Overview of Ryan White HIV/AIDS Program Health Care Coverage Assistance Coordination

January 25, 2023

NASTAD

RWHAP AND COMMERCIAL INSURANCE

Amy Killelea

January 25, 2023

PRESENTATION ROADMAP

- RWHAP insurance assistance: context and statutory authority
- Elements of an insurance assistance program
  - Client outreach, eligibility, and enrollment
  - Premium assistance
  - Prescription drug cost-sharing assistance
  - Medical cost-sharing assistance
- Financing and budget considerations for insurance assistance programs

RWHAP INSURANCE ASSISTANCE: CONTEXT AND STATUTORY AUTHORITY

FEDERAL REQUIREMENTS FOR RWHAP INSURANCE ASSISTANCE

1) The insurance must cover at least one U.S. Food and Drug Administration (FDA)- approved medicine in each drug class of core antiretroviral medicines and appropriate HIV outpatient/ambulatory health services
2) The insurance assistance program must be "cost effective"

Source: PCN 18-01: Clarifications Regarding the Use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost-sharing Assistance (hrsa.gov)

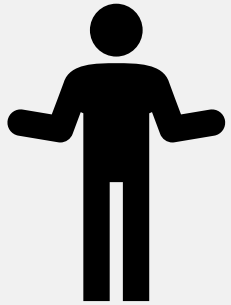
FEDERAL REQUIREMENTS FOR RWHAP INSURANCE ASSISTANCE

Cost-Effectiveness Requirements for RWHAP Health Care Coverage Purchase	
RWHAP ADAP	**RWHAP Part A, B, C, D**
The cost of paying for health care coverage premiums is cost-effective in the aggregate versus paying for the full cost for medications.	The cost of paying for the health care coverage premiums is cost-effective in the aggregate versus paying for the full cost for medications and other appropriate HIV outpatient/ ambulatory health services.

Source: PCN 18-01: Clarifications Regarding the Use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost-sharing Assistance (hrsa.gov)

ELEMENTS OF AN INSURANCE PURCHASE PROGRAM

1) OUTREACH, ELIGIBILITY, AND ENROLLMENT



- Individual market
- Employer sponsored coverage
- Medicare
- Medicaid
- Other payers/programs

PROGRAMMATIC DECISION POINTS

- Should the program utilize in-house staff to conduct eligibility and enrollment activities or contract with an outside vendor?
- Should the program utilize full-time staff/contractors or engage seasonal staff at certain high enrollment volume times of the year?
- Should the program utilize external training certification programs for enrollment staff (e.g.. Certified Application Counselor training) or develop internal training (or both)?
- How should programs limit the types of plans in which clients can enroll?

2) PREMIUM ASSISTANCE

Table 2: Insurance Costs RWHAP Clients May Face	
Premium	Monthly cost of insurance paid directly to the plan
Prescription drug cost-sharing	A co-payment (fixed dollar amount) or co-insurance (percentage of the cost of the drug) paid for medication
Medical cost-sharing	A co-payment (fixed dollar amount) or co-insurance (percentage for the cost of the service) paid for a medical visit/service
Deductible	The amount someone must pay before the insurance plan starts paying benefits. During the deductible phase, individuals must pay the full negotiated cost of the medication or service.

PROGRAMMATIC DECISION POINTS

- Should the program process premium payment in-house or contract with a vendor to make payments?
- Should the program make individual payments to a plan for each client or make bulk payments for multiple clients?
- Should the program make monthly premium payments on behalf of clients or make payments at longer intervals (e.g., quarterly)?
- Should the program purchase stand-alone dental plans in addition to individual plans?

2) PRESCRIPTION DRUG COST SHARING

Table 2: Insurance Costs RWHAP Clients May Face	
Premium	Monthly cost of insurance paid directly to the plan
Prescription drug cost-sharing	A co-payment (fixed dollar amount) or co-insurance (percentage of the cost of the drug) paid for medication
Medical cost-sharing	A co-payment (fixed dollar amount) or co-insurance (percentage for the cost of the service) paid for a medical visit/service
Deductible	The amount someone must pay before the insurance plan starts paying benefits. During the deductible phase, individuals must pay the full negotiated cost of the medication or service.

PROGRAMMATIC DECISION POINTS

- Should the program process prescription drug payment in-house or contract with a vendor (e.g., a pharmacy benefits manager) to make payments?
- Should the program use a limited pharmacy network or set up more open access?
- Should the RWHAP insurance assistance formulary mirror the ADAP formulary?

3) MEDICAL COST SHARING

Table 2: Insurance Costs RWHAP Clients May Face	
Premium	Monthly cost of insurance paid directly to the plan
Prescription drug cost-sharing	A co-payment (fixed dollar amount) or co-insurance (percentage of the cost of the drug) paid for medication
Medical cost-sharing	A co-payment (fixed dollar amount) or co-insurance (percentage for the cost of the service) paid for a medical visit/service
Deductible	The amount someone must pay before the insurance plan starts paying benefits. During the deductible phase, individuals must pay the full negotiated cost of the medication or service.

PROGRAMMATIC DECISION POINTS

- Should the program process medical cost-sharing payment in-house or contract with a vendor to make payments?
- Should the program use a limited network of providers from who it will accept cost-sharing invoices?
- Should the program limit the types of services for which it will pay medical cost-sharing?

FINANCING AND BUDGET CONSIDERATIONS FOR INSURANCE ASSISTANCE PROGRAMS

MODELS FOR FUNDING: ADAP INSURANCE ASSISTANCE (REBATE MODEL)

Program Spending	Program funding	Program revenue
Prescription drug cost-sharing	ADAP federal award, ADAP Emergency Relief Funds, Part B base or supplemental awarded to ADAP, state funds allocated to ADAP, rebates and program income generated by ADAP, other allocated funding	For ARVs: (Manufacturer ADAP Crisis Task Force rebate minus prescription drug cost-sharing) times number of monthly fills to reach plan out-of-pocket maximum times number of clients
Medical cost-sharing		
Premiums		
Vendor contracts		
Staffing - **Payment oversight** - **Enrollment oversight** - **Contract oversight**		
Infrastructure - **Data/systems**		

MODELS FOR FUNDING: RWHAP INSURANCE ASSISTANCE (PROGRAM INCOME MODEL)

Program Spending	Program funding	Program revenue
Prescription drug cost-sharing **Medical cost-sharing** **Premiums** **Vendor contracts** **Staffing** - **Payment oversight** - **Enrollment oversight** - **Contract oversight** **Infrastructure** - **Data/systems**	ADAP federal award, ADAP Emergency Relief Funds, Part B base or supplemental awarded to ADAP, state or local funds allocated to ADAP, rebates generated by ADAP Health Insurance Premium and Cost-Sharing Assistance (RWHAP Parts A, B, C, and D) Program income (across RWHAP Parts A, B, C and D)	Usual and customary insurance reimbursement price minus purchase price of drug (including ACTF rebate for ADAPs*) and any relevant pharmacy dispensing or administration fees times 12 months per year times number of clients *ADAP is eligible for AIDS Crisis Task Force (ACTF) sub-340B price on certain drugs; all other RWHAP 340B entities are eligible for 340B discounted price

INCREASING COMPETITION ACROSS RWHAP PARTS FOR INSURED CLIENTS

An example of how this competition plays out…

Commercially insured RWHAP client

ADAP	RWHAP Part C Clinic
Provides premium assistance for the client	Provides HIV care for the client
May want to pay the patient's prescription co-pay and submit for partial pay rebate (generating revenue) OR purchase the patient's drug and generate program income off of spread between issuer reimbursement and 340B price	May want to purchase the patient's drug and generate program income off of spread between issuer reimbursement and 340B price
Both ADAP and RWHAP Part C clinic are 340B entities and both are eligible for 340B pricing (and revenue generation), but because of 340B rules, only one entity is able to submit for 340B price	

QUESTIONS AND DISCUSSION

RWHAP Part B/ADAP Coordination with Medicare

Dori Molozanov
NASTAD
January 25, 2023

Overview

RWHAP Part B/ADAP Coordination with Medicare

I. The Growing Importance of Medicare for RWHAP Clients
II. Medicare Eligibility and Benefits
III. Medicare Enrollment Considerations for RWHAP Part B/ADAP Clients
IV. Medicare Premiums and Cost-Sharing
V. Partnerships and Resources

NASTAD, *RWHAP Part B/ADAP Coordination with Medicare*, https://nastad.org/resources/rwhap-part-badap-coordination-medicare (August 2022)

I. The Growing Importance of Medicare for RWHAP Clients

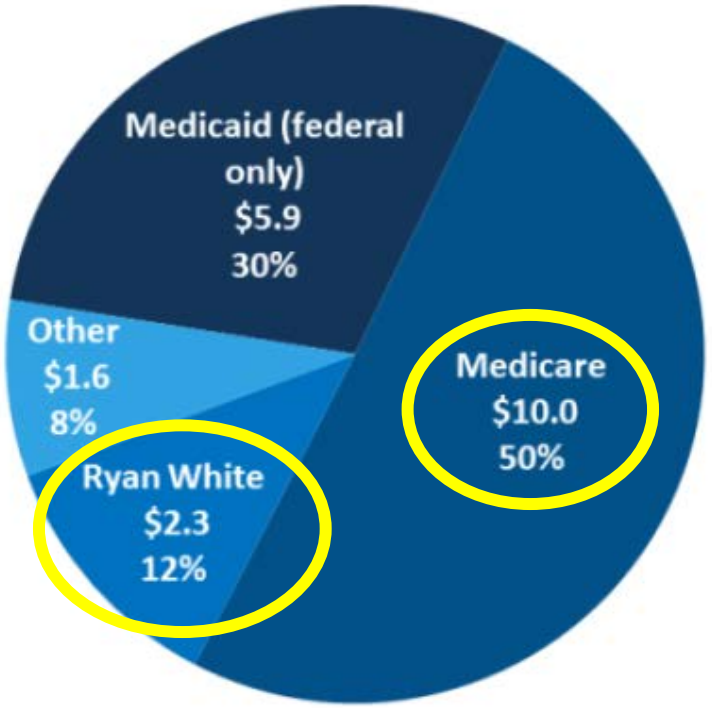
Medicare is the **single largest source** of federal financing for HIV care and treatment.

About **25% of people with HIV in care** get insurance coverage through Medicare.

Figure 1

Federal Funding for HIV/AIDS Care in the U.S., by Program, FY 2016

In Billions



Total = $19.74 Billion

SOURCE: KFF analysis of data from FY2016 Congressional Budget Justifications, White House Office of Management and Budget personal communication.
Note: Total program amounts may not add to $19.74 billion due to rounding; Percentages may not add to 100% due to rounding.

Figure 1: Federal Funding for HIV/AIDS Care in the U.S., by Program, FY 2016

Kaiser Family Foundation, *Medicare and HIV*, https://www.kff.org/hivaids/fact-sheet/medicare-and-hiv/ (Oct. 2016)

The Growing Importance of Medicare for RWHAP Clients

Of all traditional fee-for-service Medicare (Original Medicare) enrollees with HIV in 2016:

79% were under age 65 and qualify because of a disability

- This share is declining over time

21% were over age 65

- Of these, 63% became eligible based on age alone

Kaiser Family Foundation, *Medicare and HIV*, https://www.kff.org/hivaids/fact-sheet/medicare-and-hiv/ (Oct. 2016)

The Growing Importance of Medicare for RWHAP Clients

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

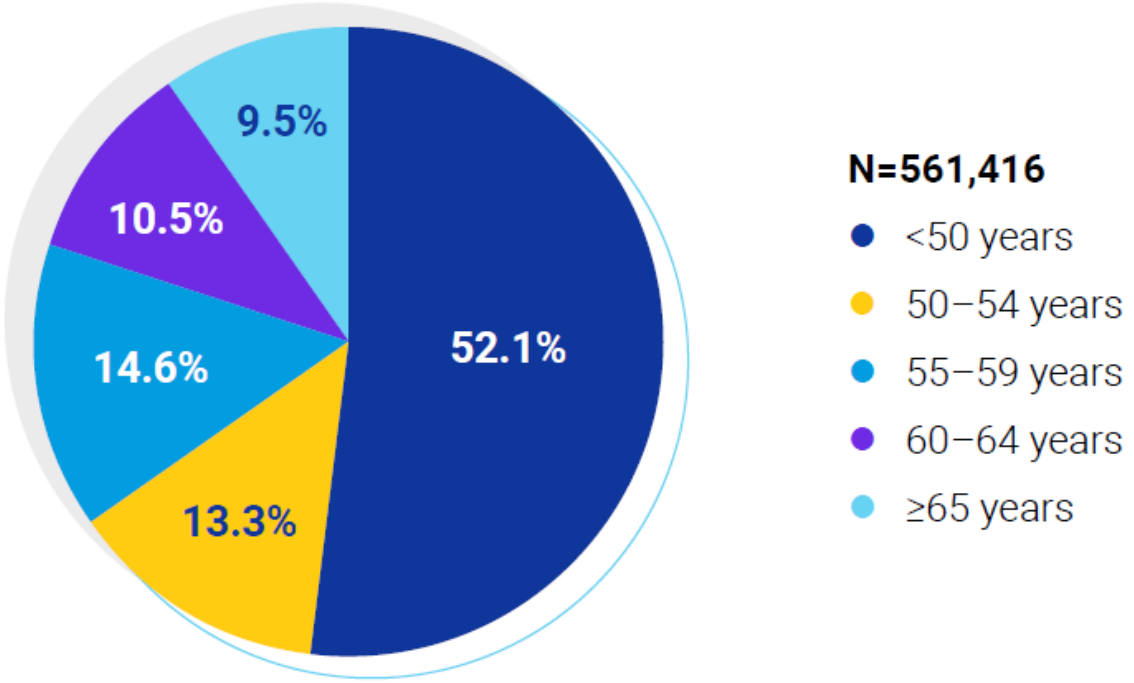
2015: 6 percent of ADAP clients served were age 65 or older

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

FIGURE 1. CLIENTS SERVED BY THE RYAN WHITE HIV/AIDS PROGRAM, BY AGE GROUP, 2020



Source: https://ryanwhite.hrsa.gov/data/

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

II. Medicare Eligibility and Benefits

Medicare Eligibility and Benefits

This section of "RWHAP Part B/ADAP Coordination with Medicare" covers:

- Different Medicare eligibility pathways
  - Age
  - Disability
  - End-stage renal disease
- Services covered under each Medicare part
  - Part A (hospital/inpatient care)
  - Part B (outpatient medical care)
  - Part C (Medicare Advantage)
  - Part D (prescription drugs)

Considerations for Non-Citizens (Age 65+)

Lawfully present non-citizen clients eligible for Medicare may still need to pay a high premium for Medicare Part A (hospital coverage), depending on whether they have sufficient work history in the U.S. (40 quarters).

With qualifying work record

- Eligible for premium-free Part A
- LPR and TPS* holders are most likely to have the required work history, but other statuses may qualify

Without qualifying work record

- Must pay premium for Part A
- Must be LPR
- Must reside in U.S. for five years immediately prior to enrollment
- May choose to enroll in Part B and Part D only

*LPR = Lawful Permanent Resident (Green Card holder)
TPS = Temporary Protected Status

Considerations for Non-Citizens (Age 65+)

If a lawfully present non-citizen client is turning 65 and is eligible for Medicare, but lacks sufficient work history for premium-free Part A:

- Does the client qualify for premium-free Medicare Part A based on their spouse's work history?
- Does the client qualify for Medicaid to assist with Medicare costs?
- Does the client have employer-sponsored coverage?
- Does the client qualify for Marketplace coverage with premium tax credits?
- Does the cost of delaying Medicare (late enrollment penalties) outweigh the benefits?

Justice in Aging, *Older Immigrants and Medicare*, https://www.justiceinaging.org/wp-content/uploads/2019/04/FINAL_Older-Immigrants-and-Medicare.pdf (April 2019)

III. Medicare Enrollment Considerations for RWHAP Part B/ADAP Clients

Medicare Enrollment Considerations for Part B/ADAP Clients

This section of "RWHAP Part B/ADAP Coordination with Medicare" covers:

- Different types of Medicare enrollment periods
- Enrollment timing considerations
- Transitioning to Medicare from other coverage
- Choosing between Original Medicare and Medicare Advantage
- State Medicaid programs that assist with Medicare costs

Enrollment Timing and Gaps in Coverage

NEW POLICY: Beginning in January 2023, Medicare coverage starts the month after enrollment (but no earlier than 65th birthday month)

NEW POLICY: New Medicare Special Enrollment Periods for clients who lose Medicaid, formerly incarcerated clients, and more.

Enrollment Timing and Gaps in Coverage

If a client missed their Initial Enrollment Period:

- For how long will the client go without coverage if they remain uninsured until the annual General Enrollment Period (Jan 1 – Mar 31)?
- Does the client qualify for a Special Enrollment Period?
- Does the client have employer-sponsored coverage?
- Does the client qualify for Marketplace coverage with premium tax credits?

IV. Medicare Premiums and Cost-Sharing

Medicare Premiums and Cost-Sharing

This section of "RWHAP Part B/ADAP Coordination with Medicare" covers:

- Medicare premiums and cost-sharing
- RWHAP allowable costs for Medicare clients
- Medicare prescription drug coverage
- Establishing an ADAP Data-Sharing Agreement with CMS
- Medicare coverage of provider-administered ARV medications (including long-acting injectables)

V. Partnerships and Resources

Partnerships and Resources

This section of "RWHAP Part B/ADAP Coordination with Medicare" covers:

- Where to find local assistance with Medicare enrollment and benefits
- User-friendly online resources about Medicare

QUESTIONS AND DISCUSSION

Contact

Dori Molozanov

Senior Manager, Health Systems Integration

NASTAD

dmolozanov@nastad.org