enforcers of the protections the Social Security Act offers to Medicaid beneficiaries against discrimination and inadequate coverage.

Although there is no deadline for a state to expand a Medicaid program in compliance with the ACA, states that are expanding may submit State Plan Amendments to the Centers for Medicare and Medicaid Services (CMS), identifying an Alternative Benefit Plan (including contracts with managed care organizations) as of January 2013.

Medicaid Expansion

In a speech delivered on September 13, 2012, the Director of the Centers for Medicare and Medicaid Services announced that the Administration would not release further guidance about the possibility of partial expansion of Medicaid (e.g., to 100% instead of 133% FPL).¹⁷ However, the announcement did leave open the possibility that partial expansion may be met with federal support after the 100% federal matching period ends (2017). This issue is now resolved, as HHS issued “Frequently Asked Questions on Exchanges, Market Reforms and Medicaid” (FAQ) on December 10, 2012, clarifying that states cannot expand Medicaid to less than 133% FPL and still receive 100% federal matching funds.

- **Community Response:** Advocates wrote to both HHS and CMS expressing strong opposition to partial Medicaid expansion and were pleased with the decision not to allow such expansion as articulated in the December 10th FAQ. Advocates must, however, continue to push state Governors and legislatures to fully implement the ACA, including its Medicaid provisions. Moreover, advocates should emphasize that disproportionate share hospital payments (federal payments that subsidize hospitals for the provision of uncompensated care) will be significantly reduced as the ACA is implemented, regardless of a state’s decision to expand Medicaid. In other words, failure to expand will result not only in lack of access to care for millions of low-income individuals, but also hospital insolvency.

Finally, states may withdraw from the Medicaid expansion provision even after expanding, unless Congress enacts a maintenance-of-effort provision that explicitly requires states to maintain current eligibility standards.

Nondiscrimination

In November, CMS issued a proposed rule for health insurance market reforms, implementing a critical provision of the ACA.¹⁸ The rule would prohibit insurance companies from: (1) denying coverage based on a pre-existing condition; or (2) charging higher premiums based on "current or past health problems, gender, occupation, and small employer size or industry." In other words, insurers may only differentiate premiums on the basis of "age, tobacco use, family size, and geography."¹⁹

- **Community Response:** This provision of the ACA is critical to individuals living with HIV/AIDS, who previously could not obtain most forms of health insurance. Prohibiting denial of coverage based on pre-existing conditions will allow all eligible residents to access affordable healthcare, regardless of health status. Advocates should strongly support this proposed rule. Public comment is due December 26.

Care Coordination

To better facilitate coordinated care for individuals living with chronic and complex conditions, including HIV/AIDS, the ACA calls for CMS – in collaboration with private insurers – to pay case management bonuses to primary care providers treating Medicare patients (\$20 per patient per month).²⁰ This strategy has been initiated, and seeks to improve delivery of preventive care, engage patients with the management of their condition(s), and provide better coordination of the treatment of multiple illnesses.

Bridge to 2014

Decline in Number of Uninsured

The U.S. Census Bureau reported that an additional 1.4 million Americans had insurance in 2011 as compared to 2010, and the number of uninsured has declined by almost 2 million in the same period.²¹ Forty percent of the decline is attributable to early implementation of the ACA (e.g., early Medicaid expansion efforts and a universal policy allowing individuals up to age 26 to remain on their parent’s health insurance plans).

Consumer Savings

Not only are more Americans insured, but also many are realizing substantial savings as a result of health reform. For example, the average Medicare beneficiary will save \$5,000 between 2010 and 2022 because of ACA reforms. Those with high prescription costs will save even more: over \$18,000. As of 2010, Medicare beneficiaries began receiving \$250 rebates after reaching the “donut hole” and are now receiving a 50% and 14% discount on brand name and generic prescriptions, respectively. These discounts will continue to increase until 2020, when expansion of Medicare prescription drug coverage eliminates the donut hole in entirety.^{22,23}

Moreover, since the provision of medical loss ratio rebates (described in the August Monitoring Report), 13 million consumers received rebates totaling \$1.1 billion dollars (an average of \$151 per family).²⁴ In addition, due to the ACA’s rate review provision (requiring that most plans disclose and justify as reasonable any premium increase of 10% or more), consumers have saved approximately one billion dollars on premiums.²⁵

Patient Centered Outcomes Research Institute Seeks Input

The Patient Centered Outcomes Research Institute (PCORI), created by the ACA,²⁶ is holding workshops (with some scheduled for December 2012), seeking patient and stakeholder feedback as they develop a research agenda and make funding decisions. PCORI has already approved a draft of research methods to evaluate comparative effectiveness research.²⁷

- **Community Response:** PCORI’s request for patient input presents an opportunity to place the HIV/AIDS agenda on their radar. PCORI is seeking research questions to improve health care delivery and/or reduce disparities. Comments may be submitted online, at pcori.org.

Congress

Sequestration

As the nation approaches the “fiscal cliff,” representing an unsustainable national deficit, Congress and the Administration are engaged in extensive debate surrounding budget cuts and raising revenue. Automatic cuts to federal programs – also known as sequestration – was included in the Budget Control Act of 2011, and is scheduled to take effect in January 2013, unless Congress takes action otherwise. This would include \$2.4 billion in cuts from federal public health programs alone, amounting to a total of \$4.9 billion in reduced spending since 2010.²⁸ Fortunately, the House has proposed to allow the Congressional Budget Office to account not only for the immediate cost of prevention programs, but also the long terms savings that would be realized ten years down the road (thereby offsetting the initial costs themselves).²⁹ This is a promising measure because most prevention programs disproportionately benefit minorities, including low-income people living with HIV/AIDS.

- **Community Response:** If sequestration (automatic budget cuts to programs including Ryan White) occurs, access to antiretroviral treatment and other critical services for people living with HIV/AIDS will be restricted. Advocates have already spoken out about the importance of this fiscal matter to those living with chronic illnesses, and should continue to do so.^{30,31}

ACA Funding Opportunities

Medicaid Community Based Services

CMS is issuing 10 “TEFT” demonstration grants (Testing Experience and Functional Assessment Tools), totaling \$45 million over 4 years. This funding is intended to support states in assessing their capacity to use quality measurement tools and e-health to better serve Medicaid beneficiaries engaged in long-term care.^{32,33}

In addition, the Obama Administration announced that HIV/AIDS would be included as one of the chronic conditions eligible for enhanced federal funding for the development of health homes, designed to coordinate care of complex healthcare needs.³⁴

Finally, the Centers for Disease Control and Prevention recently distributed \$70 million to 40 low-income communities under the Community Transformation Grants Program, established by the ACA.³⁵ This funding will support evidence-based strategies that reduce health disparities and expand preventive services within the community (e.g., increase access to healthy foods, athletic facilities, and local health workers).³⁶

Exchange Establishments & Consumer Assistance Programs

HHS has awarded \$20 million to 24 states as a part of the Consumer Assistance Program (CAP), in preparation for roll out of state based exchanges. CAP is intended to assist consumers with

the enrollment and appeals process, as well as facilitate consumer education and the processing of complaints, and oversee enforcement.³⁷

Exchange grants are being issued in phases; for those in the first year of establishment, level one grants were distributed (California, Hawaii, Iowa, New York), and for those further along in the process, level two grants have been issued (Connecticut, Maryland, Nevada, and Vermont). In addition, a new round of Exchange Establishment grants (for those beginning the process) have been awarded to Arkansas, Colorado, Kentucky, Massachusetts, Minnesota, and the District of Columbia.^{38,39}

Mental Health Funding

HHS recently awarded \$9.8 million to 24 graduate schools in social work and psychology to increase the number of providers available in rural areas as well as those with training to work with veterans and active military personnel.⁴⁰

- **Community Response:** Funding linked to placing practitioners in rural health areas is particularly important to those living with HIV/AIDS, who often suffer from mental health illnesses or substance abuse disorders, but lack access to appropriate providers.

One Stop Applications for Charitable Antiretroviral Drug Access

At the International AIDS Conference, held in July, HHS announced the initiation of a public-private partnership between the Health Resources and Service Administration, the National Alliance of State and Territorial AIDS Directors, and several pharmaceutical companies that will allow uninsured individuals living with HIV to apply for multiple patient assistance programs using one application (the common patient assistance program application). This should allow uninsured, low-income people living with HIV to access comprehensive antiretroviral drugs without navigating multiple complicated application processes.⁴¹

- **Community Response:** While charitable and promising for those in need, the common patient assistance program application program is a stopgap measure as health reform is in the early phases of implementation. Comprehensive access to healthcare coverage remains critical.

The Healthcare Reform Monitoring Project is supported by Bristol-Myers Squibb with no editorial review or discretion. The content of the report does not necessarily reflect the views or opinions of Bristol-Myers Squibb.

¹ Letter from Kathleen Sebelius, Secretary, Dept. of Health and Human Services, to State Governors (Nov. 9, 2012).

² 77 Fed. Reg. 70786 (Nov. 27, 2012).

³ Press Release, Dept. of Health & Human Services, Health Care Law Ensures Consumers Get Clear, Consistent Information About Health Coverage (Sept. 24, 2012).

⁴ Letter from AARP et al, to Hilda S. Solis, Secretary, Dept. of Labor, Kathleen Sebelius, Secretary, Dept. of Health and Human Services, and Timothy Geithner, Secretary, Dept. of the Treasury (March 7, 2012).

⁵ CA.GOV, California Health Benefit Exchange, <http://www.healthexchange.ca.gov/Pages/Default.aspx>.

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- ⁶ Health Management Associates, Illinois Navigator Program Design Final Report, Presented to Illinois Department of Insurance (June 27, 2012).
- ⁷ Letter from Kim Lewis and Abbi Coursolle, National Health Law Program, to the Honorable Diana Dooley, Chair, and Peter Lee, Executive Director, California Health Benefit Exchange (Aug. 6, 2012).
- ⁸ Press Release, AIDS Foundation of Chicago, Comments on Illinois Navigator Program Design Final Report (July 27, 2012).
- ⁹ Dept. of Health & Human Services, 45 CFR Parts 147, 155, 156, Proposed Rule: Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, § 147.150 [hereinafter, "Proposed Rule"].
- ¹⁰ Proposed Rule § 156.115(a)(2).
- ¹¹ US Preventive Services Task Force, Screening for HIV: US Preventive Services Task Force Recommendation Statement DRAFT, Nov. 20, 2012, *available at* <http://www.uspreventiveservicestaskforce.org/draftrec.htm>.
- ¹² Letter from the ACCSES et al, to State Leaders Designing Essential Health Benefits Packages (Oct, 2012).
- ¹³ Proposed Rule, § 156.120.
- ¹⁴ *See e.g.*, Center for Health Law and Policy Innovation of Harvard Law School, State Health Reform Impact Modeling Project, forthcoming (on file with Katherine Record, krecord@harvard.law.edu).
- ¹⁵ Proposed Rule, § 156.125.
- ¹⁶ Letter from Cindy Mann, Director, Centers for Medicare and Medicaid Services, to State Medicaid Directors (Nov. 20, 2012).
- ¹⁷ Stakeholder conference call with Cindy Mann, Deputy Administrator, Centers for Medicare and Medicaid Services and Director, Centers for Medicaid and CHIP Services (Sept. 13, 2012).
- ¹⁸ Patient Protection and Affordable Care Act (ACA), 42 U.S.C. § 1201 (2010).
- ¹⁹ 77 Fed. Reg. 70584 (Nov. 26, 2012).
- ²⁰ ACA § 3021.
- ²¹ U.S. Census Bureau, Health Insurance Coverage Status: 2011 American Community Survey 1-Year Estimates (Dec. 5, 2012).
- ²² Press Release, Dept. of Health & Human Services, Medicare Advantage Remains Strong (Sept 19, 2012).
- ²³ Press Release, Dept. of Health & Human Services, Through the Affordable Care Act, Americans with Medicare Will Save \$5,000 through 2022 (Sept. 21, 2012).
- ²⁴ Press Release, Dept. of Health & Human Services, Health Care Law Saved an Estimated \$2.1 Billion for Consumers (Sept. 11, 2012).
- ²⁵ ACA § 1003.
- ²⁶ ACA § 6301.
- ²⁷ Press Release, Association of American Medical Colleges, PCORI Board of Governors Approves Methodology Report (Nov. 30, 2012).
- ²⁸ OFFICE OF MANAGEMENT AND BUDGET, REPORT PURSUANT TO THE SEQUESTRATION TRANSPARENCY ACT OF 2012 (P.L. 112-155).
- ²⁹ The Preventative Health Savings Act of 2012, H.R. 6482, 112th Cong. (2012).
- ³⁰ SAVE for All, Strengthening America's Values and Economy for All, Statement of Principles (2011).
- ³¹ Letter from HIV Medicine Association to John Boehner, Speaker of the House of Representatives, Nancy Pelosi, House Minority Leader, Harry Reid, Senate Majority Leader, and Mitch McConnell, Senate Minority Leader (Sept. 10, 2012).
- ³² ACA § 2701.
- ³³ Press Release, Division of Community Systems Transformation, Demonstration Grant for Testing Experience and Functional Tools (TEFT) in Community-Based Long Term Services and Supports (Dec. 5, 2012).
- ³⁴ Press Release, Dept. of Health & Human Services, Statement from HHS Secretary Kathleen Sebelius on World Aids Day (Nov. 29, 2012).
- ³⁵ ACA § 4002.
- ³⁶ Centers for Disease Control and Prevention, Community Transformation Grants (Nov. 15, 2012).
- ³⁷ Press Release, HealthCare.gov, Consumer Assistance Program Grants: How States are Using New Resource to Give Consumers Greater Control of Their Health Care (Aug. 24, 2012).
- ³⁸ ACA § 1311.
- ³⁹ Press Release, Dept. of Health & Human Services, HHS Continues to Support State Efforts to Build Affordable Insurance Exchanges (Sept. 27, 2012).

⁴⁰ Press Release, Dept. of Health & Human Services, Health Care Law Increases Number of Mental and Behavioral Health Providers (Sept. 25, 2012).

⁴¹ Press Release, Dept. of Health & Human Services, Common Application for HIV Patient Assistance Program Expedites Application Process for Lifesaving Drugs (Sept. 12, 2012).