Health Insurance Premium & Co-Pay Assistance	Pg
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Service Category Definition - Ryan White Part B Grant
April 1, 2018 - March 31, 2019

Service Category Definition - DSHS State Services Grant
September 1, 2017 - August 31, 2018

Local Service Category:	**Health Insurance Premium and Cost Sharing Assistance**
Amount Available**:**	**To be determined**
Budget Requirements or Restrictions **(TRG Only)**:	Contractor must spend no more than 20% of funds on disbursement transactions. The remaining 80% of funds must be expended on the actual cost of the payment(s) disbursed. ADAP dispensing fees are not allowable under this service category.
Local Service Category Definition:	**Health Insurance Premium and Cost Sharing Assistance:** The Health Insurance Premium and Cost Sharing Assistance service category is intended to help people living with HIV continue medical care without gaps in health insurance coverage or disruption of treatment. A program of financial assistance for the payment of health insurance premiums and co-pays, co-insurance and deductibles to enable eligible individuals with HIV disease to utilize their existing third party or public assistance (e.g. Medicare) medical insurance. Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement that requires the insured to pay a percentage of costs for covered services/prescription Deductible: A cost-sharing requirement that requires the insured pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy. Advance Premium Tax Credit (APTC) Tax Liability: Tax liability associated with the APTC reconciliation; reimbursement cap of 50% of the tax due up to a maximum of $500.
Target Population (age, gender, geographic, race, ethnicity, etc.):	All Ryan White eligible clients with 3rd party insurance coverage (COBRA, private policies, Qualified Health Plans, CHIP, Medicaid, Medicare and Medicare Supplemental plans) within the Houston HSDA.
Services to be Provided:	Contractor may provide assistance with: • Insurance premiums, • And deductibles, co-insurance and/or co-payments.
Service Unit Definition **(TRG Only)**:	A unit of service will consist of payment of health insurance premiums, co-payments, co-insurance, deductible, or a combination.
Financial Eligibility:	Affordable Care Act (ACA) Marketplace Plans: 100-400% of federal poverty guidelines. All other insurance plans at or below 400% of federal poverty guidelines. Exception: Clients who were enrolled prior to November 1, 2015 will maintain their eligibility in subsequent plan years even if below 100% or between 400-500% of federal poverty guidelines.

<table>
<tr><td>Client Eligibility:</td><td>People living with HIV in the Houston HSDA and have insurance or be eligible (within local financial eligibility guidelines) to purchase a Qualified Health Plan through the Marketplace.</td></tr>
<tr><td>Agency Requirements (TRG Only):</td><td>Agency must:

Provide a comprehensive financial intake/application to determine client eligibility for this program to insure that these funds are used as a last resort in order for the client to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace.
Clients will not be put on wait lists nor will Health Insurance Premium and Cost Sharing Assistance services be postponed or denied due to funding without notifying the Administrative Agency.
Conduct marketing in-services with Houston area HIV/AIDS service providers to inform them of this program and how the client referral and enrollment processes function.
Establish formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance abuse provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance abuse provider site. (i.e. No need for client to physically present to Health Insurance provider.)
Utilizes the RW Planning Council-approved prioritization of cost sharing assistance when limited funds warrant it (<u>premiums take precedence</u>).

Priority Ranking of Requests (in descending order):

HIV medication co-pays and deductibles (medications on the Texas ADAP formulary)
Non-HIV medication co-pays and deductibles
Co-payments for provider visits (eg. physician visit and/or lab copayments)
Medicare Part D (Rx) premiums
APTC Tax Liability
Out of Network out-of-pocket expenses

Utilizes the RW Planning Council –approved consumer out-of-pocket methodology.
</td></tr>
<tr><td>Special Requirements (TRG Only):</td><td>Must comply with the Houston EMA/HSDA Standards of Care and, pending the most current DSHS guidance, client must:

Purchase Silver Level Plan with formulary equivalency
Take advance premium credit
No assistance for Out of Network out-of-pocket expenses without prior approval of the Administrative Agent.

Must comply with DSHS Interim Guidance. Must comply with updated guidance from DSHS. Must comply with the Eastern HASA Health Insurance Assistance Policy and Procedure (HIA-1701).</td></tr>
</table>

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y_____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y_____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y_____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup**	Date: **04/24/18**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

FY 2018 Houston EMA/HSDA Ryan White Part A/MAI Service Definition **Health Insurance Co-Payments and Co-Insurance Assistance** (Revision Date: 5/21/15)	
HRSA Service Category Title:	**Health Insurance Premium and Cost Sharing Assistance**
Local Service Category Title:	**Health Insurance Co-Payments and Co-Insurance**
Budget Type**:**	**Hybrid Fee for Service**
Budget Requirements or Restrictions:	Agency must spend no more than 20% of funds on disbursement transactions. The remaining 80% of funds must be expended on the actual cost of the payment(s) disbursed.
HRSA Service Category Definition**:**	***Health Insurance Premium & Cost Sharing Assistance*** is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.
Local Service Category Definition:	A program of financial assistance for the payment of health insurance premiums, deductibles, co-insurance, co-payments and tax liability payments associated with Advance Premium Tax Credit (APTC) reconciliation to enable eligible individuals with HIV disease to utilize their existing third party or public assistance (e.g. Medicare) medical insurance. Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement that requires the insured to pay a percentage of costs for covered services/prescription Deductible: A cost-sharing requirement that requires the insured to pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy. APTC Tax Liability: The difference paid on a tax return if the advance credit payments that were paid to a health care provider were more than the actual eligible credit.
Target Population (age, gender, geographic, race, ethnicity, etc.):	All Ryan White eligible clients with 3rd party insurance coverage (COBRA, private policies, Qualified Health Plans, CHIP, Medicaid, Medicare and Medicare Supplemental) within the Houston EMA.
Services to be Provided:	Provision of financial assistance with premiums, deductibles, co-insurance, and co-payments. Also includes tax liability payments associated with APTC reconciliation up to 50% of liability with a $500 maximum.

Service Unit Definition(s): **(RWGA only)**	1 unit of service = A payment of a premium, deductible, co-insurance, co-payment or tax liability associated with APTC reconciliation for an HIV-infected person with insurance coverage.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA Services*.
Client Eligibility:	HIV-infected individuals residing in the Houston EMA meeting financial eligibility requirements and have insurance or be eligible to purchase a Qualified Health Plan through the Marketplace.
Agency Requirements:	Agency must: • Provide a comprehensive financial intake/application to determine client eligibility for this program to insure that these funds are used as a last resort in order for the client to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace. • Ensure that assistance provided to clients does not duplicate services already being provided through Ryan White Part B or State Services. The process for ensuring this requirement must be fully documented. • Have mechanisms to vigorously pursue any excess premium tax credit a client receives from the IRS upon submission of the client's tax return for those clients that receive financial assistance for eligible out of pocket costs associated with the purchase and use of Qualified Health Plans obtained through the Marketplace. • Conduct marketing with Houston area HIV/AIDS service providers to inform such entities of this program and how the client referral and enrollment processes function. Marketing efforts must be documented and are subject to review by RWGA. • Clients will not be put on wait lists nor will Health Insurance Premium and Cost Sharing Assistance services be postponed or denied without notifying the Administrative Agency. • Establish formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance abuse provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance abuse provider site. (i.e. No need for client to physically present to Health Insurance provider.) • Utilize RWGA approved prioritization of cost sharing assistance, when limited funds warrant it. • Utilize consumer out-of-pocket methodology approved by RWGA.
Staff Requirements:	None
Special Requirements:	Agency must comply with the Houston EMA/HSDA Standards of Care and Health Insurance Assistance service category program policies.

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y:_____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
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Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y: ______ No: ______ Approved With Changes:______	If approved with changes list changes below:
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3.		

Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y: ______ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		

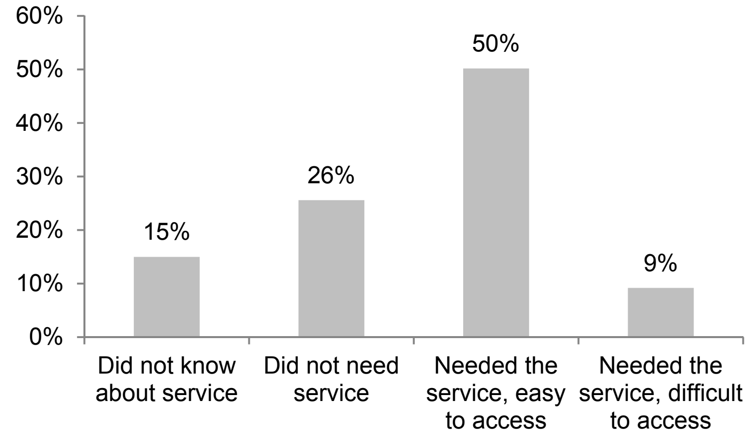
Step in Process: **HTBMN Workgroup**	Date: **04/24/18**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

HEALTH INSURANCE ASSISTANCE

Health insurance assistance, also referred to as *health insurance premium and cost-sharing assistance*, provides financial assistance to persons living with HIV (PLWH) with third-party health insurance coverage (such as private insurance, ACA Qualified Health Plans, COBRA, or Medicare) so they can obtain or maintain health care benefits. This includes funding for premiums, deductibles, Advanced Premium Tax Credit liability, and co-pays for both medical visits and medication.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 59% of participants indicated a need for *health insurance assistance* in the past 12 months. 50% reported the service was easy to access, and 9% reported difficulty. 15% stated that they did not know the service was available.

GRAPH 1-Health Insurance Assistance, 2016



(**Table 1**) When barriers to *health insurance assistance* were reported, the most common barrier type was related to health insurance coverage (31%). Health insurance-related barriers reported include being uninsured, having coverage gaps, and difficulty with ACA enrollment.

TABLE 1-Top 5 Reported Barrier Types for Health Insurance Assistance, 2016

	No.	%
1. Health Insurance Coverage (I)	15	31%
2. Education and Awareness (EA)	10	21%
3. Administrative (AD)	6	13%
4. Eligibility (EL)	6	13%
5. Financial (F)	5	10%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *health insurance assistance* this analysis shows the following:

- More males than females found the service accessible.
- More other/multiracial PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, more recently released and rural PLWH found the service difficult to access when compared to all participants.

TABLE 2-Health Insurance Assistance, by Demographic Categories, 2016

	Sex		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	14%	19%	8%	17%	16%	20%	35%	18%	8%
Did not need service	25%	27%	26%	27%	25%	0%	30%	23%	28%
Needed, easy to access	52%	42%	54%	46%	53%	67%	30%	50%	54%
Needed, difficult to access	8%	12%	11%	10%	6%	13%	4%	9%	9%

TABLE 3-Health Insurance Assistance, by Selected Special Populations, 2016

Experience with the Service	Unstably Housed[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	21%	12%	0%	16%	15%	5%
Did not need service	27%	25%	0%	24%	24%	27%
Needed, easy to access	42%	56%	100%	42%	47%	64%
Needed, difficult to access	9%	7%	0%	18%	15%	5%

[a]Persons reporting housing instability [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

HIV/AIDS Bureau (HAB) Ryan White HIV/AIDS Program (RWHAP)

Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds

Standalone Dental Insurance Frequently Asked Questions

1. Can recipients offer both standalone dental insurance premiums and/or cost sharing assistance under the service category Health Insurance Premiums and Cost Sharing Assistance **and** RWHAP Oral Health Care services in their program?

   Recipients and subrecipients are able to provide both service categories within their programs as long as the standalone dental insurance premium and/or cost sharing assistance and Oral Health Care services are provided in compliance with the requirements for each described in *PCN #16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds*.

2. Can recipients/subrecipients use RWHAP funds to pay for oral health care services that exceed annual expenditure caps established by standalone dental insurance plans?

   RWHAP recipients and subrecipients are in the best position to understand the unique needs of their client populations, determine which costs are cost-effective to pay, and ensure availability of the resources equitably for eligible clients. It is up to the recipient and subrecipient to identify which costs they will cover related to standalone dental insurance, which can include: premiums, deductibles, co-payments, and/or costs above the cap. The recipient or subrecipient must have policies and procedures in place to ensure these services are available to all eligible RWHAP clients.

3. Can ADAP funds or pharmaceutical rebates be used to purchase standalone dental insurance premiums and/or cost sharing assistance?

   ADAP funds cannot be used to purchase standalone dental insurance premiums and cost sharing assistance because standalone dental insurance does not cover the cost of medications necessary in treatment for people living with HIV. See *PCN #13-05 Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost Sharing Assistance for Private Health Insurance* for requirements for ADAPs to pay for Health Insurance Premiums and Cost Sharing Assistance for Individuals.

   However, as *PCN #15-04 Utilization and Reporting of Pharmaceutical Rebates* explains, "the RWHAP legislation requires that rebates collected on ADAP medication purchases be applied to the RWHAP Part B Program with a priority, but not a requirement, that the rebates be placed back into ADAP. These rebates must be used for the statutorily permitted purposes under the RWHAP Part B Program which are limited to core medical services including ADAP, support services, clinical quality management, and administrative expenses (including planning and evaluation) as part of a comprehensive system of care for low-income individuals living with

HIV." Pharmaceutical rebates earned by the RWHAP Part B Program may be used to pay for standalone dental insurance premiums and/or cost sharing assistance.

4. When does the addition of standalone dental insurance to the Health Insurance Premiums and Cost Sharing Assistance for Low-Income Individuals service category take effect?

   PCN #16-02 is in effect for all awards made on or after October 1, 2016, including competing continuations, noncompeting continuations, supplements, and new awards.

HIV Patients Do Better With Insurance Than Drug Assistance

Marcia Frellick | October 09, 2015

SAN DIEGO — Low-income HIV patients who transitioned to Affordable Care Act health plans in Virginia, a state that did not expand Medicaid, had better outcomes and were more likely to attain viral suppression than their peers who continued to receive medications through the state's AIDS Drug Assistance Program, according to a new study.

This finding is important for public health because the more viral suppression, the fewer transmissions, said Kathleen McManus, MD, from the division of infectious diseases and international health at the University of Virginia in Charlottesville.

"We also found that the relationship is a dose-related response," she said during a news conference here at IDWeek 2015. "If someone enrolled in Affordable Care in January, they were more likely to achieve virologic suppression than if they enrolled by April or June."

Many low-income patients with HIV face obstacles to getting care. Some fall through the cracks because they earn too much to get Medicaid coverage, but not enough to pay for insurance and medications.

Before the Affordable Care Act, the Virginia AIDS Drug Assistance Program provided antiretroviral therapy to the uninsured and underinsured living with HIV, typically through HIV clinics funded by the Ryan White Program. When Affordable Care was introduced, the AIDS Drug Assistance Program helped eligible patients sign up for a plan and paid for the premiums, deductibles, and medication copays.

Dr McManus and her team assessed data collected by the Virginia Department of Health from January 1, 2013 to December 31, 2014. They identified 3933 HIV-infected adults enrolled in the state AIDS Drug Assistance Program before July 1, 2013 who were eligible for Affordable Care. Of these, 47.1% enrolled in the insurance plans.

Decision to Enroll

The decision to enroll was affected by many factors, including age, sex, where patients got their care, and the amount of tax credits received.

Patients 25 to 44 years of age were less likely to enroll than those 18 to 24 years or those older than 44 years. In addition, "patients with AIDS were less likely to enroll than patients with HIV, and women were more likely to enroll than men," Dr McManus reported.

Viral suppression, the most important HIV clinical outcome, was achieved by more patients enrolled in Affordable Care than in the drug assistance program (85.5% vs 78.7%).

This study provides yet more evidence that having insurance improves outcomes for people with chronic diseases, said Dr McManus.

Affordable Care provides more comprehensive care for the same amount of money, or less, and patients might have done better because they had access to medications and treatments beyond HIV-specific drugs, she explained.

The Ryan White program, which works with cities, states, and local community-based organizations to provide HIV-related services, gives patients "access to HIV care, but that doesn't always mean that someone can get their primary care, their diabetes care, or their colonoscopy," she pointed out.

And, because HIV medications are so expensive, providing insurance is more cost-effective than paying for the medications directly, said Dr McManus. Before Affordable Care, Virginia's AIDS Drug Assistance Program often had a waitlist.

The association should continue to be tracked over time, say the researchers, as more people living with HIV remain on insurance for longer periods of time.

The Program or the Patients?

The better virologic outcomes achieved by the patients who enrolled in insurance plans might be a function of the kinds of patients who chose to enroll in an insurance plan, rather than an advantage of the plans themselves, said Loren Miller, MD, from the University of California at Los Angeles.

"For example, more motivated patients with better health-seeking behavior might have chosen insurance plans," Dr Miller told *Medscape Medical News*.

Regardless, it is very reassuring that clinical outcomes do not worsen in patients transitioning from drug programs to insurance plans. "In fact, outcomes may be better for those who chose the insurance plans," he said.

These findings could trigger a reassessment of the way AIDS Drug Assistance Program funds are spent, and inspire expanded choices to maximize clinical outcomes for HIV-infected patients, he added.

Dr McManus and Dr Smith have disclosed no relevant financial relationships.

IDWeek 2015: Abstract 728. Presented October 9, 2015.

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Send comments and news tips to news@medscape.net.

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HIV/AIDS Patients Struggle with High Healthcare Costs

By **Vera Gruessner (http://healthpayerintelligence.com/about-us)** on January 21, 2016

AIDS United has joined its efforts with Partners for Better Care, which aims to reduce healthcare costs and make medical care more affordable and accessible.

The high costs within the healthcare industry are often associated with managing the health of patients living with chronic medical conditions. At the J.P. Morgan's Healthcare Conference in early January, **James L. Madara (http://healthpayerintelligence.com/news/cms-ama-delve-into-past-and-future-of-healthcare-market)**, the Executive Vice President of the American Medical Association, provided his opinion on how chronic medical conditions have been a major driver of healthcare costs around the nation.

"I have to say, when one thinks of the evolving healthcare market, technology, digital revolution, biomedical advances, and precision medicine are some of the things that come to mind, but we sometimes lose track that the overarching driver that will dictate the direction of innovation is the shifting nature of disease burden itself," Madara said at the conference.

"This driver, as many of you know, has radically changed. I have to say, it's changed in a way that's kind of crept up on us. It's changed from acute disease to chronic disease, but much of our healthcare structure is still tilted toward this old paradigm of acute disease."

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exchange)

to chronic disease. So currently, when we talk about chronic disease, we're talking about 2.5 trillion dollars."

"Science also indicates that we'll probably have more and more chronic disease. We're less good at cures than we would like to be, but not bad at taking previously acute, fatal disease and converting it to a chronic, manageable condition."

To hear more about how chronic medical conditions – in particular HIV and AIDS – is driving healthcare costs and posing financial obstacles for those living with the disease, *HealthPayerIntelligence.com* spoke with Michael Kaplan, President and CEO of AIDS United.

AIDS United has joined its efforts with **Partners for Better Care (http://healthpayerintelligence.com /news/key-steps-toward-affordable-health-insurance-platforms)**, which aims to reduce healthcare costs and make medical care more affordable and accessible for American citizens. When asked why AIDS United chose to join the Partners for Better Care organization, Kaplan answered, "The quick answer is due to a perfect alignment of interest."

High healthcare costs: Few HIV cases receive proper treatment

"To go into more detail and a little background, I've been living with HIV since 1992 and working in this field and we have seen an immense amount of progress particularly in the last five years. We now are in a place of understanding, whether you ask the NIH or the CDC, we have all the tools to end the HIV epidemic. It's possible but the challenge is getting there," he continued.

"The challenge is that while we know today that treatment can extend the life of a person infected to almost that of the uninfected and we know today that a person on treatment and virally-suppressed is almost impossible to transmit HIV to another person, the reality today in the US is that less than one-third of the 1.2 million Americans living with HIV are on treatment and virally-suppressed," Kaplan explained.

"All of that has to do with access issues. It has to do with affordability, transparency and everything from dignified and culturally-competent care to knowing what drugs are covered in the formulary. I will mention that the perfect alignment of interest is why we got involved with Partners

for Better Care."

The financial impediments affecting AIDS/HIV patients

When asked to describe some financial and insurance-based challenges that affect people living with AIDS and HIV, Kaplan responded, "Historically with the epidemic, we spent in the United States for about a decade or two dealing with insurance companies pushing most people living with HIV off of private insurance."

"Up until 2014, the only way a person with HIV could be ensured is either an employer-based plan or, if you were unemployed, hope that you were impoverished enough to qualify for Medicaid," he clarified. "Now with the new health reforms and the Affordable Care Act, clearly, health plans can no longer discriminate based on pre-existing conditions, but we still have some behavioral problems happening on the part of the insurance industry."

"While the Affordable Care Act guarantees me the right to now get insurance in a full market whether or not employed and while my HIV status is at poverty, I don't have to have AIDS to get Medicaid, I can simply get it because I'm impoverished."

"The challenges that are existing now are a few. One is we've seen through the exchanges a real lack of transparency meaning that the network of providers are often not only inadequate but inadequately documented. You don't know if you really have the providers you need if you purchased an insurance plan."

"We actually see that even more so through the formularies for drugs. This year got better but in the first year of buying plans on the exchange, if you were trying to figure out if your treatments were covered, good luck!" Kaplan exclaimed.

"I like to think I'm fairly educated. I've run nonprofits for a long time and I've led organizations – I spent an hour and a half the first year of the exchanges with a representative from one of the health plans and she couldn't figure out if my HIV drugs were covered or not," he claimed. "If the insurance providers can't, thinking that beneficiaries can is a joke."

"We're getting better on the transparency of formularies but it's not where it needs to be. The other issue that happened is that in most states, HIV drugs have been moved up to specialty tiers. In many states, this also means a higher co-pay or a higher coinsurance than many people experienced before."

"We have seen some successful winds. For example, in Florida, there was threat of legal action that got the insurers to move some of the HIV drugs – particularly those that were not as new – off of the specialty tiers. But we're still seeing in the bulk of states, the bulk of HIV medicines being placed on the highest tier with the highest co-pay and the highest co-insurance."

"Many people who used to have access to treatment through drug purchase programs under Ryan White have been moved into private insurance plans and, all of a sudden, found out they had even bigger expenditures than they ever expected," he positioned.

"Again, the transparency of formularies and the treatment of HIV drugs and Hepatitis drugs are some of the financial challenges that many are experiencing," Kaplan explained. "The other financial challenge, quite frankly, is that in the US we have very different HIV epidemics

depending where you live. In Massachusetts, New York, and California, we have seen a gradual decrease in new infections. In Louisiana, Texas, and many of the southern states, we're seeing a continued increase."

"Yet, where HIV aligns with poverty, it is the states where many are having the greatest increases that refuse to do Medicaid expansion for their poorest citizens and, so, that financial factor comes in as well," Kaplan concludes.

Solutions health payers could take

When asked what steps health payers should take to improve transparency, health literacy and educate consumers on their health plan coverage options, Kaplan mentioned, "I would say that the most important part is engaging in a dialogue. I remember not too long ago, there was a new head of Pharma and payers were creating a dialogue."

"The one thing missing was the patient voice," he relayed. "While health payers are engaging with Pharma, there needs to be a 3-way dialogue. It should not be just the providers and payment process reps like private insurers but the 3rd voice needs to be the patient and consumers who tend get the short end of the stick."

"The other part of the solution is purely about due diligence and making documentation clear including what's in a formulary and who's in the plan's provider network," he stated.

Federal regulations for minimizing out-of-pocket healthcare costs

In reference to a question about any regulations the federal government could adopt to minimize the patient costs of prescription drugs and other out-of-pocket expenses, Kaplan responded, "There has been legislation and policy introduced in several states that have put a cap on co-pays and coinsurance. Bravo for those states but this is not a national solution."

"It really is luck of the draw for the states," he continued. "There has not been adequate legislation introduced and whatever has been introduced hasn't passed in the federal government."

"There needs to be a stronger enforcement of nondiscriminatory policies found within the Affordable Care Act," Kaplan mentioned. "There should be no discrimination among the diseased. The other broader area is that the Obama administration should allow states that haven't expanded Medicaid to allow even those states to get the three full years of full Medicaid expansion if they choose to pursue the funding in the future."

The Ryan White HIV/AIDS program

When asked about his perspective on the Ryan White HIV/AIDS program and how it has helped people living with the disease, Kaplan answered, "The Ryan White Care Program started in the 1990s because private insurance pushed people off of their plans."

"Healthcare providers also refused to take care of us," he continued. "It may have been due to fear or homophobia. Doctors were terrified of people living with HIV. The Ryan White Care program is now at about $2.6 billion. Historically, up until 2014, there really were few other choices for poor people to get HIV treatment."

“The AIDS drug assistance program helps provide $800 to $900 million to ensure people can afford HIV drugs. Recently, we’ve been able to successfully move people off of this program onto Medicaid or help them buy insurance through the exchange. It’s vital to provide comprehensive care.”

“The Ryan White program continues to be critical for several reasons,” he clarified. “It covers supportive services to help people remain engaged and in treatment. Some top barriers of ensuring HIV treatment is lack of transportation, stable housing, and lack of providers. However, all of these issues are tackled through the Ryan White program.”

“In states that haven’t expanded their Medicaid programs, the Ryan White program helps purchase insurance for low-income people living with HIV or AIDS,” he mentioned. “The best study area is to pair the Ryan White program with health reform. Massachusetts did its own version of health reform earlier on and is seeing better results for patients with AIDS. Massachusetts saw a steep decrease in new infections than in any other state.”

“It’s beneficial to repair the Ryan White program to supplement health reform,” he concluded. “The dream is to move all states to full health reform and pair it with the Ryan White program.”

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