

AIDS Foundation

OF CHICAGO

Public Financing and the Delivery of HIV/AIDS Care: Securing the Legacy of Ryan White (2004)

Committee Goals

In response to the second reauthorization of the Ryan White Care Act (RWCA), the Institute of Medicine (IOM) was charged to convene an expert committee to look at the future of public financing and delivery of HIV care. Though the charge was framed within the context of the RWCA, the Committee on the Public Financing and Delivery of HIV care interpreted this charge as a challenge to set out a forward-looking vision for HIV care that meets the needs and makes the most of the opportunities presented by the third decade of HIV/AIDS and beyond.¹

The Committee's goals:

- Examine the feasibility of creating a publicly funded system of care that is accessible, equitable, cost-effective, of high quality, comprehensive, and easily negotiable.
- Assess the costs stemming from current barriers to care.
- Propose changes to financing system.
- Limit target population to low-income individuals with HIV/AIDS.
- Identify recommendations that are unencumbered by financing, delivery options, political feasibility or timeframe constraints.

Problems Identified

Before beginning the creation of a proposal, the Committee assessed the problems of the current system and the various barriers to care.²

Current system falls short:

- 20% of individuals with HIV/AIDS are uninsured
- 42% do not receive regular care
- Lack of sustained access to Highly Active Anti-Retroviral Therapy (HAART) for all those who need it
- Lack of access to food, transportation and housing services inhibits retention in medical care³
- Due to HAART, HIV/AIDS is now a chronic illness, not an acute terminal illness

Reasons identified:

- Current system fails to recognize that HIV/AIDS is a nationwide epidemic, not a state-by-state epidemic
 - AIDS Drug Assistance Program (ADAP) eligibility varies from state to state
 - Large disparities across states in care quality (types of drugs, number of prescriptions, in-patient/out-patient care, supportive services)
 - Varying state eligibility requirements for RWCA and Medicaid
 - All result in fragmentation of coverage (Recommendation 6)
- Enrollment caps in ADAP
- Difficult to find experienced providers under Medicaid, due to insufficient reimbursement levels (Recommendation 4)
- State Medicaid pays 33% more than FCP for antiretroviral medications⁴ (Recommendation 5)
- Multiple funding sources for care providers (Recommendation 1)

Goals of a Federal System of Care

The Committee determined the goals of a federal system of care to be:

- *To improve the quality and duration of life for those with HIV and promote effective management of the epidemic by providing access to comprehensive care to the greatest number of low-income individuals with HIV infection⁵*

¹ Executive Summary, pg. 4

² Ibid, pgs. 5-9, unless noted otherwise

³ Ibid, pg. 6

⁴ Ch. 6: Recommendations, pg. 172

- Ensure low-income HIV-positive individuals receive *early* and *continuous* access to a comprehensive set of medical and ancillary services that meet standard of care
- Promote delivery of high-quality services
- Facilitate the provision of services with a minimum of administrative costs
- Ensure accountability
- Provide uniform access to services⁶
- Reduce barriers in accessing services

Recommendations for Program

Though the Committee's charge came through the reauthorization of the RWCA, the members decided that adding to RWCA wasn't the answer. Therefore, the Committee proposed a new national entitlement program, called the HIV Comprehensive Care Program (HIV-CCP). Their recommendations⁷ covered seven core areas:

1. Nature of HIV-CCP⁸
 - Nationally funded *entitlement* program. *Entitlement* programs guarantee services to all who meet eligibility criteria, as opposed to *discretionary* programs like the RWCA that are appropriated a maximum amount of funds.
 - Administered at the state level
 - State participation would be voluntary
2. Eligibility⁹
 - HIV-positive status, rather than AIDS diagnosis
 - At or below 250% of Federal Poverty Level (\$8,980 for individual in 2003)¹⁰
 - Non-eligible (due to income) could pay adjusted premium
3. Comprehensive care¹¹
 - The Committee concluded that the clear delineation of a minimum benefits package is essential to an effective response to the epidemic. These benefits include:
 - Antiretroviral therapy and other medications, including those that prevent complications and support retention in care
 - Obstetric and reproductive health services
 - Treatment for mental health and substance abuse problems on both an in-patient and out-patient basis
 - Case management services
 - HIV prevention services (risk reduction education in the clinical and community setting)
 - Primary care services
4. HIV care provider reimbursement¹²
 - Providers should be reimbursed at the higher levels offered by Medicare
 - Higher reimbursement should attract more qualified providers
 - Reimbursement should be Medicare level plus 5% for services provided at Centers of Excellence (Recommendation 6)
5. Drug purchasing
 - Congress should implement measures to lower cost of drugs
 - Enact either Federal Ceiling Price (FCP) or federal supply schedule price, now available to the Veterans Administration
 - Should lead to 9-25% decrease in price
 - Medicaid currently pays 33% more than the FCP for medications
6. Centers of Excellence (COE)
 - COE must be formed to centralize and standardize care and services
 - COE should:

⁵ Executive Summary, pg. 10, unless noted otherwise

⁶ Executive Summary, pg. 11

⁷ Though they provide no recommendations concerning correctional facilities, they do warn of the crisis in prisons and caution that developing effective ways to manage HIV infection should be made a higher priority.

⁸ Ch. 6: Recommendations, 165

⁹ Ibid, pg. 167

¹⁰ Medicaid requires 75% of FPL (\$2694 for an individual in 2003)

¹¹ Ch. 6: Recommendations, pg. 169

¹² Ibid, pg. 171

- Ensure effective treatment and resource utilization
 - Coordinate care and social support across many providers
 - Be accountable to patients
7. Refocusing of the Ryan White Care Act¹³
- Should meet the needs of low-income individuals not covered by HIV-CCP
 - Low-income immigrants
 - Undocumented immigrants
 - Low-income people who for some reason cannot be covered by HIV-CCP
 - Those eligible for both should be on HIV-CCP
 - Should cover testing and prevention services
 - Should act as a link to COE

Cost

The committee estimates that the cost of implementing this program would be \$5.6 billion over 10 years.¹⁴

- Incremental cost for providing HAART to those not receiving it: \$2.65 billion
- Cost per Quality Adjusted Life Year (QALY): \$42,972
- The program's QALY is "comparable to other widely accepted health care investments:" typically cost per QALY under \$50,000 is considered a "good buy"
- An additional \$574 million would need to be spent in the first year

Health and Fiscal Benefits

Health:

- Estimated 58,697 (approx. 1/3) of those who need HAART do not receive it would gain access¹⁵
- This would result in the prevention of 19,825 premature deaths (a 55.9% decline over 10 years) and the addition of 129,385 QALYs
- From 199,852 people in program, 7,994 new infections can be expected per year- 3,198 (40%) can be averted with proposed prevention programs¹⁶
- Estimated 82% of those who need HAART will receive it through HIV-CCP¹⁷

Fiscal:¹⁸

- In the first year, states would collectively save \$1.154 billion
- \$602 million would be saved in RWCA refocusing
- COE would save \$144 million in 10 years, \$524 million in 30 years on supportive costs
- If the FCP is used, the program would save \$419.3 million per year just on drugs
- Study estimates that the cost will be easily offset by medical expenses saved over 10 years

Alternative Strategies Examined

Before deciding to propose a new program, the Committee explored several alternatives, including:

- Expanding the RWCA
- Providing Medicare coverage to all HIV infected people
- Expanding use of the 1115 Waiver for HIV care
- Creating an optional Medicaid eligibility category for people with HIV
- Expanding Medicaid coverage for HIV infected individuals via enhanced federal match
- Creating a federal block grant for HIV care

The Committee decided that in order to fulfill their charge to propose a "publicly funded system of care that is accessible, equitable, cost-effective, of high quality, comprehensive, and easily negotiable," they could not work within the current parameters of the RWCA, Medicare, and Medicaid. They concluded that they must propose an entirely new program that would formulate an appropriate and proportional response to the epidemic of HIV/AIDS among low-income populations in the United States.

¹³ Ibid, pg. 174

¹⁴ Ibid, pg. 158

¹⁵ Study mentions that the only way to insure all who need HAART receive it would be through universal health care (Prologue, pg. 1)

¹⁶ Ibid, pg. 163

¹⁷ Ibid, pg. 155

¹⁸ Ibid, pg. 157-163