Health Care Reform Checkup

It’s official: President Obama’s sweeping overhaul of the U.S. health care system has been signed into law. But what does this landmark legislation mean for those of us living with—or at risk for—HIV/AIDS? With the help of our friends at Harvard Law School, POZ dissects the life-changing bill and highlights how it can affect our care and treatment.

May 6, 2010 By James Wortman , Robert Greenwald and Maggie Francis

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On March 23, President Barack Obama signed H.R. 3590, the $940 billion Patient Protection and Affordable Care Act of 2010, a bill that extends health care coverage to 32 million uninsured Americans and creates an individual mandate requiring uninsured individuals to purchase insurance beginning in 2014. Days later, Obama lent his pen to a separate reconciliation bill—which included a package of “fixes” to the Senate version of the bill—and health care history was made. It is the most comprehensive reform made to the United States’ health care system since the passage of Medicare and Medicaid in 1965.

HIV/AIDS organizations and people living with the virus from around the country applauded the new law, which includes several key provisions that will improve health care for people living with HIV. It will put a stop to health insurance exclusions based on pre-existing conditions. Eventually, it will end the waiting periods of up to a year for health insurance coverage for those with pre-existing conditions such as HIV—a time span that could prove deadly for someone newly diagnosed with AIDS. It will eliminate the Medicaid disability requirement, and it will increase access to Medicaid for millions of people.

Of particular interest to people living with HIV—especially those who are older or classified as “disabled” because of an AIDS diagnosis—is the law’s provision that would close the Medicare Part D treatment gap (colloquially called the “doughnut hole”) by 2020, making prescription medications more affordable for senior citizens and people with AIDS.

The bill also prevents Medicare recipients who receive their HIV treatment through an AIDS Drug Assistance Program (ADAP) from being subject to additional prescription drug costs. In 2010, $250 rebates for doughnut hole costs will be distributed, and beginning in 2011, pharmaceutical companies will be required to provide a 50 percent discount on brand-name drugs in the doughnut hole. In addition, starting in 2011, ADAP contributions will be counted toward the Medicare Part D True Out-of-Pocket (TrOOP) spending limit.

“The president and congressional leaders are to be commended for championing legislation that will extend health insurance coverage to nearly 95 percent of all people in the U.S. when the

program is fully implemented," David Ernesto Munar, vice president of the AIDS Foundation of Chicago, told *POZ.* "For the fight against HIV/AIDS, nothing could be more important. Health inequality perpetuates late testing and entry into care, HIV-related health disparities and high rates of preventable infections and deaths. Medicaid expansion, Medicare fixes and greater insurance market regulation will make vital health and preventative care services more affordable and accessible for people living with and at risk for HIV/AIDS."

For HIV-positive Americans, perhaps the most important piece of the new legislation is its provision barring insurance companies from denying or discontinuing coverage based on pre-existing conditions, which include HIV/AIDS and other chronic illnesses such as cancer, diabetes or heart disease. The provision goes into effect in 2014 for adults, but will apply to children under 19 starting this September. Adults with pre-existing conditions may buy into a national risk pool until the exchanges come online. While not cheap, they're still better than total exclusion.

"With HIV, both because of its medical component and also [because of] the stigma associated with it, there are many people who dread the thought of their employer, particularly a new employer, finding out about their [HIV] status," says Marjorie J. Hill, PhD, chief executive officer of Gay Men's Health Crisis, a leading New York City AIDS service organization. "And while this [law] doesn't necessarily [eliminate HIV-related] stigma—we still have lots of work to do—it does mean that if someone who is HIV positive changes their job, they don't have to worry about losing their medical benefits."

Health care reform may even lead more people to get tested, Hill adds. The new law helps alleviate the fear of getting tested because people no longer have to worry that if they test positive they'll be dropped from their current insurance or will be prevented from switching to or starting a new one. "The fewer barriers there are to testing, the more people will get tested, and the earlier they will get tested," Hill says.

Improvements to private health insurance include: prohibiting lifetime limits on coverage in 2010; eliminating the aforementioned pre-existing condition exclusions; and forbidding charging higher premiums based on gender or health status in 2014. Combined, these elements will increase access to health care for more Americans.

The scope of coverage will be increased through a new mandatory benefits package that, among other items, includes prescription drugs, mental health and substance abuse treatment, preventative care and chronic disease management in 2014. The law will increase affordability through subsidies for people with incomes of up to 400 percent of the federal poverty level (FPL), which translates to $43,320 for an individual and $88,200 for a family of four. At present, the FPL stands at $14,404 for individuals and $29,326 for a family of four.

Furthermore, the law prohibits caps on how much health care a plan will cover during any given year or over a person's lifetime. It also adds 16 million people to Medicaid—the federal health program for low-income people and those with certain disabilities—by raising the eligibility threshold to 133 percent of the FPL.

According to Kathie Hiers, CEO of AIDS Alabama and a member of the Presidential Advisory Council on HIV/AIDS, “A lot of people living with HIV are now going to qualify for Medicaid, so we’re very excited about that.” But she advises people living with HIV that the Medicaid expansion—including the aforementioned pre-existing conditions provision and the ability to buy coverage through state-run marketplaces called “exchanges”—does not go into effect until 2014.

“We’ve got a ways to go before all of this gets implemented,” Hiers explains. “I would encourage [HIV-positive] folks to be careful to protect the benefits they have now and not do anything to lose their placement on an ADAP [wait list] or anything like that until these changes actually do go into effect and we see how states are going to be able to afford them.”

In spite of the advantages that health care reform brings to people living with HIV, the law falls short in addressing all of our community’s needs. The law fails to address the underfunded ADAPs that provide treatment to people who cannot afford antiretroviral therapy. According to a recent report by the National Alliance of State and Territorial AIDS Directors (NASTAD), as of March 25, ADAPs in 11 states have been forced to put a total of 777 people on drug waiting lists this year. As a result, advocates have called on the president to support ADAP with $126 million from the fiscal year 2010 emergency funds.

Many advocates say they are disappointed that the Early Treatment for HIV Act (ETHA) did not make it into the final version of the bill. ETHA would give states the option of extending Medicaid coverage to low-income people who are HIV positive but who have not yet progressed to AIDS, at which point they would be considered disabled.

However, others argue that since the new law extends Medicaid to all Americans with incomes within 133 percent of the federal poverty level, many HIV-positive people will now be eligible for coverage. (ETHA advocates hoped to extend Medicaid for HIV-positive people within 200 percent of the poverty level.)

“There were some legislators who suggested that maybe there wasn’t going to be a need [for ETHA] because of health care reform,” Hill says. “But we felt there was a strong need, and there obviously continues to be a need. Medication is still a challenge for many individuals.”

Many advocates also lament the relatively early abandonment of the measure’s public option, which would have been a government insurance option to compete with private companies. And finally, there is the issue that the bill restores $250 million for abstinence-until-marriage sex education.

“I think we could have done better with health care reform,” says Jay Adams, president of the AIDS Task Force of the Upper Ohio Valley and HIV care coordinator for the Ryan White Part B program in West Virginia. “But given the political environment, I think we did the best we could.”

Some key components of the bill won’t go into effect until 2014, and ongoing legislative assaults will likely continue to threaten health care reform. Nonetheless, there is no question that this

historic health care reform is a big step in the right direction for our best health.

The new law invests in prevention, wellness and public health activities. It allocates resources for efforts to reduce health disparities, and it supports the clinical workforce with an emphasis on the needs of underserved communities.

In short, this bill is likely to save many more lives threatened by HIV. Hopefully, this reform will destigmatize HIV/AIDS by putting it on parity with other health concerns in terms of how it is covered. In turn, this will encourage more people to get tested for HIV and to connect to the health care that could save their lives.

Yet while the new law provides unprecedented opportunities to improve health care access, affordability and quality of care for people living with HIV/AIDS, it is critical that we as a community continue to work toward a future of high quality, equitable and sustainable health care for every American.

Advocacy from the community will be necessary both to encourage new reforms and to provide health care access for those who are uninsured or underinsured during the transitional period before the reform fully takes effect. We will also need to work to protect existing programs like the Ryan White CARE Act.

As GMHC's Hill reminds us, the HIV advocacy community must remain vigilant in supporting—and advising—the president on issues most important to those living with the virus.

"The Obama administration is a friend, and with so much hope and so much need, it's easy to forget that," Hill says. "We need to stand with our friend—but not stand silently."
