ADAPs Support Expanded Insurance Coverage and Access to Care

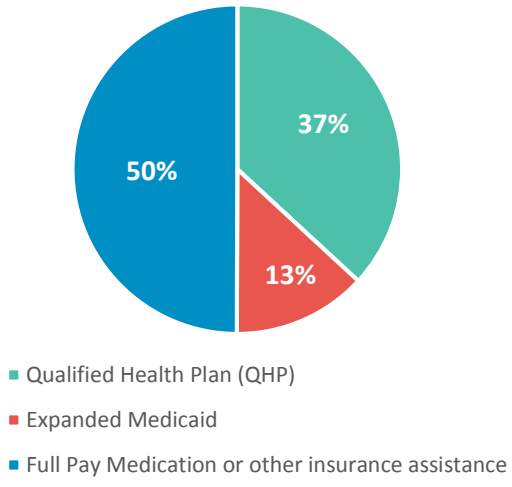
August 2016

Overview

The Ryan White Program serves more than 500,000 people — over half of the diagnosed people living with HIV (PLWH) in the United States. The Ryan White Program is a crucial safety net system of care, providing services and filling gaps not covered by public and private insurance. Part B of the Ryan White Program funds state and territorial health departments to provide care, treatment, and supportive services, including the AIDS Drug Assistance Program (ADAP), for low-income uninsured, and underinsured PLWH. By providing access to medications for uninsured individuals and premium and co-payment assistance for individuals with insurance, ADAPs provide access to essential medications, medical care, and supportive services for low-income PLWH. As of January 31, 2016, ADAPs served 177,787 people, a large proportion of whom had some form of insurance. The changing healthcare landscape – including implementation of the Affordable Care Act (ACA) and related healthcare systems reforms – has required the Ryan White Program and ADAPs to innovate to continue providing their clients with access to the best possible care and treatment.

Since 2014, NASTAD has conducted an annual request for information (RFI) that assesses ADAPs' support of clients enrolled in qualified health plans and expanded Medicaid. In 2016, 52 ADAPs responded to the RFI which measured enrollment as of January 31, 2016.

National ADAP Client Insurance Status as of 01/31/16



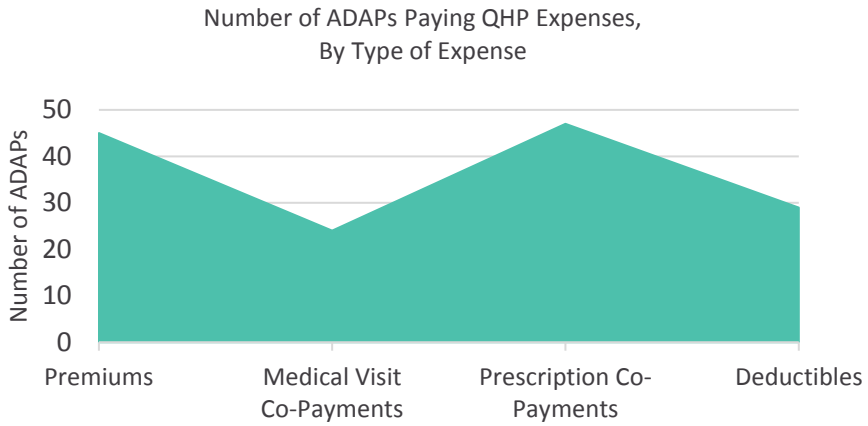
ADAPs Maximize Open Enrollment in 2016

ADAPs support insurance for people living with HIV.

Access to insurance is essential to improving retention in care to reach and maintain viral suppression1 and ADAPs play a critical role in ensuring access to quality care through insurance purchasing. Since the ACA was enacted, tens of thousands of PLWH have gained access to public and private insurance with the support of ADAPs. Data reported by 52 ADAPs show that 177,878 clients were served as of January 31, 2016. Of those served, 65,547 were enrolled in a Qualified Health Plan (QHP) and 23,431 were enrolled in Medicaid for 2016, an increase of 27% and 14%, respectively, reported in 2015. Without ADAP, clients may not have been able to afford to enroll in QHPs to gain access to health insurance coverage.

Qualified Health Plans

As of January 31, 2016, 52 jurisdictions reported that ADAPs supported 65,547 clients (37%) with enrollment in QHPs during the third ACA open enrollment period. Because a large portion of ADAP clients (21%) are receiving Federal premium tax credits (PTCs) or cost-sharing reductions (CSRs), it is cost-effective for ADAPs to cover the cost of their QHP



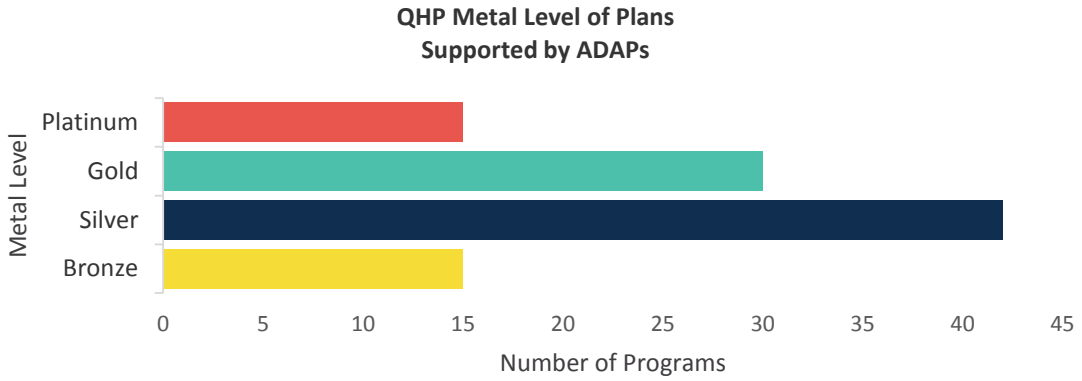
coverage.[2] Ryan White Part B and ADAPs are covering a range of insurance-related costs for clients: 45 ADAPs pay for premiums, 24 pay for medical visit co-payments/ co-

[1] Kathleen McManus, MD at the University of Virginia, School of Medicine compared viral suppression rates among ADAP clients enrolled in a Qualified Health Plan (QHP) to ADAP clients on the standard form of care. Eighty-eight percent of clients enrolled in insurance reached viral suppression and only 78% of clients on the standard form of care reached viral suppression within two years. To read more, click here.

[2] To qualify for PTCs, clients must have income between 100 and 400% Federal poverty line (FPL). To qualify for CSRs, clients must have an income between 100 and 250% FPL and must enroll in a silver-level plan. To learn more, click here for NASTAD's Health Reform Issue Brief.

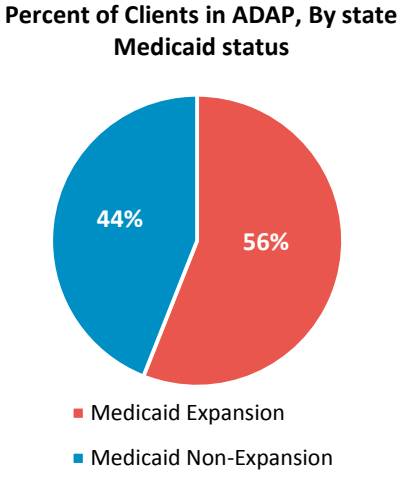
insurance,[3] 47 pay prescription co-payments/co-insurance, and 30 pay medical and/or prescription deductibles.

QHPs are available in different metal levels (bronze, silver, gold, and platinum), reflecting different QHP actuarial values. The higher the metal level, the more generous the plan cost sharing design, with platinum being the most generous metal level. Because individuals must enroll in a silver level plan to be eligible for CSRs, silver-level plans make up the vast majority of plans that ADAPs are supporting. However, there has also been an increase in gold and platinum level plans being supported by ADAPs. These plans may be more cost effective for clients not eligible for CSRs. Though the monthly premiums are higher in these higher metal level plans, the cost sharing tends to be far lower.



Medicaid

As of January 31, 2016, ADAPS supported 23,431 clients to enroll in expanded Medicaid since their state expanded Medicaid. Whether or not the ADAP pays for any related Medicaid expense, ADAP program staff help clients navigate insurance options and direct them to Medicaid. Eight ADAPs, however, do pay Medicaid premiums, nine pay medical visit co-payments/coinsurance, 15 pay prescription co-payments/coinsurance, and five pay the mandatory contribution to prescribed accounts. Prescribed accounts are also referred to as Health Savings Accounts (HSAs) for Medicaid. The HSAs allow beneficiaries to contribute to a savings account each month,

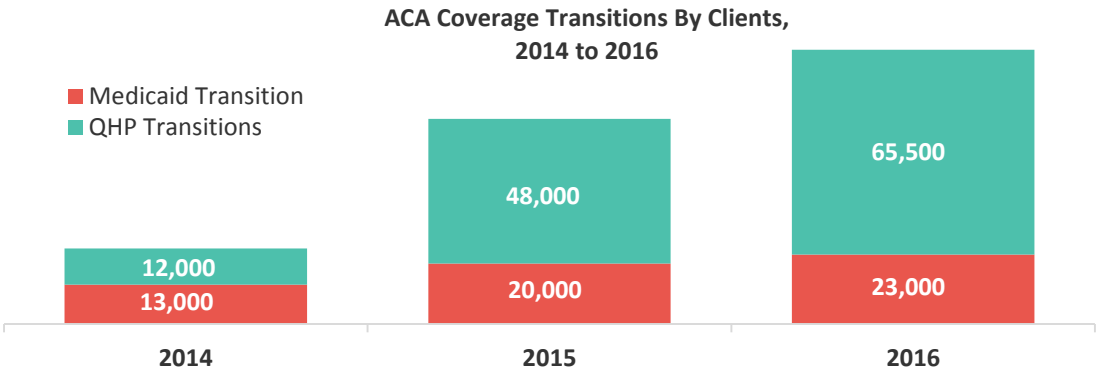


[3] Federal ADAP funds cannot be used to pay for medical visit co-payments/co-insurance; however, may states use State funding to provide this type of assistance to their clients.

which can then be used over time to cover health care expenses.

ADAPs are purchasing QHPs for clients who fall into the "Medicaid gap"

In non-Medicaid expansion states, ADAPs provide essential services for PLWH. While some ADAPs continue to pay for medications based on the traditional ADAP model, some ADAPs are purchasing unsubsidized insurance coverage for their clients below 100% of the Federal Poverty Level (FPL) who would otherwise fall into the Medicaid gap. Twenty-nine ADAPs reported purchasing QHPs for clients under 100% of FPL. This assistance and coverage has been critical to improving the health outcomes of these clients and highlights the innovative approaches that are possible for ADAPs regarding insurance purchasing.



Conclusion

Enrolling clients in public or private health insurance does not replace the need for public health programs like ADAPs, as they work together to improve the overall health of PLWH. As healthcare systems continue to change and evolve, so too do ADAPs. In addition to providing a crucial safety net for individuals with no access to insurance, ADAPs are now assisting tens of thousands of insured individuals with ensuring they are able to afford and meaningfully access their insurance benefits. In addition, ADAPs continue to innovate to meet the changing needs of clients with insurance coverage, including covering access to critical mental health, substance use, and hepatitis C medications. ADAPs must continue to be able to serve their clients and navigate insurance options for them in order to improve health outcomes.