

April 2015 | Issue Brief

The Ryan White Program and Insurance Purchasing in the ACA Era: An Early Look at Five States

Issue Brief: Lindsey Dawson, Jennifer Kates

Executive Summary

The Ryan White Program, enacted in 1990, is the nation's safety net program for HIV care and treatment and serves about half a million people with the disease in the United States. The federal government has authorized the use of Ryan White funds for purchasing health insurance on behalf of clients since the enactment of the program and using funds this way has increased over time. While insurance purchasing has always been a permissible use of Ryan White funds, its role has become both more important and more complex with the implementation of the Affordable Care Act (ACA), as many more people with HIV have become newly eligible for insurance coverage. How Ryan White grantees at the state and local levels elect to move forward with insurance purchasing in the ACA era has key implications for the program and for the clients it serves.

This brief discusses the historic role the Ryan White Program has played in helping clients purchase insurance coverage and provides an early look how grantees have elected to use Ryan White funds and ready systems for insurance purchasing in the ACA era, in five states – California, Florida, Georgia, New York, and Texas. The focus of this brief is on the first open enrollment period (lasting from October 2013 through April 2014) and on insurance purchasing activities conducted through the health insurance marketplaces for qualified health plans (QHPs). The findings of this brief are based on stakeholder interviews, focus groups with HIV positive individuals, and reviews of federal, state, and local documents.

Key findings from the state studies include:

- Most insurance purchasing in the Ryan White Program occurs through AIDS Drug Assistance Programs (ADAPs), a component of the state (Part B) program. ADAPs approached the first open enrollment period with different degrees of insurance purchasing experience and this often paralleled the degree to which they were prepared to offer insurance purchasing through the marketplaces. Among the states in this analysis, two ADAPs moved ahead with larger scale insurance purchasing programs (California and New York), two (Florida and Georgia) operated small-scale or pilot programs, and one (Texas) did not pursue an insurance purchasing program that could support QHP coverage.
- All ADAPs examined here, including those more proactively pursuing QHP premium assistance, faced challenges. For those embracing QHP premium support, stakeholders described technical and/or process issues related to leveraging existing systems – which in some cases needed to be updated – for larger scale enrollment and challenges in orchestrating third party payments.

- In the states that less aggressively pursued QHP insurance purchasing, stakeholders explained that challenges ran deeper and were often related to operating programs in states that were, overall, resistant to ACA implementation. As a result, stakeholders in these states reported that ADAPs were unable to sufficiently prepare for client enrollment through the marketplaces, were only able to conduct limited insurance purchasing, or, in the case of one state, were not able to start a QHP insurance purchasing program altogether.
- States also varied in their ability to assist with cost-sharing assistance beyond premiums. While one state was able to provide complete cost-sharing assistance, other states provided only limited support beyond paying premiums. Stakeholders worried that without full cost-sharing assistance, clients would find insurance expenses unaffordable and may not be able to maintain their coverage, jeopardizing their care and treatment.
- Part As, often by funding AIDS Service Organizations (ASOs), frequently stepped in to fill gaps in coverage and assist with costs not met through ADAP program insurance purchasing. This included covering premiums in states whose ADAPs had no or limited QHP insurance purchasing programs, helping with cost-sharing not supported by ADAPs, and preventing gaps in care and treatment during bumpy enrollment processes or coverage transitions. In some cases additional support was obtained through private foundations and pharmaceutical assistance programs.
- The ADAPs that had the most limited QHP insurance purchasing programs in this study operated in states that did not expand Medicaid. Conversely, the states that embraced premium support for QHPs through their ADAP programs early on also expanded Medicaid, offering clients more robust coverage options.
- The federal government encouraged Ryan White Program grantees to “vigorously pursue” client enrollment into available coverage, including QHPs. While this directive was clear to some grantees and helped to underpin efforts to enroll clients in QHPs with insurance purchasing assistance, others found the directive difficult to interpret. Some stakeholders trying to operate programs in states that were more resistant to ACA implementation overall reported a conflict between what was being asked of them by the federal government with regard to enrollment under the Ryan White Program and state-level decisions opposing to ACA implementation which lead to limited insurance purchasing opportunities.

Introduction

First enacted in 1990, the Ryan White Program – the largest federal grant program designed specifically for people with HIV – has grown to become a critical part of the HIV health care delivery system in the U.S., providing care, treatment, and support services to more than half a million low-income people with HIV each year.¹ The program is administered by the Health Resource Services Administration’s (HRSA) HIV/AIDS Bureau (HAB) and functions as a safety net, filling in gaps in care for people with HIV. The Ryan White Program is a “payer of last resort,” meaning that whenever possible, services must first be reimbursed by other available payers (e.g., public or private health insurance) before Ryan White funds can be used.

Ryan White funds primarily pay for medical and support services and for the direct cost of medications for those who are uninsured or underinsured. Additionally, the federal government has authorized the use of program funds to assist clients in purchasing new health insurance or continuing existing insurance coverage, which includes paying for premiums, deductibles, co-payments, and co-insurance (see Table 1). Using funds this way, compared to directly purchasing care and medications, can provide clients with more comprehensive

health coverage than they might have been able to obtain on their own and has been shown to be cost effective for the program compared to the cost of directly purchasing medications.²

Insurance Term	Definition
Premium	The amount owed to an issuer (health insurance company) on a monthly basis to keep a policy active, typically paid by an individual or a third party, such as an employer or the Ryan White Program.
Deductible	The set dollar amount an individual enrolled in a plan must pay before the health plan starts to pay for services. Depending on the plan, an issuer may pay for certain services before meeting the deductible. Deductibles are sometimes covered by a third party, such as the Ryan White Program.
Co-payment	A fixed amount an individual enrolled in a health plan pays “out-of-pocket” toward the cost of a covered health service such as a doctor’s visit, laboratory test, hospital visit, or a prescription drug. These may vary by type of service. Co-payments are sometimes covered by a third party, such as the Ryan White Program.
Co-insurance	A fixed percentage of the total cost of a health service, such as a doctor visit, laboratory test, hospital visit, or a prescription drug that an individual enrolled in a health plan pays “out-of-pocket” towards that service. Co-insurance is sometimes covered by a third party, such as the Ryan White Program.

While insurance purchasing, also referred to as premium assistance or premium support, has been a permissible use of Ryan White funds since the program’s inception, its role has become both more important and more complex with the implementation of the Affordable Care Act (ACA). Because of the ACA, tens of thousands of people with HIV have new insurance options, with some accessing insurance coverage for the first time. Therefore, Ryan White grantees and sub-grantees – states, territories, cities, providers, and other organizations providing services to people with HIV (collectively referred to as AIDS Service Organizations or ASOs in this brief) – have new opportunities to assist clients with the costs of private health insurance. In fact, federal policy guidance has encouraged Ryan White grantees to provide this assistance where appropriate.³

While some Ryan White grantees have substantial experience using their funds for premium assistance, others are newer to this arena. Moreover, because the ACA has made significant changes to the health care environments in all states, even grantees with experience in insurance purchasing are facing new challenges and decisions. How Ryan White grantees at the state and local levels elect to move forward with insurance purchasing in the ACA era has key implications for the program and for clients’ access to coverage.

As such, it is important to examine the decisions around insurance purchasing that Ryan White grantees are making in the ACA era. Doing so will help provide an understanding of the various ways insurance purchasing programs are being implemented and allow for analysis of how these programs impact insurance coverage and ultimately health outcomes for people with HIV. This policy brief provides an early look at the insurance purchasing experiences of Ryan White-funded entities in five states – California, Florida, Georgia, New York, and Texas – during the first open enrollment period (October 2013 through April 2014). While Ryan White can assist with insurance purchasing and cost-sharing related to both public and private insurance, this report examines private insurance purchased through the health insurance marketplaces established under the ACA.

The report is based on interviews with more than 60 stakeholders across the five states (7-12 per state) 10 focus groups conducted with people with HIV (two per state), and a review of federal, state, and other documents.

Stakeholders held a range of public and private positions in fields related to HIV service delivery and policy development. Interviews and focus groups were conducted between March and September of 2014, so may not reflect more recent decisions made within states with respect to insurance purchasing, particularly those occurring during subsequent open enrollment periods. In addition, the experiences of these five states and of those interviewed are not meant to be representative of all states or all people living with HIV.

Background

INSURANCE PURCHASING UNDER RYAN WHITE PRE-ACA

The federal government has authorized the use of Ryan White funds to assist with insurance purchasing since the program was first enacted in 1990. While most parts of the Ryan White Program are authorized to use funds for this purpose (Parts A, B, C, and D)⁴, the primary source of Ryan White funding for insurance purchasing is the AIDS Drug Assistance Program (ADAP), a component of Part B funding which is provided by the federal governments directly to states to help pay for HIV care and treatment services (states may also contribute their own funds for services).

ADAP was initially created to directly purchase HIV medications for infected individuals and this is still its dominant function in most states. Insurance purchasing, however, has grown rapidly over time given its cost-effectiveness and ability to provide clients with more comprehensive care (covering services not provided through Ryan White, such as non-HIV drugs, emergency room visits, and hospital stays), compared with purchasing medications directly. Insurance purchasing under ADAP has grown from supporting coverage for 6% of ADAP clients nationwide in 2003 to 35% in 2013.⁵

Over time, Ryan White reauthorizations and policy guidance have put greater emphasis on grantees' ability to use Ryan White funds to help clients obtain insurance coverage. Policy notices have clarified aspects of the law related to insurance purchasing, emphasized the permissibility of this function, and to provided implementation guidance to grantees (see Tables 2 and 3). For example, while the initial authorization of The Program and subsequent guidance focused on insurance *continuation* (assisting clients in maintaining existing coverage), later policies specified that funds could also be used for *purchasing* new coverage (emphasized in notice 99-01 and explicitly affirmed in the 2006 reauthorization legislation). Further, the 2006 reauthorization of the program stipulated that 75% of grant awards must be spent on "core medical services," identifying insurance purchasing as one such service.

Table 2: Law & Policies Related to Use of Ryan White Funds for Insurance Purchasing

Policy	Significance
Ryan White Comprehensive AIDS Resources Emergency Act of 1990	First authorizes the Ryan White Program. Sections 2612(a)(3) and 2615(a) permit Title II program funds (funding provided to states, now called Part B) to be used for “maintaining a continuity of health insurance” and ensuring eligible individuals receive “medical benefits under a health insurance program.” Further, Sec. 2616(a) and (c)(4) specify that “a state may use [their]...grant...to establish a program...to provide treatments that have been determined to prolong life or prevent the serious deterioration of health arising from HIV” and that the state shall “facilitate access to treatment for such individuals.”
Ryan White CARE Act Amendments of 1996	First reauthorization of the Ryan White Program. Given advances in HIV antiretroviral therapy, Sec. 2616(a) is modified to permit states to “establish a program...to provide therapeutics to treat HIV disease or prevent the serious deterioration of health arising from HIV disease”...and the state shall “facilitate access to treatment for such individuals.”
HRSA HIV/AIDS Bureau (HAB) Program Policy Notice 97-01 (1997)	Policy clarifies eligibility for services provided by Ryan White. It states that funds awarded under Title I and II (now called Parts A and B) are permitted to cover the cost of continuing family health insurance, including for non-infected individuals, to ensure coverage continuation of a family member with HIV. Along with 97-02, this policy gives explicit permission to use Ryan White funds for insurance continuation to Title I (Part A grantees, in addition to Title II (Part B) grantees (as stipulated in legislation). (Later replaced by DSS Program Policy Guidance No. 1, June 2000 and later included in Policy Notice 10-02)
HRSA HAB Program Policy Notice 97-02 (1997)	Permits Title I and II (now called Pars A and B) grantees to cover the cost “of public or private health insurance co-payments and deductibles for low-income individuals.” Policy states that grantees must “make reasonable efforts to secure other funding...whenever possible” and that “aggressively and consistently” pursuing other payment sources is an appropriate use of funds.” Along with 97-01, this policy gives explicit permission to use Ryan White funds for insurance continuation to Title I (Part A) grantees (in addition to Title II grantees as stipulated in legislation). (Later replaced by DSS Program Policy Guidance No. 2, June 2000 and later included in Policy Notice 10-02)
HRSA HAB Policy 99-01 (1999): The Use of Title II AIDS Drug Assistance Program (ADAP) Funds to Purchase Health Insurance	Policy states that ADAP funds may be used to assist with insurance costs (e.g. premiums, co-payments, and deductibles). It also makes clear that funds may be used for both purchasing new and continuing existing insurance, and lays out specific guidelines for using ADAP funds this way, including through a cost effectiveness requirement. (Available at: ftp://ftp.hrsa.gov/HAB/ADAPTitleII.pdf) (Later replaced by HRSA HAB Policy Notice 7-05, 2007)
Ryan White CARE Act Amendments of 2000	Second reauthorization of the Ryan White Program. Sec. 2616 (e)(1)(a) codifies policy 99-01 in statute, making clear in the law that ADAP funds can be used to assist with both insurance purchasing and continuation, stating that funds may be used “to provide the therapeutics described...by paying on behalf of individuals with HIV disease the costs of purchasing or maintaining health insurance...whose coverage includes a full range of such therapeutics and appropriate primary care services.” Includes the requirement that insurance coverage must be cost effective compared to the direct purchase of drugs.
Ryan White Treatment Modernization Act of 2006	Third reauthorization of the Ryan White Program. Requires Part A, B, and C grantees to “use not less than 75% [of grant award] to provide core medical services” and identifies “health insurance premium and cost sharing assistance” as one such core service (see Sections 2604(c), 2612 (b), and 2651(c)). This reauthorization marked the first time Part C grantees were given explicit permission in legislation to provide premium and cost-sharing support.
Ryan White HIV/AIDS Treatment Extension Act of 2009	Fourth reauthorization of the Ryan White Program. No changes made to insurance purchasing authority.
HRSA HAB Policy Notice 10-02 (Reissued 2010): Eligible Individuals & Allowable Uses of Funds for Discretely Defined Categories of Services	Replaces DSS Program Policy Guidances No. 1 and No. 2 (were previously issued as policies 97-01 and 97-02). Consolidates policies and updates to reflect technical changes in 2006 reauthorization and extends authority to Part C grantees. Policy states that funds through Parts A, B, and C may be used for insurance premiums (and related cost-sharing such as co-payments and deductibles) and that such expenses are an allowable service category and are a core medical service. States that funds may be used to cover the cost of continuing family health insurance, including for non-infected individuals, to ensure coverage continuation of a family member with HIV. In reference to the payer of last resort requirement, policy states “grantees must assure that funded providers make reasonable efforts to secure non-Ryan White HIV/AIDS Program funds whenever possible.”

*Unless otherwise noted, legislation and current policies can be found at <http://hab.hrsa.gov/manageyourgrant/policiesletters.html> and <http://hab.hrsa.gov/abouthab/legislation.html>

THE AFFORDABLE CARE ACT & INSURANCE PURCHASING UNDER RYAN WHITE

The Patient Protection and Affordable Care Act (ACA), signed into law by President Obama in 2010, provided for comprehensive health reform, expanding health insurance options – among other provisions – for millions of people in the U.S., including tens of thousands of people with HIV. The most significant coverage expansions began in 2014, when individuals were able to obtain subsidized coverage by enrolling in Qualified Health Plans (QHPs), private insurance sold through state and federally-run health insurance marketplaces. In addition, Medicaid coverage in states that chose to expand their programs was extended to eligible adults up to 138% of the federal poverty level (FPL).⁶ These developments, coupled with other key provisions of the ACA, including an end to pre-existing condition exclusions, prohibition on insurance rate setting tied to health status, and a ban on annual and lifetime caps on coverage, meant that many more uninsured and underinsured people with HIV, including Ryan White clients, would have access to more comprehensive health insurance.

Beginning in 2013, HRSA issued guidance through a series of policy notices to help clarify requirements and expectations related to enrollment in these new forms of coverage. Guidance discussed the use of Ryan White funds in the context of the ACA, both generally and specifically related to insurance purchasing through the new health insurance marketplaces (see Table 3). Since, as a payer of last resort, Ryan White funds cannot be used for services when “payment has been made or can reasonably be expected to be made” by another payer, it was expected that grantees would help ensure that clients enrolled in the new forms of coverage for which they were eligible.⁷ Policy notices 13-01 and 13-04 addressed the need for grantees to secure non-Ryan White funds wherever possible, including by enrolling eligible clients in Medicaid and marketplace plans, noting that grantees should “vigorously pursue” enrollment. In addition, guidance moved beyond simply permitting grantees to use funds for insurance purchasing. HRSA now “strongly encouraged” grantees “to use RWHAP [Ryan White HIV/AIDS Program] funds to help clients purchase and maintain health insurance coverage, if cost-effective and in accordance with...policy.”⁸

**Table 3: Law & Policies Related to Use of Ryan White Funds
for Insurance Purchasing and the Affordable Care Act**

Policy	Significance
HRSA HAB Policy Clarification Notice 13-01 (Revised 12/13): Clarifications Regarding Medicaid-Eligible Clients and Coverage of Services by the Ryan White HIV/AIDS Program	Reiterates that grantees are expected to secure non-program funds for services whenever possible and enroll clients in available coverage options including, Medicaid, specifically applying this policy to the Medicaid expansion population through the ACA. If a client is currently enrolled in private coverage with premium assistance, the client may remain in that coverage only if it is more cost-effective. Ryan White can cover the cost of services not covered or partially covered by Medicaid. This is a revised policy.
HRSA HAB Policy Clarification Notice 13-04 (Revised 9/13): Clarifications Regarding Clients Eligible for Private Health Insurance and Coverage of Services by Ryan White HIV/AIDS Program	Specific to the ACA, lays out the expectation that grantees will “vigorously pursue” enrollment of eligible clients into eligible coverage, including into marketplace plans (QHPs) and includes broad documentation requirements. Policy states that “grantees are strongly encouraged to use [program]...funds to help clients purchase and maintain health insurance coverage, if cost-effective...” This is a revised policy.
HRSA HAB Policy Clarification Notice 13-05 (Revised 6/14): Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance	Reiterates HAB policy regarding use of funds to assist with purchasing private insurance. In addition to addressing Part A, B, and C grantees, policy also extends authority to purchase insurance to Part D grantees. Specifically considers the role the ACA will have on insurance options for people with HIV and lays out specific conditions plans must meet before Ryan White funds can be used for insurance purchasing, including cost-effectiveness and that any policy purchased covers at minimum “one drug in each class of core antiretroviral therapeutics from the HHS” HIV Treatment Guidelines, along with appropriate primary care services. A previously issued version of this policy included a more stringent formulary requirement. This is a revised policy.
HRSA HAB Policy Clarification Notice 13-06 (Revised 6/14): Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance Medicaid	Reiterates HAB policy regarding use of funds to assist with costs associated with Medicaid plans. In addition to addressing Part A, B, and C grantees, policy also extends authority to purchase insurance to Part D grantees. Specifically considers the role the ACA will have on insurance options for people with HIV and lays out specific conditions plans must meet before Ryan White funds can be used for insurance purchasing, including cost-effectiveness and that any policy purchased covers at minimum “one drug in each class of core antiretroviral therapeutics from the HHS” HIV Treatment Guidelines, along with appropriate primary care services. A previously issued version of this policy included a more stringent formulary requirement. This is a revised policy.
CMS Interim Final Rule “Patient Protection and Affordable Care Act; Third Party Payment of Qualified Health Plan Premiums.” CMS-9943-IFC. (March 2014)	In wake of legal challenge, requires qualified health plan (QHP) issuers to accept premium and/or cost-sharing payments made by the Ryan White Program (and other federal, state, and tribal programs) on behalf of enrollees (i.e. 3 rd party payments). (Available at: https://www.federalregister.gov/articles/2014/03/19/2014-06031/patient-protection-and-affordable-care-act-third-party-payment-of-qualified-health-plan-premiums)
HRSA HAB Policy Clarification Notice 14-01 (2014): Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Advance Premium Tax Credits under the Affordable Care Act	Builds on policy 13-05, states that clients between 100%-400% of the Federal Poverty Level (FPL) and enrolled in QHPs with premium support may be eligible for premium tax credits. Explains that grantees should relay to clients covered with premium support the importance of accurately reporting income and that grantees must have procedures in place to recoup tax credits paid back to clients in cases of over payment of premiums (if premiums were paid for by the program). It also announced a public comment period (closed Aug. 2014) to consider allowing programs to pay funds back to IRS on client’s behalf, if original tax credit was overestimated and premium underpaid.

* Unless otherwise noted, policies can be found at: <http://hab.hrsa.gov/manageyourgrant/policiesletters.html>

In addition to the guidance released by HRSA, the Centers for Medicare and Medicaid Services (CMS), which has promulgated private insurance regulations under the ACA, released an interim final rule requiring QHP issuers to accept premium and cost-sharing payments made by the Ryan White Program, and other entities, on behalf of enrollees, also known as third party payments.⁹ This rule was issued in response to a lawsuit in

Louisiana in which an issuer in that state refused to accept premium payments from the Ryan White Program made on behalf of enrollees. While the issuer stipulated the intent of their policy was to prevent fraud, advocacy groups filed the lawsuit against the issuer claiming that the policy served to deter those with HIV from enrolling in the company's marketplace plans and as such violated non-discrimination provisions in the ACA.¹⁰¹¹ The interim final rule served to settle the lawsuit.

Given the new insurance opportunities provided by the ACA, the guidance from HRSA encouraging grantees to pursue new coverage options, and the payer of last resort requirement, most grantees are working to help ensure Ryan White clients enroll in coverage for which they qualify, including in the private market.¹² In particular, many ADAPs worked to ready their systems to assist with marketplace insurance purchasing for the 2013-2014 open enrollment period.¹³ While the majority of ADAPs had some form of insurance purchasing infrastructure in advance of the ACA, states needed to decide if they would use their existing systems to purchase QHPs, and, if so, if those systems had the capacity. Data from the National Alliance of State and Territorial AIDS Directors (NASTAD) indicates that, as of June 2014, most states had moved to use ADAP funds to assist with QHP coverage, enrolling at least 16,000 ADAP clients into QHPs in the 2013-2014 open enrollment season.¹⁴ Only six states (Texas, Alabama, Mississippi, Idaho, Pennsylvania, and North Carolina) had not done so, though, most were planning to do so in the future. Additionally, Florida was operating a pilot insurance purchasing program for a limited number of clients (details included in the Florida case study, see Appendix).¹⁵

Findings

To provide a closer look at how grantees have elected to use Ryan White funds and ready systems for insurance purchasing in the ACA era, this analysis explores the early experiences of five states – California, Florida, Georgia, New York, and Texas – during the first open enrollment period (October 2013 through April 2014). The analysis focuses on ADAP activities related to the purchase of QHPs through the health insurance marketplaces. In addition, insurance purchasing that occurred at local levels is also explored, particularly when it supplemented ADAPs' provision of insurance assistance to clients. Local level insurance purchasing occurs in many cases when Part As (Ryan White funded urban areas with a high burden of HIV/AIDS) award funding to ASOs (sub-grantees of the program) to assist with this support.

The states examined here were chosen for several reasons. First, together, they account for half of all people living with an HIV diagnosis in the United States (see Table 4).¹⁶ Similarly, about half of all Ryan White clients live in these five states (see Table 4). Second, each state has made different decisions regarding ACA implementation. Two of the states, California and New York, expanded their Medicaid programs and established their own state-based insurance marketplaces where residents can shop for private coverage. The other three states – Florida, Georgia and Texas – have not expanded their Medicaid programs and are relying on the federal insurance marketplace. Lastly, the ADAPs in these states had varying experiences with insurance purchasing prior to the ACA. While ADAPs in California and New York had substantial insurance purchasing experience prior to the ACA, programs were more limited in Florida, Georgia and Texas.

Table 4. Case Study States: Select Characteristics and Status of Insurance Purchasing in the First Open Enrollment Season

State	Medicaid Expansion Decision ¹	Type of Marketplace ²	No. of People with an HIV Diagnosis ³	No. of Ryan White Clients Served ⁴	Ryan White Clients <100% FPL ⁴	Percent Uninsured Ryan White clients ⁴	ADAP QHP Insurance Purchasing	Part A QHP Insurance Purchasing [*]
California	Yes	State	117,814	58,177	64%	27%	Yes	Yes
Florida	No	Federal	98,650	55,325	62%	32%	Pilot	Yes
Georgia	No	Federal	39,102	20,683	69%	48%	Yes	Yes
New York	Yes	State	129,379	75,001	66%	15%	Yes	No
Texas	No	Federal	72,010	36,502	70%	38%	No	Yes
United States	-	-	912,308	536,219	67%	28%	-	Yes

Sources: ¹KFF State Health Facts: *State Decisions on Health Insurance Marketplaces and the Medicaid Expansion*; ²KFF State Health Facts: *Health Insurance Marketplace Types*; ³CDC. (2015). *HIV Surveillance Report Vol. 25, Diagnoses of HIV Infection in the United States and Dependent Areas, 2013*. (US total does not include dependent areas); ⁴HRS A HAB. *Ryan White HIV/AIDS Program 2012 State Profiles*; ^{*}Not all Part As in state necessarily participating.

Cross-cutting observations related to state approaches to insurance purchasing are discussed below. Detailed analyses of approaches to insurance purchasing in the first open enrollment period for the five states can be found in the Appendix.

PRIOR INSURANCE PURCHASING EXPERIENCE FACILITATED ACA ERA ARRANGEMENTS, BUT CHALLENGES PERSIST

State ADAPs varied significantly in the degree to which they participated in insurance purchasing in advance of the ACA and this often paralleled the degree to which they were prepared to offer insurance purchasing through the marketplaces. For instance, ADAPs in California and New York had relatively robust insurance purchasing infrastructures in advance of the ACA and were capable of working with private insurance. These programs were able to better align processes with the new ACA era coverage opportunities and enroll clients in QHPs through their existing infrastructures.

However, enrolling clients was not without challenges for California and New York. In particular, stakeholders in both states cited challenges pertaining to technical or process issues encountered when enrolling clients. Navigating relationships with insurance companies who had had limited experience with ADAP as a third-party payer was also sometimes difficult. For instance, both states faced challenges meeting initial premium due dates. Sometimes the challenge was obtaining bills from clients, creating accounts in their own systems, and getting payments out the door to issuers in time. In other cases, challenges surfaced related to accurately attributing ADAP payments to client policies with the issuer.

In both states, but especially in California, these challenges sometimes led to significant delays in the enrollment and payment for clients. In California, some clients were dis-enrolled from coverage due to long delays in getting payments to issuers. Additionally, in California, clients and other stakeholders reported that, in some cases, clients needed to front premium payments for several months before ADAP insurance assistance became effective. Some believed these delays resulted because the systems in place to handle premium payments were “out-of-date” and “manual.” Stakeholder described a state infrastructure in need of updating in order to handle the surge of new enrollees. In New York, stakeholders described some similar process problems

as those in California, although they seemed to occur to a lesser degree and stakeholders appeared to more quickly identify solutions when facing a barrier, such as re-enrolling clients that were dropped from coverage.

Florida and Georgia ADAPs had less experience with insurance purchasing compared with California and New York, so had less robust infrastructures from which to build upon going into open enrollment. Coming into the first open enrollment season, the insurance purchasing experience of these ADAPs was mostly limited to coordinating payments with Medicare Part D, COBRA and the state Pre-Existing Condition Insurance Plan (PCIP).¹⁷ Therefore, they were less experienced with the private insurance market. While both attempted to get some QHP insurance purchasing off the ground, systems were not prepared to engage all clients at the beginning of the open enrollment period. In addition, it was not clear to stakeholders at the outset if or how the ADAPs would handle QHP purchasing, which made it challenging for Part As and local ASOs to prepare to assist in insurance purchasing and enrollment.

Stakeholders also described concerns regarding the contractors needed to run insurance purchasing systems. In Georgia, it took several months to iron out negotiations with their Pharmacy Benefits Manager (PBM), delaying the roll out of premium support. In Florida, stakeholders were unsure the third party organization assigned to assist with premium payments in the past could handle the increased capacity if a surge of new clients enrolled into QHPs.

However, by the end of the first open enrollment period in 2014, both states were operating small or pilot QHP insurance purchasing systems for a limited number of clients. According to stakeholders in both states, the enrollees consisted primarily of clients who were previously being served by insurance purchasing through PCIP and COBRA plans and, for the most part, were not those who were previously uninsured. During the first enrollment season, Florida enrolled about 60 clients, almost all of whom had previous coverage, and Georgia enrolled 200-300 clients, 190 of whom had previously been served through the state PCIP. Stakeholders in both states reported planning was underway to expand programs to provide more QHP premium and enrollment assistance in 2015.

The Texas ADAP had a very limited insurance purchasing program in advance of 2014, which was largely focused on assisting Medicare beneficiaries. Unlike the other four states examined, Texas was unable enroll clients into QHPs with insurance purchasing support. While lack of prior insurance purchasing experience was certainly the case in Texas, stakeholders also highlighted that the ADAP was not given the necessary authority at the state level to assist clients with enrollment in such coverage (discussed in more depth below).

STATE-LEVEL APPROACHES TO ACA IMPLEMENTATION IMPACTED THE SCOPE OF QHP INSURANCE PURCHASING

While prior insurance purchasing arrangements impacted an ADAPs' ability to move ahead with QHP purchasing, stakeholders also cited state political atmospheres around ACA implementation as an important factor. According to stakeholders in Florida, Georgia, and Texas, state ADAPs had difficulty operationalizing insurance purchasing through the marketplaces in part due to opposition to ACA implementation at levels of the state government above that of the ADAP office. Stakeholders in a range of positions in all three states spoke of informal "gag orders" that made it challenging for state employees to engage in activities that could be perceived as helping to implement ACA or drive enrollment. While Florida and Georgia were ultimately able to

move forward with insurance purchasing in the first open enrollment period to some extent, stakeholders across both states explained that it was challenge to ready systems for even small scale enrollment within atmosphere opposed to ACA-related activities. In Texas, the resistance to ACA implementation was felt most sharply. Stakeholders explained that larger state decisions surrounding ACA implementation prevented the ADAP from leveraging funds to assist with insurance premiums and that the ADAP was not permitted to facilitate any enrollment through the health insurance marketplace.

While stakeholders in these states commented that ADAP programs recognized the benefits of enrolling clients into QHPs with premium support, efforts in states with environments resistant to ACA implementation focused on getting programs off the ground, rather than addressing new system readiness issues, as was the case in California and New York. Indeed, conversations with stakeholders in Florida, Georgia, and Texas were starkly different than those in California and New York. ADAPs in the latter two states could pursue coverage options available under the law openly, with support of other state offices, and communicate their plans with the clients and community members without constraint.

COST-SHARING ASSISTANCE BEYOND PREMIUM SUPPORT VARIED BY STATE

Stakeholders explained that for people with HIV, access to cost-sharing assistance can play an important role in helping clients meet out-of-pocket obligations associated with insurance, which can be significant. Stakeholders were especially concerned with costs related to prescription medications and deductibles and believed that access to cost-sharing assistance could ultimately determine whether an individual remains covered and stays engaged in care and treatment. In the states examined, ADAPs differed in their ability to offer cost-sharing assistance beyond premium support, including for deductibles, co-payments, and co-insurance. While enrollees receive some protection as a result of the annual out-of-pocket limit under the ACA (\$6,350 in 2014), paying out-of-pocket to reach that limit could be challenging for Ryan White clients, many of whom live on limited incomes.¹⁸ During the first open enrollment period:

- New York's ADAP offered full cost-sharing assistance to those enrolled in their insurance purchasing program and, of these five states examined, was the only ADAP to do so (e.g. for deductibles and co-payments and co-insurance for laboratory tests, provider visits, and prescription drugs).
- California's ADAP offered support for a limited number of costs, including those associated with HIV drugs (such as co-payments and co-insurance), and has plans to expand this assistance in 2016.
- Georgia's ADAP program was not able to offer cost-sharing assistance in 2014 but worked closely with the Atlanta Region Part A, which was able to step in and assist with these costs for some (see below for more detail). Additionally, the ADAP has plans to include cost-sharing assistance as part of their program in the future.
- Florida's pilot ADAP insurance purchasing program offered partial cost-sharing assistance for HIV medications (such as co-insurance, and co-payments) to the limited number of enrollees in the program.
- Texas did not provide cost-sharing assistance (the state ADAP did not offer premium support).

STATES SOUGHT ALTERNATIVE OPTIONS WHEN ADAPs FACED CHALLENGES PROVIDING PREMIUM AND COST-SHARING ASSISTANCE

In some cases where ADAPs have played a less active role in providing premium support or cost-sharing assistance, and in cases where there have been challenges implementing premium support, other Ryan White grantees and sub-grantees, such as Ryan White Part As, ASOs, and external entities, have stepped in to provide assistance.

In California, Florida, Georgia, and Texas, some Part A programs worked to help fill in gaps.¹⁹ In Florida, the Miami-Dade Part A helped some clients pay premiums when it was unclear if the ADAP would establish an insurance purchasing program. Similarly, in Texas, the Dallas and Harris County Part As helped clients gain QHP coverage when it became clear to stakeholders that premium assistance would not be available through the ADAP. In Georgia, the Fulton County Part A, which includes about 80 percent of the state's Ryan White population, contributed to the pool of ADAP funds set aside for insurance purchasing and was also helping with some cost-sharing not available through ADAP. In California, the Orange County Part A stepped in to help clients with premiums as a stop-gap measure while third party payment delays were resolved with ADAP.

Part As often worked in collaboration with local ASOs to deliver these premium and cost-sharing support services. Some ASOs have historically used Part A funds to deliver premium assistance, although in the past, this assistance has primarily supported those with COBRA, PCIP or employer coverage. In the ACA era some ASOs also used these funds to support QHP coverage. For instance, one Dallas ASO that has been providing premium support for clients for over 20 years using Part A funding began providing premium support for QHPs from the start of the first open-enrollment.

Some Part As, however, found determining cost-effectiveness, which is a HRSA requirement, challenging and were anxious about their ability to assist with these costs. ADAPs could demonstrate cost-effectiveness fairly easily by comparing the cost of paying for prescription drugs directly to purchasing insurance and providing cost-sharing support, which often provided an overall cost-savings to the program. As Part As do not pay for prescription drugs (which is an ADAP function), some worried about being able to demonstrate cost-effectiveness as clearly. In addition, noting the variability across plans and between enrollees, some Part As and funded ASOs found it difficult to estimate out-of-pocket costs and know how many clients they would be able to serve at the beginning of the first open enrollment with their limited funds before plan benefit designs were understood and utilization patterns established.

Pharmaceutical assistance programs (PAPs) sponsored by pharmaceutical companies and other non-Ryan White entities were also tapped to help clients meet out-of-pocket obligations, such as deductibles, co-insurance, and co-payments. For instance, one such program, the Patient Access Network (PAN) Foundation, had assisted 2,500 people with HIV with premiums and other cost-sharing across the country as of June 2014.²⁰

Lastly, Stakeholders and clients reported that case managers played an important role in helping clients navigate access to these various insurance purchasing and assistance opportunities both within and outside of ADAP.

AMONG THESE STATES, INSURANCE PURCHASING PROGRAMS WERE LESS ROBUST IN STATES NOT EXPANDING MEDICAID PROGRAMS

As a safety-net provider Ryan White plays a particularly important role in maintaining clients in HIV care and treatment. Stakeholders described that this is especially true in states not expanding their Medicaid programs. QHP premium assistance can potentially offer clients access to comprehensive health insurance coverage, helping to meet both their HIV and non-HIV care needs. This could be especially important for those low-income clients in non-expansion states without access to Medicaid. However, in the states examined in this study, those in non-expansion states (Florida, Georgia, and Texas) who might most benefit from marketplace coverage with premium assistance, in many cases had the most limited access, at least via ADAP programs during the first year of marketplace coverage.²¹ Conversely, those states in this study that had the most robust QHP premium assistance programs enrollment also expanded their Medicaid programs (California and New York).

FOR SOME STAKEHOLDERS THE “VIGOROUSLY PURSUE” POLICY SUPPORTED INSURANCE PURCHASING, BUT FOR OTHERS IT POSED CHALLENGES

HRSA encouraged grantees to “use RWHAP [Ryan White HIV/AIDS Program] funds to help clients purchase and maintain health insurance coverage, if cost-effective...”²² and to “vigorously pursue” enrollment into available coverage, including private insurance, in order to meet the payer of last resort requirement. As a result, grantees looked to premium assistance to facilitate access to QHP coverage through the health insurance marketplaces. While some grantees and sub-grantees found it very difficult to interpret HRSA’s guidance to “vigorously pursue” client enrollment into QHPs, others assumed that nothing had changed in terms of their grant requirements and noted that HRSA was reiterating past policy. The push to “vigorously pursue” coverage may have helped encourage some grantees to engage more actively in premium support, particularly for grantees that felt comfortable with this requirement and who lived in states actively implementing the ACA.

For those that had more difficulty with the directive, which in this case happened to be those in states with an overall environment that was resistant to ACA implementation, stakeholders felt they were receiving conflicting instructions. On the one hand, stakeholders explained that grantees wanted to comply with the HRSA requirement, but on the other hand they explained grantees felt unable to move forward given the inability to launch a widespread insurance purchasing effort due to resistance to ACA implementation at the state-level. More broadly, several stakeholders discussed experiencing significant confusion while trying to figure out what it meant to define and document vigorous pursuit of enrollment. Some felt they were unable to gain clarity in conversations with federal officials. While HRSA has since provided greater detail on the policy, many grantees and sub-grantees felt that additional and uniform guidance on meeting and documenting this requirement would have been useful during the first open enrollment period.²³

Conclusion

As a result of health insurance reforms under the ACA, along with the payer of last resort provision, it has become increasingly common for ADAPs and other Ryan White grantees to use program funds to provide insurance premium assistance to support client enrollment into QHPs. This brief provided a look at early experiences with QHP insurance purchasing during the first open enrollment period in five states, focusing on QHP purchasing within ADAP. The states observed here each had past experience with insurance purchasing,

but not all states were able to translate that experience into supporting QHP coverage during the first open enrollment under the ACA. It appeared that those ADAPs with the most insurance purchasing experience were better able to translate that experience into insurance purchasing of QHPs. In addition, while ADAPs in each of the five states faced obstacles launching QHP insurance purchasing programs in the first open enrollment period, those operating in states opposed to ACA implementation appeared to have the greatest difficulty getting these programs off the ground. As a result, access to QHP coverage with premium and cost-sharing assistance, varied for clients across states.

Looking ahead, as ACA implementation continues, the Ryan White Program will play an important role in all states, as a provider of critical services to people with and affected by HIV, as well as a purchaser of insurance on behalf of clients. This latter role will likely grow and become increasingly important, especially as HRSA continues to require grantees to “vigorously pursue” client enrollment into coverage, enforcing the payer of last resort requirement. As enrollment continues and challenges are addressed in the coming years, it will be important to monitor insurance purchasing activities in order to assess how different state approaches impact cost-effectiveness, insurance access, and ultimately health outcomes of clients.

Appendix

These state case studies provide a closer look at how each of the five states covered in this report – California, Florida, Georgia, New York and Texas – have elected to use Ryan White funds for insurance purchasing in the ACA era. Findings are based on early experiences during the first open enrollment period and focus on ADAP premium assistance for QHPs, although assistance provided by other entities is also examined where appropriate. Past and ACA era experiences and decision making around insurance purchasing are summarized in each state case study below.

CALIFORNIA

California's ADAP had relatively robust health insurance purchasing experience prior to the ACA, including in assisting with private insurance. This experience, coupled with new insurance options available in the state-run health insurance marketplace, provided a solid foundation to pursue insurance purchasing of QHPs in the ACA era. However, despite this experience, challenges arose. These were largely related to the process of aligning the existing purchasing system with the realities of the new health insurance landscape, utilizing older systems for larger scale enrollment, and the ADAP's relationship as a third party payer to insurance companies. While most insurance purchasing occurred via the state's ADAP, Ryan White Part As and ASOs played an important role in easing some of the transition challenges faced by the ADAP, including providing assistance when coverage might have otherwise lapsed. Despite these obstacles, which caused significant problems for some, once enrolled and were premiums paid, clients reported satisfaction with the ability of ADAP to provide assistance with coverage. While some clients continue to face high out-of-pocket costs, others are paying significantly less than in the past and have expressed relief at the protections afforded with insurance coverage offered through the ACA. Specific details that emerged from the research include:

KEY ACA DECISIONS WITH IMPLICATIONS FOR RYAN WHITE INSURANCE PURCHASING

California created its own state-run health insurance marketplace called *Covered California*, and elected to expand its Medicaid program to eligible adults under 138% FPL. In addition, as of 2011, many in the state had access to expanded Medicaid coverage prior to the ACA through an 1115 Medicaid Demonstration Waiver. This demonstration project, known as the Low Income Health Program (LIHP), allowed counties to expand eligibility to up to 200% FPL and aimed to serve as a "bridge" to full Medicaid expansion under the ACA. Stakeholders believed that having clients enrolled in this early expansion made for easier transitions to both Medicaid expansion under the ACA (for those up to 138% FPL) and to QHPs with premium support (for those above 138% FPL). Given that most Ryan White clients have relatively low incomes and because the payer of last resort requirement means that clients must enroll in other coverage if it is available, many were thought to have been enrolled in the LIHP programs leading up to 2014.²⁴

PRE-ACA EXPERIENCE WITH INSURANCE PURCHASING

California's Ryan White Program had an insurance purchasing infrastructure through its ADAP in place prior to the ACA. As of June 2013, 8,973 individuals, or 40% of ADAP clients in the state, were being served through insurance purchasing, including for private insurance.²⁵ California had a greater number of ADAP clients engaged in premium support than any other state at this time.²⁶

ADAP ROLE IN PREMIUM SUPPORT UNDER THE ACA

Ahead of the 2013-2014 open enrollment period, California prepared to move eligible Ryan White clients into QHP coverage and provide insurance purchasing assistance. However, understanding that engagement of clients in new systems sometimes takes time, knowing many clients would gain Medicaid coverage, and because the ADAP could not assist with all out-of-pocket costs, the initial wave of enrollees was expected to be modest.

The state Office of AIDS'-Health Insurance Purchasing Program (OA-HIPP) uses ADAP funds to manage insurance purchasing efforts. OA-HIPP encouraged eligible clients, including those who had been in the LIHP and had incomes higher than Medicaid eligibility level (some LIHP enrollees had incomes up to 200% FPL), to enroll in QHPs. In addition to providing access to more comprehensive health coverage, stakeholders reported that encouraging enrollment met the "vigorously pursue" policy and fulfilled the payer of last resort requirement.

OA-HIPP provided assistance with premiums and cost-sharing for HIV prescription medications. Other cost-sharing assistance however, such as for physician visits, laboratory tests, and non-HIV medications, was not provided. Despite the fact that insurance in the state of California had lower caps on out-of-pocket spending than federally required, stakeholders worried that costs not supported through the state program would be unaffordable for some clients and result in clients not enrolling or using their QHP coverage once enrolled. In an effort to address these concerns, California Governor Jerry Brown included a proposal to provide comprehensive support for premiums and all cost-sharing for ADAP clients in the revised May 2014 state budget, signed into law in June 2014.²⁷ While this will likely provide financial relief for clients in the future, this more comprehensive assistance does not go into effect until January 2016.

Despite a clear interest in fostering an ADAP that could wrap around QHPs, some stakeholders questioned whether the state was capable of meeting increased demand, even at the low levels projected for the first year. Going into the 2013-2014 open enrollment period there were concerns that the system was still manual and paper-based rather than online and synched with other electronic eligibility and enrollment systems. Stakeholders reported that the state struggled with administrative issues and that current systems need updating in order to handle the increase in client load as new individuals gained coverage and leveraged insurance purchasing support. These updates include enhancing mechanisms for enrollment and getting checks out to issuers in time to meet premium payment due dates. While the state has future plans to update these systems, stakeholders reported that these adaptations had been incremental and did not immediately address problems.

As a result of these challenges, stakeholders reported that some clients faced significant problems in enrolling in coverage with OA-HIPP assistance, including experiencing long enrollment delays and not having premium payments get to issuers in time to meet payment due dates. Some stakeholders reported three to four month enrollment delays. In some cases, clients reported having to front the first several months of premiums in order to retain coverage. In other situations, clients were dis-enrolled from their insurance when the OA-HIPP payment did not make it to the issuer in time. Stakeholders explained that it was sometimes difficult to assess whether complications were a result of enrollment and processing delays on the ADAP end or because of

problems at the issuer end (e.g. not knowing how to process third party payments or accurately attributing them to client's accounts).

Despite these sometimes significant challenges, stakeholders believed that the early Medicaid expansion along with the ADAP's previous experience with premium assistance helped the state prepare for the transition of clients into QHP coverage in 2014.

NON-ADAP COST-SHARING ASSISTANCE

In some instances, county Part A programs and AIDS Service Organizations (ASOs), funded through parts of Ryan White (Part A and non-ADAP Part B) helped address the initial enrollment delays and other hurdles to ensure that coverage was maintained and interruptions minimized, often temporarily assisting with payments. For instance, the Orange County Part A stepped in to help clients with premiums as a stop-gap measure while third party payment delays were resolved with ADAP

FLORIDA

Despite getting off to a late and challenging start, Florida did get a very limited pilot program off the ground at the close of the first open-enrollment period. Prior to the ACA, the Florida ADAP had more experience in continuing COBRA or PCIP coverage for clients than in purchasing new private coverage. In addition, the state did not choose to expand Medicaid, which meant coverage options for clients overall were fairly limited during the first open enrollment. Stakeholders explained that overarching state resistance to ACA implementation, at levels above that of the ADAP office, initially made pursuing widespread insurance purchasing more challenging. However, stakeholders described the pilot program as a first step and anticipated greater engagement with insurance purchasing in the future. Specific details that emerged from the research include:

KEY ACA DECISIONS WITH IMPLICATIONS FOR RYAN WHITE INSURANCE PURCHASING

Florida did not create its own health insurance marketplace and thus defaulted to the federal-facilitated marketplace, *Healthcare.gov*. In addition, Florida did not expand its Medicaid program to eligible adults under 138% FPL.

PRE-ACA EXPERIENCE WITH INSURANCE PURCHASING

Florida first began using Ryan White funding for insurance purchasing in 1989 through a limited demonstration project, the AIDS Insurance Demonstration Project. This was expanded to serve individuals statewide in 1994 and later rebranded as the AIDS Insurance Continuation Program (AICP), now part of ADAP.²⁸ AICP assists enrollees who already have insurance with maintaining their private health coverage, including those with COBRA policies. It is also not available to all those with HIV served by ADAP as it requires that an individual have an AIDS diagnosis or be HIV symptomatic. As of June 2013, 2,745 ADAP clients, or 20% of all state ADAP clients,²⁹ were served through insurance purchasing or continuation, the majority of who were enrolled in AICP. The state had far less experience with supporting client enrollment directly into the private market.

ADAP ROLE IN PREMIUM SUPPORT UNDER THE ACA

According to stakeholders, the state ADAP was not fully prepared to assist Ryan White clients with their QHP premiums during the first open enrollment season. At the start of the open-enrollment period, there was considerable confusion among ASOs, advocates, and, in some cases, Ryan White Part As, as to whether the ADAP office would offer insurance purchasing assistance for clients enrolling in QHPs. Stakeholders explained that the ADAP faced significant constraints as to what information could be released about their plans to pursue insurance purchasing given the resistance to ACA implementation at the state level. Many had heard that the ADAP had plans to cover premiums, but had little idea of a timeline or an implementation agenda. As a result, some stakeholders were frustrated by a lack of communication from the ADAP office and perceived inaction. Further, some worried about how grantees and sub-grantees could comply with the need to “vigorously pursue” enrollment into QHPs if there was no premium support available through the state’s ADAP office.

On March 7, 2014, just shy of when the first open enrollment period was expected to close, the ADAP released a memo announcing pilot project for approximately 500 clients meeting certain criteria for enrollment into QHPs with premium support.³⁰ About 60 clients ultimately enrolled in QHPs through the pilot and were supported with premium assistance and cost-sharing assistance for HIV medications. Most of those taking part had prior coverage, many transferring from the AICP and the state PCIP. Only a small handful of those clients enrolled in QHPs through the pilot were previously without another other form of coverage.

The existing AICP provider was enlisted to coordinate enrollment and third party payments. Stakeholders expressed concern about the ability of the AICP provider to handle QHP enrollment and third party payments in the future when enrollment was expected to increase. Similar to the frustrations expressed in California, some stakeholders noted that the current system for enrollment and third party payments relied on manual processes and out-of-date technology with limited capacity.

Lastly, stakeholders expressed concerns about the level of communications about the pilot project. For instance, the ADAP selected certain QHPs it determined to be cost-effective and would support with premium assistance, but that information was not clearly communicated externally. As a result, some clients enrolled in plans the ADAP was unable to support. It was expected that many clients who enrolled in these unsupported plans would be unable to maintain coverage as a result of high out-of-pocket costs, particularly those associated with drug cost-sharing (i.e. coinsurance and copayments) and deductibles.³¹

NON-ADAP COST-SHARING ASSISTANCE

Over the course of the first open-enrollment period, Part As in the state were concerned with whether and when the ADAP would establish a QHP insurance purchasing program and what their role should be as they attempted to plan for their clients’ needs. Some wrestled with whether it was feasible to provide insurance purchasing out of their own budgets as a stopgap measure to help clients enroll in QHPs. Ultimately, Part As made different decisions. Broward County, for instance, decided not to pursue premium assistance because they were unable to find such a program to be cost-effective, as required by HRSA. The Miami-Dade program did elect to pursue insurance purchasing for clients, using an ASO to enroll a small number of individuals into coverage and assisting with premiums and cost-sharing. However, stakeholders report that they approached premium assistance cautiously in view of finite funding and there have been reports of limited success in light

of the difficulty in assessing overall costs to the program. In addition, some clients who enrolled in plans without ADAP assistance sometimes relied on industry Patient Assistance Programs (PAPs) and other non-profit assistance programs to help meet out-of-pocket costs.

GEORGIA

At the close of the first open enrollment period, insurance coverage remained limited for Ryan White clients in Georgia. The state did not choose to expand Medicaid and QHP premium support through the state's ADAP did not take hold until after the first open enrollment period opened. Once the program got off the ground, the majority of those enrolled had previous coverage through the state PCIP. Additionally, stakeholders explained that state resistance to ACA implementation made pursuing insurance purchasing more challenging for Ryan White grantees, including the state's ADAP program. Specific details that emerged from the research include:

KEY ACA DECISIONS WITH IMPLICATIONS FOR RYAN WHITE INSURANCE PURCHASING

Georgia did not create its own health insurance marketplace and thus defaulted to the federal-facilitated marketplace, *Healthcare.gov*. In addition, Georgia did not expand its Medicaid program to eligible adults under 138% FPL.

PRE-ACA EXPERIENCE WITH INSURANCE PURCHASING

Prior to the ACA, Georgia's ADAP program had little capacity to assist with premiums, doing so mainly for PCIP and COBRA clients. The ADAP was not experienced with enrolling clients into private insurance.

ADAP ROLE IN PREMIUM SUPPORT UNDER THE ACA

Both the ADAP and the Atlanta metro region, Fulton County, Part A (the only Part A in the state) shared a commitment to develop an insurance purchasing infrastructure for QHP assistance by allocating funds to the program. However, there were delays in implementing insurance purchasing in the state. Stakeholders explained that ADAP was constrained by a state policy environment that made planning related to the ACA highly sensitive, including making it challenging for some Ryan White grantees to discuss implementation openly, which complicated their ability to meet the requirement to "vigorously pursue" coverage. Others felt that expectations around the requirement to "vigorously pursue" enrollment lacked clarity and highlighted this as an additional obstacle.

Stakeholders also noted that delays in contracting with the pharmacy benefits manager (PBM) that would administer the program, contributed to the slow implementation of the insurance purchasing program. QHP insurance purchasing did not begin until after enrollment opened during the first season and was relatively modest in scope. During the first open enrollment period, between 200-300 individuals with HIV enrolled in QHPs with ADAP premium support but without other cost-sharing assistance. Many of these clients were brought in from the state pool of about 190 Ryan White PCIP enrollees. Stakeholders believed that with the PBM in place, QHP insurance purchasing would be rolled out to a greater number of ADAP clients in future open enrollments.

Stakeholders across the state have had some concerns about the affordability of plans once clients were enrolled. In particular, the high-level of cost sharing associated with HIV drugs in some plans raised questions

about whether clients would be able to afford treatment even when premiums are covered through the insurance purchasing program.

NON-ADAP COST-SHARING ASSISTANCE

Some stakeholders reported hearing that clients were going without drugs as a result of the limited cost-sharing assistance, but that, in most cases, clients and ASOs were able to take measures, such as linking clients to PAPs and foundations, to provide financial assistance to prevent gaps in treatment. In addition, in August 2014, the Part A, which serves approximately 80% of the state's Ryan White clients, established a program for clients to access cost-sharing assistance by awarding funds to three of their 15 partner agencies to distribute. However, it was unclear at the time how many people could be served.

NEW YORK

New York's ADAP had an insurance purchasing system in place with the ability to enroll clients into the private market in advance of the ACA. As a result, many clients were able to transition into marketplace coverage with insurance assistance with relative ease. While challenges did arise and had real implications for individual enrollees, stakeholders reported that systems within the state appeared ready to enroll ADAP clients in QHPs with premium and cost-sharing support. The initial barriers experienced in New York related to coordinating third party payments when enrolling Ryan White clients into QHPs with premium support, but in most-cases these were surmountable obstacles. Specific details that emerged from the research include:

KEY ACA DECISIONS WITH IMPLICATIONS FOR RYAN WHITE INSURANCE PURCHASING

New York established a state-based marketplace called *New York State of Health* and elected to expand its Medicaid program to eligible adults under 138% FPL. In addition to expanding its Medicaid program, prior to 2014, New York's state Medicaid included eligibility for parents up to 150% FPL and up to 100% FPL for childless adults. Under the ACA, like in California, stakeholders saw this early expansion as contributing to smoother enrollment into ACA-era Medicaid and QHP coverage, for those 138% FPL to 150% FPL.

PRE-ACA EXPERIENCE WITH INSURANCE PURCHASING

In June 2013, 28% of ADAP clients were served through insurance purchasing or continuation.³² Because the state had gone through an early Medicaid expansion, a large number of ADAP clients received coverage through that program, which is why despite having a fairly robust insurance purchasing program ahead of the ACA, the share of clients relying on that support might be lower than expected.

ADAP ROLE IN PREMIUM SUPPORT UNDER THE ACA

During the 2013-2014 open enrollment period, approximately 2,800 new clients gained access to QHP coverage with premium and full cost-sharing support, including about 1,200 individuals transitioning off of PCIP coverage. Many ADAP clients were enrolled in New York's expanded Medicaid program prior to the 2014 open enrollment period. Those who had incomes above 138% FPL were encouraged to move into QHP coverage. The state Part B program conducted outreach to providers and clients regarding QHP enrollment and plan selection to help this process go more smoothly. Those below 138% FPL retained Medicaid coverage, most moving into the Medicaid expansion population at recertification. A range of stakeholders report that the early

Medicaid expansion program coupled with an existing insurance purchasing infrastructure in advance of open enrollment allowed for a fairly smooth transition of clients into QHP coverage in 2014.

While New York ADAP clients had access to the premium assistance program and enrollment was fairly straightforward, process issues surfaced in getting the first premium payments to plans on time. Stakeholders also reported challenges in making sure that ADAP premium payments were credited to the right client accounts. They explained that issuers typically do not provide a policy number to an enrollee until a first premium is paid, but that ADAP needs a policy number to ensure premium payments were applied to enrollee accounts accurately. In some cases this “catch-22” caused confusion and enrollment delays. Stakeholders also reported instances of enrolled clients receiving bills from insurance companies that would be due with very little notice, making timely third party payment difficult. Despite ADAP efforts to turn payments over quickly, occasionally the timeframe would be too short and an enrollee would be terminated. Although stakeholders reported that the ADAP office and case-workers moved quickly to resolve these issues, fixes became more challenging after open-enrollment closed.

NON-ADAP COST-SHARING ASSISTANCE

Stakeholders spoken to for this study report that the ADAP insurance purchasing systems is working smoothly enough in New York so that ASOs and Part As have not needed to commit funds to provide this type of assistance.

TEXAS

In Texas, health insurance coverage options for Ryan White clients remain limited in the ACA era. Texas did not expand its Medicaid program, nor has its ADAP been able to provide insurance purchasing for QHPs. Stakeholders surmise that ADAP has been unable to provide insurance purchasing support as a result of a larger state policy environment that has been resistant to ACA implementation rather than as a result of decision making out of the ADAP office. ASOs and Part As have played an important role in making insurance coverage possible in the regions they serve when ADAP could not. Specific details that emerged from stakeholder interviews and other research include:

KEY ACA DECISIONS WITH IMPLICATIONS FOR RYAN WHITE INSURANCE PURCHASING

Texas did not create its own health insurance marketplace and thus defaulted to the federal-facilitated marketplace, *Healthcare.gov*. In addition, Texas elected not to expand its Medicaid program to eligible adults under 138% FPL.

PRE-ACA EXPERIENCE WITH INSURANCE PURCHASING

Texas has had limited experience using Ryan White funding for insurance purchasing. As of June 2013, about 1,500, or 14%, of ADAP clients received premium support or continuation assistance.³³ Most of this support assisted Medicare beneficiaries with Part-D costs. In addition, the state had a small pre-ACA pilot program for insurance purchasing, unrelated to QHPs, which reached about 150 ADAP clients, primarily focused on supporting client’s COBRA coverage and high-cost employer plans.

ADAP ROLE IN PREMIUM SUPPORT UNDER THE ACA

Beyond the limited activities described above, there is no other Ryan White insurance purchasing within the ADAP, including for QHPs. Stakeholders throughout Texas described state opposition to ACA implementation has as having impacted ADAP's ability to move forward with developing a premium assistance program that supports QHP purchasing. The ADAP has not yet received permission from the state to use funds for QHP premium assistance, despite stakeholder expectations that such a program would be cost-effective. Similarly, stakeholders surmise that the inability of the ADAP office and Part B to be more communicative with sub-grantees, Part As, and community members, about aligning Ryan White programs with the ACA, including around the requirement to vigorously pursue enrollment, is a result of the larger state policy environment.

NON-ADAP COST-SHARING ASSISTANCE

Because the state did not actively use ADAP funds to support enrollment in QHPs through insurance purchasing, some Part As, which appear to have faced less restrictions, have stepped in to provide assistance where possible, typically through ASOs. Access, however was often dependent on living within particular service areas. For instance, the Houston area Part A (Harris County) is using Ryan White dollars to assist clients with insurance premiums and cost sharing. The Part A partnered with a local ASO to deliver these services. Approximately 90-95% of the Part A clients enrolled in QHPs reportedly received some kind of financial assistance to help with the costs of coverage.

The Dallas Part A reallocated some of their funds from their outpatient medical services category to their health insurance services category as a result of the ACA and anticipate that more funding will be needed for insurance purchasing in the future. The Dallas Part A funds a handful of programs to provide insurance assistance and has done so historically, prior to the ACA. The largest funded program is an ASO that has offered premium assistance for approximately 20 years and had nearly 400 clients enrolled in the program in 2013. This ASO continues to provide insurance purchasing assistance for local clients through QHPs. However, stakeholders note that funding is limited and dependent on grant cycles, which has meant that, on occasion, the program has put new enrollment on hold as it waits for funding.

¹ Department of Health and Human Service, Health Resources Services Administration. FY 2015 Congressional Budget Justification. Available at <http://www.hrsa.gov/about/budget/budgetjustification2015.pdf>

² See: Amanda Bowes, Ann Lefert, and Britten Pund. National Alliance of State and Territorial AIDS Directors (NASTAD). *National ADAP Monitoring Project Annual Report. February 2014*. Available at: <http://www.nastad.org/docs/NASTAD%20National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20February%202014.pdf> and Fakuda, Dawn. "Fitting the Ryan White Program & Health Care Reform Together, Experience in Massachusetts." Presented for HIVHealthreform.org webinar, *Working together, The Ryan White Program and Health Care Reform*. 5/20/12. Presentation available at: <http://www.hivhealthreform.org/webinars/webinar-archive/>

³ Health Resources and Services Administration, HIV/AIDS Bureau. *Clarifications Regarding Clients Eligible for Private Health Insurance and Coverage of Services by Ryan White HIV/AIDS Program*. Policy notice: 13-04. Revised 6/6/14. Available at: <http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1304privateinsurance.pdf>

⁴ Part A of the Ryan White Program funds the urban areas most significantly impacted by the HIV/AIDS epidemic. Part B funds all 50 states and U.S. Territories and includes, the AIDS Drug Assistance Program (ADAP) as well as other base and supplemental awards. Part C provides funds directly to public and private organizations to provide primary care and support services to people with HIV. Part D funds public and private organizations to provide family-centered and community-based services to children, youth, and women living with HIV and their families. For more detail see the Kaiser Family Foundation factsheet on the Ryan White Program: <http://kff.org/hivaids/fact-sheet/the-ryan-white-program/>

⁵ M. Danielle Davis, et al. National ADAP Monitoring Project Annual Report. May 2004. Available at: <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/national-adap-monitoring-project-2004-annual-report.pdf>;

⁶ Amanda Bowes, Ann Lefert, and Britten Pund. National Alliance of State and Territorial AIDS Directors (NASTAD). *National ADAP Monitoring Project Annual Report. February 2014*. Available at: <http://www.nastad.org/docs/NASTAD%20National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20February%202014.pdf>

⁶ Under the ACA states were required to expand their Medicaid programs to all eligible adults up to 138% of the federal poverty level. However, a Supreme Court decision effectively made Medicaid expansion a state option by taking away the federal enforcement mechanism. While most low-income adults are eligible for this program in expansion states, beneficiaries must meet citizenship requirements, not be incarcerated, and be ineligible for Medicare, along with meeting the income requirements.

⁷ See Sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1), and 2671(i) of the Public Health Service Act.

⁸ Health Resources and Services Administration, HIV/AIDS Bureau. *Clarifications Regarding Clients Eligible for Private Health Insurance and Coverage of Services by Ryan White HIV/AIDS Program*. Policy notice: 13-04. Revised 6/6/14. Available at: <http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1304privateinsurance.pdf>

⁹ CMS Interim Final Rule “Patient Protection and Affordable Care Act; Third Party Payment of Qualified Health Plan Premiums.” CMS–9943–IFC. (March 2014)

¹⁰ Lambda Legal. Press Release: *Lambda Legal Files Federal Lawsuit Against Louisiana Insurers for Dumping People With HIV*. September 20, 2014. August 29, 2014: http://www.lambdalegal.org/news/20140220_la_lambda-legal-files-federal-lawsuit-against-insurers

¹¹ Sharon Begley. “Louisiana insurers to accept funds from federal AIDS program for Obamacare premiums.” *Reuters*, March 10, 2014. Accessed August 29, 2014: <http://www.reuters.com/article/2014/03/10/obamacare-aids-idUSL2NoM71Y220140310>

¹² In addition to pursuing enrollment in the private market, ADAPs have also worked to enroll eligible clients in Medicaid expansion programs, in states expanding their programs. In addition, ADAPs in all states are able to enroll clients who were previously eligible but not enrolled in the traditional Medicaid program.

¹³ One reason that ADAPs were particularly interested providing assistance for QHPs, rather than other forms of private coverage, is because many Ryan White clients would be eligible to receive subsidized coverage based on their incomes which is only available through coverage purchased on the health insurance marketplaces.

¹⁴ KFF NASTAD Correspondence

¹⁵ Amy Killelea. *Ryan White Part B Services The Impact of State Health Care Reform*. HIVHealthreform.org Webinar Series. June 24, 2014. Available at: http://www.hivhealthreform.org/wp-content/uploads/2014/06/6_Month_ACA_Checkup_slides.pdf

¹⁶ Centers for Disease Control and Prevention. *HIV Surveillance Report, 2013; vol. 25*. February 2015. http://www.cdc.gov/hiv/pdf/g-1/hiv_surveillance_report_vol_25.pdf.

¹⁷ Pre-Existing Condition Insurance Plans (PCIPs) are high risk pools created through the ACA as a precursor to the marketplaces for those denied access to the private insurance market

¹⁸ In 2012, almost 90% of Ryan White clients were below 200% of the Federal Poverty Level, (*Ryan White HIV/AIDS Program 2012 State Profiles* <http://hab.hrsa.gov/stateprofiles/Client-Characteristics.aspx#chart6>).

¹⁹ Discussion of Part A activities are provided as examples. Insurance purchasing activities in all Part As in each state are not recounted.

²⁰ Correspondence with Patient Access Network Foundation.

²¹ While not the case in the states examined here, early numbers indicate that overall QHP premium assistance has played a more significant role in states not expanding their Medicaid programs.

²² Health Resources and Services Administration, HIV/AIDS Bureau. *Clarifications Regarding Clients Eligible for Private Health Insurance and Coverage of Services by Ryan White HIV/AIDS Program*. Policy notice: 13-04. Revised 6/6/14. Available at: <http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1304privateinsurance.pdf>

²³ Since the first open enrollment period, HRSA has provided additional information on what is meant by vigorously pursuing enrollment, including in disseminating information to grantees through webinars. See <http://hab.hrsa.gov/affordablecareact/webinars/ryanwhiteprogramaffordable.pdf> and <https://careacttarget.org/calendar/ryan-white-grantees-and-advanced-premium-tax-credits>.

²⁴ LIHPs were county run and LIHP eligibility limits varied by county of residence. In addition a few counties in the state did not participate in the program at all.

²⁵ Bowes, Lefert, and Pund. *National ADAP Monitoring Project Annual Report. February 2014*.

²⁶ Bowes, Lefert, and Pund. *National ADAP Monitoring Project Annual Report. February 2014*.

²⁷ California State Budget 2015–2015. Available at <http://www.ebudget.ca.gov/>

²⁸ Florida Department of Health and Health Council of South Florida, Inc. presentation. AIDS Insurance Continuation Program (AICP). Accessed 10/27/14 available at: <http://www.theaidsinstitute.org/sites/default/files/attachments/AICP.pdf>

²⁹ Bowes, Lefert, and Pund. *National ADAP Monitoring Project Annual Report. February 2014*.

³⁰ Florida Department of Health, Division of Disease Control and Health Protection, Bureau of Communicable Diseases. *Ryan White Part B AIDS Drug Assistance Program (ADAP). March 2014*. Available at: http://www.floridahealth.gov/%5C/diseases-and-conditions/aids/adap/_documents/ryan-white%20part-B-ADAP-march.pdf

³¹ Cost-sharing for HIV drugs can be as much as 50% of the cost of a drug costing more than \$2,000 and deductibles, especially for bronze level plans, were sometimes upwards of \$6,000.

³² Bowes, Lefert, and Pund. *National ADAP Monitoring Project Annual Report. February 2014*.

³³ Bowes, Lefert, and Pund. *National ADAP Monitoring Project Annual Report. February 2014*.