AAHIVM
AMERICAN ACADEMY OF HIV MEDICINE

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July 26, 2007

The Honorable John Dingell
Chairman
House Ways and Means Committee
2125 Rayburn House Office Building
Washington, DC 20005

The Honorable Charlie Rangel
Chairman
House Energy and Commerce Committee
1102 Longworth House Office Building
Washington, DC 20005

The Honorable Frank Pallone
Chairman
Health Subcommittee
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20005

The Honorable Pete Stark
Chairman
Health Subcommittee
House Ways and Means Committee
1135 Longworth House Office Building
Washington, DC 20005

Chairmen Dingell, Rangel, Pallone and Stark:

The American Academy of HIV Medicine (AAHIVM) would like to thank the House Ways and Means Committee for drafting such a courageous health care bill as the Children's Health and Medicare Protection (CHAMP) Act. We endorse this bill and heartily support its immediate passage by the House. AAHIVM represents 2000 physicians, physician assistants, and nurse practitioners who specialize in HIV medicine.

This bill would significantly cover more children who are in need of health care, while also enhancing the larger Medicare and Medicaid programs for many other populations, such as those with disabilities. We are particularly grateful for those changes that will improve access to lifesaving care and treatment for people living with HIV/AIDS across the U.S. and are further supportive of the many other provisions in the bill that improve the Medicaid and Medicare for low-income and disabled populations for whom often no other healthcare safety net exists.

Moreover, we are impressed by your diligent attention to binding pay-go rules by finding opportunities and offsets to pay for these needed enhancements towards better health care coverage for those most in need.

AAHIIVM has been on the record before and again endorsing the equalization of payments between Medicare Advantage plans and fee-for service Medicare. The majority of low-income Medicare beneficiaries with HIV/AIDS prefer the security and stability of the traditional Medicare program and the current overpayment for Medicare Advantage plans has unfairly increased their Part B premiums.

The American Academy of HIV Medicine is also pleased to see a provision in this bill to protect Medicare reimbursements for physicians at their current level. Physician compensation already represents a dire hindrance in the domestic battle against HIV/AIDS, as doctors are not making enough money to keep their practices afloat. Specific to Medicare, a significant proportion of care and treatment for people with HIV disease is performed under the Medicare delivery system. Nearly 20% of all federal spending on HIV care and treatment is expended through the Medicare program, and yet less than 2% of total HIV Medicare payments or only $360/patient annually, goes towards paying health care providers[1]. For these and other reasons, fewer clinicians are choosing HIV medicine as a specialty, while the number of patients continues to grow[2].

This bill includes a number of additional provisions of particular importance to persons living with HIV/AIDS and other vulnerable populations including:

Section 221 – Including costs incurred by AIDS Drug Assistance Programs (ADAPs) and Indian Health Service in providing prescription drugs toward the annual out of pocket threshold under Part D. This policy change is one of the HIV community's highest priorities and we were pleased to see its inclusion. ADAPs are state and federal discretionary funded programs of Ryan White that are the safety net under Medicare and Medicaid. ADAPs may wrap around Medicare Part D by helping people with HIV/AIDS cover deductibles, coinsurance and co-payments, but these costs have been barred from counting toward TrOOP. ADAPs' supplemental coverage is vital to beneficiaries who do not qualify for the low income subsidy and who face co-payments as high as $200 or $400 a month per prescription for their HIV drugs. This provision will ensure that Medicare beneficiaries are protected, while allowing ADAPs to maximize the reach of their limited funds. For every dollar that Medicare catastrophic coverage pays for, there is an increased ADAP dollar to provide life-saving HIV medications for other uninsured or underinsured people living with HIV/AIDS.

Section 225 – Codification of special protections for six protected drug classifications, including HIV Antiretrovirals. Another of our highest priorities, we appreciate the strengthening of protections for Medicare beneficiaries with HIV/AIDS and other serious conditions by codifying the requirement that Medicare Part D plans cover "all or substantially all" drugs in the six classes of drugs that are critical to treating HIV/AIDS, mental health conditions, cancer, epilepsy, and autoimmune diseases. The current protections offered through CMS guidance are not guaranteed beyond the current year and are being ignored by drug plans with little censure. In a survey of HIV medical providers, 54% reported that they cared for Medicare beneficiaries with HIV/AIDS who had gone without antiretrovirals due to challenges with Part D coverage. Historically, private insurers nationwide have recognized the importance of providing uninterrupted and unrestricted coverage of antiretrovirals and the other drug classes by including nearly all of the drugs in these classes on their formularies.

Other critical inclusions include:
Section 133 – State option to expand or add coverage of certain pregnant women under CHIP. Expanding access to prenatal care for pregnant women is critical to eliminating nearly all perinatal transmission of HIV/AIDS in the U.S. While perinatlly acquired AIDS cases have declined by 94 percent since 1992, access to prenatal care is the greatest barrier to reducing the number of case even further.

Section 203 — Parity for mental health coinsurance.
Under current law, Medicare cost-sharing for outpatient mental health services is 50%, compared to 20% for most other services. This provision would phase down cost-sharing for mental health services by 5% per year, starting in 2008 until it reaches parity with 20% cost-sharing for physical health services.

Section 211 — Improving assets tests for Medicare savings program and low-income subsidy program
This provision Increases the low-income subsidy (LIS) resource standard to $17,000 for a single individual ($34,000 for couples) for Parts B and D. Starting in 2010, the limit increases annually by $1,000 per individual and $2,000 per couple.

Section 215 — Elimination of part D cost-sharing for certain non-institutionalized full-benefit dual eligible individuals
We were pleased to see this provision as well which eliminates Part D cost-sharing for full-benefit dual eligibles in community settings who, but for the provisioning of home- and community-based care would require nursing facility care. Applies to persons covered under section 1915 (both HCBS waivers and HCBS option) and 1115 waivers.

Section 217 -- Cost-sharing protections for low-income subsidy-eligible individuals. People living with HIV/AIDS generally depend on access to 8 to 14 prescriptions a month to suppress HIV, manage treatment side effects and manage co-occurring conditions. Co-payments and other cost sharing, disproportionately burden people who are the sickest, the most in need of drugs and struggling to live on very low monthly incomes that range from $600 to $1,200.

Section 222 – Permitting mid-year changes in enrollment for formulary changes that adversely impact an enrollee. Although plans are required to cover all or substantially all antiretrovirals, people living with HIV/AIDS take multiple medications in other classes, and this protection is needed if mid-year formulary changes threaten their access to these drugs.

Section 223 – Removal of exclusion of benzodiazepines from required coverage under the Medicare prescription drug program. Benzodiazepines are typically low-cost medications commonly used by individuals

with mental illness, which is a common co-occurring condition for persons living with HIV. This change will ensure that individuals can access these drugs under Part D on par with other medication classes.

Section 401 — Equalizing payments between Medicare Advantage plans and fee-for-service Medicare
This important provision phases out the overpayment to Medicare Advantage plans over four years from 2008-2011. The Medicare Advantage overpayment policy harms people who prefer to remain in the traditional Medicare program by artificially increasing their Part B premiums. This change would implement a critical recommendation from the Medicare Payment Advisory Commission (MedPAC). Also this section eliminates remaining spending authority in 2012 and 2013 under the regional PPO stabilization fund.

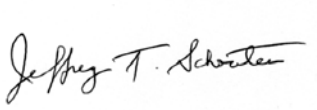
Section 803 — Authority to continue providing adult day health services approved under a State Medicaid Plan
In the past, the adult day services programs for people with intellectual and other developmental disabilities were covered under the Medicaid rehab option. In 1989, the Congress imposed a moratorium on states adding rehab option coverage of adult day services for these populations, but permitted states with these programs to continue operating them. Recently, the ability of states with these programs to continue operating them has been challenged by CMS when they have sought to make other changes to their Medicaid state plan. The CHAMP Act prohibits the Secretary of HHS from withholding, suspending, disallowing, or otherwise denying matching Medicaid payments to states for providing adult day services under their state plan that was approved during or before 1994.

Section 804 — State option to protect community spouses of individuals with disabilities
This provision clarifies that states have the option to protect the community spouses of individuals with disabilities who are participating in home- and community-based services programs under section 1915 (including the HCBS option) and persons covered by 1115 waivers. This addresses a problem faced by New York in which, in a reversal of longstanding policy, CMS has told the state that they cannot extend spousal impoverishment protections to medically needy home- and community-based services (HCBS) waiver participants. This provision restores the previous policy and has implications for all states wishing to protect spouses of people receiving community-based long-term services.

Section 814 — Moratorium on certain payment restrictions
Finally, we support this provision which Imposes a one year moratorium from the date of enactment that prohibits the Secretary from taking any action (through promulgation of regulation, issuance of regulatory guidance, use of federal payment audit procedures, or other administrative action, policy, or practice, including a Medical Assistance Manual transmittal or letter to State Medicaid directors) to restrict coverage or payment for rehabilitation services, or school-based administration, transportation, or medical services if such restrictions are more restrictive in any aspect than those applied to such coverage or payment as of July 1, 2007.

This bill includes significant enhancements to the delivery of HIV clinical care to our patients. We thoroughly endorse its passage and once again, congratulate its authors for its clear vision for American children and others in need. We look forward to working with you and the Senate for the passage of this bill as well as the later passage of the Early Treatment for HIV Act (ETHA) at another point in this Congressional session. If we may be of service to you as this process continues, please contact Greg Smiley, Director of Public Policy for AAHIVM, at (202) 659-0699 or greg@aahivm.org.

Sincerely,



Jeff Schouten, M.D.
Chair
American Academy of HIV Medicine

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[1] Cubanski J, Neuman T, Kates J , Carbaugh A, Han E. The role of Part D for people with HIV/AIDS:coverage and cost of antiretrovirals under Medicare Drug Plans. Kaiser Family Foundation, July 2006; Presented: President's Advisory Council on HIV/AIDS, 2006.

[2] Saag M. Ryan White Care Act Reauthorization: we need help. Topics in HIV Medicine, IAS-USA;14:93-4, 2006.