Across the spectrum of health systems among developed nations, the US has the most serious epidemic among developed nations. The US has the most market oriented system. The ACA maintains that market orientation. Efforts to expand access to insurance coverage and reform how health services in the US are financed and delivered go back roughly a century. The US health system supports innovation and the highest quality care is often found here, yet we generally get less for our investment in terms of improved health than other nations.

The ACA responds to pressing national concerns. Efforts to expand access to insurance coverage and reform how health services in the US are financed and delivered go back roughly a century:

- Across the spectrum of health systems among developed nations, the US has the most market oriented system. The ACA maintains that market orientation.
- Despite investing more than any other nation in terms of total health spending and per capita spending, the US health system performs poorly on many population-level metrics, and we face a major challenge of increasing costs. Also, we are witnessing continued erosion of the employer-sponsored market.
- Roughly 16% of the US population, or about 50 million Americans are uninsured.
- The US health system supports innovation and the highest quality care is often found here, yet we generally get less for our investment in terms of improved health than other nations.

The US has a relatively stable, concentrated epidemic. The US has the most serious epidemic among developed nations:

- Approximately 1.1 million Americans living with HIV and about 50,000 new infections per year. (A decline from the mid 80s when we had about 130,000 infections per year)
- Heavily concentrated among gay and bisexual men (gay men), black Americans, Latinos, and substance users. (Other highly impacted groups in specific communities across the country)
- Gay men have always comprised the largest number and proportion of cases and the majority of AIDS deaths. Today, they are 2% of the US population, yet account for 64% of new infections. HIV rates are stable or falling for all groups in the US, except for young gay men of all races. (New infections among young black gay men increased by 48% from 2006-2009, even though they engage in comparable or lower risk than other gay men)

HIV in the United States

<table>
<thead>
<tr>
<th>Key HIV</th>
<th>Infections</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSM</td>
<td>11,206</td>
</tr>
<tr>
<td>Heterosexual Women</td>
<td>5,100</td>
</tr>
<tr>
<td>Heterosexual Men</td>
<td>2,708</td>
</tr>
<tr>
<td>Black Male IDUs</td>
<td>1,300</td>
</tr>
<tr>
<td>Black Female IDUs</td>
<td>1,200</td>
</tr>
<tr>
<td>Hispanic Women</td>
<td>1,156</td>
</tr>
<tr>
<td>Other</td>
<td>953</td>
</tr>
</tbody>
</table>

Source: Centers for Disease Control and Prevention, December 2013.
Roughly two-thirds of federal HIV funding is for care and treatment.

Federal Funding for Domestic HIV/AIDS, 2012

- Ryan White: 17%
- Medicare: 20%
- Medicaid: 16%
- NIH (domestic): 13%
- CDC: 11%
- VA (Veterans Affairs): 9%
- SAMHSA: 6%
- Other: 1%
- Social Security: 1%

Total = $23.31 Billion


Large numbers of people with HIV lack health insurance.

Source: Kaiser Family Foundation, May 2014.

Thirty percent of Ryan White clients are uninsured.

Ryan White Clients by Payer, 2010

- Medicaid: 50%
- Medicare: 14%
- Other Public: 14%
- Other Insurance: 7%
- Uninsured: 36%
- Private: 15%

Key provisions of the ACA are already in effect.

1. Expansions of coverage or services
   - Medicaid: Coverage for childless adults
   - Medicare: ADAP counts toward TTYOP
   - Medicare: Closing the drug coverage gap
   - Insurance protections for consumers: Lifetime limits and rescission on coverage
   - Insurance protections for consumers: Pre-existing condition insurance plan (PCIP)
   - Young adult dependent coverage

2. Affordable Care Act (ACA) Overview

Key provisions of the ACA are already in effect.

Prevention
- Prevention and Public Health Fund
- Free prevention services and annual HIV screenings for women

Health system improvements
- Medicaid: Health homes
- Medicare: Increased payments for primary care
- Medicaid/Medicare: Integrated care for dual eligibles
- New investments in health centers and National Health Service Corps
- Health disparities data collection
Most coverage expansions will take place on January 1st 2014

Key provisions

• Expanded Medicaid coverage
• Establishment of health insurance marketplaces
• Premium and cost sharing subsidies
• Guaranteed availability of coverage: prohibits pre-existing condition exclusions
• No annual limit on coverage
• Essential health benefits (EHBs) and essential community providers (ECPs)
• Individual requirement to have insurance

The Supreme Court’s Decision

INDIVIDUAL MANDATE: Is the requirement to have health insurance coverage a constitutional exercise of Congress’ power?

– Court held that the mandate is a valid exercise of the power to tax (5-4 decision).

ANTI-INJUNCTION ACT: Does the Court have jurisdiction to decide the case when it did, prior to the payment of the tax penalty for failure to obtain coverage?

– Court determined it is not barred from reviewing the merits of the individual mandate (9-0 decision).

SEVERABILITY: If the individual mandate is found to be unconstitutional, can this be severed from the rest of the law or must the whole law be struck down?

– Because it upheld the mandate, the Court did not need to decide this issue. The dissenters who would have struck down mandate stated that they would not have found the law to be severable and would have struck down the entire law.

MANDATORY MEDICAID EXPANSION: Can Congress require states to expand Medicaid to all persons below 138% of poverty as a condition of participation in Medicaid?

– Court found that the mandatory expansion is unconstitutionally coercive, but remedied this by limiting the Secretary’s ability to withhold all federal Medicaid funds for failure to expand. Court permits the Secretary to withhold only Medicaid funds for newly eligible beneficiaries, effectively making the expansion an option for states (5-4 decision).

Slight majority of HIV+ in states expanding Medicaid

Nearly half of HIV+ are in states not expanding Medicaid. States not expanding are concentrated in the south, a region disproportionately impacted by HIV with a relatively weak health care and HIV care capacity.

And, half of HIV+ in states defaulting to Federal exchange

What is happening in the Mountain Plains AETC?

State | Expanding Medicaid? | Type of Marketplace
--- | --- | ---
CO | Yes | State
KS | No | Federal
ND | Yes | Federal
NE | No | Federal
NM | Yes | State
SD | No | Federal
UT | No | Partnership
WY | No | Federal

MPAETC represents 2.43% (~21,100) of diagnosed people with HIV in the US in 2010. Of these, 65% are in states that will expand Medicaid in January 2014 and 35% are in states that will not.

Anticipated Impact of the ACA
Key actions for consumers

- Local plan options to be available on September 1st
- Enrollment begins on October 1st
- Coverage begins on January 1st
- There is a penalty for not having coverage (affordability exception): Greater of 1% of annual income or $95 in 2014 rising to $695 or 2.5% of income by 2016 with subsequent inflation adjustments
- Determine if your state has expanded Medicaid and whether you are income eligible (<138% poverty, $1,321 in monthly income in 2013)
- Higher income people and people not eligible for Medicaid are eligible for coverage from the marketplaces with premium subsidies (100-400% of poverty, $95-3,830/month and cost sharing assistance (100-250%, $956-2,394/month)
- Determine where you want to go for your care, and select a plan where your doctor is in network
- Talk to others when deciding and seek out assistance if needed
- Encourage all friends and family to enroll in coverage

Is ACA implementation proceeding smoothly?

- The press reports on problems with implementation, how are things going?
  - Implementation is an enormous undertaking and most of the federal responsibilities require coordinated joint action from HHS, Treasury, and Labor. Major key milestones have been met and coverage expansion will take place on time. There will be bumps along the way, but the core provisions of the ACA are falling into place.
- Will the exchanges be ready?
  - All indications are that the state-based exchanges will be ready and the Feds have promised that the federal exchanges will be operational by January 1st. Initially, some may be bare bones efforts
- Is the delayed enforcement of the employer mandate a sign of broader problems?
  - No. Impacts few employers and was requested by employer community. Need to work out impact on consumers requesting exchange tax credits

What will this mean for HIV providers?

- Most patients with HIV will retain their current Medicaid or private insurance coverage
- For those that rely on Ryan White for supplemental services, this need will continue
- Many people with HIV whose primary source of coverage is Ryan White will move into Medicaid or private insurance coverage—providers will need to become part of health plan networks so that they can continue treating all of their HIV patients
- Essential community provider rules create an opportunity for Ryan White providers to help health plans satisfy minimum network requirements
- Ryan White funding will be needed in the future, but HIV clinics will need to diversify and build the capacity to do third-party billing
- Even if they do not see this as their role, patients will turn to providers as the trusted resource for navigating the health system changes

What will this mean for people with HIV?

- Most people with HIV will not experience major changes in their coverage
- For people who are uninsured and/or only receive Ryan White, most (except for the undocumented and those below poverty who are ineligible for marketplace subsidies in states that do not expand Medicaid) will gain new access to stable and affordable coverage
- For people with HIV in states that do not expand Medicaid, they should not be worse off than they are today—emphasizes need for Ryan White providers to help health plans satisfy minimum network requirements
- Likely to be a bumpy transition to new coverage—the Medicare Part D implementation experience showed us that most people will need assistance navigating the transition
- There will be gaps in coverage and treatment denials in the early months, but...
- The end result will be a more stable system of care for people with HIV, yet the Supreme Court’s decision will lead to more variability across states and potentially increased disparities

What are issues to watch?

- Will qualified health plans (QHPs) exist in every county of every state? If not, what will the Feds do?
- Most states will have decent competition among plans, but will every consumer have a choice of plans?
- Will state information technology (IT) systems be ready?
- What enforcement will exist in states resisting implementation? Feds will have the authority to regulate, but will they have the resources?
- Will the Federal outreach plan be sufficient? Continued partisan obstruction has meant that funding has been (too) limited to do extensive outreach

Decision tree for consumers

- Do you have comprehensive insurance through your job?
  - Keep your current insurance
- Do you have Medicaid or Medicare?
  - Keep your current insurance
- Are you under 26 and a dependent of your parents?
  - You may be eligible for under your parent’s insurance plan
- Are you a non-citizen legal resident?
  - You are eligible for ACA coverage, although you are ineligible for Medicaid and some other public benefits for the first 5 years in the US. The requirement to have insurance applies.
- Are you a non-citizen undocumented resident?
  - You are ineligible for ACA coverage. If you have HIV, you can access Ryan White services
- Are you uninsured?
  - Your income will determine whether you are eligible for Medicaid or a private insurance plan purchased from a marketplace, and whether you are eligible for premium and cost-sharing subsidies

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Using the ACA to Implement the National HIV/AIDS Strategy

Collective action is needed

- Support outreach and enrollment assistance: Target patients, providers, and the general public to educate about the coming transition, new options, and where to turn for help
- Focus on coverage gaps during the immediate transition: Experience with Part D tells us there will be people denied medications at the point of sale. Consider support for HarborPath, PAPs, and other programs that seek to prevent drug denials during the transition
- Support early treatment initiation: Insurance coverage is just one element of quality care for people with HIV. To improve performance along the cascade, we must address provider and patient barriers to early treatment initiation
- Focus on the cascade: The health system is effective at performing certain functions (see strong performance once people have been retained in care). Work to build the capacity of the health system to improve linkage, retention, re-engagement, and adherence supports

Ryan White will remain critical

- Third largest source of financing for HIV care after Medicaid and Medicare. Roughly 500,000 people with HIV receive at least one service from Ryan White, some count on it for most of their care
- FY 2012 federal funding level was $2.4 billion
- Core functions of Ryan White not supplanted by the ACA, but the context in which the program operates is changing, and this creates new opportunities
- Ryan White has never been a static program, but the new opportunities may demand even more changes than past reauthorizations
- We need both short-term strategies to support people with HIV through the immediate transition period caused by the ACA and a long-term vision of how Ryan White fits into a more integrated and efficient health care system
- We have some time to make thoughtful decisions about the future and the HIV community should work with policy makers to chart a new course over the next few years

Massachusetts gives up hope

- Began implementing health reform more than a decade ago, to near universal access
- Changed how Ryan White funding was used in state, with greater share of resources shifting from paying for care to paying for:
  - Insurance continuation
  - Co-payments
  - Support services to help engage people with HIV in care and support adherence
- State has observed decline in new HIV diagnoses, high viral load suppression
- Attributes to the combination of expanded insurance coverage, ART access, and extensive HIV community care network including Ryan White providers


Getting all people with HIV virally suppressed is our goal

- Biggest drop-offs in the care continuum result from inadequate linkage, retention, re-engagement, and adherence supports — functions the health system has not been historically good at performing

The HIV Treatment Cascade in the United States

Source: Adapted from CDC “HIV in the United States — Diagnosis of Care,” July 2013.

Thank you!