North Carolina Department of Health and Human Services

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

Adam Sholar
Legislative Counsel
Director of Government Affairs

April 1, 2014

SENT VIA ELECTRONIC MAIL

The Honorable Ralph Hise, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 1026, Legislative Building
Raleigh, NC 27603

The Honorable Justin Burr, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 307A, Legislative Office Building
Raleigh, NC 27603-5925

The Honorable Mark W. Hollo, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 639, Legislative Office Building
Raleigh, NC 27603-5925

Dear Senator Hise and Representatives Burr and Hollo:

Pursuant to Session Law 2013-360, Section 12E.5(b), the Department of Health and Human Services is submitting this report on alternative options for serving individuals diagnosed with HIV/AIDS who are eligible to receive services under the AIDS Drug Assistance Plan (ADAP), including the State Medicaid program and the federally facilitated Health Benefit Exchange.

Questions concerning this report may be directed to Maribeth Wooten within the Division of Public Health at (919) 707-5051, or at Maribeth.Wooten@dhhs.nc.gov.

Sincerely,

Adam Sholar

Cc: Dr. Robin Cummings
Rod Davis
Penelope Slade-Sawyer
Maribeth Wooten
Pam Kilpatrick
Kristi Huff
Brandon Greife
Susan Jacobs
Theresa Matula
Joyce Jones

Sarah Riser
Pat Porter

Steve Owen
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Mark Trogdon, Director
Fiscal Research Division
Legislative Office Building
300 North Salisbury Street, Suite 619
Raleigh, NC 27603-5925

Dear Mr. Trogdon:

Pursuant to Session Law 2013-360, Section 12E.5(b), the Department of Health and Human Services is submitting this report on alternative options for serving individuals diagnosed with HIV/AIDS who are eligible to receive services under the AIDS Drug Assistance Plan (ADAP), including the State Medicaid program and the federally facilitated Health Benefit Exchange.

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Alternative Options for Serving Eligible

AIDS Drug Assistance Program (ADAP) Clients

State of North Carolina

Department of Health and Human Services

April 1, 2014

Legislative Reporting Requirement

Session Law 2013-360, Section 12E.5 requires the Department of Health and Human Services (DHHS), Division of Public Health (DPH) to submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on alternative options for serving individuals diagnosed with HIV/AIDS who are eligible to receive services under the AIDS Drug Assistance Program (ADAP), including the State Medicaid program and the federally facilitated Health Benefit Exchange.

Executive Summary

In March 2010, Congress passed the Patient Protection and Affordable Care Act (ACA). This legislation has the potential to impact the delivery of healthcare services provided to HIV positive individuals, particularly those served by the North Carolina AIDS Drug Assistance Program (ADAP). Notably, the ACA provides an opportunity for uninsured ADAP clients to purchase health insurance through the federally-facilitated health benefit exchange.

In accordance with the legislative mandate, DPH explored alternative options for serving clients with HIV/AIDS. Pertinent facts and findings are:

- Presently, clients served by ADAP are not eligible for Medicaid in North Carolina. ADAP is the payer of last resort.
- Approximately 90% of clients served by the ADAP Pharmacy Program are eligible for insurance coverage through the federally-facilitated health benefit exchange (also known as the Marketplace).
- Approximately 65% of these ADAP clients eligible for Marketplace coverage will not be eligible for subsidies because subsidies are not available for individuals with incomes at/below 100% of the Federal Poverty Level (FPL).
- A variety of factors impact the cost of Marketplace coverage in NC (age, county of residence, tobacco use, family size, and type of plan).
- While current annual premiums and maximum out of pocket (MOOP) costs are known for Marketplace plans in NC, increases to these annual rates and MOOP costs are unknown at this time and will impact costs in the future.

Consideration of a two-phase insurance completion pilot program would allow further assessment of the feasibility and cost benefits of transitioning ADAP clients to the Marketplace.

- Phase 1 would allow up to 1,000 ADAP clients to enroll in a Marketplace insurance plan of their choice. ADAP would pay all medication cost-sharing up to the maximum out of pocket cost allowable, which is currently set at $6,350. Clients would be required to cover premiums and cost-sharing for all covered services other than prescription medication.
- Phase 2 would allow ADAP to additionally pay for insurance premiums if cost neutrality or savings for ADAP were determined during Phase 1.

An additional option to consider is changing the current income calculation used to determine ADAP eligibility to the Modified Adjusted Gross Income (MAGI) calculation. This calculation is in compliance with the ACA, is recommended by the federal funder for ADAP (Health

Resource Services Administration, or HRSA) and is currently used by the NC Medicaid program.

DHHS is committed to exploring effective and efficient strategies for enabling people living with HIV/AIDS to have access to care and treatment services regardless of their income. While changes in funding care delivery programs are occurring nationwide, North Carolina's HIV/AIDS prevention and care strategies and services should be considered foundational to comprehensive plans to end the spread of HIV and AIDS. Our ADAP and Ryan White networks of care are implementing nationally recognized services to qualified HIV positive patients in order to achieve viral suppression. The viral suppression success rate among ADAP clients is more than twice that of the general HIV positive population, reducing medical complications and costs and preventing disease transmission. Continued state investment in ADAP and support for the continuation of Ryan White federal dollars to augment the state's HIV/AIDS prevention, care and treatment programs remain critical in the fight against HIV.

Background

HIV in North Carolina

There are an estimated 36,500 people in North Carolina who are HIV positive; of those, as many as 7,000 are unaware of their infection. The Division of Public Health's HIV/STD Care and Prevention Unit has active and engaging strategies to identify all cases of HIV infection, to link those individuals to appropriate medical care, and to support their ability to stay in care and on an antiretroviral medication regimen.

Recent advances in medicine and the definitive international study known as HPTN 052 led by the University of North Carolina, Chapel Hill, demonstrated that HIV positive people who are virally suppressed (have an undetectable amount of HIV in their blood) have a reduced ability to transmit the virus to others by 96%. This is a significant and critical finding for the protection of public health: it is highly unlikely that a person can contract HIV from an infected person who is virally suppressed. As a result, the most important issues in HIV today are 1) identifying all people who are HIV positive; and 2) assuring that they are in care and on medication as prescribed. Individuals who achieve and maintain viral suppression are anticipated to live much longer and healthier lives, able to work, raise families and contribute to society in a way that had previously been very difficult. Without proper care and treatment, HIV is still considered a fatal condition.

HIV represents a significant health disparity in North Carolina. In 2011 the rate of HIV diagnoses in blacks was 10 times greater than whites. 20% of all newly diagnosed cases of HIV were among males 13-24 year of age of all races. HIV was also the third leading cause of death in black women ages 25-44 and the sixth for black men of the same age.

As a result of these disparities and in light of the proven importance of viral suppression, new protocols are being created for the state's Bridge Counseling program. This includes enhanced efforts of field staff to locate people living with HIV who have fallen out of care, and to re-connect them with proper care and treatment. The Care and Prevention in the United States (CAPUS) federal grant award was provided to eight states to address the disproportionate effects of HIV on the minority community. In North Carolina, this award has created additional interventions designed to overcome the social and structural barriers of staying in care and on medication, with the intention that minority clients will begin to achieve higher viral suppression and better health.

AIDS Drug Assistance Program

The ultimate goal of the AIDS Drug Assistance Program (ADAP) is to assure that HIV positive clients are kept in care and adherent to their medication. From 2008 to 2013, the program experienced a 29% growth. As of January 31, 2014, there were 7,084 clients enrolled in ADAP, and 76% of these clients were virally suppressed. ADAP provides HIV medicines to low-income residents of North Carolina under two models:

- The ADAP Pharmacy Program (APP) serves HIV positive residents of North Carolina with incomes below 300% FPL and with no other third party coverage; 81% of all ADAP clients

are served through APP. The program purchases medications from a contracted wholesaler and distributes medications directly to clients through a contracted pharmacy. The actual average cost per enrollee per month for APP was $661 in calendar year 2012.

- The HIV specific State Pharmaceutical Assistance Program (SPAP) serves HIV positive residents of North Carolina with incomes below 300% FPL who also have Medicare Part D prescription drug coverage; 19% of ADAP clients are served through SPAP. Clients on SPAP pay their monthly Medicare Part D premiums and the program pays all HIV medication co-payments through a contracted Pharmacy Benefits Manager (PBM). In calendar year 2013, the average cost per enrollee per month for SPAP was $160. DHHS recommends this group continue on SPAP since they already have insurance and are not impacted by the creation of the federally-facilitated health benefit exchange (Marketplace). The SPAP currently serves over 1,300 ADAP clients.

  The SPAP was piloted between March 2009 and February 2010. During the pilot, over 700 clients were served through SPAP, and the program recognized significant savings when its cost per client was compared to the cost per client for the ADAP Pharmacy Program during the same time period. The SPAP was permanently implemented in March 2011. DHHS's specific recommendations contained in this report regarding an ACA insurance completion pilot are based in part on the lessons learned from implementing SPAP.

  ADAP's State Pharmacy Assistance Program (SPAP) enrolls HIV positive residents of North Carolina with incomes below 300% FPL who also have Medicare Part D prescription drug coverage. SPAP has saved DPH over $14M (approximately 70%) over the past three years. The specific options presented in this report are based on the lessons learned from implementing SPAP and the ADAP Pre-Existing Condition Insurance Program (PCIP) pilot in 2013.

The Affordable Care Act (ACA)

The ACA includes a number of provisions that take effect between 2010 and 2020. In particular, the ACA required that in 2014 all individuals have health insurance coverage or pay a penalty, if not eligible for an exemption. The ACA established the Health Insurance Marketplace, an online resource designed to help buying health insurance.

Under the ACA, the health insurance industry is more regulated than previously. Insurance companies cannot deny coverage based on a pre-existing condition and plans must include statutory essential health benefits. Additionally, insurance carriers participating in the Marketplace are required to offer qualified health plans (QHP). QHPs all offer the same essential health benefits coverage, but are differentiated based on their amount of cost sharing or "actuarial value". The actuarial value refers to the average amount of insurance expenses that would be paid for by the insurance plan. QHPs fall into five categories or metal levels (categories do not indicate the quality of the plan or the amount of care that is provided):

- Bronze plans cover 60% of the actuarial value. These plans typically have the lowest monthly premiums and the highest out of pocket costs.

- Silver plans cover 70% of the actuarial value. Cost-sharing subsidies are only available with silver plans.
- Gold plans cover 80% of the actuarial value.
- Platinum plans cover 90% of the actuarial value. These plans typically have the highest monthly premiums and the lowest out of pocket costs.
- Catastrophic plans generally have lower monthly premiums, but are only available to people under 30 years old or with hardship exemptions. Consumers pay all costs up to a certain threshold and then full coverage begins.

Under provisions of the ACA, there are multiple factors that impact premium costs[1] in the Marketplace, including:

- Age
- County of residence (there are 16 pricing regions in North Carolina; rural regions experience higher premiums)
- Tobacco use (users pay higher premiums)
- Family size
- Plan type

Marketplace insurance premium costs will also vary depending on insurance carrier, metal level and specific plan selected. While current annual premiums and maximum out of pocket (MOOP) costs are known for plans available in North Carolina, increases to annual rates and maximum annual limits set on out of pocket cost are unknown at this time and will impact costs in the future.

In order to make insurance coverage more affordable, the federal government offers premium subsidies and/or cost-sharing subsidies for income-eligible consumers as follows:

- Premium subsidies are available for individuals with incomes between 100% and 400% of the FPL ($11,490-$45,960/year) in the form of tax credits or up-front discounts in the form of reduced premiums
- In the Marketplace, cost sharing is defined as the share of costs between an insured person and an insurer. This includes deductibles, coinsurance and copayments but does not include premiums or the cost of non-covered services. Cost-sharing subsidies are available for individuals with incomes between 100% and 250% of the FPL ($11,490-$28,725/year) under the condition they enroll in a Silver plan. These subsidies are in the form of discounts that reduce the maximum out of pocket cost.

Federal Funds Supporting ADAP in North Carolina

The federal Health Resources Services Administration (HRSA) oversees the Ryan White Care funds provided to states. Ryan White funds provide core medical and support services to low income people living with HIV disease who have no other resources for their care. In North Carolina, ADAP is funded with both Ryan White federal dollars and state appropriations.

[1] https://www.healthcare.gov/what-factors-affect-marketplace-health-plan-premiums/

As of January 1, 2014, approximately 90% of clients served by the North Carolina ADAP Pharmacy Program are eligible to enroll in health insurance coverage on the federally-facilitated health benefit exchange (Marketplace). However, approximately 65% of these clients will not be eligible for subsidies on the Marketplace because subsidies are not available for individuals with incomes at/below 100% of FPL. This renders insurance coverage on the Marketplace financially out of reach for these clients. Therefore, the need for federal Ryan White funds for both core medical and medication services will continue in our state.

HRSA does allow Ryan White funding (including ADAP funds) to be used to assist eligible clients with the costs associated with insurance coverage if they are cost neutral on the aggregate level compared to the cost per client for ADAP. HRSA encourages cost saving strategies such as covering insurance-associated costs to ensure that all clients eligible for Ryan White programs can maintain access to care. HRSA also recommends coordination with insurance coverage (through the Marketplace or with other private insurance), including paying cost sharing or premiums or both. A number of states are pursuing these options.

Under federal law, states are required to expend state appropriations as matching funds up to a maximum amount of one state dollar for every two federal Ryan White Part B dollars (the rate that applies to North Carolina). Maintenance of effort (MOE) requires that all Ryan White Part B grantees contribute at least the same amount of state funds for HIV-related activities as the previous fiscal year. Last year 8,042 people living with HIV in North Carolina received medical care, medical case management and supportive services through regional networks of care funded through these federal Ryan White funds. 6,876 people were provided medication by ADAP.

Alternative Options for Serving ADAP Clients

Medicaid

ADAP applicants are required to apply for Medicaid before they can be determined eligible for ADAP. ADAP is administered through the federal Ryan White program, which is a payer of last resort. Applicants who are enrolled in Medicaid are not eligible for ADAP.

DPH currently verifies client Medicaid eligibility during federally-required ADAP reauthorizations twice annually. If an ADAP client becomes eligible for Medicaid or other insurance (with medication coverage) between reauthorization periods, the client should be removed from ADAP immediately. If the contracted vendors (pharmacy or PBM) identify through their own historical records that a client has other payment sources, the contracted vendor notifies ADAP and the client's eligibility status is reviewed. DPH also performs eligibility reviews on a random sample of clients on a quarterly basis.

Enhanced collaboration and data sharing between DHHS' Divisions of Medical Assistance and Public Health will produce more frequent monitoring of ADAP clients' eligibility for Medicaid coverage to ensure ADAP clients are transitioned to full Medicaid coverage and to ensure ADAP is the payer of last resort.

Federally Facilitated Health Benefit Exchange (Marketplace) Options

In the Marketplace, subsidies and cost-sharing reductions are based on annual income as reflected in the following table:

Income (% FPL)	Contribution (% Income) to Premium	Contribution (% Income) to Cost-sharing
100 – 133	2	6
134 – 150	3 – 4	6
151 – 200	4 – 6.3	13
201 – 250	6.3 – 8.05	27
251 – 300	8.05 – 9.5	30

Approximately 35% of clients on APP (or 2,000 individuals) are likely to be eligible for federally funded subsidies to assist in paying monthly premiums or cost sharing (co-pays, co-insurance and deductibles) or both for Marketplace plans. Options for these clients are:

- ADAP clients with incomes between 100-250% FPL are eligible for subsidies to assist with premiums and cost-sharing
- ADAP clients with incomes between 250-300% FPL are eligible for premium-only subsidies.

ADAP staff created a matrix of all current ADAP pharmacy program enrollees by region, age and income. A preliminary analysis was conducted to examine possible savings that could be realized by offering ADAP clients options to use the Marketplace plans instead of receiving only ADAP coverage. The options explored were:

Option 1 - ADAP pays only medication cost-sharing (similar to the SPAP for Medicare eligible ADAP clients); and
Option 2 - ADAP pays insurance premiums in addition to medication cost-sharing.

Assumptions for this preliminary analysis were:

- Only Blue Cross Blue Shield (BCBS) Advantage plans from the Marketplace were factored into this analysis since Advantage plans are available in all 100 counties and offer the broadest network that includes current Ryan White providers of HIV/AIDS care. (In North Carolina, there are currently two insurance carriers offering QHPs in the federally facilitated Marketplace: Blue Cross Blue Shield of NC (BCBSNC) and CoventryOne. BCBSNC is offering three plan types (Blue Advantage, Blue Select, Blue Value) for a total of 26 different plans. Blue Advantage plans are covered by a large, preferred-provider network (PPO) and are available in all metal levels, as well as catastrophic. Blue Select plans are covered by a tiered benefit network and are only available in Silver and Gold. Blue Advantage and Blue Select plans are offered in all 100 counties of the state. Blue Value plans are covered by a limited, point of service provider network and are available in all metal levels, as well as catastrophic. Blue Value plans are only available in 28 counties. CoventryOne is also offering three plan types, for a total of 25 different plans. However, CoventryOne only covers 39 counties and does not offer the Platinum plan option.)

- Tobacco use could not be taken into account in either option since ADAP does not collect this data. ACA allows up to a 20% premium surcharge on tobacco users; however, the impact of the surcharge could be greater than 20% because it is calculated based on the pre-subsidized premium.
- All preliminary analyses were based on 2014 pricing for premiums, deductibles and surcharges currently available. These costs are likely to increase over time.

Results of this preliminary analysis are as follows:

- For Option 1 (ADAP pays only medication cost-sharing. This includes deductibles, coinsurance and copayments):
  - Depending on the plan selection that clients make, ADAP staff estimated the program could realize between $9M and $36M in savings, secondary to broad variability of costs related to age, county of residence, tobacco use and family size. Given this degree of cost variance, actuarial analysis is needed to provide more comprehensive projections to better evaluate cost savings using this approach.
  - The advantages of this option are likely significant annual savings to ADAP. This option also puts HIV medication within reach of individuals, if they are able to afford their premiums.
  - Disadvantages include the possibility that clients will find premiums are still unaffordable and therefore they might choose not to participate. Also, until clients reach their maximum out of pocket costs (MOOP), they must continue to pay all cost-sharing for all other coverage except medication. This could be a deterrent to enrollment.

- For Option 2 (ADAP pays insurance premiums and medication cost-sharing):
  - For every combination of age, region and income, ADAP staff selected the BCBS Advantage Plan with the lowest annual cost (combined premiums and cost-sharing).
  - Preliminary analysis indicated the program could realize as much as $10M in savings if all ADAP clients were covered in this manner. This option could result in savings even while paying both premiums and cost sharing because all clients are subject to a maximum out of pocket cost (MOOP) of $6,350 or less. Age and income of clients affect the price of monthly premiums. However, at the aggregate level, preliminary analysis shows the total cost of providing this option is still a potential cost savings for ADAP since current annual cost per enrollee is approximately $7,836/year.
  - This option is more complex and is the basis of Phase 2 of a potential pilot described below. Actuarial analysis is needed to provide more comprehensive projections to better evaluate cost savings using this approach.
  - Should actuarial analysis indicate that Option 2 is not cost neutral at the aggregate level, this option would not be a viable alternative.

Methods for Exploring Alternatives Options for Serving ADAP Clients

A two year insurance completion pilot could be implemented to assess the feasibility and impact of coordination with insurance available through the federal Marketplace. During the pilot, ADAP funds could be used to pay for the costs associated with insurance. This is allowable under federal law if doing so is cost neutral. Such a pilot could roll out in two phases.

Phase 1

- Would begin during open enrollment for the Marketplace for coverage in calendar year 2015 (open enrollment begins fall 2014).
- Would begin after an actuarial analysis determines at least cost neutrality to ADAP and a cost sharing payment system is put in place.
- Allows up to 1,000 ADAP clients to enroll in an insurance plan of their choice through the Marketplace.
- Clients would be responsible for their premiums and the program would cover all medication cost-sharing (medication co-payments, medication co-insurance, medication payments toward deductibles, and medication payments during coverage gaps) up to the maximum out of pocket cost limit for Marketplace plans (currently $6,350, as compared to current annual cost per ADAP enrollee of approximately $7,836).
- Would be preceded by enrollment of a small number of clients to test payment systems and projections.

The use of ADAP dollars to fund only medication cost sharing (not premiums) is consistent with the program benefits currently available in the SPAP (for Medicare Part D recipients).

Phase 2

- Would cover premiums as well as all medication cost sharing for up to 2,000 ADAP clients.
- Would not begin until Phase 1 is successfully implemented, an actuarial analysis determines at least cost neutrality to ADAP, and a premium payment system is put in place.

ADAP already contracts with a pharmacy benefits manager (PBM) for SPAP that is capable of managing the required coordination of benefits for both proposed phases. In order to implement Phases 1 and 2 of a pilot, the program would need to amend the existing PBM contract.

Throughout the pilot, ADAP would use the services of an actuary to analyze the multiple factors that influence cost neutrality and/or savings prior to implementation of each phase. Actuarial analysis would assess cost neutrality, participant utilization, participant feedback and health outcomes at the end of 2014 and 2015.

Upon completion of a successful pilot, consideration could be given to permanent implementation of the insurance completion program with the flexibility to change the program based on lessons learned during the pilot, in order to manage the program as efficiently as possible.

An additional alternative for serving ADAP clients would be changing the ADAP income calculation used for eligibility determination (program-wide, including Ryan White Part B). The income calculation known as MAGI (Modified Adjusted Gross Income) is the required calculation for ACA. The federal government already strongly recommends using MAGI and is likely to begin requiring it for Ryan White programs (including ADAP) in 2015. NC Medicaid is already using MAGI. A change to MAGI will impact ADAP eligibility, and therefore enrollment, but it is likely to be minimal. ADAP currently does not collect all of the necessary information to determine MAGI because it currently uses gross income for ADAP eligibility determination. As of the date of this report, approximately 2.5% of clients enrolled in ADAP have incomes between 251% and 300% FPL, and it appears this is the segment of the population

that is most likely to be impacted by moving to MAGI. Of this income group, only 16.5% have household sizes that might be affected, although some of these are still likely to be unaffected. A detailed cost analysis completed prior to such a change, to determine estimated cost to implement, must occur.

DHHS is committed to exploring effective and efficient strategies for enabling people living with HIV/AIDS to have access to care and treatment services regardless of their income. While changes in funding care delivery programs are occurring nationwide, North Carolina's HIV/AIDS prevention and care strategies and services should be considered foundational to comprehensive plans to end the spread of HIV and AIDS. Our ADAP and Ryan White networks of care are implementing nationally recognized services to qualified HIV positive patients in order to achieve viral suppression. The viral suppression success rate among ADAP clients is more than twice that of the general HIV positive population, reducing medical complications and costs and preventing disease transmission. Continued state investment in ADAP and support for the continuation of Ryan White federal dollars to augment the state's HIV/AIDS prevention, care and treatment programs remain critical in the fight against HIV.