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UCSF Alliance HEALTH PROJECT
SERVICES FOR THE LGBTQ AND HIV COMMUNITIES

HIV COUNSELOR PERSPECTIVES

The Affordable Care Act

Introduction

President Barack Obama signed the Patient Protection and Affordable Care Act into law in March 2010, envisioning a comprehensive package of health care reforms that would expand access to medical coverage for millions of uninsured Americans. Despite an incredibly rocky rollout, plagued with court challenges and computer glitches, the Affordable Care Act (also known as "the ACA," or "Obamacare") has resulted in 11 million more insured people: 8 million who signed up for private insurance through state exchanges,

It is crucial that test counselors spread the word that pre-existing conditions like HIV and HCV can no longer prevent a person from getting insurance.

and 3 million new Medicaid enrollments.[1] In California, 1.4 million people gained coverage under expanded Medi-Cal rules, while 1.9 million purchased coverage through the state's health exchange.[2]

Expanded opportunities for health coverage are particularly important for people living with HIV and viral hepatitis, who have historically faced unique challenges in obtaining and maintaining health insurance, whether private or public. For people living with HIV, the Ryan White HIV/AIDS Program has helped bridge many of the gaps in paying for care.

This issue of *Perspectives* highlights the key provisions of the Affordable Care Act that relate to people living with HIV and viral hepatitis, discusses

why the Ryan White HIV/AIDS Program is still needed, despite new insurance access through the marketplace "exchanges" and Medicaid expansion, and explains how counselors can be helpful to clients who may benefit from coverage under the ACA. It also notes some of the challenges that remain as implementation continues.

We can help clients understand that they may now qualify for Medi-Cal even if they have been denied in the past.

Purpose of Health Care Reform

The goal of the ACA is to extend adequate medical coverage to both uninsured and underinsured people. The U.S. Census Bureau estimates that in 2011, 48.6 million Americans lacked health insurance.[3] Many people living with high-cost, chronic illnesses like HIV and hepatitis C were denied private insurance coverage because of these pre-existing health conditions, and others had reached the limit on what their policies would pay because of lifetime or annual caps. Also in 2009, a Harvard study estimated that 62.1 percent of bankruptcies (among both insured and uninsured people) were due to the burden of unpaid medical bills.[4] Among people living with HIV, only 17 percent are covered by health insurance through their employer, as compared with 54 percent of the general U.S. population. The proportion of uninsured people living with HIV (29 percent) is more than double the proportion of uninsured people in the U.S. population as a whole (14 percent). This lack of adequate insurance leads to a heightened demand for Ryan White HIV Program monies to fund services to make up the gap, and contributes to a situation in which 42 percent to 59 percent of low-income people with HIV do not receive regular care.[5]

In 2010, the White House released the first comprehensive and coordinated National HIV/AIDS Strategy (NHAS). The NHAS and ACA mandates are complementary: emphasizing preventing new infections through testing and treatment; ensuring early, consistent, and quality care for people living with HIV; and reducing health disparities. Similarly, advocates for viral hepatitis prevention, care, and treatment have noted the ACA's potential to facilitate earlier diagnosis of viral hepatitis (including hepatitis C), prevent new infections, and improve access to care and treatment for those who are living with the illness.[6] Treatment options and outcomes for both HIV and HCV have never been better, making access to both care and appropriate medications crucial.

Key Provisions of the ACA

There are nine key provisions of the Affordable Care Act that vitally impact the health of people living with or at risk for HIV and HCV:

1. Health care insurers may not exclude pre-existing conditions. Previously, insurers had been allowed to deny (or limit) coverage to people with high-cost health conditions like HIV and HCV. The ACA prohibits insurers from refusing to enroll people into coverage because of such pre-existing conditions, or refusing to cover expenses related to those conditions.

2. Insurers may not set premiums based on health status. For example, it is illegal now to charge people more for insurance because they have HIV or HCV.

3. Insurers may not cancel or rescind coverage when a person develops a high-cost medical condition.

4. Insurers may not institute annual or lifetime coverage caps. In the past, insurers could set a limit on how much of the insurer's money could be spent caring for and treating a person over the person's lifetime, or even for a given year. Once that cap was met, insurance payment ceased, regardless of the effect on the patient. These caps have now been eliminated.

5. States can expand Medicaid services. California, like 26

other states and the District of Columbia, has expanded the Medicaid program to include people who were previously ineligible, as is discussed in greater detail below.

6. Creation of health insurance marketplaces. These new "exchanges," where people can purchase private insurance coverage, and where people with low incomes can receive subsidized coverage, are discussed below.

7. Plans must cover prevention. HIV testing for all people aged 15 to 65 years old, as well as people of other ages who are considered at "high risk," must be covered under both Medicaid expansion and state health insurance exchange plans. Hepatitis C screening is also covered for adults who are deemed as at "high risk."[5]

8. Plans must cover "essential health benefits" services. There are 10 categories of essential health services that are covered, including: preventive and wellness services and chronic disease management; prescription drugs; laboratory services; and mental health and substance use disorder services.

9. *Out-of-pocket costs are limited.* The most that an individual can pay for covered essential health benefits is $6,350 per year. After that, the insurance company should pay 100 percent of these services. For a family, the amount is $12,700.[7]

Why Medicaid Expansion Matters

Medicaid (known in California as "Medi-Cal") is a health care program funded through a partnership between the states and the federal government. It is the largest health care program for low-income individuals in the United States, and also the largest payer for HIV care.[7] Before the ACA, there were two primary criteria that a person had to meet in order to be eligible for Medicaid: they had to be financially eligible, and they had to belong to certain categories of people (called "categorical eligibility"). Under Medicaid expansion (as described below), many more people are eligible.

The law originally required all states to expand Medicaid

Figure 1. Federal Poverty Levels

FEDERAL POVERTY LEVELS						
Size of Household	138%	150%	200%	250%	300%	400%
1	$15,856	$17,235	$22,980	$28,725	$34,470	$45,960
2	$21,403	$23,265	$31,020	$38,775	$46,530	$62,040
3	$26,951	$29,295	$39,060	$48,825	$58,590	$78,120
4	$32,499	$35,325	$47,100	$58,875	$70,650	$94,200
5	$38,046	$41,355	$55,140	$68,925	$82,710	$110,280

Some people may qualify for "premium assistance," which is a subsidy that will lower the amount a person pays for coverage under Covered California. This subsidy is calculated based on where a person falls in the federal poverty level scale. Above is a table where a person can find their own income, as well as the percent of the Federal poverty level that that income represents. If a person makes 138 percent of the federal poverty level or less, they are likely to qualify for Medi-Cal, with some exceptions. People who make up to 400 percent of the federal poverty level may be eligible for premium subsidies. Please visit *https://www.coveredca.com/coverage-basics/PDFs/CC-health-plans-booklet-rev3.pdf*, from which this graphic is taken, and this text adapted, for more information.

coverage by 2014, but in 2012 the Supreme Court ruled that the Medicaid expansion would be optional, at each state's discretion.[8] As of March 2014, 26 states, plus the District of Columbia, had adopted Medicaid expansion, and 57 percent of people living with HIV lived in "expansion" states.[8] In California, between October 2013 and April 2014, approximately 1.9 million people newly enrolled in Medi-Cal as a result of changes in the categorical and financial eligibility criteria.[9]

Medicaid used to count only people in certain categories as eligible for coverage, for example: children, parents with dependent children, pregnant women, low-income older adults, and people with disabilities. Whenever a state wanted to cover a non-disabled, non-elderly adult with no dependent children, a special waiver was needed, or the state had to cover the cost without using any additional federal money. As a result, before the ACA, many low-income, childless adults with HIV could not get access to medical care—even if they were sick—until they were officially declared disabled. In the case of hepatitis C, a person might have to wait decades to become incapacitated enough to be declared disabled, and by that time, treatment options might be narrowed or eliminated.

For both HIV and HCV, access to early screening, treatment, and care prevents suffering and damage to the individual with the illness, and reduces the chances of further transmission to others. Among the critical care and services that Medicaid covers is HIV antiretroviral therapy. These therapies curtail disease progression, often preventing disability. Further, suppressing the virus through drug treatment greatly diminishes the probability of HIV transmission.[1] In fact, "treatment as prevention" is so effective that "national treatment guidelines recommend initiation of [HIV treatment] as soon as one is diagnosed with HIV."[10]

Eliminating the "categorical eligibility" requirement, as the ACA has done, means that more people with HIV will have secure and affordable access to HIV treatments and other preventative services *before* they become disabled. In addition, hepatitis C therapies that are covered by Medicaid will also be available to newly eligible people. In April 2014, California's Medi-Cal program also loosened restrictions on providing the highly effective PrEP (pre-exposure prophylaxis) drug Truvada to HIV-negative people, removing a possible barrier to access for this prevention intervention.[11]

Under the ACA, the second prong of Medicaid eligibility—financial eligibility—still exists, but has been modified to allow the program to expand. Under the ACA's "Medicaid expansion," there is no asset test (eliminating an important barrier to care), and there is a new income eligibility level (138 percent of the federal poverty level [FPL], see Figure 1 above). Citizens and legal residents who fall under this threshold in states that have expanded Medicaid coverage (such as

Figure 2. Sites That Can Help

- **Project Inform**
  http://www.projectinform.org/category/hcr/
- **Kaiser Family Foundation**
  http://kff.org/health-reform/
- **Healthcare.gov**
- **Covered California**
  https://www.coveredca.com
- **NASTAD**
  http://nastad.org/care_and_treatment/resources.aspx?category=health%20reform
- **Target Center**
  https://careacttarget.org/library/affordable-care-act-ryan-white-hivaids-program

California) are now eligible for Medicaid. Unlike the "exchanges" or "marketplaces" created under the ACA, "open enrollment" for Medicaid is year-round. Clients without current or adequate health insurance should be referred to resources that can assist them in determining whether or not they may qualify for Medicaid. In California, one such resource is the California Department of Health Services web page: "Do You Qualify for Medi-Cal Benefits?" at *http://www.dhcs.ca.gov/services/medi-cal/Pages/DoYouQualifyForMedi-Cal.aspx*.

Covered California

In addition to expanding Medicaid, the ACA creates new health insurance "marketplaces." These marketplaces, or "exchanges" are designed to allow individual and small business purchasers of insurance to choose among plans that are certified as adequate by the exchange, and to compare benefits across plans more easily.[8] Unlike the Medicaid expansion, which some states opted out of, every state has a health insurance marketplace. However, some states, including California, have elected to create and run their own plans. Other states have either defaulted to having their marketplaces be run by the federal government, or have chosen to run their exchanges in partnership with the federal government.[12]

Covered California (as California's marketplace is called) uses a competitive process to select plans, and sets standards for the health insurance plans that are related to the choice, value, quality, and service that the plans offer clients. To be considered adequate or "qualified," health insurance plans must cover 10 categories of "essential health benefits," including, as noted above, services such as chronic disease management, prescription drugs, and mental health and substance abuse disorder services. Covered California selected 11 plans to be offered in the exchange during the first open enrollment period, and these will likely change year to year.

Covered California can help people determine if they are eligible for low- or no-cost Medi-Cal, or for a premium subsidy with a marketplace policy. People whose incomes fall between 100 percent and 400 percent of the FPL (for that year, 2013's numbers are described by Figure 1, above) are eligible for tax credits to offset premium costs. Additional subsidies are available to reduce cost-sharing expenses for people whose incomes are between 100 percent and 250 percent of the FPL.[8]

During the first open enrollment period, which ran from October 1, 2013, to April 15, 2014, nearly 1.4 million Californians enrolled in Covered California, exceeding projections by more than half a million people. Californians, who make up 12 percent of the national population, comprised 17.5 percent of the approximately 8 million health insurance marketplace enrollees nationwide.[13] The next general open enrollment period begins November 15, 2014. But people who have a "qualifying life event" get special enrollment periods of their own. For example, if a person moves to a new state, gets married, divorced, loses other health insurance, or adds a child to the family, they can enroll outside of the general open enrollment period.

Why We Still Need the Ryan White HIV/AIDS Program

Under the Affordable Care Act, all Americans who are eligible are required to either have health insurance, or pay a tax penalty. This mandate includes those who receive services from the Ryan White HIV/AIDS Program, which has been a key source of funding for HIV/AIDS care since 1990. Now, some of the services that are provided by the Ryan White program may be replaced by Medicaid, or by private insurance through the marketplaces. This is a major step toward increasing access to care for people with HIV, but that does not mean that Ryan White program services are no longer necessary. Because gaps in coverage will still exist, Ryan White services are still desperately needed, although they will likely change over time.

The services funded through

the Ryan White HIV/AIDS Program have an impact on every point in the HIV Treatment Cascade—from testing to retaining HIV-positive people in care, to achieving an undetectable viral load. Eighty-one percent of HIV-positive uninsured people in care depended on Ryan White–funded services in 2009, while 31 percent of those with insurance also used this funding to support their care, because gaps in coverage remain, even with insurance.[8] Further, services such as dental and vision care, medication adherence, and other HIV-specific case management and psychosocial stabilization services are typically not offered through non-Ryan White coverage.[5]

The AIDS Drug Assistance Program (funded through the Ryan White program) allows patients below a certain income threshold access to medications relevant to their HIV care that are not covered by their insurance. For some people with prescription coverage, ADAP may continue to help pay premiums and co-payments, while for others it may provide access to specific antiviral treatments that are not covered by a specific insurance company plan.

Finally, since 43 percent of people living with HIV live in states that are not participating in Medicaid expansion,[8] many low-income HIV-positive people will continue to be left without insurance coverage. Programs will continue to use Ryan White funding to cover HIV care for these individuals, as well as remaining gaps in care for the insured. At the same time, programs will have to carefully coordinate their use of this and other funding sources to ensure that Ryan White remains the payer of last resort.

Challenges that Remain

Despite the fact that the ACA provides new or improved coverage for people living with or at risk for HIV and hepatitis C, many implementation challenges remain. For example, even though federal law requires that insurance through the exchanges provide prescription drug coverage, state formularies are not required to cover all the medications that people with HIV or hepatitis C are likely to need. Some plans charge participants unreasonable co-pays and co-insurance for the drugs they need.[14] Project Inform has done an analysis of the formularies of the health plans available through Covered California, and has found that many plans classify anti-HIV drugs in a way that makes them financially inaccessible to most people with HIV. Their analysis also revealed that many plans have inadequate medication options available to people seeking to treat chronic HCV infection.[15]

It will also take time for the Health Resources and Services Administration (HRSA), state health departments, health care providers, and other stakeholders to fully integrate Ryan White–funded services with coverage under Medicaid expansion and private insurance coverage through the exchanges. Undoubtedly, some people will experience frustration and delayed or interrupted care as a result. Further, insurance coverage alone does not remove cost and stigma as obstacles to care. For example, HRSA has noted that "minority clients who have historically faced barriers to accessing care … may not be comfortable accessing new ACA coverage options."[16]

Finally, not everyone is covered by the offerings of the ACA. Undocumented immigrants cannot buy plans on the state health care exchanges, and are only eligible for "emergency" Medicaid, which is restricted. Legal immigrants face a five-year waiting period in most states before they can receive Medicaid services, but they can purchase insurance and receive subsidies through state-exchange plans.[5]

What Counselors Can Do

Linking clients, especially clients who may be living with HIV or HCV, to care is one of the most crucial, lifesaving, functions that HIV test counselors perform. Let your clients know that health care is more accessible and affordable now, and that there are providers who can help them find the best insurance or service options for their situations. When you test a client whose result is HIV-positive or HCV-reactive, actively link that person to a

provider who can help the client take the next steps in testing and care. Begin to share the message of empowerment with these clients, a message that can be reinforced when they are linked with case managers or other providers who can help them to navigate and advocate for themselves in a confusing and sometimes frustrating system.

Know the available resources in your community for helping people apply for Medi-Cal—no matter how their test results come back. Be aware of any special resources for people who test HIV-positive or preliminary positive, or HCV-reactive. Remember that there is no specific open enrollment period for Medi-Cal—people can apply year-round. And spread the message that many people in California are now eligible for Medi-Cal, even though they may have been ineligible in the past.

Remember special open enrollment periods. As noted above, clients who have a "qualifying life event" (like having recently moved to California, getting married, divorced, or having added a child to their family) are eligible for their own special enrollment period (SEP) in Covered California, and do not need to wait until the fall for the general open enrollment period. In California, military reservists who return from active duty and people who are leaving incarceration also qualify for SEP.

If your client is HIV-positive and doesn't qualify for Medi-Cal or a SEP, explore the Ryan White services in your area. There are also often county services available to people who don't have other coverage.

Lastly, stay aware of changes as the ACA implementation continues. Counselors can learn more about the Affordable Care Act and its potential impact on their clients by visiting web sites such as those listed in Figure 2.

Conclusion

The Affordable Care Act offers the opportunity to shrink many of the gaps in health coverage for people with high-cost illnesses like HIV and chronic HCV. Test counselors, who are on the front lines of linkage to care, can play a vital role in informing their clients about these new options, and referring them to providers who can help the clients access these new benefits and care. ■

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Test Yourself

Review Questions

1. **True or False**: In 2012, the Supreme Court ruled that all states are required to expand Medicaid coverage by 2014.

2. **Which of the following is a benefit of eliminating the "categorical eligibility" requirement for Medicaid, as the ACA has done?** a) Ryan White services are no longer needed for people living with HIV; b) More people living with HIV will have access to treatments and preventative services before they become disabled; c) Stigma as will no longer be an obstacle to care; d) All of the above

3. **What is California's private insurance marketplace called?** a) California Health Resources and Services Administration; b) The AIDS Drug Assistance Program; c) Covered California; d) Medi-Cal.

4. **Which of the following would allow a person to enroll in private health care coverage in the marketplace outside of the general open enrollment period?** a) If a person recently moved here from another state; b) If a person gets married, divorced, or adds a child to the family; c) If a person loses other health insurance; d) All of the above

5. **True or False**: The open enrollment period for Covered California and for Medi-Cal is the same.

6. **In California, as of April 2014, how many people had obtained new health care coverage under the Affordable Care Act, in both the state insurance marketplace and expanded Medi-Cal?** a) Fewer than 500,000; b) Between 501,000 and 1 million; c) between 1 million and 2 million; d) between 2 million and 4 million.

Discussion Questions

1. What referrals would be useful for an HIV/HCV test counselor to have in hand when speaking to an uninsured or underinsured client?

2. What do you see as the biggest obstacles to regular medical care for your testing clients? How have any of these changed since the enactment of the Affordable Care Act?

3. What resources have you found most useful for keeping on top of changes under the Affordable Care Act?

4. What steps do you take to actively link clients who test HIV-positive or HCV-reactive to care?

Answers

1. True
2. b
3. c
4. d
5. False. Medi-Cal has no open enrollment period.
6. d

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Executive Director: James W. Dilley, MD

Editor: Robert Marks

Author/Editor: Michelle Cataldo, LCSW

Research Support: Suhitha Uppalapati

Clinical Advisor: George Harrison, MD

Reviewers: Anne Donnelly, Clark Marshall, MPH, Perry Rhodes III, and Jen Shockey, MPH

Test Yourself Questions: Suhitha Uppalapati

Design & Production: Lisa Roth

Proofreading: Suzy Brady, Lawrence Sanfilippo, Suhitha Uppalapati

Circulation: Stephen Scott

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Contact Us:
Michelle Cataldo, LCSW
UCSF Alliance Health Project, Box 0884
San Francisco, CA 94143-0884
415-476-2626
e-mail: *michelle.cataldo@ucsf.edu*

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