

Ryan White HIV/AIDS Program Client Eligibility Determinations: Considerations Post-Implementation of the Affordable Care Act

Policy Clarification Notice (PCN) #13-03

Scope of Policy: Ryan White Parts A, B, C, D, and Part F where funding supports direct care and treatment services.

Summary and Purpose of Policy

As the Affordable Care Act is implemented, more people living with HIV/AIDS (PLWH) will become eligible for public or private health coverage. This Policy Notice outlines the Ryan White HIV/AIDS Program (RWHAP) expectations for client eligibility determinations in the context of Affordable Care Act implementation. It reviews the new coverage options that will be available to many people living with HIV/AIDS, recommends that RWHAPs standardize RWHAP financial eligibility determinations with the eligibility process for these new coverage options, and reviews RWHAP recertification. The Health Resources and Services Administration, HIV/AIDS Bureau (HRSA/HAB) recently issued *Policy Clarification Notice #13-02: Clarifications on Ryan White Program Client Eligibility Determinations and Recertifications Requirement* (<http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1302clienteligibility.pdf>).

Background

Under the Affordable Care Act, beginning January 1, 2014, options for health care coverage for PLWH will be expanded through new private insurance coverage options available through the Health Insurance Marketplace (also referred to as the Exchange) and the expansion of Medicaid in states that choose to expand. Additionally, health insurers will be prohibited from denying coverage because of a pre-existing condition, including HIV/AIDS. An overview of these health care coverage options may be reviewed at <http://hab.hrsa.gov/affordablecareact/keyprovisions.pdf>.

By statute, RWHAP funds may not be used for any item or service “for which payment has been made or can reasonably be expected to be made” by another payment source.¹ This means that grantees and subgrantees must assure that they make reasonable efforts to secure non-RWHAP funds whenever possible for services to individual clients. Grantees and their subgrantees are expected to vigorously pursue eligibility for other funding sources (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and other private health insurance) to extend finite RWHAP grant resources to new clients and/or needed services.

Grantees and subgrantees should also assure that individual clients are enrolled in health care coverage whenever possible or applicable, and are informed about the

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

consequences for not enrolling.² Please note that the RWHAP will continue to be the payer of last resort and will continue to provide those RWHAP services not covered or partially covered by public or private health insurance plans.

Recommendations

RWHAP Eligibility Determination – Affordable Care Act Considerations

Modified Adjusted Gross Income (MAGI)

Grantees should be aware that the Affordable Care Act standardizes and streamlines the methodology for determining financial eligibility for insurance affordability programs. Beginning January 1, 2014, states must use modified-adjusted gross income (MAGI)-based methodologies to make Medicaid and CHIP eligibility determinations for most applicants. The Affordable Care Act streamlines income-counting rules for Medicaid and CHIP and aligns them with rules that will be used in determining eligibility for premium tax credits and cost-sharing reductions for purchasing a qualified health plan through the Health Insurance Marketplace. MAGI-based methodologies must be used regardless of whether a state proceeds with the Medicaid expansion or not.

MAGI is based on federal tax rules for determining adjusted gross income (with some modification). MAGI will be used for most Medicaid/CHIP enrollees, including children, pregnant women, parents, and the new adult group. In most cases, MAGI will not apply to the elderly, individuals with disabilities, those receiving or treated as receiving Supplemental Security Income, and the medically needy. Eligibility determinations for MAGI-excepted groups will be made using current methods. Grantees and subgrantees are encouraged to contact their state Medicaid agency to learn more about how MAGI will be implemented in their state. More information on MAGI-based methodologies can be found at: <http://www.medicaid.gov/State-Resource-Center/Eligibility-Enrollment-Final-Rule/Medicaid-CHIP-Eligibility-and-Enrollment-Webinars.html>

HRSA/HAB strongly encourages RWHAP grantees to consider aligning their RWHAP financial eligibility requirements with the new Affordable Care Act MAGI-based methodologies in order to reduce the burden on clients and to support coordination with the eligibility determination processes for insurance affordability programs.

Alignment of RWHAP Client Eligibility Determination Processes

The Affordable Care Act establishes one streamlined application for individuals and families to apply for health coverage through the Marketplace, including insurance affordability programs (premium tax credits and Medicaid/CHIP). The Marketplace

² Under the Affordable Care Act, starting in 2014, if someone can afford it but doesn't have health insurance coverage in 2014, they may have to pay a [fee](#). See HealthCare.gov, What if someone doesn't have health insurance?, <https://www.healthcare.gov/what-if-someone-doesnt-have-health-coverage-in-2014>. Under no circumstances may RWHAP funds be used to pay the fee for a client's failure to enroll in minimum essential coverage.

will also make it easy for consumers to keep their coverage year to year through a simple eligibility redetermination process.

Medicaid eligibility determinations and enrollment will continue to occur at any time throughout the year. Enrollment in qualified health plans offered through the Marketplace will occur during the open enrollment period.³ Special enrollment periods may be triggered by certain qualifying life events such as moving to a new state, eligibility changes for premium tax credits, or loss of employer-sponsored coverage, etc.⁴ Individuals who do not enroll during the open enrollment period will not have another opportunity to enroll in a qualified health plan until the next open enrollment period, unless they experience a qualifying life event that triggers a special enrollment period.

As such, HRSA/HAB strongly encourages RWHAP grantees to consider aligning the RWHAP recertification process with the Marketplace annual eligibility and enrollment processes in order to reduce burden on clients, increase coordination, maximize clients' enrollment with appropriate insurers, and ensure compliance with payer of last resort requirements. RWHAP grantees and subgrantees must continue to follow the initial eligibility determination and recertifications timelines and documentation requirements in *Policy Clarification Notice #13-02: Clarifications on Ryan White Program Client Eligibility Determinations and Recertifications Requirement* (<http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1302clienteligibility.pdf>).

Notice of Affordable Care Act Medicaid and/or Marketplace Eligibility Determinations

As individuals apply for different health coverage options, the Marketplace and/or state Medicaid agency will provide them with a timely written notice of their eligibility determination. The Marketplace will also provide individuals with an annual redetermination notice. The RWHAP grantee may consider requiring proof of the Medicaid and/or Marketplace notice of eligibility determination and annual redetermination notice as part of the RWHAP eligibility determination and recertifications processes in order to reduce burden on clients and to allow RWHAP coordination with the Medicaid and/or Marketplace eligibility determination processes. RWHAP grantees and subgrantees must continue to follow the initial eligibility determination and recertifications timelines and documentation requirements in *Policy Clarification Notice #13-02: Clarifications on Ryan White Program Client Eligibility Determinations and Recertifications Requirement* (<http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1302clienteligibility.pdf>).

Additional Information

Over the coming months, additional information will be released to grantees regarding the Affordable Care Act and the RWHAP and posted at

³ The initial open enrollment period for the individual Marketplaces will be from October 1, 2013, through March 31, 2014. After the initial open enrollment period, annual open enrollment will occur from October 15 to December 7 every year. See 45 C.F.R. § 155.410.

⁴ See 45 C.F.R. 155.420(d) for more examples of events that will trigger a special enrollment period.

<http://hab.hrsa.gov/affordablecareact/>. In addition, HealthCare.gov (<http://www.healthcare.gov>) has resources and important information on Affordable Care Act implementation. Please check both websites regularly.

Clarifications Regarding Clients Eligible for Private Health Insurance and Coverage of Services by Ryan White HIV/AIDS Program

Policy Clarification Notice (PCN) #13-04

Relates to HAB Policy #13-01, #13-02, #13-05

Scope of Coverage: Ryan White Parts A, B, C, D, and Part F where funding supports direct care and treatment services.

Purpose of PCN

This policy notice clarifies HRSA policy regarding the Ryan White HIV/AIDS Program (RWHAP) and its relationship to clients' eligibility and enrollment in private health insurance.

Background

By statute, RWHAP funds may not be used "for any item or service to the extent that payment has been made, or can reasonably be expected to be made..." by another payment source.¹ This means grantees must assure that funded providers make reasonable efforts to secure non-RWHAP funds whenever possible for services to individual clients. Grantees and their contractors are expected to vigorously pursue eligibility for all other funding sources (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance) to extend finite RWHAP grant resources to new clients and/or needed services.

This PCN clarifies how the RWHAP payer of last resort requirement applies to clients eligible for private insurance coverage. Grantees and subgrantees should also refer to *Policy Clarification Notice #13-01: Clarifications Regarding Medicaid-Eligible Clients and Coverage of Services by Ryan White HIV/AIDS Program* (<http://hab.hrsa.gov/manageyourgrant/pinspals/1301pcnmedicaideligible.pdf>) to understand the RWHAP expectations and requirements for individuals who may be eligible for Medicaid.

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

Instructions

Client Eligibility and Enrollment into Private Health Insurance

For policy years beginning on or after January 1, 2014, insurers will be prohibited from denying coverage because of a pre-existing condition, including HIV/AIDS, and many RWHAP clients may become newly eligible for private health insurance.

Because the RWHAP is the payer of last resort, RWHAP grantees and subgrantees must make every reasonable effort to ensure all uninsured RWHAP clients enroll in any health coverage options for which they may be eligible. This means that grantees and subgrantees are expected to ensure that clients who are determined by the state Medicaid agency and/or the Marketplace to be ineligible for public programs (Medicaid, CHIP, Medicare, etc.) are also assessed for eligibility for private health insurance (e.g., employer-sponsored health plans and health plans offered through the Marketplace).

Under existing guidance, grantees and subgrantees must make every reasonable effort to ensure eligible uninsured RWHAP clients expeditiously enroll in private health insurance plans whenever possible, and inform clients about any consequences for not enrolling. Specifically, RWHAP clients should be informed that under the Affordable Care Act, starting in 2014, if someone can afford it but doesn't have health insurance coverage,² they may have to pay a fee.³ Some individuals may be exempt from the Affordable Care Act's requirement to enroll in health coverage. In these circumstances, the Health Insurance Marketplace or the Internal Revenue Service (IRS) will provide individuals with certificates of exemption if they meet certain criteria.⁴ RWHAP clients who obtain a certificate of exemption may continue to receive services through the RWHAP. Under no

² To meet the individual responsibility requirement under the Affordable Care Act individuals will need coverage such as individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE or certain other coverage. See HealthCare.gov, What if someone doesn't have health insurance?, <https://www.healthcare.gov/what-if-someone-doesnt-have-health-coverage-in-2014>. See also Internal Revenue Service, Questions and Answers on the Individual Shared Responsibility payment Question #5, <http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision>.

³ Starting January 1, 2014, if someone doesn't have a health plan that qualifies as minimum essential coverage, he or she may have to pay a fee that increases every year: from 1% of income (or \$95 per adult, whichever is higher) in 2014 to 2.5% of income (or \$695 per adult) in 2016. The fee for children is half the adult amount. The fee is paid on the 2014 federal income tax form, which is completed in 2015. See HealthCare.gov, What if someone doesn't have health insurance?, <https://www.healthcare.gov/what-if-someone-doesnt-have-health-coverage-in-2014>.

⁴ Individuals may be exempt from paying the fee for failing to enroll in minimum essential coverage if they (1) are members of a religious sect that is recognized as conscientiously opposed to accepting any insurance benefits and adhere to the tenets of that sect; (2) are members of a recognized health care sharing ministry; (3) are members of a federally recognized Indian tribe; (4) have household income below the minimum threshold for filing a tax return; (5) only went without the required coverage for a short coverage gap of less than three consecutive months during the year; (6) were certified by a Health Insurance Marketplace as having suffered a hardship that makes them unable to obtain coverage; (7) cannot afford coverage because the minimum amount the individual must pay for premiums is more than eight percent of the individual's household income; (8) are in jail, prison or similar penal institution or correctional facility after the disposition of charges; and (9) are not U.S. citizens, U.S. nationals, or aliens lawfully present in the U.S. See IRS, Questions on Individual Shared Responsibility Provision Question #6, <http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision>.

circumstances may RWHAP funds be used to pay the fee for a client's failure to enroll in minimum essential coverage.

Grantees should be aware that clients can only enroll in a private health plan during an open enrollment period,⁵ unless they qualify for a special enrollment period based on a qualifying life event, such as moving to a new state, eligibility changes for premium tax credits and/or cost-sharing reductions, or loss of employer-sponsored coverage.⁶ If a client misses the open enrollment period and cannot enroll, it is expected that the grantee will make every reasonable effort to ensure the client enrolls into a private health plan upon the next open enrollment period. If a client qualifies for a special enrollment period, it is expected that the grantee will make every effort to ensure the client enrolls in a private health plan before the special enrollment period closes.

HAB will require grantees to maintain policies regarding the required process for the pursuit of enrollment for all clients, to document the steps during their pursuit of enrollment for all clients, and establish stronger monitoring and enforcement of subgrantee processes to ensure that clients are enrolled in coverage options for which they qualify. If after extensive documented efforts on the part of the grantee, the client remains unenrolled in health care coverage, the client may continue to receive services through the RWHAP.

It is also expected that RWHAP grantees collect and maintain documentation verifying client eligibility for other health coverage or a certificate of exemption from the Marketplace or IRS. *See Policy Clarification Notice #13-02: Clarifications on Ryan White Program Client Eligibility Determinations and Recertifications Requirement* (<http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1302clienteligibility.pdf>).

Effective Date of Coverage

Individuals enrolling in a new private health plan may experience a gap in coverage between submission of their enrollment application and the date on which the health plan will begin to pay for services received by the individual. Generally, payments for items or services will not be made, or cannot reasonably be expected to be made, by the health plan until the effective date of coverage begins. As such, RWHAP funds may be used to pay for items or services up until a client's effective date of coverage if those items or services are not covered by any other funding source. RWHAP funds may not be used to pay for items or services received on or after the effective date of coverage if they are covered by the client's insurance plan. In the event that RWHAP-funded services were provided on or after the effective date of coverage, grantees and subgrantees providing those services must

⁵ The initial open enrollment period for the individual Marketplaces will be from October 1, 2013, through March 31, 2014. After the initial open enrollment period, annual open enrollment will occur from October 15 to December 7 every year. See 45 CFR 155.410.

⁶ See 45 CFR 155.420(d) for more examples of events that may trigger a special enrollment period.

make every reasonable effort to collect payment from the private insurance plan for those RWHAP-funded services.

Coverage of Services by Ryan White HIV/AIDS Program for Clients Enrolled in Private Health Insurance

Once a client is enrolled in a private health plan, RWHAP funds may only be used to pay for any Ryan White HIV/AIDS Program services not covered or partially covered by the client's private health plan.

In addition, RWHAP grantees are strongly encouraged to use RWHAP funds to help clients purchase and maintain health insurance coverage, if cost-effective and in accordance with RWHAP policy. *See Policy Clarification Notice #13-05 Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance*

(<http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1305premiumcostsharing.pdf>)

Health Plan Provider Networks

RWHAP funds generally may not be used to pay for services that the client receives from a provider that does not belong to the client's health plan's network, unless the client is receiving services that could not have been obtained from an in-network provider.

Some health plans may have "tiered" networks that require individuals to pay more to see some providers. As such, providers in any covered tier are not considered "out-of-network." Grantees and subgrantees are not prohibited from using RWHAP funds to pay for out-of-pocket expenses when the client receives services from a provider in a higher-cost tier, including client out-of-pocket expenses. However, the effect of such payments on available resources should be considered by grantees and subgrantees prior to making such allocations.

Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance

Policy Clarification Notice (PCN) #13-05

Relates to HAB Policy #'s 10-02 and 7-05

Scope of Coverage: Ryan White Parts A, B, C, D, and Part F where funding supports direct care and treatment services.

Purpose of PCN

This policy clarification notice reiterates HRSA policy regarding the use of Ryan White HIV/AIDS Program (RWHAP) for premium and cost-sharing assistance for the purchase and maintenance of private health insurance coverage. It also provides RWHAP grantees and subgrantees with additional guidance on using RWHAP funds for premium and cost-sharing assistance.

Background

Under the Affordable Care Act, beginning January 1, 2014, options for health care coverage for PLWH will be expanded through new private insurance coverage options available through Health Insurance Marketplaces (also referred to as Exchanges) and the expansion of Medicaid in States that choose to expand. Health insurers also will be prohibited from denying coverage because of a pre-existing condition, including HIV/AIDS. An overview of these health care coverage options may be reviewed at <http://hab.hrsa.gov/affordablecareact/keyprovisions.pdf>.

By statute, RWHAP funds may not be used for any item or service “for which payment has been made or can reasonably be expected to be made” by another payment source.¹ This means that grantees and subgrantees must assure that they make reasonable efforts to secure non-RWHAP funds whenever possible for services to individual clients. Grantees and their subgrantees are expected to vigorously pursue eligibility for other funding sources (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and other private health insurance) to extend finite RWHAP grant resources to new clients and/or needed services.

Grantees and subgrantees should also assure that individual clients are enrolled in health care coverage whenever possible or applicable, and informed about the consequences for not enrolling.²

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

² Under the Affordable Care Act, starting in 2014, if someone can afford it but doesn't have health insurance coverage in 2014, they may have to pay a [fee](#). See HealthCare.gov, What if someone doesn't have health insurance?, <https://www.healthcare.gov/what-if-someone-doesnt-have-health-coverage-in-2014>. Under no circumstances may RWHAP funds be used to pay this fee for a client's failure to enroll in minimum essential coverage.

The RWHAP will continue to be the payer of last resort and will continue to pay for RWHAP services not covered by or partially covered by private health insurance plans.

As Affordable Care Act implementation continues, clients will become eligible for and enroll in qualified health plans offered in the Marketplace. RWHAP grantees and subgrantees should consider helping individual clients pay for premiums and/or cost-sharing, if cost-effective.

Requirements and Expectations for RWHAP Grantees and Subgrantees

By statute, RWHAP funds awarded under Parts A, B, and C may be used to support a Health Insurance Premium and Cost-Sharing Assistance Program, a core medical service, for eligible low-income HIV positive clients.³ Consistent with the RWHAP statute, "low-income" is to be defined by the EMA/TGA, State, or Part C grantee. RWHAP Part D grantees may also use funds to purchase and maintain health insurance, if cost-effective.

RWHAP funds may be used to cover the cost of private health insurance premiums, deductibles, and co-payments to assist eligible low-income clients in maintaining health insurance or receiving medical benefits under a health insurance or benefits program, including high risk pools. However, RWHAP funds may not be used to pay for any administrative costs outside of the premium payment of the health plans or risk pools.

If resources are available, Part A planning bodies and Ryan White Part B, C and D grantees may choose to prioritize and allocate funding to health insurance premium and cost-sharing assistance for low-income individuals in accordance with Section 2615 of the Public Health Service Act. The grantee must determine how to operationalize the health insurance premium and cost-sharing assistance program, including the methodology used by the grantee to: (1) assure they are buying health insurance that at a minimum, includes pharmaceutical benefits equivalent to the HIV antiretroviral and opportunistic infection related medications on the Part B ADAP formulary as well as coverage for other essential medical benefits; and (2) assess and compare the aggregate cost of paying for the health insurance option versus paying for the full cost for medications and other essential medical services. The grantee may consider providing the resource allocation to the Part B/AIDS Drug Assistance Program (ADAP) which currently operates the health insurance continuation programs in some States and, therefore, has the infrastructure to verify coverage status and process payments to health plans for premiums, co-payments and deductibles, and to pharmacies for medication co-payments and deductibles.

³ See Section 2604(c)(3)(F), Section 2612(c)(3)(F), and Section 2651(c)(3)(F) of the Public Health Service Act.

Requirements and Expectations Specific to Part B AIDS Drug Assistance Program (ADAP)

ADAP funds may be used to cover costs associated with a health insurance policy, including co-payments, deductibles, or premiums to purchase or maintain health insurance coverage. In order to use Part B ADAP funds to purchase health insurance, State ADAPs must provide HRSA/HAB with the methodology used by the State to: (1) assure that the health insurance plan, at a minimum, includes pharmaceutical benefits equivalent to the HIV antiretroviral and opportunistic infection related medications on the Part B ADAP formulary; and (2) assess and compare the aggregate cost of paying for the health insurance option versus paying for the full cost for medications.

Grantees should refer to HAB Policy Notice-07-05, "The Use of Ryan White HIV/AIDS Program Part B ADAP Funds to Purchase Health Insurance" (<http://hab.hrsa.gov/manageyourgrant/files/partbadapfundspn0705.pdf>).

RWHAP Premium and Cost-Sharing Assistance and the Affordable Care Act

The Affordable Care Act increases access to affordable health insurance by establishing a Health Insurance Marketplace in every state where individuals may purchase private health insurance. Many individuals may be eligible for premium tax credits and cost-sharing reductions to help pay for private health insurance offered in the Marketplace. Consequently, RWHAP grantees and subgrantees should take into consideration other sources of premium and cost-sharing assistance when determining how to operationalize a premium and cost-sharing assistance program, as discussed below.

Use of RWHAP Funds for Clients Eligible for Advance Premium Tax Credits

Many RWHAP clients with incomes between 100-400% of the federal poverty level (FPL) without access to certain types of minimum essential coverage⁴ may be eligible for premium tax credits to offset the cost of purchasing a qualified health plan⁵ through their state's Marketplace.⁶ The amount of the premium tax credit is

⁴ "Minimum essential coverage" refers to the type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes employer-sponsored coverage, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage as defined in Internal Revenue Code Section 5000(a).

⁵ A qualified health plan is a health insurance plan that is certified by a Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum

based on the individual's income and the cost of the second-lowest cost silver plan⁷ available to them offered in the Marketplace. Once an individual enrolls in a qualified health plan in the Marketplace, the individual can control how much of the projected tax credit is used to help pay the monthly health plan premiums. The tax credit is sent directly to the insurance company and applied to the individual's premium, so the individual pays less out of his/her own pocket.

Grantees and subgrantees may use RWHAP funds to pay for any remaining premium amount owed to the health insurance company that is not already covered by the RWHAP client's premium tax credits. Grantees and subgrantees should take the following into consideration when operationalizing their health insurance premium and cost-sharing assistance program:

- State-based Marketplaces have flexibility to implement a process for premium payment aggregation. Grantees and subgrantees should work with health insurance issuers and/or the State-based Marketplace to establish a coordinated process that facilitates premium payments by the RWHAP for individual clients.
- In states with a Federally-Facilitated Marketplace, grantees and subgrantees will need to work directly with health insurance issuers to facilitate premium payments by the RWHAP for individual clients.

Use of RWHAP Funds for Clients Eligible for Cost-Sharing Reductions

Many RWHAP clients with incomes between 100-250% FPL who receive the advance premium tax credits may also be eligible for additional cost-sharing reductions to lower their out-of-pocket expenses, such as co-payments and deductibles. In order to receive cost-sharing reductions, individuals must receive a premium tax credit and enroll in a silver level plan offered in the Marketplace.

As discussed above, RWHAP funds may only be used to purchase and maintain health insurance that is cost-effective. In determining which qualified health plan in the Marketplace is the most cost-effective for clients eligible for cost-sharing reductions, grantees and subgrantees are encouraged to analyze the formulary adequacy and other essential medical benefits, the cost of the premium, and the effect of any cost-sharing reductions on the overall cost of the qualified health plan.

amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold. See <http://www.healthcare.gov/glossary/q/qhp.html>.

⁶ Legal residents with incomes below 100% FPL who have been in the United States for less than five years may also be eligible for advance premium tax credits provided they are not eligible for Medicaid or other minimum essential coverage.

⁷ There are four types of coverage that will be offered in each Marketplace: bronze, silver, gold, and platinum. A silver level qualified health plan (QHP) is a health plan offered in the Marketplace with an actuarial value (AV) of 70 percent. A bronze level QHP has an AV of 60 percent, a gold level QHP has an AV of 80 percent, and a platinum QHP has an AV of 90 percent.

RWHAP grantees and subgrantees should inform clients regarding these analyses to assist RWHAP clients in enrollment decisions.

Even if an individual is eligible for cost-sharing reductions, he/she may still incur some cost-sharing in his/her health plan. RWHAP funds may be used to cover any remaining costs of co-payments and deductibles if the grantee has established a Health Insurance Premium and Cost-Sharing Assistance Program and HRSA/HAB has received the methodology used to determine if the program is cost-effective.

Use of RWHAP Funds for Clients Not Eligible for Premium Tax Credits and Cost-Sharing Reductions in a Health Insurance Marketplace

Grantees and subgrantees should consider that some individuals are ineligible for premium tax credits and cost-sharing reductions:

- Clients under 100% FPL in states that do not implement Medicaid expansion;⁸
- Clients with incomes above 400% FPL;
- Clients who have minimum essential coverage other than individual market coverage (*e.g.*, Medicaid, CHIP, TRICARE, employer-sponsored coverage, and certain other coverage defined in Internal Revenue Code Section 5000(a)) available to them, but choose to purchase in the Marketplace; and
- Clients who are ineligible to purchase insurance through the Marketplace.

If resources are available, RWHAP grantees and subgrantees are strongly encouraged to use RWHAP funds for premium and cost-sharing assistance for these individuals when it is cost-effective, as appropriate. As discussed above, the grantee and subgrantee must ensure that use of RWHAP funds for premium and cost-sharing assistance for these clients is cost-effective.

Conclusion

RWHAP funds may be used to help clients purchase and maintain health insurance, if cost-effective and in accordance with RWHAP policy. It is important for grantees and subgrantees to understand the new insurance options available to clients under the Affordable Care Act. Many clients may also be eligible to receive advance premium tax credits and/or cost-sharing reductions to help pay for private health insurance in the Marketplace. RWHAP grantees and subgrantees should take into consideration other sources of premium and cost-sharing assistance when determining how to operationalize a premium and cost-sharing assistance program. Grantees and subgrantees should also work directly with health insurance issuers and/or the Marketplace to coordinate payment of premiums and cost-sharing for clients.

⁸ However, please note that legal residents with incomes below 100% FPL who do not qualify for Medicaid or other minimum essential coverage may be eligible for premium tax credits and cost-sharing reductions.

To learn more about the Affordable Care Act, grantees are encouraged to visit the HIV/AIDS Bureau's Affordable Care Act website (<http://hab.hrsa.gov/affordablecareact/>) and HealthCare.gov (<http://www.healthcare.gov>).

I AM ESSENTIAL

For Immediate Release
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OBAMA ADMINISTRATION LIMITS DRUG COVERAGE FOR EXPANDED MEDICAID BENEFICIARIES

Sweeping Changes Issued during July 4th Holiday

Washington, DC—On the Friday after the July 4th holiday, when Washington DC was on vacation, including most patient groups and the media, the Obama Administration released a final rule here that radically changes the Medicaid program by limiting access to prescription medications.

Medicaid beneficiaries have historically been able to access all drugs manufactured by companies that participate in the drug rebate program, which has included most medications. In the final essential health benefits rule for the new expanded Medicaid program, the Obama Administration backed off its proposed rule that appeared to carry forward this historical practice. Instead, they say it was all a misunderstanding and have issued a clarification that dramatically limits the number of drugs each state must cover in its formularies.

“We are totally shocked by this radical departure from current Medicaid practice,” said Carl Schmid, Deputy Executive Director of The AIDS Institute. “This will limit patients in the expanded Medicaid program to far fewer drugs, potentially denying them access to the medications prescribed by their doctors and putting their health at risk.” He added, “To announce this when no one was looking just adds insult to injury.” Schmid, whose organization strongly supports the Affordable Care Act, has helped lead the “I Am Essential” coalition of patient groups on implementation of the essential health benefits. Seventy-nine groups signed onto a letter this past February in support of the proposed approach outlined in a proposed rule on how drugs would be covered, but voiced concern to the quantity limits states could impose, along with some other issues.

In the final rule, CMS included a “clarification” that said the reference in the proposed rule that prescription drugs for essential health benefits for the expanded Medicaid population would follow the requirements under Section 127 “may have been over-inclusive” and does not pertain to coverage of drugs for expanded Medicaid beneficiaries. (Section 127 of the Social Security Act includes the provision that all drugs manufactured by companies that participate in the drug rebate program must be covered on each state Medicaid program.) Instead, CMS is now saying the same process to determine coverage of medications for the private insurance market will have to be followed. That process requires plans to cover the greater of one drug

per class or the same number of drugs as contained in each class of drugs included in the state Medicaid benchmark plan selected. Patient groups have strongly come out in opposition to this process since it narrows coverage and potential access to medications.

“Medicaid expansion is set to begin in less than 6 months, and we still do not know what each state will cover in terms of drugs and other services,” commented Andrew Sperling, Director of Federal Legislative Advocacy, National Alliance on Mental Illness (NAMI). “We will be closely monitoring implementation and how the needs of patients are being met. We cannot risk patient drug regimens being interrupted or having access to a lifesaving treatment be denied. If this ends up being the case, we will be back to urge the Administration to abandon its approach so that no patient will be denied coverage of medically necessary services.”

In the final rule, despite vigorous opposition from patient groups, allows states to place additional restrictions on drug coverage. States can impose quantity and duration limits, require prior authorization, and other utilization management techniques. CMS states that in doing so plans cannot discriminate against patients and there must be appeal procedures in place and emergency supplies provided. CMS also rejected the patient groups’ concern with the proposed \$8/non-preferred drug co-pay but does spell out an avenue in which patients can receive the drug at the \$4 preferred drug cost if the preferred drug would be less effective or have adverse effects.

In a positive clarification, CMS stated in the final rule that Grade “A” and “B” USPSTF and other preventative services that will be required as part of each state’s Medicaid essential health benefits must be offered with no patient co-pays.

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July 1, 2013

Ryan White and ACA Questions – Atlanta EMA

1. *Will there be a transition period from January 1st until the end of the budget period for the implementation of the ACA? Or will the payer of last resort kick in and we will have to immediately delete folks from our rolls for primary care.*

As the Part A grant FY 2013 budget period runs through 02/28/14, Part A grantees and sub-funded providers will need to address potential changes in client eligibility for all their Ryan White clients. This is a two-fold level of responsibility related to Medicaid expansion, in those States that decide to do so, and enrollment in the health insurance marketplace. Issues related to Medicaid are addressed in the recently released Policy Clarification Notice found at

<http://hab.hrsa.gov/manageyourgrant/pinspals/1301pcnmedicaideligible.pdf>.

HAB/HRSA is currently reviewing/developing policy options related to the Payer of Last Resort requirement and the larger expansion of health insurance through the marketplaces.

2. *Can Part A pay Health Insurance Premiums and Health Insurance Co-pays? Would it be based on the same criteria as Part B? Would Part A be able to fund additional staff under these categories to process payments, etc. or would that need to come from admin funds?*

Part A funds can be utilized for cost sharing needs/opportunities (premiums, deductibles, co-pays) that may present as a result of ACA implementation. In fact, HAB anticipates that cost-sharing, as a core medical service will become increasingly common after ACA implementation given the cost-effectiveness of assisting with full insurance coverage. While it will not be required that Part A jurisdictions utilize criteria identical to Part B, we recommend that discussions occur to explore the possibility of common criteria, as well as the possible integration of A and B funds into a single effort, similar to contributions that EMAs/TGAs make to the State ADAP. Processing payments under cost sharing efforts is an act of providing a service (i.e., ensuring provision of health insurance coverage); therefore it is not deemed as an administrative cost. However, standard administrative costs relative to the provision of this service, similar to any other funded service, should be applied to the administrative cost cap and it is necessary that grantees and subcontracted providers be able to clearly delineate and document direct costs of providing this service versus administrative costs to support the service.

3. *Will we have flexibility this year (FY12) to assist clients with enrollment into a health insurance? For example, can we change our Medical Case Management to Non-Medical Case Management services and reduce the amount of funding directed toward core medical services. The EMA does not have a medical waiver currently in place and the soonest would be for the FY14 funding cycle.*

Part A grantees are encouraged to work with their Planning Councils, to modify their system of care to meet the needs of their jurisdiction. Please refer to <http://hab.hrsa.gov/affordablecareact/outreachenrollment.html>, for guidance on the flexible utilization of Ryan White funds for outreach and enrollment activities. EMAs/TGAs that do not have an approved core medical services waiver for FY 2013 must adhere to the 75/25 requirement. We recommend that you submit a request for FY 2014, which if approved, would become effective with the start of the FY 2014 budget period 03/01/14.

4. *Will the State ADAP funding still be available for persons enrolled in a health insurance exchange or will their meds need to come under the health insurance coverage?*

Part B ADAP funds will continue to provide completeness of coverage for needed pharmaceutical services. We encourage Part A grantees to coordinate closely with their State ADAP in order to plan for any changes which might impact the EMA/TGA.

5. *Without Medicaid expansion, there will be approximately 44% of the (Atlanta) EMA's population requiring primary care services through Ryan White Part A. How will we know if individuals have been enrolled in a health insurance program when the only notification will go to the individual?*

See the recently released HAB policy clarification notice found at <http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1302clienteligibility.pdf>. It is expected that such a determination would be made during the required Ryan White eligibility and/or recertification process.

6. *When will HAB be able to provide us with some guidance – a technical assistance call, comprehensive FAQ's, guidance from the Project Officer? When we were in DC in November it was indicated that info from HAB would be forthcoming soon. It is now March. Enrollment is supposed to begin in October.*

Since November, HAB has hosted three ACA webinars targeting Ryan White Program grantees and stakeholders. In January, HAB launched an ACA webpage on the HAB website where stakeholders and Ryan White Program grantees may find recently posted ACA-related guidance including letters, policy clarification notices and links to ACA educational tools. The archived webinars are also available on this webpage for review. You may visit <http://hab.hrsa.gov/affordablecareact/index.html> to review these materials. Additionally, there are a significant number of technical assistance resources found on the Ryan White TARGET Center website at <https://careacttarget.org/library/affordable-care-act-and-ryan-white-hiv-aids-program-learning-modules>. **We are planning a webinar to review recently issued HAB policies in July or early August. We anticipate additional opportunities for technical assistance in the coming months.**

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Global Female Condom Day

» [Global Female Condom Day](#)

Global Female Condom Day

September 16, 2013 marks the second annual Global Female Condom Day—a day of education and advocacy to increase awareness, access, and use of female condoms.

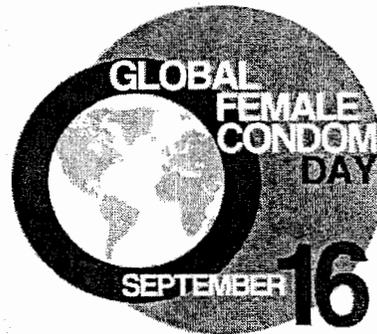
Female condoms are powerful tools for pleasure and prevention. They empower and protect, but more people need to know about female condoms and be able to access them. Advocacy and education are critical to build awareness and support for this highly effective prevention tool for women and men.

You can help make that happen! Take the pledge to take action along with female condom advocates around the world on September 16.

As the day of action approaches, we will let you know ways – large and small – that you can be a part of the global movement for female condoms. Here are a few ways that individuals and organizations will take action on Global Female Condom Day:

- Educate their communities about what female condoms are, who can use them, how to use them, and where to access them.
- Spread the word about female condoms through personal and organizational social media networks with blogs, Facebook posts, and tweets.
- Advocate for expanded female condom access at local health departments, community clinics, local businesses, service agencies, and pharmacies.
- Host mini film festivals featuring Female Condoms Are _____ films.
- Make 10-second videos saying why they support female condoms.

In the coming weeks, we will post tools and tips to help female condom advocates take action in their communities. Be sure to watch the National Female Condom Coalition website for everything you need to plan your Global Female Condom Day activities.



Executive Order -- HIV Care Continuum Initiative

EXECUTIVE ORDER

July 15, 2013

ACCELERATING IMPROVEMENTS IN HIV PREVENTION AND CARE IN THE UNITED STATES THROUGH THE HIV CARE CONTINUUM INITIATIVE

By the authority vested in me as President by the Constitution and the laws of the United States of America, and in order to further strengthen the capacity of the Federal Government to effectively respond to the ongoing domestic HIV epidemic, it is hereby ordered as follows:

Section 1. Policy. Addressing the domestic HIV epidemic is a priority of my Administration. In 2010, the White House released the first comprehensive National HIV/AIDS Strategy (Strategy), setting quantitative goals for reducing new HIV infections, improving health outcomes for people living with HIV, and reducing HIV-related health disparities. The Strategy will continue to serve as the blueprint for our national response to the domestic epidemic. It has increased coordination, collaboration, and accountability across executive departments and agencies (agencies) with regard to addressing the epidemic. It has also focused our Nation's collective efforts on increasing the use of evidence-based approaches to prevention and care among populations and in regions where HIV is most concentrated.

Since the release of the Strategy, additional scientific discoveries have greatly enhanced our understanding of how to prevent and treat HIV. Accordingly, further Federal action is appropriate in response to these new developments. For example, a breakthrough research trial supported by the National Institutes of Health showed that initiating HIV treatment when the immune system was relatively healthy reduced HIV transmission by 96 percent. In addition, evidence suggests that early treatment may reduce HIV-related complications. These findings highlight the importance of prompt HIV diagnosis, and because of recent advances in HIV testing technology, HIV can be detected sooner and more rapidly than ever before.

Based on these and other data, recommendations for HIV testing and treatment have changed. The U.S. Preventive Services Task Force now recommends that clinicians screen all individuals ages 15 to 65 years for HIV, and the Department of Health and Human Services Guidelines for Use of Antiretroviral Agents now recommends offering treatment to all adolescents and adults diagnosed with HIV.

Furthermore, ongoing implementation of the Affordable Care Act provides a historic opportunity for Americans to access affordable, quality health care. The Act is expanding access to recommended preventive services with no out-of-pocket costs, including HIV testing, and, beginning in 2014, insurance companies will not be able to deny coverage based on pre-existing conditions, including HIV. Starting October 1, 2013, Americans can select the coverage that best suits them through the new Health Insurance Marketplace, and coverage will begin January 1, 2014.

Despite progress in combating HIV, important work remains. Since the publication of the Strategy, data released by the Centers for Disease Control and Prevention show that there are significant

gaps along the HIV care continuum -- the sequential stages of care from being diagnosed to receiving optimal treatment. Nearly one-fifth of the estimated 1.1 million people living with HIV in the United States are undiagnosed; one-third are not linked to medical care; nearly two-thirds are not engaged in ongoing care; and only one-quarter have the virus effectively controlled, which is necessary to maintain long-term health and reduce risk of transmission to others.

In light of these data, we must further clarify and focus our national efforts to prevent and treat HIV infection. It is the policy of my Administration that agencies implementing the Strategy prioritize addressing the continuum of HIV care, including by accelerating efforts to increase HIV testing, services, and treatment along the continuum. This acceleration will enable us to meet the goals of the Strategy and move closer to an AIDS-free generation.

Sec. 2. Establishment of the HIV Care Continuum Initiative. There is established the HIV Care Continuum Initiative (Initiative), to be overseen by the Director of the Office of National AIDS Policy. The Initiative will mobilize and coordinate Federal efforts in response to recent advances regarding how to prevent and treat HIV infection. The Initiative will support further integration of HIV prevention and care efforts; promote expansion of successful HIV testing and service delivery models; encourage innovative approaches to addressing barriers to accessing testing and treatment; and ensure that Federal resources are appropriately focused on implementing evidence-based interventions that improve outcomes along the HIV care continuum.

Sec. 3. Establishment of the HIV Care Continuum Working Group. There is established the HIV Care Continuum Working Group (Working Group) to support the Initiative. The Working Group shall coordinate Federal efforts to improve outcomes nationally across the HIV care continuum.

(a) Membership. The Working Group shall be co-chaired by the Director of the Office of National AIDS Policy and the Secretary of Health and Human Services or designee (Co-Chairs). In addition to the Co-Chairs, the Working Group shall consist of representatives from:

- (i) the Department of Justice;
- (ii) the Department of Labor;
- (iii) the Department of Health and Human Services;
- (iv) the Department of Housing and Urban Development;
- (v) the Department of Veterans Affairs;
- (vi) the Office of Management and Budget; and
- (vii) other agencies and offices, as designated by the Co-Chairs.

(b) Consultation. The Working Group shall consult with the Presidential Advisory Council on HIV/AIDS, as appropriate.

(c) Functions. As part of the Initiative, the Working Group shall:

- (i) request and review information from agencies describing efforts to improve testing, care, and treatment outcomes, and determine if there is appropriate emphasis on addressing the HIV care continuum in relation to other work concerning the domestic epidemic;
- (ii) review research on improving outcomes along the HIV care continuum;

- (iii) obtain input from Federal grantees, affected communities, and other stakeholders to inform strategies to improve outcomes along the HIV care continuum;
- (iv) identify potential impediments to improving outcomes along the HIV care continuum, including for populations at greatest risk for HIV infection, based on the efforts undertaken pursuant to paragraphs (i), (ii), and (iii) of this subsection;
- (v) identify opportunities to address issues identified pursuant to paragraph (iv) of this subsection, and thereby improve outcomes along the HIV care continuum;
- (vi) recommend ways to integrate efforts to improve outcomes along the HIV care continuum with other evidence-based strategies to combat HIV; and
- (vii) specify how to better align and coordinate Federal efforts, both within and across agencies, to improve outcomes along the HIV care continuum.

(d) Reporting.

- (i) Within 180 days of the date of this order, the Working Group shall provide recommendations to the President on actions that agencies can take to improve outcomes along the HIV care continuum.
- (ii) Thereafter, the Director of the Office of National AIDS Policy shall include, as part of the annual report to the President pursuant to section 1(b) of my memorandum of July 13, 2010 (Implementation of the National HIV/AIDS Strategy), a report prepared by the Working Group on Government-wide progress in implementing this order. This report shall include a quantification of progress made in improving outcomes along the HIV care continuum.

Sec. 4. General Provisions. (a) Nothing in this order shall be construed to impair or otherwise affect:

- (i) the authority granted by law to an executive department, agency, or the head thereof; or
 - (ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.
- (b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.
- (c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

BARACK OBAMA



Inovio Pharmaceuticals

Jul 12th 2012

Inovio Pharmaceuticals HIV vaccine featured on ABC-TV

Inovio Pharmaceuticals (AMEX:INO) was recently featured on ABC-TV news for its Pennvax-G HIV vaccine, which could be a breakthrough in the crusade to treat and prevent the HIV/AIDS virus.

In the report, ABC said Inovio may be closer than any other company to producing an effective vaccine for HIV, a virus that erupted in the 1980s and has killed over 30 million people worldwide, according to the United Nations.

Inovio CEO Joseph spoke with ABC, saying that Inovio's synthetic vaccines are "revolutionizing" the vaccine industry by using cutting-edge technology.

Synthetic vaccines aren't traditional like ones for the flu that take a dead virus to create a vaccine, but are actually computer-designed and then manufactured and tested in the traditional way.

ABC noted that Inovio's vaccine is also revolutionary in another way, as it is designed to prevent the disease, and more importantly, to treat HIV. The vaccine is also designed to deal with the HIV's ability to mutate.

"We can make a vaccine not just against a single strain of HIV for instance, but also against multiple, global strains," said Kim in the segment.

According to the news report, since 2008, the National Institutes of Health has given Inovio \$25 million to further its research.

Inovio estimates it may be five to seven years before the Pennvax-G HIV vaccine is ready to go to market. The company is also working on vaccines for the flu, prostate, cervical and other types of cancers.

To watch the full ABC report, visit <http://www.10news.com/video/31253603/index.html>.

Earlier this week, Inovio said that the first patients have been treated in its clinical study testing immune responses in elderly adults that were immunized with the company's H1N1 universal flu vaccine.

The phase 1 study will look at the ability of Inovio's SynCon vaccine alone, as well as in combination with the 2012 seasonal influenza vaccine, to generate protective levels of immune responses.

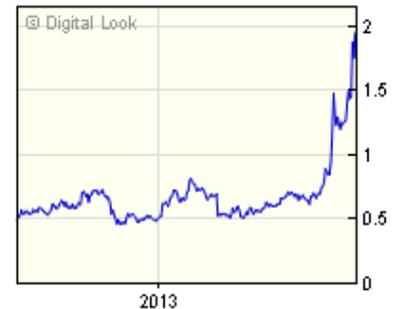
The company will also look at the vaccine's ability to generate specific antibody immune responses against unmatched flu strains, and T-cell immune responses that can be helpful in fighting the flu, especially for the elderly, which are absent from current flu vaccines.

Inovio's SynCon technology allows it to design synthetic vaccines with the potential to protect against unmatched sub-types and strains of pathogens, including newly emergent, unknown strains of a virus that will periodically emerge through mutation, as in the case of influenza.

The H3N2, H1N1, and Type B influenza strains represented in each year's seasonal influenza vaccine are updated annually, but only protect against a single strain within each of these subtypes.

When a selected strain mutates, the annual vaccine may not provide protection, as witnessed with the 2009 swine flu

1 Year Share Price Graph



Share Information

Code: INO
Listing: NYSE AMEX
Sector: Pharmaceuticals & Biotechnology
Website: www.inovio.com

Company Synopsis:

Inovio Pharmaceuticals, Inc. is focused on the discovery, development, and delivery of a new generation of vaccines, called DNA vaccines, to prevent or treat cancers and chronic infectious diseases. This next generation of immunotherapies could potentially protect millions of people from debilitation or death from diseases without adequate treatments.

action@proactiveinvestors.com



H1N1 pandemic.

The company noted that the population most susceptible to the flu, those over 65 years of age, represent about 90 per cent of annual flu deaths in the US as older people's immune systems are typically weaker.

The phase 1 open label study will take place at the University of Manitoba in Winnipeg, Canada, funded in part by a grant from the Canadian Institute of Health Research, Inovio said.

Shares of Inovio were up 2.20 per cent as at 2:15 pm EDT on Thursday, trading at 46 cents.

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