



HIV/HEPATITIS HEALTH REFORM WATCH

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The HIV/Hepatitis Health Reform Watch is a new resource from NASTAD to provide periodic updates and resources on the implementation of the landmark *Patient Protection and Affordable Care Act* (PPACA) as it pertains to HIV/AIDS and hepatitis programs and those living with these diseases.

The PPACA makes significant progress in ensuring that people living with HIV/AIDS have access to affordable, high-quality care. To name just a few of the most impactful provisions, the law expands Medicaid for people with incomes up to 133 percent of the Federal Poverty Level (FPL) regardless of health status; allows ADAP contributions to count toward the out of pocket expenses limit under Medicare Part D providing relief to ADAPs to serve other clients, and eliminates preexisting condition exclusions that have been a barrier to coverage for people living with HIV/AIDS. The law also expands access to clinical preventive services and invests \$15 billion over ten years in prevention and wellness.

Spotlight Issue

Temporary High Risk Pool Program

Per PPACA, the Department of Health and Human Services (HHS) is in the process of establishing temporary federally funded high risk insurance pools in each state. An individual will be eligible to participate in a high risk pool if the person is a citizen or lawfully present in the United States, has not had creditable coverage during the previous six months, and has a pre-existing condition. The high risk insurance pool provides states an opportunity to expand coverage to people living with HIV and/or viral hepatitis that have been excluded from coverage due to their preexisting condition.

States have the following options:

- Operate a new high risk pool alongside a current state high risk pool;

- Establish a new high risk pool (in a state that does not currently have a high risk pool);
- Build upon other existing coverage programs designed to cover high risk individuals;
- Contract with a current HIPAA carrier of last resort or other carrier, to provide subsidized coverage for the eligible population;
- Do nothing, in which case HHS would carry out a coverage program in the state.

Two or more states may elect to join together to establish and operate a single qualified high risk pool that covers enrollees in each state.

Currently 35 states operate state based high risk pools. Under the law, states must agree to maintain funding at FY2009 levels for existing high risk pools.

The law provides \$5 billion of federal funds to support the temporary high risk pool program. The \$5 billion will pay claims in excess of the premiums collected from members in the pool. Funds will be available beginning on July 1, 2010 and end January 1, 2014 when state-based health insurance exchanges become available.

Benefits are determined by the Secretary. Coverage may not limit benefits for preexisting conditions and must have an actuarial value of at least 65 percent of the total costs of the benefits provided. The out-of-pocket limits can be no greater than those linked to amounts for high-deductible health plans with linked health savings accounts or \$5,950 for individuals and \$11,900 for families, excluding premiums. Premiums charged to enrollees may vary on the basis of age, by a factor not greater than 4 to 1.

On April 2, HHS Secretary Sebelius sent a [letter](#) to states asking them to declare by April 30, 2010 whether they would run the federally funded high risk pool themselves or defer to HHS to find a third party to run it. 48 states and DC have [reported](#) back to HHS, with 29 states and DC opting to run their own program, 19 opting for HHS to administer the program, and two seeking further clarification.

- States opting to operate their own high-risk pool program: Alaska, Arkansas, California, Colorado, Connecticut, District of Columbia, Illinois, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Missouri, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Vermont, Washington, West Virginia and Wisconsin.

- States opting to have HHS run the program, “federal fallback states”, include: Alabama, Arizona, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Louisiana, Minnesota, Mississippi, Nebraska, Nevada, North Dakota, South Carolina, Tennessee, Texas, Virginia, and Wyoming.
- States delaying their decision: Rhode Island and Utah.

HHS has provided potential allocation amounts for states in their [fact sheet](#) on the program. They are using a formula almost identical to the Children’s Health Insurance Program (CHIP) using a combination of factors including nonelderly population, nonelderly uninsured, and geographic cost as a guide. HHS intends to reallocate allotments after a period of not more than two years, based on an assessment of state actual enrollment and expenditures. Some states have expressed concern that \$5 billion will be insufficient to support such a program for the full three and half years. This has been substantiated by an April 22 [memo](#) from the CMS Actuary that estimates the funds will be exhausted by 2012.

On May 10, 2010, HHS’ [Office of Consumer Information and Insurance Oversight](#) released a [solicitation](#) for proposals for states to operate qualified high risk pools which are due June 1, 2010. HHS will award contracts to states that have submitted acceptable contract proposals on July 1, 2010. The proposals must include a timeframe for accepting enrollments. States can submit questions on the solicitation or the program in general to highriskpools@cms.hhs.gov.

Issues for consideration:

- In the 35 states that currently have high risk insurance pools there is wide variability in how a person is deemed uninsurable. They fall into two broad categories. The first is a list of medically eligible conditions and the second is a letter of denial of coverage. HIV and viral hepatitis are often on the list of eligible conditions which makes it far less cumbersome for an enrollee than applying and being denied coverage. States will have to determine the definition of uninsurable for their solicitation proposal and HHS will have to determine this for federal fallback states.
- Some of the existing state high risk pools offer premium assistance or subsidies for low income people. The law does not prohibit states or other sources from providing assistance to low-income enrollees, but it is also not explicitly addressed. This is particularly important for Ryan White Part B and ADAP. HHS would like states to address this issue in their solicitation proposals. This will also be an issue as HHS determines the parameters for the contractors in the federal fallback states.
- As part of the state solicitation proposal states will include their strategies for limiting program costs to the anticipated allocations available for each

state. Therefore it is likely that states will institute waiting lists or enrollment caps to stay within their allotted funding.

- Start up issues in establishing the high risk pools are inevitable. This will be particularly the case for the eight states and DC that will run their own pool but don't currently have an existing one. Like the establishment of the CHIP program, this will result in variability across states in spending and carryover of funding.
- The twenty states with an existing high risk pool that will be establishing a federally funded pool will have to identify the best way to run parallel programs with different premiums and financing. This will also require branding of a new program for enrollment with a potentially similar sounding name as their existing pool.
- States have expressed concern that while the program is federally funded they will still be on the hook for administrative expenses. States can use the federal funds and premiums collected to cover the associated administrative expenses.

High Risk Pool Resources:

- [HHS Fact Sheet](#)
- [HHS High Risk Pool Solicitation](#)
- National Conference of State Legislatures (NCSL) - [Fact Sheet](#)
- NCSL - [Coverage of High-Risk Individuals: State and Federal High-Risk Pools](#)
- NCSL webinar - [Health Reform: What Legislators Need to Know about High Risk Pools](#) and [slides](#)
- Center for Medicare Advocacy - [Health Care Reform Brings State High Risk Health Insurance Pools](#)
- Kaiser Family Foundation - [Issues for Structuring Interim High-Risk Pools](#)
- Kaiser Family Foundation - [Questions about Temporary High-Risk Pools](#)

Prevention and Wellness

HHS is close to announcing the allocation method for distributing the \$500 million included in FY2010 for the Prevention and Public Health Fund.

NASTAD believes that HIV prevention activities will be eligible for some portion of the funding. The Association of State and Territorial Health Officials (ASTHO) has developed a section-by-section [funding table](#) that summarizes the appropriated or authorized funding for public health under the PPACA.

Federal Regulations

HHS has issued several regulations for public comment on aspects of health reform.

- [Dependent Coverage of Children To Age 26](#): Young adults, up to age 26, will be allowed to stay on their parent's insurance coverage. This rule examines when young adults will be allowed to remain on their parent's plan, and if they have already dropped off, when and how plans will allow them back on. Comments are due August 11, 2010 and rules go into effect September 23, 2010.
- [Web Portal](#): HHS must launch a website by July 1, 2010 that will allow consumers to view health insurance options in their states, including information about policies, premium prices and Medicaid and CHIP eligibility. Comments are due June 4, 2010.
- [Reinsurance for Early Retirees](#): The Early Retiree Reinsurance Program provides reimbursement to employment-based plans for a portion of the cost of the health benefits for early retirees. The program must be implemented by June 21, 2010 and lasts through January 1, 2014. Comments are due June 4, 2010.

Resources

Please see NASTAD's resource [document](#) for additional information related to health reform.