Ryan White HIV/AIDS Program Part B/ADAP Health Care Coverage Coordination in 2024 and Beyond

Dori Molozanov

Senior Manager, Health Systems Integration

NASTAD

Presentation Outline

- Federal requirements for Ryan White HIV/AIDS Program (RWHAP) health care coverage assistance programs
- Private health insurance coordination
- Medicare coordination
- Medicaid coordination
- “Unwinding” Medicaid Protections in Place During the COVID-19 Pandemic
- Programmatic Considerations

Learning Objectives

- Identify opportunities to expand insurance coordination to include additional types of coverage and costs
- Understand key state and federal policies affecting access to coverage and care in 2024 and beyond
- Learn about emerging challenges for programs serving insured clients aging with HIV

Federal Requirements

Ryan White HIV/AIDS Program (RWHAP) funds may be used for premiums and cost-sharing associated with private insurance, Medicare, and Medicaid when doing so is determined to be cost effective in the aggregate and includes coverage for both:

- HIV outpatient/ambulatory health services, **and**
- Prescription drug coverage that includes at least one drug in each class of core antiretroviral therapeutics

HRSA Policy Clarification Notice (PCN) # 18-01,
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/18-01-use-rwhap-funds-premium-cost-sharing-assistance.pdf

Private Health Insurance Coordination

Private Health Insurance Coordination Overview

Individual Market

- Health coverage purchased by an individual for themselves and/or their family members
- Includes Marketplace and off-Marketplace plans

[Excludes any coverage that does not comply with the Affordable Care Act (ACA), such as short-term limited duration insurance.]

Group Market

- Coverage offered by an employer, union, or association to its workers/members (may also be available to dependents)
- Includes large group and small group

Helpful resource: Health Reform Beyond the Basics, https://www.healthreformbeyondthebasics.org/

Private Insurance Coordination: Individual Market

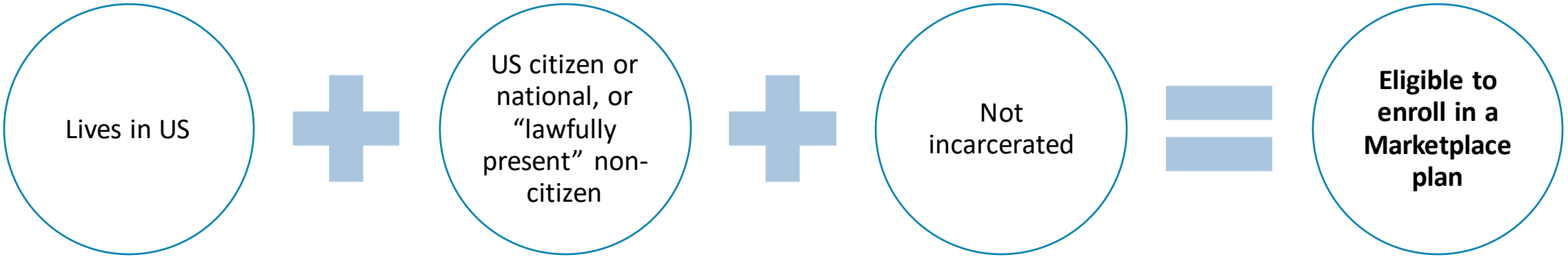
Marketplace

- Immigration-related requirements
- Purchased through healthcare.gov or state-based Marketplace
- Financial assistance available for premiums and cost-sharing
- Clients may be required to file taxes
- Subject to all Affordable Care Act (ACA) consumer protections

Off-Marketplace

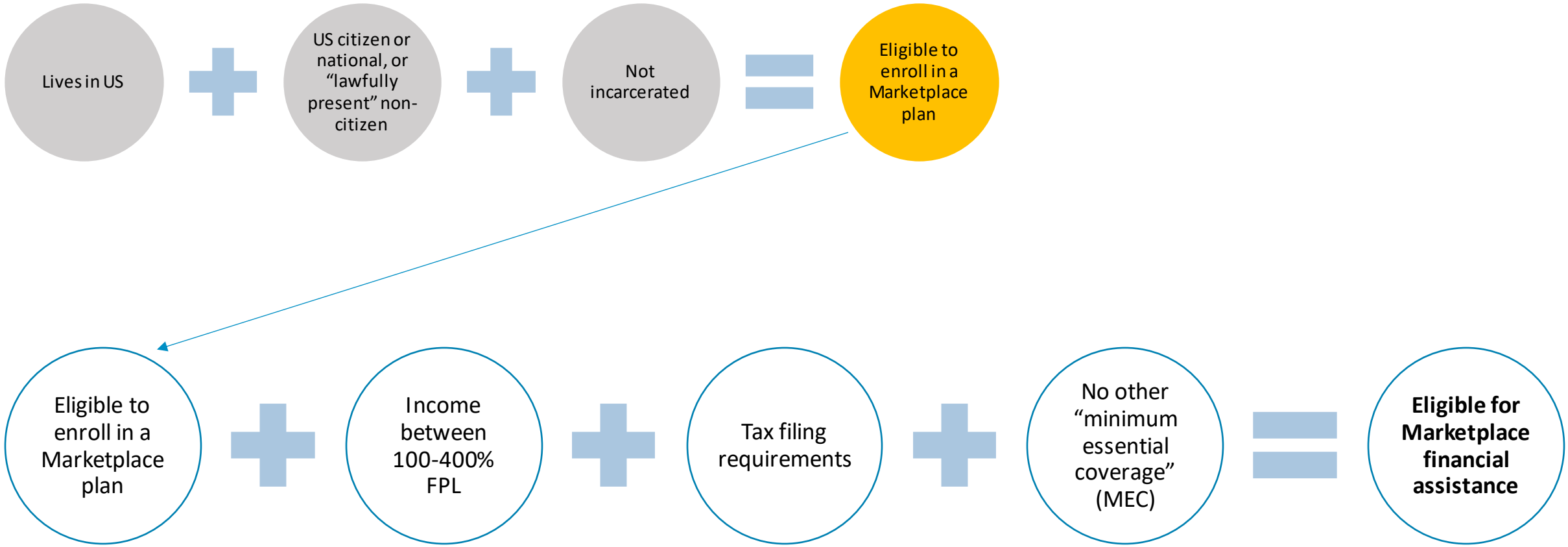
- No immigration-related requirements
- Purchased directly from insurance companies
- No financial assistance - enrollees pay full cost for coverage
- No tax filing requirements
- Subject to all Affordable Care Act (ACA) consumer protections

Marketplace Eligibility - Coverage



Helpful resource: *Immigration status and the Marketplace*, healthcare.gov, https://www.healthcare.gov/immigrants/immigration-status/

Marketplace Eligibility – Financial Assistance



Types of Marketplace Financial Assistance

- **Premium Tax Credit (PTC):** A tax credit that Marketplace enrollees can claim to offset monthly premiums.
  - Advance premium tax credits (APTCs): Premium tax credits claimed in advance, as a discount on monthly premiums.
- **Cost-sharing reduction (CSR):** A discount that lowers the amount Marketplace enrollees must pay for cost-sharing / out-of-pocket costs (deductibles, copayments, and coinsurance).
  - Available only for Silver-level plans
  - Often referred to as "extra savings" (or something similar) on Marketplace platforms

Marketplace Financial Assistance: Income Requirements

Income

- APTCs: >100% FPL
- CSRs: 100-250% FPL (three tiers)
- Some non-citizens below 100% FPL will qualify for maximum APTCs and CSRs

Helpful resources:

Yearly Income Guidelines and Thresholds, Health Reform Beyond the Basics, https://www.healthreformbeyondthebasics.org/reference-guide-yearly-thresholds/

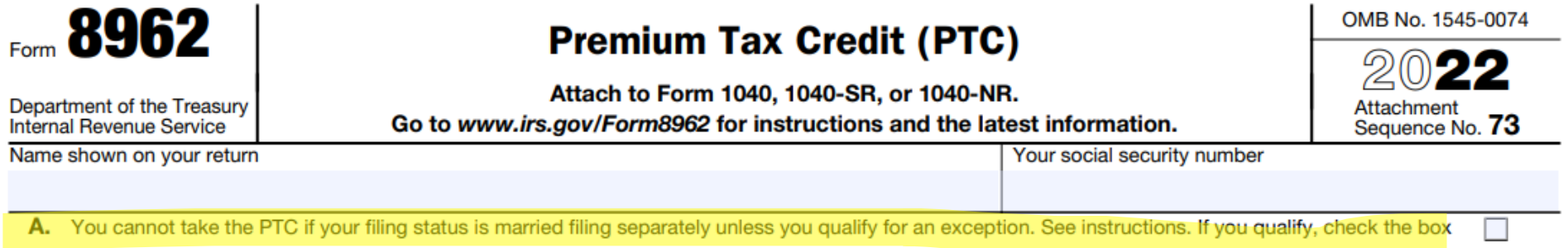
Health Reform Beyond the Basics:

- *Cost-Sharing Charges,* https://www.healthreformbeyondthebasics.org/cost-sharing-charges-in-marketplace-health-insurance-plans-answers-to-frequently-asked-questions/
- *Cost-Sharing Reductions,* https://www.healthreformbeyondthebasics.org/cost-sharing-charges-in-marketplace-health-insurance-plans-part-2/
- *Premium Tax Credit,* https://www.healthreformbeyondthebasics.org/premium-tax-credits-answers-to-frequently-asked-questions/

Marketplace Financial Assistance: Tax Filing Requirements

Tax filing status

- Must file federal taxes and "reconcile" APTCs
- May not file as Married Filing Separately
  - Exception: Victims of domestic violence or spousal abandonment. No proof needed.
    - If Marketplace application does not ask about this, the client can indicate on the application that they are unmarried, without fear of penalty for misreporting marital status. ("Updated Guidance on Victims of Domestic Abuse and Spousal Abandonment," CMS, July 2015)



Form **8962**

Department of the Treasury
Internal Revenue Service

Premium Tax Credit (PTC)

Attach to Form 1040, 1040-SR, or 1040-NR.
Go to *www.irs.gov/Form8962* for instructions and the latest information.

OMB No. 1545-0074

2022

Attachment Sequence No. **73**

Name shown on your return

Your social security number

A. You cannot take the PTC if your filing status is married filing separately unless you qualify for an exception. See instructions. If you qualify, check the box ☐

Marketplace Financial Assistance: Minimum Essential Coverage (MEC)

Clients eligible for the following types of minimum essential coverage (MEC) are ineligible for APTCs/CSRs (even if they don't actually enroll in the MEC):

- Most group coverage
  - Client may receive APTCs/CSRs during waiting period
- Premium-free Medicare Part A
- Full-benefit Medicaid coverage
- Children's Health Insurance Program (CHIP)
- Most TRICARE programs

Marketplace Financial Assistance: MEC

Clients enrolled in the following types of MEC are ineligible for APTCs/CSRs:

- COBRA
- Student health plans offered by colleges/universities*
  - https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/minimum-essential-coverage
- Medicaid for pregnant persons or "medically needy," Section 1115 Waiver programs*
  - https://www.medicaid.gov/medicaid/eligibility/minimum-essential-coverage/index.html
- Medicare Part A with premiums
- Department of Veterans Affairs (VA) coverage
- Some TRICARE programs

*** Must be designated as MEC by CMS**

Coverage/Programs Not Considered MEC

Coverage/programs that are NOT considered MEC for the purposes of Marketplace financial assistance (and therefore do not impact APTC/CSR eligibility):

- RWHAP
- Limited-benefit Medicaid coverage (e.g., family planning services)
- Products that are not comprehensive health coverage
  - Short-term limited duration insurance (STLDI)
  - Fixed indemnity plans
  - Healthcare sharing ministries

Helpful resource: *Minimum Essential Coverage Reference Chart,* https://www.healthreformbeyondthebasics.org/minimum-essential-coverage-reference-chart/

Marketplace Open Enrollment Period

Open Enrollment Period: The annual period when any eligible individual can enroll in a Marketplace plan.

- Healthcare.gov: November 1 – January 15
- State-based Marketplaces: most run through January 15, but may end as early as December 15

Helpful resources:

- ACE TA Center: https://targethiv.org/ace/marketplace#enrolling
- *Marketplace Enrollment Checklist Guide,* https://www.healthreformbeyondthebasics.org/marketplace-enrollment-checklist-guide/
- *Plan Comparison Worksheet*, https://www.healthreformbeyondthebasics.org/plan-comparison/ (available in 8 languages)

Marketplace Special Enrollment Periods

Special Enrollment Period (SEP): A time outside of Open Enrollment Period when eligible individuals who have experienced a "qualifying life event" (QLE) may enroll in or switch plans.

- Available for up to 60 or 90 days after QLE
  - Some SEPs are available up to 60 days in advance
- State-based Marketplaces may create additional SEPs
- Off-Marketplace SEP rules may be different from Marketplace
- Proof of QLE not needed for most SEPs
  - Exception: New enrollments under Loss of Coverage SEP

Helpful resource: *SEP Reference Chart,* https://www.healthreformbeyondthebasics.org/sep-reference-chart/

Marketplace Application and Enrollment

Coverage effective dates

- **Open Enrollment Period:** enroll by Dec. 15 for Jan. 1 start date
  - Some State-Based Marketplaces have a later deadline for January 1 coverage
- **Special Enrollment Periods:** typically the first day of the month following plan selection

Data-Matching Issues (DMIs)

- If Marketplace cannot verify immigration status or annual income, client may need to provide additional documentation

Private Insurance Coordination: Types of Group Market Plans

Self-insured

- Employer provides coverage directly, may use third-party administrator
- Regulated by federal government
- More common for large group plans
- Exempt from many important ACA consumer protections

Fully-insured

- Employer purchases coverage from insurer
- Regulated by state
- Applicability of ACA consumer protections depends on the size of the employer

Private Insurance Coordination: Small and Large Group Markets

Small group (fully-insured)

- Up to 50 full-time employees
  - CA, CO, NY: up to 100
- Subject to all ACA consumer protections, same as individual market

Large group (fully-insured)

- 51+ full-time employees
  - CA, CO, NY: 101+
- Subject to some ACA consumer protections, including but not limited to:
  - Pre-existing condition exclusions
  - Guaranteed issue/renewal

Helpful resource:
ACA Consumer Protections for Private Coverage, https://navigatorguide.georgetown.edu/aca-consumer-protections-for-private-coverage

Group Health Coverage Enrollment

- **Annual Enrollment Period or Open Season:** The annual period when eligible employees and dependents can sign up for coverage through their employer, or switch to a different plan.
- **Special Enrollment Opportunity:** A time outside of open season when eligible employees and dependents who have experienced a "qualifying event" may sign up for coverage.
  - Special enrollment opportunity must last at least 30 days (or 60 days, if employee lost eligibility for Medicaid/CHIP)

Private Insurance Legal Protections: Non-Discrimination

Non-discrimination protections

- HIV medications must be covered in a non-discriminatory way
  - Pay attention to formulary adequacy – exclusions, utilization management, high tiering
  - Applies to: individual market, fully-insured small group
- ACA Section 1557: updated federal regulations expected in early 2024

Helpful resource:
Plan Information for 2023, Out2Enroll, https://out2enroll.org/2023-cocs/

Private Insurance Legal Protections: Third-Party Payments

Third-Party Payment Rule (45 CFR § 156.1250)

- Issuers must accept premium and cost-sharing payments from Ryan White HIV/AIDS Program (RWHAP) recipients and subrecipients
  - Includes hospital-based RWHAP
- Applies to: all products sold by issuers offering Marketplace plans

Private Insurance Legal Protections: Mail Order Opt-Out

Mail-Order Opt-Out Rule (45 CFR § 156.122)

- Issuers must allow enrollees to opt-out of mail order pharmacy
- Issuers may charge different cost-sharing for brick-and-mortar v. mail order pharmacy, but must count all payments towards deductible/out-of-pocket max
- Applies to: all plans subject to Essential Health Benefits (individual market, fully-insured small group)

Private Insurance Legal Protections: Guaranteed Issue

Guaranteed issue requirements (45 CFR § 147.104)

- Insurers must accept every individual that applies for coverage
- Insurers are prohibited from requiring Social Security Numbers or proof of immigration status for ***off-Marketplace*** enrollment
- Insurers may require proof of in-state residency for off-Marketplace enrollment
  - Documentation requirements cannot be used as a proxy for refusing coverage based on HIV status, immigration status, or any other impermissible factor

Private Insurance: Challenges

- Special Enrollment Period access
  - Confusing/unclear requirements for state-based Marketplaces and off-Marketplace plans
- Premium tax credit reconciliation and recoupment
  - Recipients paying Marketplace premiums must "vigorously pursue" PTC refunds clients receive
- Ever-changing federal policy landscape
  - Temporary COVID-19 protections and flexibilities
- Enforcement of plan or issuer violations
  - Self-funded v. fully-insured can be difficult to discern
  - Client privacy concerns
- Limited pharmacy benefits
  - E.g., formulary exclusions, prior authorization, narrow pharmacy networks

Medicare Coordination

Medicare: Overview

Medicare is the federal health insurance program for:

- People who are 65 or older
- Certain younger people with disabilities
- People with End-Stage Renal Disease (ESRD)

Components/parts of Medicare:

- Part A (hospital/inpatient care)
- Part B (outpatient medical care)
- Part C (Medicare Advantage)
- Part D (prescription drugs)

Helpful resources:

- *ACE TA Center,* https://targethiv.org/ace/medicare
- *Medicare Interactive,* Medicare Rights Center, https://www.medicareinteractive.org/

The Importance of Medicare

- In 2020, 28% of all people with HIV in the US were estimated to be covered by Medicare
- Medicare is the second largest source of federal financing for HIV care in the US
  - Medicare accounted for 39% of all federal HIV spending in FY22
- Medicare enrollees with HIV are:
  - Disproportionately under age 65
  - More likely to originally qualify for Medicare based on disability rather than age

Medicare and People with HIV, Kaiser Family Foundation, https://www.kff.org/hivaids/issue-brief/medicare-and-people-with-hiv/

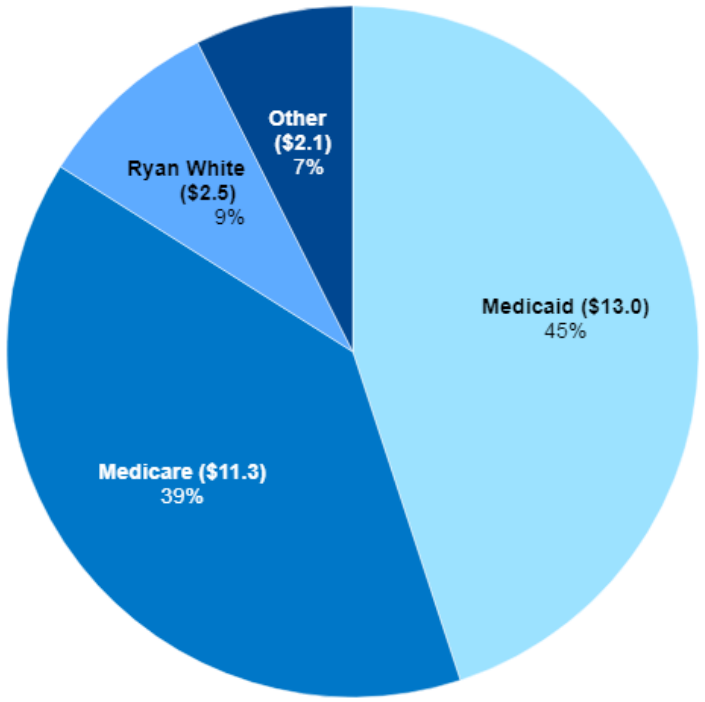
Medicare Financing for HIV Care and Treatment

Figure 3

Medicare is the Second Largest Source of Federal Financing for the Care and Treatment of People with HIV

FY2022 U.S. Federal Funding, In Billions.

Total Federal Funding = $29 billion



NOTE: Total Medicaid funding includes only federal spending. A small amount of VA prevention funding is included in "other" as it was not possible disaggregate care and prevention funding for that account (possibly around $18m). Several accounts in "other" are amounts that have been carried forward from FY17.

SOURCE: Calculation based on KFF review of Congressional Budget Justifications, other budget documents, and personal agency correspondence • PNG

KFF

Medicare and People with HIV, Kaiser Family Foundation, https://www.kff.org/hivaids/issue-brief/medicare-and-people-with-hiv/

The Growing Importance of Medicare for RWHAP Clients

2008: 2 percent of ADAP clients served were age 65 or older

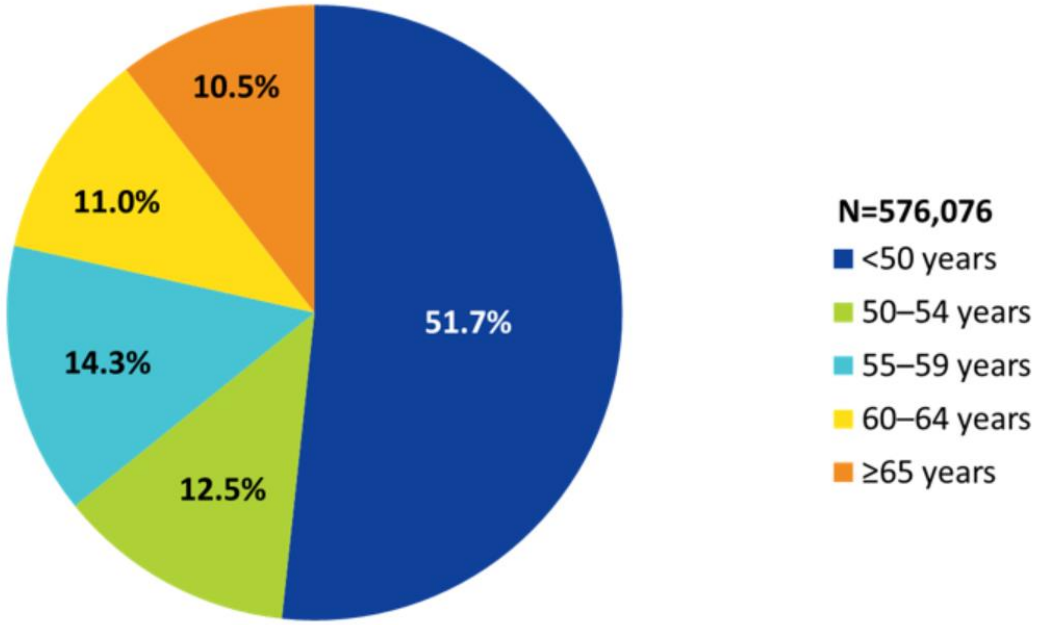
2015: 6 percent of ADAP clients served were age 65 or older

2018: 8 percent of ADAP clients served were age 65 or older

2020: 10 percent of ADAP clients served were age 65 or older

2021: 11 percent of Part B/ADAP clients served were age 65 or older

Clients Served by the Ryan White HIV/AIDS Program, by Age Group, 2021—United States and 3 Territories[a]



Older Adults Served by RWHAP, 2021, HRSA Ryan White HIV/AIDS Bureau, https://ryanwhite.hrsa.gov/data/reports

NASTAD, *Part B and ADAP Monitoring Project*, https://nastad.org/adap-monitoring-project.

ADAP Practices Related to Medicare Costs

ADAP practices related to Medicare premium payment (2021):

- Jurisdictions paying Medicare Part C premiums: 26
- Jurisdictions paying Medicare Part D premiums: 33

ADAP practices related to Medicare cost-sharing payment* (2021):

- Jurisdictions paying Medicare Part B cost-sharing: 21
- Jurisdictions paying Medicare Part C cost-sharing: 34
- Jurisdictions paying Medicare Part D cost-sharing: 42

* Some jurisdictions may cover copays/coinsurance only after the client has met their deductible

NASTAD, *Part B ADAP Monitoring Project*, https://nastad.org/adap-monitoring-project.

How Can RW/ADAP Support Medicare-Eligible Clients?

- Providing wraparound services and supports
- Supporting clients with transition to Medicare from other coverage
- Assessing Medicare coverage options
- Assisting with applications for cost-saving programs
- Identifying financial assistance and/or assessing alternative coverage options for clients that must pay Medicare Part A premiums
- Identifying local assistance for clients experiencing challenges with Medicare or Social Security benefits

Helpful resource: *RWHAP Part B/ADAP Coordination with Medicare*, NASTAD, https://nastad.org/resources/rwhap-part-badap-coordination-medicare

RWHAP and Medicare: Challenges

- There is currently no mechanism by which RWHAP can pay Medicare Part B premiums for the vast majority of clients
- Some clients may need to pay high premiums for Medicare Part A
  - RWHAP funds cannot be used for Medicare Part A premiums or cost-sharing
- Emerging access issues related to HIV treatment in nursing homes and other inpatient settings

Medicare Part D Updates

- Medicare Part D Low-Income Subsidy (LIS) (also known as “Extra Help”)
  - Social Security program that helps with Medicare Part D costs
- Starting in January 2024:
  - Partial LIS (currently for 135-150% FPL) will be eliminated
  - **Full LIS (currently <135% FPL) will be available to individuals up to 150% FPL**

Medicaid Coordination

Medicaid: Overview

Medicaid is a joint state-federal health insurance program for certain low-income groups, including:

- Children and parents
- Pregnant persons
- People with disabilities
- People age 65+
- Childless adults (in the 41 jurisdictions that have adopted "Medicaid expansion")

Helpful resource: *ACE TA Center, https://targethiv.org/ace/medicaid*

The Importance of Medicaid

- Medicaid is the largest source of health coverage for people with HIV in the US
  - Medicaid covers 40% of non-elderly adults with HIV, compared to 15% of total non-elderly adult population
- Medicaid is the largest source of public spending for HIV care in the US
  - Medicaid accounted for 45% of all federal HIV spending in FY22
- Thirty-six percent of people with HIV live in non-expansion states
  - Largely FL, GA, TX

Medicaid and People with HIV, Kaiser Family Foundation, https://www.kff.org/hivaids/issue-brief/medicaid-and-people-with-hiv/

“Unwinding” Medicaid Protections in Place During the COVID-19 Pandemic

“Unwinding” Medicaid Protections After COVID-19

- Medicaid “continuous coverage” protections have expired
  - States must initiate all renewals by March 31, 2024
  - States must complete all renewals by May 31, 2024
- Permissible grounds for termination of Medicaid coverage:
  - Client does not respond to request for information
  - Client determined no longer eligible after proper renewal process

Unwinding Medicaid PHE Requirements

- Did Medicaid begin my client's renewal at the permissible time?
  - Must be at least 12 months since last completed, successful renewal
- Did Medicaid perform a proper renewal for my client?
  - Renewal forms must have clear, "plain language" instructions and deadline
  - Requests for information must be specific and not overly burdensome
  - For most clients, renewal forms must be prepopulated
- Did Medicaid properly terminate my client?
  - Termination permitted after renewal is complete and any appeals are resolved
  - 90-day reconsideration period for clients who return information late
- Did Medicaid provide a proper termination notice to my client?
  - Notice must clearly state the reason for termination and the effective date
  - Notice must be written in plain language
  - Notice must include information about appeals and language or disability access

Supporting Clients During Medicaid Unwinding

- Understand state process for Medicaid renewals
- Monitor common issues/barriers within your state
- Support clients with Medicaid appeals/re-enrollment
- Conduct client outreach and screening for other coverage
- Prepare for possible RWHAP enrollment surge
- Educate enrollment partners in the community about RWHAP

Procedural Medicaid Denials/Disenrollments

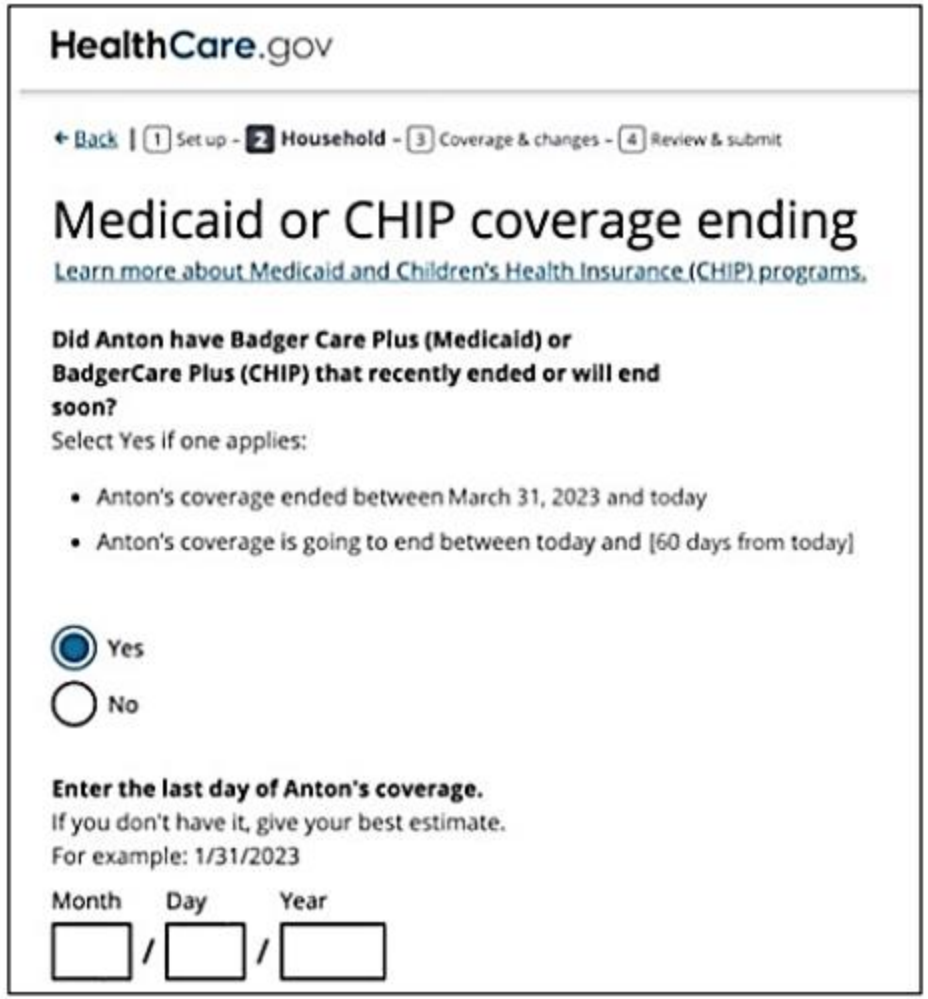
Clients (and their family members) at most risk of losing Medicaid despite still being eligible:

- Children
- Clients from racial and ethnic minorities
- Clients in rural areas
- Clients with limited English proficiency
- Clients with no broadband access

Transitioning from Medicaid to the Marketplace: "PHE Unwinding" SEP

"PHE Unwinding" Special Enrollment Period (SEP)

- Available March 31, 2023 - July 31, 2024
- Available to clients who self-attest to losing Medicaid due to "unwinding" between 3/31/23 and 7/31/24



Transitioning from Medicaid to the Marketplace: Special Enrollment Periods

PHE Unwinding SEP

- Timing: No 60-day deadline. Clients do not need to know the date of Medicaid termination.
- Documentation: None. Clients self-attest to losing Medicaid during specified timeframe.
- Access: Available in all states using healthcare.gov. State-based Marketplaces may choose to adopt.

Loss of Minimum Essential Coverage (MEC) SEP

- •Timing: Available up to 60 days before or 90 days* after Medicaid ends.
- Documentation: Clients may need to document loss of Medicaid before new coverage can begin.
- Access: Available in all Marketplaces.

* State-based Marketplaces may have shorter or longer SEP window

Transitioning from Medicaid to the Marketplace

Low-Income SEP

- Anyone with income <150% FPL can enroll in or switch Marketplace plans once per month
- Available through 2025 in healthcare.gov
- Optional for states with their own Marketplaces
- State-based Marketplace flexibilities
  - Increase income cutoff
  - Limit to new enrollments only (current enrollees may not switch plans)

Transitioning from Medicaid to Medicare

New Medicare enrollment policies, as of January 1, 2023:

- Coverage begins the month after enrollment
- New Medicare Part B SEP for clients who delayed Medicare enrollment because they were enrolled in Medicaid
  - No Late Enrollment Penalty (LEP) or gap in coverage
  - Also applies to clients who missed or delayed Medicare enrollment due to an emergency or disaster, incarceration, or other "exceptional circumstances"

Part B Special Enrollment Periods for exceptional circumstances, Medicare Interactive, https://www.medicareinteractive.org/get-answers/medicare-health-coverage-options/original-medicare-enrollment/part-b-special-enrollment-periods-for-exceptional-circumstances

Transitioning from Medicaid to Employer Coverage

Special Enrollment Rights

- Clients have 60 days after loss of Medicaid/CHIP eligibility to enroll in an employer-sponsored plan
  - 30 days for other qualifying life events
  - COVID-19 protection: **Clients who lose Medicaid/CHIP eligibility on or before July 10, 2023 can request enrollment in their employer plan until at least September 8, 2023.**
- Applies to employees and eligible family members (if employer offers dependent coverage)
- Applies to all types of employer plans

Local/Community Resources

- Certified Application Counselors (CACs) and Navigators
- State Health Insurance Assistance Programs (SHIPS): https://www.shiphelp.org/
- Local Social Security Office locator: https://www.ssa.gov/locator/
- Area Agencies on Aging (AAA): https://eldercare.acl.gov/Public/About/Aging_Network/AAA.aspx
- Aging and Disability Resource Centers (ADRC): https://www.usaging.org/adrcs

Screening Clients for Insurance Eligibility

- Immigration status
- Income
- Age
- Disability
- Enrollment periods
- Recent life changes
- Availability of other comprehensive coverage
- Expected start or end date of other comprehensive coverage

Programmatic Considerations

Insurance Coordination: RWHAP Considerations

- Enrollment and eligibility activities
  - Staffing
  - Training
- Plan selection
  - Limited v. broad
  - Cost-effectiveness
- Premium assistance
  - Payment process, frequency
  - Partnerships with insurers
- Cost-sharing assistance
  - Payment process
  - Pharmacy and provider networks
  - ADAP formulary
- Vendor contracting

Helpful resources: *Use of RWHAP Funds for Health Care Coverage Costs*, HRSA HAB, https://targethiv.org/library/use-rwhap-funds-health-care-coverage-costs

Webinar: Overview of Ryan White HIV/AIDS Program Health Care Coverage Assistance Coordination, NASTAD, https://nastad.org/events/overview-ryan-white-hivaids-program-health-care-coverage-assistance-coordination

Questions?

Contact Information

Dori Molozanov

NASTAD

Senior Manager, Health Systems Integration

dmolozanov@nastad.org