



HIV/HEPATITIS HEALTH REFORM WATCH

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The HIV/Hepatitis Health Reform Watch provides periodic updates and resources on the implementation of the landmark *Patient Protection and Affordable Care Act* as it pertains to HIV/AIDS and hepatitis programs and those living with these diseases. The legislation hereafter will be referred to as the Affordable Care Act or ACA.

Spotlight Issue

Medicaid Expansion

Medicaid covers the health and long-term care services for over sixty million low-income Americans, including many individuals with HIV/AIDS. The Affordable Care Act expands Medicaid significantly in order to cover more uninsured people. Specifically, by January 1, 2014, states will be required to expand Medicaid coverage to non-elderly, non-pregnant individuals (under age 65) with incomes less than 133 percent of the federal poverty level. These individuals will be hereafter referred to as the “newly eligible.” 133 percent of FPL is equivalent to \$14,400 per year for an individual and \$29,300 for a family in 2010. There will no longer be a requirement that people living with HIV have a disability diagnosis of AIDS to qualify for the program. As a result, many low-income adults without children, low-income parents and, in some instances, children covered through the Children’s Health Insurance Program (CHIP) will now be made eligible for Medicaid. The law’s changes in eligibility rules will help people living with HIV by reducing barriers to obtain Medicaid coverage and increasing their access to prescription drugs, primary care services, mental health services and dental

care. In total, Medicaid, along with CHIP, is expected to cover an additional 16 million people by 2019.¹

Through the state plan amendment process, states have the option to phase-in the expansion to the newly eligible after April 1, 2010 as long as the state does not extend coverage to (1) individuals with higher income before those with lower income or (2) to parents unless their children are enrolled Medicaid or other coverage. The income eligibility level for all newly eligible individuals must be the same and any reasonable income methodology may be used when calculating eligibility categories.

States choosing to expand Medicaid early will receive their regular federal medical assistance percentage (FMAP) rather than the enhanced FMAP that states are receiving from the economic recovery package (the American Recovery and Reinvestment Act, or ARRA). Beginning in 2014, states will receive full federal financing for three years and a higher matching rate for expansion populations, as defined by individuals with incomes between the state's Medicaid eligibility level from December 1, 2009, and 133 percent of poverty.

States have a Maintenance of Effort (MOE) requirement and must maintain the eligibility and enrollment policies and procedures that were in effect on March 23, 2010. If a state violates MOE, it will lose all federal matching funding for its entire Medicaid program until the violation is corrected.

Because many states are facing budget cuts, it will be difficult for states to expand Medicaid this year. Furthermore, it will be difficult to expand the programs without the federal government paying 100 percent of the expansion, which will not be available to states until 2014. For the few states that already provide coverage to low-income individuals, the early Medicaid expansion option will enable them to obtain additional federal funds for services they already provide.

Under ACA, newly eligible individuals will receive benefits through statutorily defined benchmark or benchmark equivalent benefit plans. The benefits package can be more limited than that available to current Medicaid recipients. But these plans must include prescription drugs and mental health benefits. Certain populations are exempt from enrollment in these plans and maintain their current benefits. States can choose benefits equivalent to the state's own employee health benefits plan, the Federal

¹ Congressional Budget Office, "H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation)" (March 20, 2010).

Employees Health Benefits Program (FEHBP), the HMO with the largest non-Medicaid enrollment in the state, or Secretary-approved coverage.

The Kaiser Family Foundation has provided an analysis on the national and state-by-state estimates resulting from Medicaid expansions in health reform. This analysis assumes that states will implement health reform and achieve levels of participation among newly eligible individuals similar to that of current enrollment rates in Medicaid. Based on these assumptions, Medicaid expansions will significantly increase coverage and reduce the number of uninsured, while limiting the increase in state spending. Approximately 95 percent of all new spending will come from the federal government between 2014 and 2019, with the 100 percent federal matching rate in 2014. While the federal share of costs varies based on state coverage levels, states will generally benefit from a large influx of federal dollars. Furthermore, state spending is expected to increase only 1.4 percent relative to baseline, which is small in relation to the estimated 27.4 percent increase in enrollment and 22.1 percent increase in federal spending for Medicaid. In general, states with high uninsured rates and low coverage levels will receive the largest increase in federal funding and coverage. Depending on the state's participation in the implementation of health reform, Medicaid expansion with the support of federal funding will allow states to reduce costs resulting from uncompensated care. Further information on state-by-state estimates can be seen at the Kaiser Family Foundation's ["Medicaid Expansion in Health Reform: National and State Estimates of Coverage and Cost."](#)

In June, Connecticut was the first state to include low-income adults in its Medicaid program under the health reform expansion, allowing approximately 45,000 adults to become eligible for Medicaid. Individuals in Connecticut with an annual income up to 56 percent of the FPL, or \$6,650 per year for an individual, will be able to enroll in Medicaid in 2010. The enrollees under the expanded coverage will receive the standard Medicaid benefit package for adults, including: inpatient and outpatient hospital services, physician services, laboratory services, prescription drugs, mental health services, immunizations, and emergency services. Federal funds will be available to Connecticut with the regular federal Medicaid matching rate under the coverage expansion, with estimated savings to the state of \$53 million by July 2011. For additional information, see the Department of Health and Human Services' news release, ["Connecticut First in Nation to Expand Medicaid Coverage to New Groups Under the Affordable Care Act."](#)

States can expand access to Medicaid for non-disabled persons with HIV prior to 2014 through the 1115 waiver process. 1115 waivers are a way that states can test new coverage approaches under Medicaid. The cost-

neutrality requirement, that it cost the federal government no more than it would have with the waiver, has been a barrier to states to take up this option. The 1115 waiver would allow states that are already spending significant state dollars on HIV care and treatment to receive a federal match for those expenses. This would allow states to maximize their state resources and relieve the fiscal pressure on their Ryan White Programs, including strained AIDS Drug Assistance Programs. States would receive their regular federal Medicaid matching rate.

Medicaid Expansion Resources

- Center for Medicare and Medicaid Services - [New Option for Coverage of Individuals under Medicaid](#)
- Center for Medicare and Medicaid Services - [Medicaid Prescription Drug Rebates](#)
- Families USA - [Medicaid Maintenance of Effort](#)
- Families USA - [Early Medicaid Expansions under Health Reform](#)
- House Ways and Means Committee - [Maintaining and Improving Medicaid](#)
- Kaiser Family Foundation - [Optimizing Medicaid Enrollment](#)
- Kaiser Family Foundation - [Financing New Medicaid Coverage Under Health Reform: The Role of the Federal Government and States](#)
- Kaiser Family Foundation - [Medicaid Expansion in Health Reform: National and State Estimates of Coverage and Cost](#)
- Kaiser Family Foundation - [The Role of Section 1115 Waivers in Medicaid and CHIP: Looking Back and Looking Forward](#)

Prevention and Wellness

During the release of the National HIV/AIDS Strategy it was announced that the \$30 million from the Prevention and Public Health Fund designated for HIV prevention activities would be used to assist in implementing the Strategy. In remarks at the International AIDS Conference, Jeff Crowley noted that the \$30 million would be for new investments to achieve strategy goals including supporting combination prevention activities; states' plans to support strategy efforts; and STI and HIV surveillance. Thus far, a funding opportunity announcement (FOA) has been released allocating \$5.6 million for "[HIV/AIDS Surveillance: Enhancing Laboratory Reporting](#)" to improve reporting of CD4s and viral loads. ASTHO has developed a [summary](#) of the allocation of funds for the entire \$500 million distribution in FY2010 through the Fund.

Nominations Sought for HHS Minority Health Committee

The HHS Office of Public Health and Science is [seeking nominations](#) for members of the Advisory Committee on Minority Health due October 20. The Committee will advise HHS on improving the health of the racial and ethnic groups served by the Office of Minority Health. To qualify, an

individual must possess demonstrated expertise working on issues and/or matters impacting the health of racial and ethnic minority populations.

Federal Regulations

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

- [Insurance Preventive Benefits](#): Interim final rules were issued on July 19 to implement the new preventive benefits package for group health plans and health insurance coverage in the group and individual markets. Comments are due September 17. Under ACA, plans will not be allowed to charge cost-sharing on preventive services under specified conditions. Covered services include those that have received a grade of A or B from the U.S. Preventive Services Task Force and recommendations from the Advisory Committee on Immunization Practices. At a future date, the Health Resources and Services Administration (HRSA) will issue additional recommendations for women, infants, children and adolescents. HHS has prepared a number of [fact sheets](#) about this provision and its impact on specific populations, as well as a list of covered [services](#). The benefits go into effect September 23, 2010.
- [Medicare Preventive Health Benefits](#): Proposed rules were issued on July 13 and comments are due by August 24. The final rule is expected to be released around November 1. CMS issued a [fact sheet](#) about the rule.
- [Patients' Bill of Rights](#): An Interim Final Rule was issued on June 28 and comments are due by August 27. The rules:
 - Prohibit pre-existing condition exclusions for children under age 19 beginning in September, and for adults beginning in 2014;
 - Prohibit lifetime limits on the amount of coverage and restrict annual dollar limits on coverage;
 - Prohibit arbitrary rescissions of insurance;
 - Require payment of emergency services at in-network rates and without prior authorization;
 - Provide for direct access to ob/gyns;
 - Require plans to allow pediatricians to be the primary care provider for children; and
 - Provide for a choice of health care providers.
- [Pre-Existing Condition Insurance Plan Program \(PCIP\)](#): An Interim Final Rule was issued on July 30 and comments are due by September 28. The rules are for the twenty-one federal fall back states that contracted with HHS to establish PCIPs. The PCIPs will function until the exchanges are up and running in 2014. HHS has developed a fact sheet "[About the New Pre-Existing Condition Insurance Plan.](#)"

- [Planning and Establishment of State-Level Exchanges](#): A request for comment was issued on August 3 and comments are due by October 4. HHS is seeking comment on the types of standards Exchanges should be required to meet. HHS will use this input in developing the standards to support the establishment and operation of Exchanges. HHS has developed a fact sheet "[Establishing Health Insurance Exchanges and a New Competitive Marketplace](#)."
- [Electronic Health Records](#): Final rules were issued on July 13 on the "meaningful use" of electronic health records. CMS has additional [information](#) regarding the programs.
- [Group Health Plans Appeals and External Review Processes](#): Interim final rules were issued on July 23 and comments are due by September 21. The rule will enforce appeals processes for consumers in all health insurance and group health plans. Accompanying the new rule is a \$30 million grant program for states to establish and strengthen consumer assistance offices. A [fact sheet](#) about the rule and the grant program is also available.

Funding

- [Personal Responsibility Education Program \(PREP\)](#): The Administration for Children and Families at HHS made \$55 million in funding available to states and territories through the Personal Responsibility Education Program (PREP), established under the Affordable Care Act. States have until August 30, 2010 to submit a letter of intent with the full application due December 10.
- [Title V State Abstinence Education Grants](#): The Administration for Children and Families at HHS made \$50 million available for state grants to support programs to promote abstinence, reauthorized under the Affordable Care Act. States have until August 30, 2010 to submit a letter of intent with the full application due February 1, 2011.

Resources

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

Previous Volume

[Volume One](#) spotlighted the Temporary High Risk Insurance Pool Program. [Volume Two](#) highlighted the expansion of insurance coverage to young adults.

Founded in 1992, NASTAD is a nonprofit national association of state and territorial health department HIV/AIDS program directors who have programmatic responsibility for administering HIV/AIDS and viral hepatitis health care, prevention, education, and supportive services programs funded by state and federal governments. For more information, visit www.NASTAD.org.