

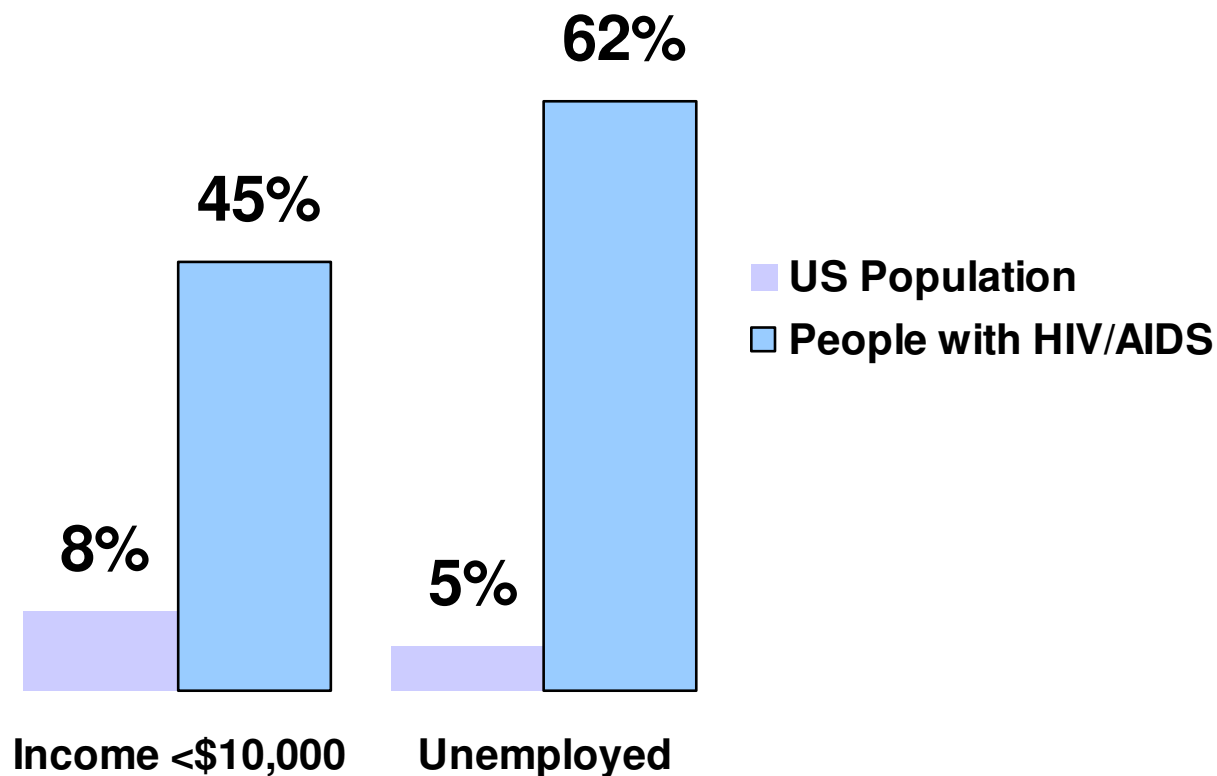
# HIV and Health Care Reform

PACHA - March 24, 2009

Andrea Weddle, HIV Medicine Association

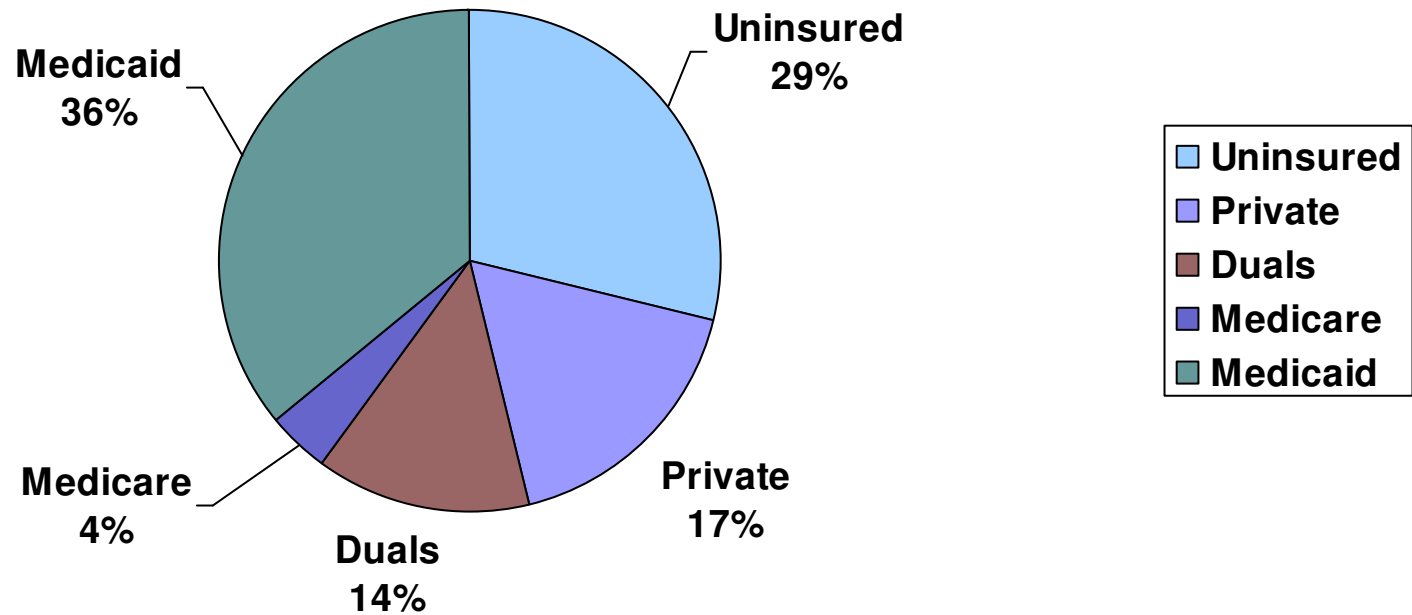
Laura Hanen, National Alliance of State and  
Territorial AIDS Directors

# U.S. Population and People with HIV/AIDS: Income & Unemployment



SOURCE: Kaiser Family Foundation based on US Census Bureau, 2006; Kaiser State Health Facts Online; Cunningham WE et al. "Health Services Utilization for People with HIV Infection Comparison of a Population Targeted for Outreach with the U.S. Population in Care." *Medical Care*, Vol. 44, No. 11, November 2006. NOTE: US income data from 2005, US unemployment data from 2006. 1998 estimates were also 8% and 5%, respectively, rounded to nearest decimal; HCSUS data from 1998.

# Health Care Coverage of People with HIV/AIDS



SOURCE: Kaiser Family Foundation based on Fleishman JA et al., "Hospital and Outpatient Health Services Utilization Among HIV-Infected Adults in Care 2000-2002, Medical Care, Vol 43 No 9, Supplement, September 2005.; Fleishman JA, Personal Communication, July 2006

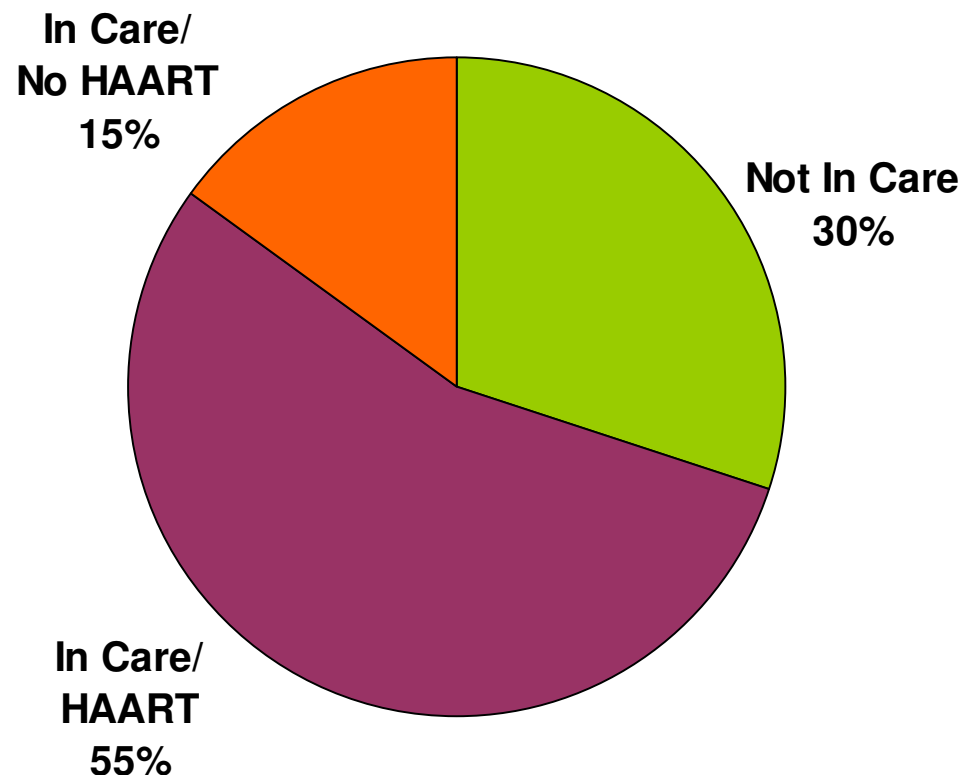
## Disparities in Access to Care: HCSUS Findings

- **HCSUS: nationally representative sample of HIV-infected patients that were interviewed over a three-year period beginning in 1996.**
- **Less likely receive ARV therapy if African American or Hispanic or uninsured or on public insurance**
- **Other factors affecting access to ARV therapy:**
  - Geography (more difficult in rural areas)
  - Race/ethnicity of physician
  - Ability to meet basic needs, eg, food, housing
  - Co-occurring conditions
  - Case management services

Source: Rand Corporation. *Disparities in Care for HIV Patients*, 2006. Online at [www.rand.org](http://www.rand.org).

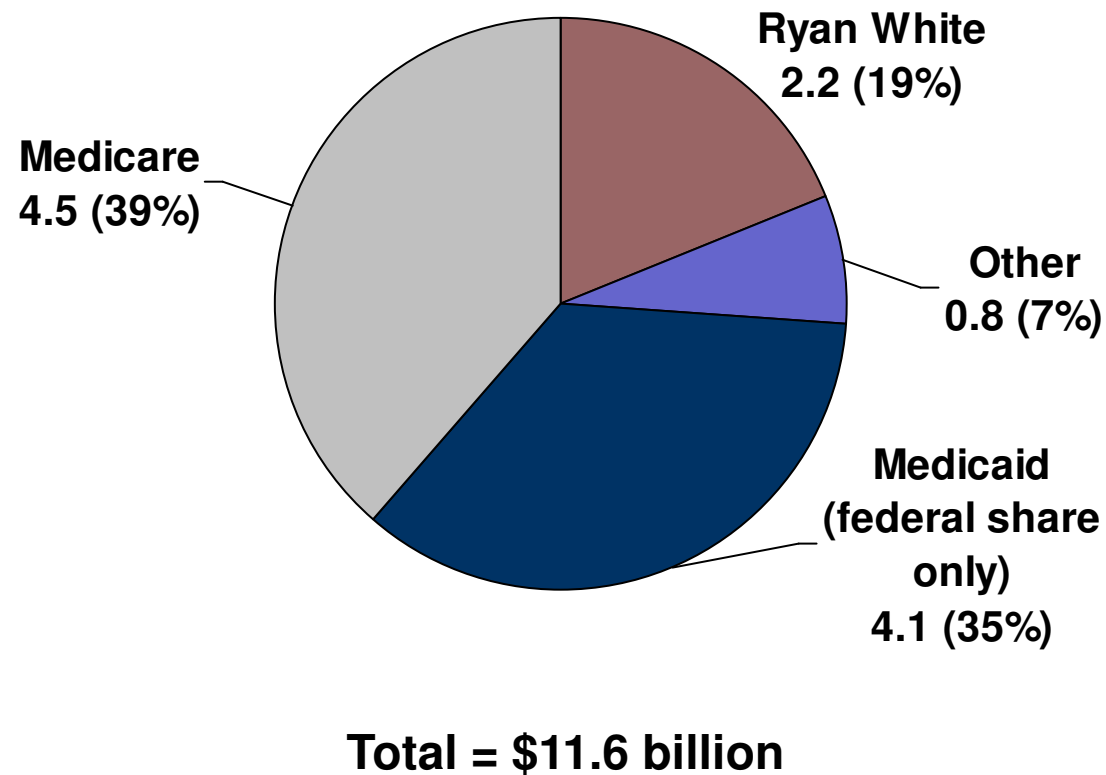
# In & Not in Care: Receipt of HAART by Those Eligible for HAART, 2003

Of those aged 15-49 estimated to be eligible for HAART



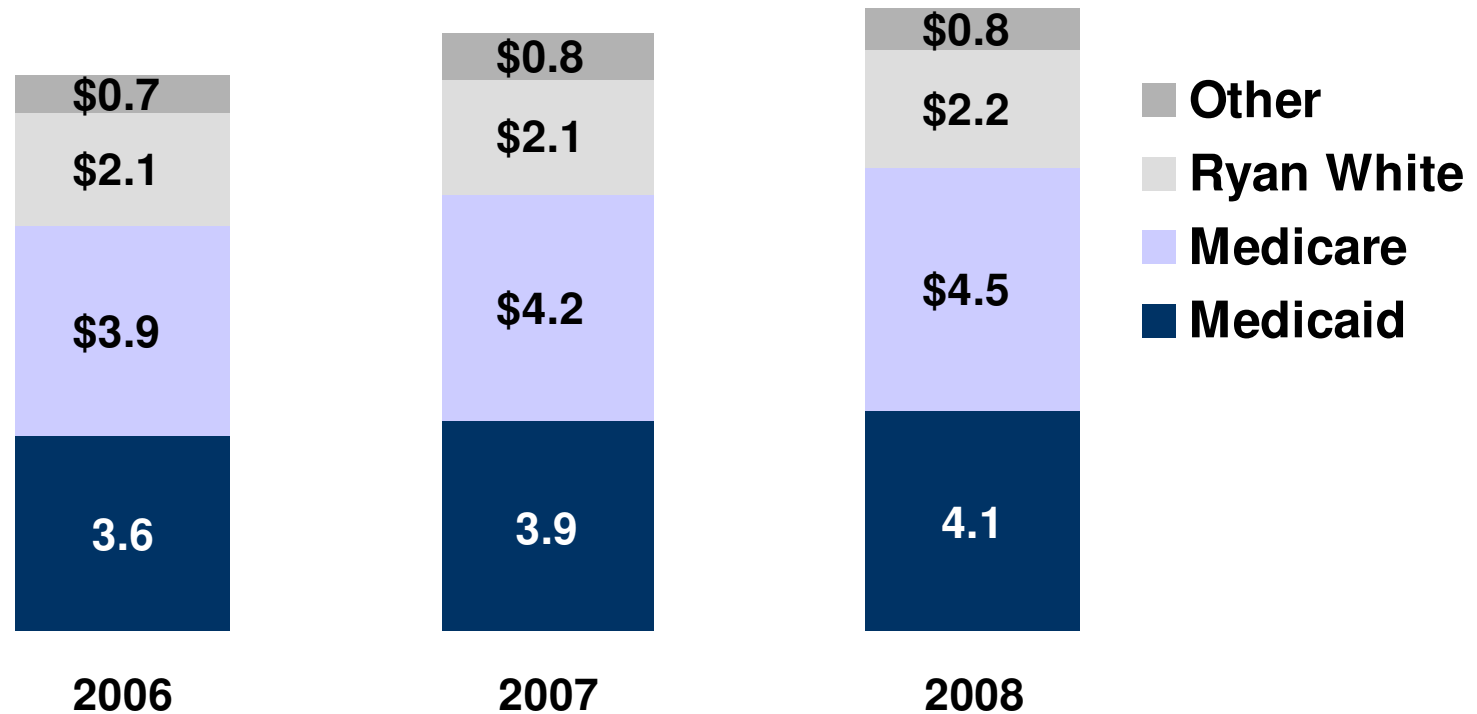
Source: Teshale EH et al., "Estimated Number of HIV-infected Persons Eligible for and Receiving HIV Antiretroviral Therapy, 2003--United States", Abstract #167, 12th Conference on Retroviruses and Opportunistic Infections; February 2005

# Federal Funding for HIV/AIDS Care by Program, FY 2008 (in billions)



Sources: OMB, CMS Office of the Actuary, HHS Office of Budget, 2008; CRS. AIDS Funding for Federal Government Programs: FY1981–FY2009, April 2008; KFF. Fact Sheet: U.S. Federal Funding for HIV/AIDS: The FY 2009 Budget Request; April 2008.

# Federal Spending on HIV Care Through Medicaid, Medicare, and Ryan White, FY 2006-2008 (in billions)



Sources: OMB, CMS Office of the Actuary, HHS Office of Budget, 2008; CRS. AIDS Funding for Federal Government Programs: FY1981–FY2009, April 2008; KFF. Fact Sheet: U.S. Federal Funding for HIV/AIDS: The FY 2009 Budget Request; April 2008.

# Medicaid and HIV

- Largest provider of care to HIV population
  - Covers 1 in 4 persons with HIV receiving care
  - Covers ≈200,000
  - Estimated federal spending of \$4.1 billion in FY2009
- Covers ≈ 55% of adults living with HIV/AIDS and 90% of children and youth
- Provides prescription drugs, an optional benefit

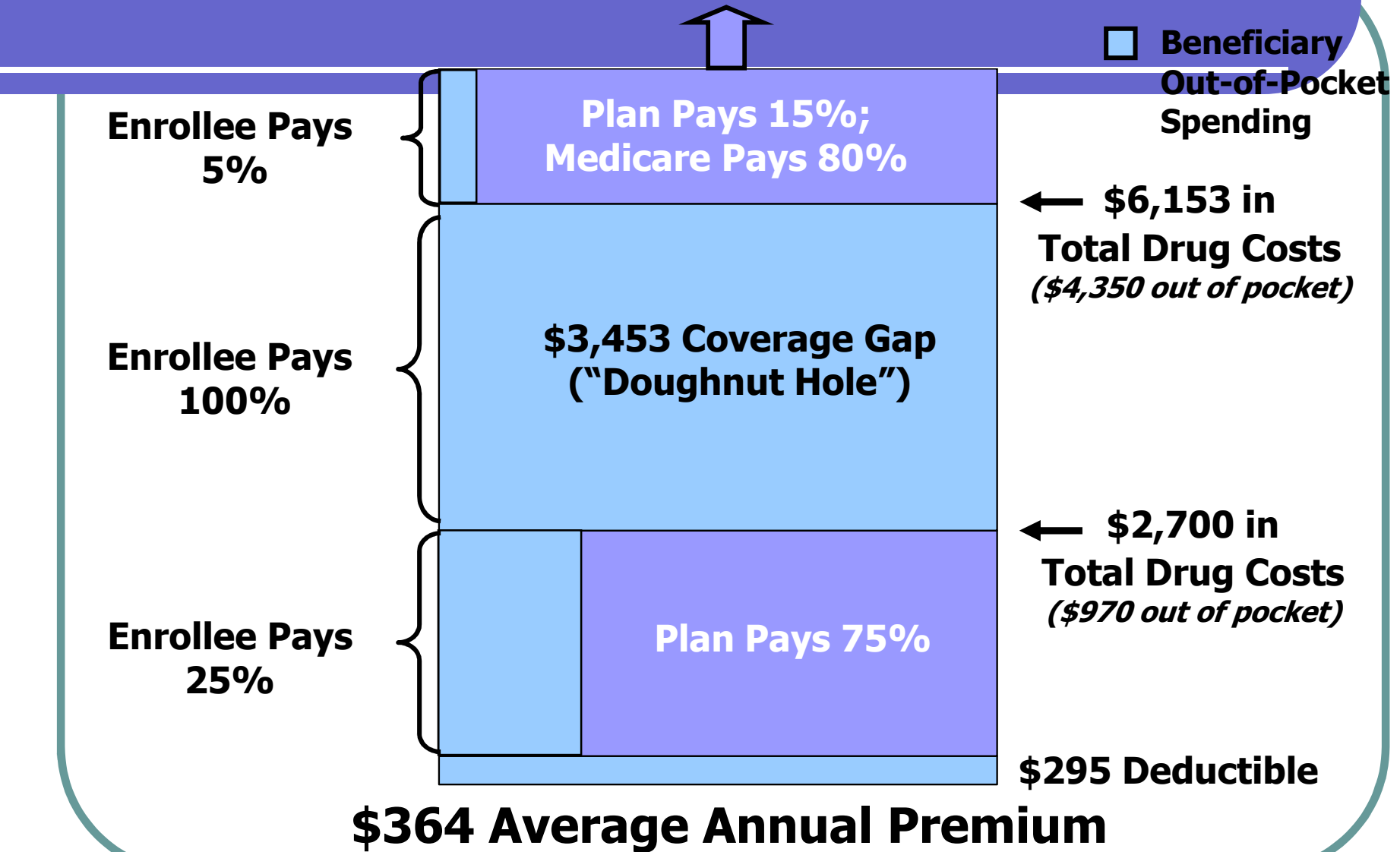
# Medicaid Eligibility for People with HIV

- Two main groups of coverage: Mandatory and Optional
- Majority of HIV-positive individuals covered under mandatory population
- Eligible for mandatory population by being disabled AND low-income
- HIV diagnosis does not make you eligible for Medicaid
- Must have AIDS diagnosis to be considered “disabled” for Supplemental Security Income
- Catch 22

# Medicare - Overview

- Medicare is second largest source of HIV/AIDS coverage
  - Serves  $\approx$  100,000
  - CMS estimates \$4.5 billion in FY2008
- 80% jump from 1997-2003 in number of Medicare beneficiaries with HIV
- Majority of Medicare beneficiaries with HIV/AIDS qualify through SSDI
- Medicare beneficiaries more likely to be male, under age 65 and disabled, black and live in urban areas
- 5-month waiting period for SSDI benefits
- 24-month waiting period for SSDI beneficiary to get on Medicare

# Standard Medicare Prescription Drug Benefit, 2009



Note: Annual premium amount based on \$30.36 national average monthly beneficiary premium. Amounts are rounded to nearest dollar.

SOURCE: Kaiser Family Foundation illustration of standard Medicare drug benefit for 2009.

# Medicare Part D

- Majority of HIV-positive Medicare beneficiaries are dual-eligibles
- All plans must cover all antiretrovirals (ARVs) in all formulations
  - Prior authorization not allowed on ARVs
- Plans have complete control over tier placement of drugs
- Many ADAPs provide wrap-around services to Medicare eligible clients
  - Pay premiums and co-pays, cover expenses once in donut hole
  - ADAP expenses don't count towards TrOOP therefore individual doesn't reach the catastrophic limit
  - ADAPs only cover drugs on their formulary

# Medicaid and Medicare

## **MEDICAID:**

Needs Based Entitlement Program

Eligibility for disabled w/ low-income, few assets, citizenship, state residency AND disability

Program varies by state

Primary entry for PWHIVs is SSI

## **MEDICARE:**

Entitlement Insurance Program

Eligibility for disabled based on work history

2 year waiting period post eligibility

Primary entry for PWHIVs is SSDI

***Both programs have the same cruel disability standard:  
You have to get sick and disabled to get  
access to the health care services that could have  
prevented you from getting sick in the first place.***

## We have a disability care system, not a health care system!

- The two primary publicly funded health care programs don't provide care that meets the U.S. government's own HIV treatment guidelines.
- To get access to almost  $\frac{3}{4}$  of the pie chart -- you have to get sick and disabled in order to get the care and medications that could have kept you healthy.
- This is the primary barrier.

# Ryan White Program

- Serves over 500,000 people
- Only health program for non-disabled people with HIV
- Funding is not keeping up with need
- Can't meet all the health care needs of people with HIV/AIDS through an annual, discretionary funded program

# Moving Forward:

- **Recommendations for Improving Access to Health Care for People with HIV/AIDS**
  - **Adapted from HIV Health Care Access Working Group's 2009 Principles and Platform**

# Start with Federal Programs: Promote Health Rather than Disability

## Medicare

- Eliminate 2-year waiting period for health coverage
- Offer buy-in option to younger populations

# Make Medicare Part D Work for People with HIV/AIDS

- Eliminate cost sharing barriers
  - Allow ADAP to count as TrOOP
  - Modify specialty tier status
  - Impose cap on cost sharing
- Continue formulary protections for drug classes critical to vulnerable populations
- Eliminate or reduce burdensome prior authorization requirements
- Subsidize a mandatory enhanced Medicare Part D option to offer comprehensive coverage for generic and brand name drugs with no coverage gap

## Promote Health Care Access: Medicaid

- Eliminate categorical eligibility for Medicaid, e.g., expand to all low-income regardless of disability status
- Increase income eligibility for Medicaid up to 200% federal poverty level (around \$22,000 per year)
- Enact Early Treatment for HIV Act to offer enhanced federal support and ensure adequate eligibility and coverage for people with HIV

## Meaningful Coverage is Key

- Use HIV as a benchmark - a system that meets needs of PWAs will meet needs of anyone in the U.S.
- Comprehensive benefits critical to retain PWA in care, support adherence, and treat co-morbid conditions
- Treatment costs are 2.6 times higher per year at later stages of HIV disease

## Promote Earlier Diagnosis and Access to HIV Care

- Require coverage for voluntary, routine HIV testing in standard preventive services package for private insurers
- Incorporate prevention benefit into Medicaid, mandate coverage for routine HIV testing
- Cover voluntary, routine HIV testing under Medicare

# Opportunity to Prevent Comorbidities

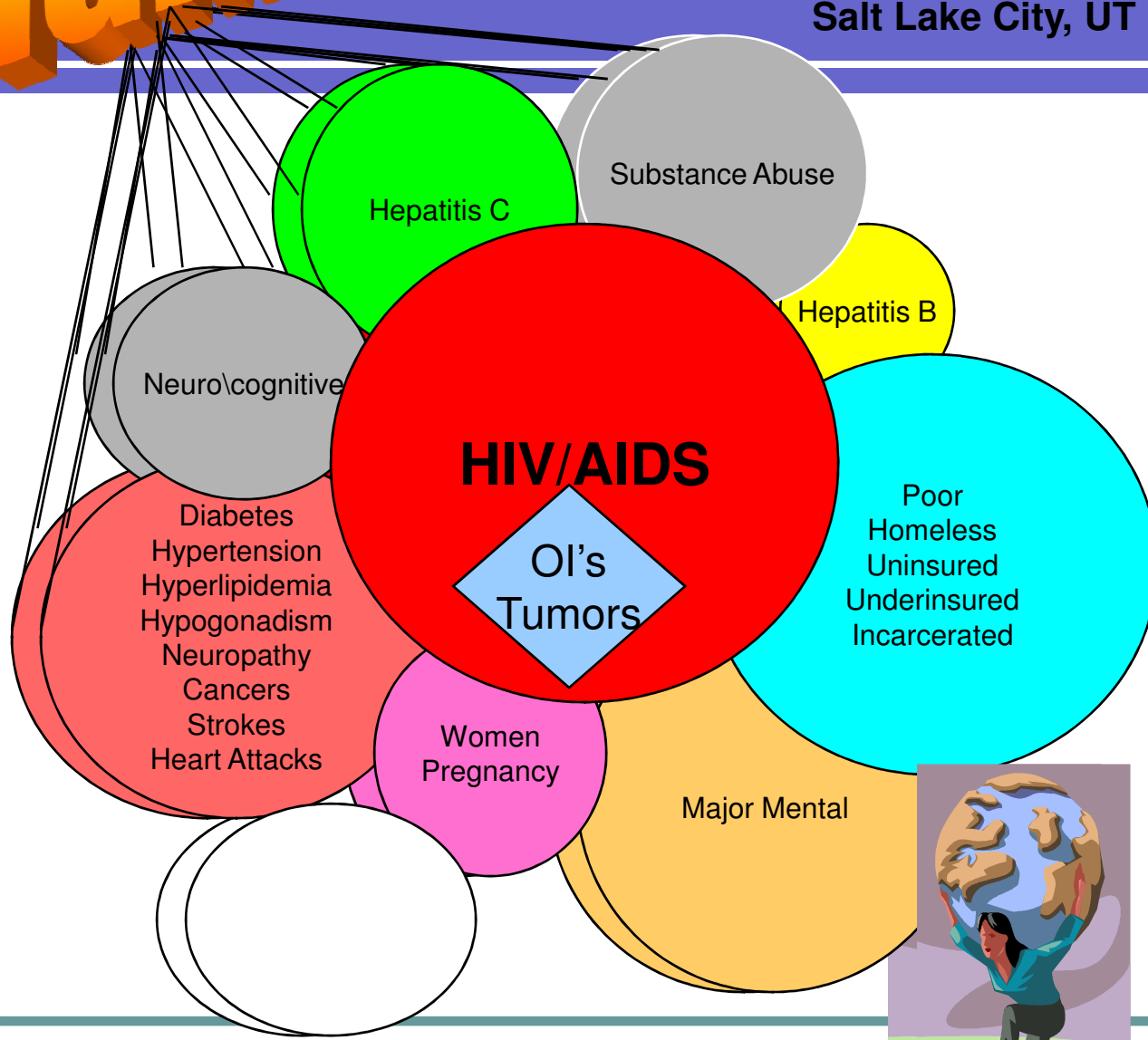
- At least 25% PWA have hepatitis C; 10% hepatitis B
- Prevention benefit for PWA should cover
  - Hepatitis A and B vaccination
  - Hepatitis C screening

## Build On What Works: Ryan White HIV Clinics and Programs

- Ryan White helped us develop coordinated, comprehensive HIV care programs, i.e., medical homes for people with HIV/AIDS
- Integrate these programs into the reformed system
- Develop reimbursement systems to adequately support and improve access to these programs
- Use as a model for other chronic conditions

# STIGMA

Developed by Kristen Ries MD,  
Division of Infectious Diseases  
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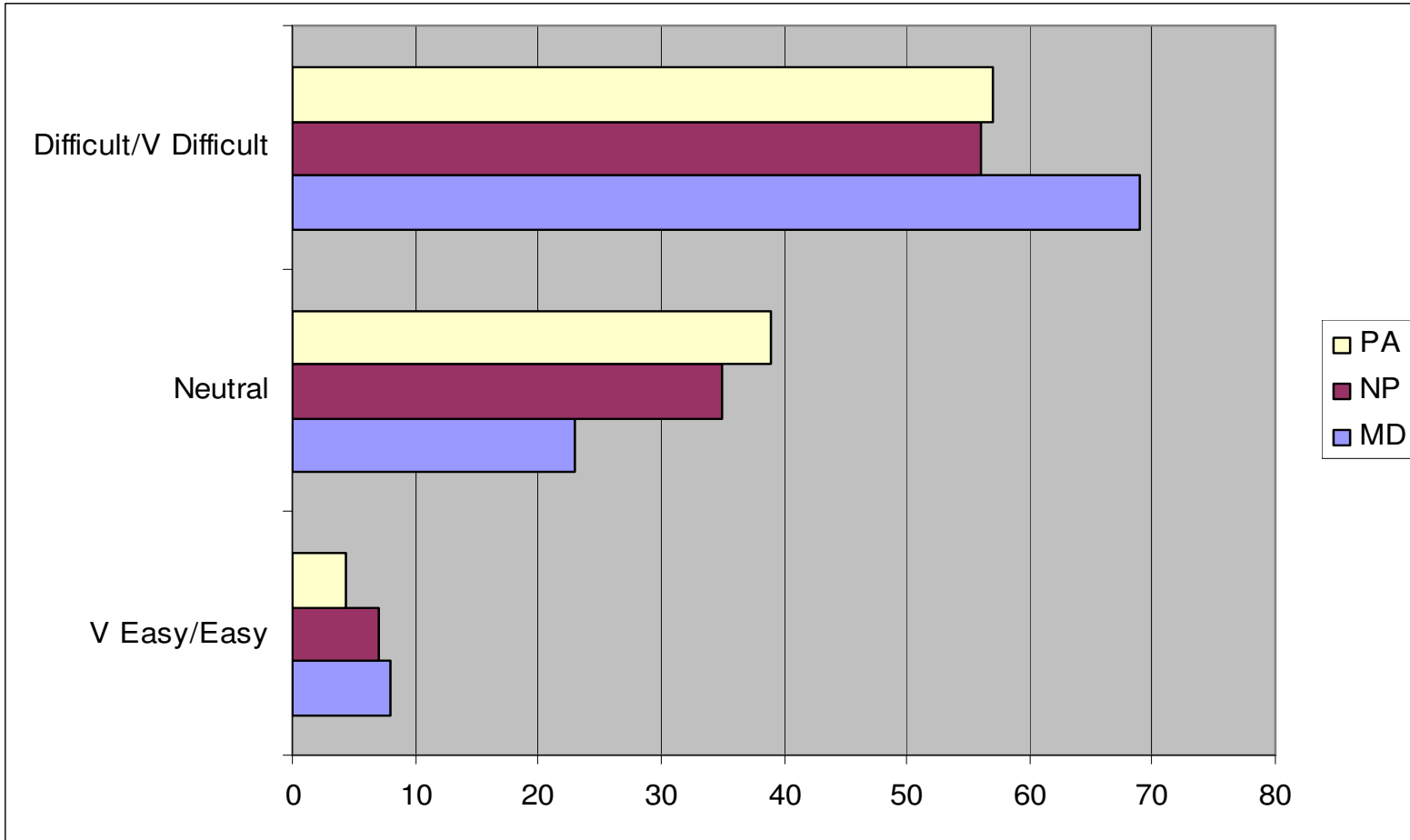
KMR



# What Makes Them Work

- Flexible funding
- Multi-disciplinary care teams including experienced HIV medical providers
- Provide (or coordinate access to) comprehensive medical and social services
- Culturally competent and dedicated staff

## How difficult is it for Ryan White Part C programs to recruit primary care providers? (%)



**NOTE:** Results from a survey of Ryan White Part C grantees conducted in summer 2008. Seventy percent of the 363 Ryan White Part C grantees (252) responded and are included in the analysis.

# Addressing the HIV Medical Workforce Crisis

- Integrate HIV medical workforce issues into primary care workforce initiatives
- Offer loan forgiveness for working in Ryan White-funded clinics, e.g., National Health Service Corps
- Conduct national study to assess regional variations in need and to identify barriers
- Develop reimbursement systems that support specialized primary care

# Improve Access to Private Insurance

- **ACCESS**

- Ensure coverage regardless of health status
- Eliminate pre-existing conditions exclusions
- Ensure portability of coverage

- **AFFORDABILITY**

- Limit the cost of premiums
- Cap total out-of-pocket spending

- **COVERAGE**

- Comprehensive benefits package

➤ **Offer public insurance plan option**

# Contact Information

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