Access to Care: Medicaid, Medicare and Ryan White

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Director of Government Relations
Who is NASTAD?

- A non-profit national association of state health department HIV/AIDS program directors who administer HIV/AIDS prevention, care and treatment programs funded by state and federal governments

NASTAD’s Programs
- Government Relations/Public Policy
- HIV Prevention & Surveillance
  - Communities of Color
  - Youth
  - Viral Hepatitis
- HIV Care & Treatment
  - Ryan White CARE Act
  - ADAP TA and Monitoring
- Global AIDS Technical Assistance
Overview of Presentation

• HIV/AIDS Care in the U.S.
• Medicaid and HIV/AIDS
• Medicare and HIV/AIDS
• Budget Reconciliation
• Ryan White Challenges
HIV/AIDS Care
HIV Health Care

• Growing number of people living with HIV/AIDS in need of prescription drugs and other care and support services
• As payer of last resort, other system changes (e.g., Medicaid, Medicare) can increase or decrease demand for Ryan White CARE Act services
• State-by-state variability in Medicaid, ADAP, and (pending 2006) Medicare formularies
• CDC estimates 55% of people with HIV receiving HAART
• IOM estimates 233,000 HIV-positive Americans do not have consistent access to HAART
HIV Health Care Funding

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>ADAP - AIDS Drug Assistance Program</th>
<th>Private Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare (Part D)</td>
<td>Special Populations Corrections Veterans</td>
<td>Insurance Continuation Assistance Programs</td>
</tr>
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</table>
Insurance Coverage of People with HIV/AIDS in Care, 1996

- Uninsured: 20%
- Medicare Only: 6%
- Medicaid Only: 29%
- Private: 31%
- Dual Medicaid & Medicare: 13%

Federal Funding for HIV/AIDS Care, FY 2005  
(in millions)

- Medicare: $2,900
- Medicaid (federal only): $5,700
- Ryan White: $2,073
- FEHB: $370
- VA: $390
- Other: $219

Medicaid and HIV

- Medicaid largest provider of care to HIV population
  - ≈195,000 Medicaid beneficiaries with HIV/AIDS
  - Estimated federal spending of $5.7 billion in FY2005 and $6.3 billion in FY2006
- Covers ≈ 55% of adults living with HIV/AIDS and 90% of children and youth
- As the largest source of HIV care, any Medicaid policy changes could have a big impact on Ryan White Programs
Medicaid and HIV

- 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
## Medicaid and HIV

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
<th>Mandatory/Optional</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSI beneficiaries</td>
<td>Severely disabled AND low-income (74% of FPL)</td>
<td>Mandatory</td>
</tr>
<tr>
<td>Parents, children, pregnant women</td>
<td>Low income; income &amp; asset criteria vary by category &amp; state</td>
<td>Mandatory; states may offer higher income thresholds</td>
</tr>
<tr>
<td>Medically Needy</td>
<td>Severely disabled and low income (median = 56% of FPL) after subtracting incurred medical expenses</td>
<td>Optional (35 states use this option for people with disabilities)</td>
</tr>
<tr>
<td>Workers with Disabilities</td>
<td>Severely disabled; low-income; for persons returning to workforce</td>
<td>Optional</td>
</tr>
<tr>
<td>Poverty-level expansion</td>
<td>Allows for income above SSI levels up to FPL</td>
<td>Optional (19 states use this option)</td>
</tr>
<tr>
<td>State Supplementary Payment (SSP)</td>
<td>Allows for coverage of those receiving SSP</td>
<td>Optional (21 states use this option)</td>
</tr>
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Medicaid and HIV – State Trends

• In 2005 states sought a number of changes
  – 22 submitted waivers to restructure program
  – 17 enacted Medicaid reform commissions
  – 4 states increased enrollment in Medicaid Managed Care
  – 10 tightened asset test and 6 increased “look-back” period
  – 3 eased asset requirements for working disabled
  – 50 enacted measures to control costs of pharmaceutical benefits
    • Prior authorization; preferred drug lists; supplemental drug rebate programs; limiting the number of prescriptions per month; restricting brand name drugs or mandating generic substitution
  – Majority increased cost sharing including co-pays
  – Many states restoring cuts in eligibility and benefits and services
Medicaid and HIV – Outlook

• View looking forward is fluid
  – Double digit growth
  – 17 state commissions
  – Decline in FMAP reimbursement rates
  – Movement of duals off of Medicaid onto Medicare Part D
  – Likely $10 billion cut in federal spending over next 5 years
  – Federal Medicaid Commission offering long-term solutions in December
  – Demand from Governors and state legislatures to reform program
  – Impact of Katrina
Medicaid and HIV - Early Treatment for HIV Act

• Sens. Gordon Smith (R-OR) & Hillary Clinton (D-NY) introduced S 311
• Reps. Nancy Pelosi (D-CA), Jim Leach (R-IA) & Ileana Ros-Lehtinen (R-FL) will introduce companion
• Allows states the option to expand their Medicaid programs to cover HIV positive people, before they become disabled, without having to receive a waiver
• No need for 1115 Medicaid waiver - not viable
• Enhanced match rate maximizes state dollars already being spent
• Medicaid program not kept up with science of treatment
• Context of broader Medicaid Waiver activity
Medicare and HIV

• Medicare is second largest source of HIV/AIDS coverage
  – Serves ≈ 85,000, includes ≈ 55,000 dual eligibles
  – CMS estimates cost of $2.9 billion in FY 2005 and $3.2 billion in FY2006
• ≈ 20% of HIV+ persons have Medicare, will increase as pop. lives longer
• Majority of Medicare beneficiaries with HIV/AIDS qualify through SSDI; 82% below age 50
• 5-month waiting period for SSDI benefits
• 24-month waiting period for SSDI beneficiary to get Medicare
### Medicare and HIV - Eligibility

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<tr>
<th>Category</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals age 65 and over</td>
<td>Sufficient number of work credits to qualify for Social Security payments</td>
</tr>
<tr>
<td>Individuals under age 65 with permanent disability</td>
<td>Sufficient number of work credits to qualify for SSDI payments due to disability; also includes spouses and adults disabled since childhood</td>
</tr>
<tr>
<td></td>
<td>Have been receiving SSDI payments for at least 24 months</td>
</tr>
<tr>
<td>Individuals with End-Stage Renal Disease, any age</td>
<td>Sufficient number of work credits to qualify for Social Security payments</td>
</tr>
</tbody>
</table>

**SOURCE:** Kaiser Family Foundation, *Fact Sheet: Medicare and HIV/AIDS*, September 2004
Medicare and HIV – Drug Benefit

• For first time Medicare will have a drug benefit – Part D
• Starts January 1, 2006
• Drugs provided through prescription drug plans or Medicare Advantage
  – Every region has 11 to 20 organizations offering PDPs; 10 with nationwide coverage
• Benefit is voluntary, except for duals; penalties exist for late enrollment
• Majority of HIV-positive Medicare beneficiaries are duals
• Some in Congress want to delay implementation
• Cuts to Medicare are likely through reconciliation
Medicare Out-of-Pocket Drug Spending in 2006

New Medicare Legislation

- **Deductible $250**
- **No Coverage**
- **Partial Coverage up to Limit**
  - 25%
- **Catastrophic Coverage**
  - 5%
- **$2,250**
- **$5,100** (equivalent to $3,600 in out-of-pocket spending)
- **$2,850 Gap**


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Medicare and HIV – Benefit Structure

• Many populations receive subsidized drug benefit
  – Below 135% FPL
    • No premium
    • No deductible
    • No gap in coverage (donut hole)
    • Co-pays $1/$2 generic; $3/$5 brand name
  – Between 135% and 150% FPL
    • $50 deductible
    • Sliding premium assistance
    • 15% of drug costs through donut hole
Medicare and HIV – Dual Eligibles

• Dual eligibles Concerns
  – Medicaid drug coverage ends on December 31, 2005
  – Very tight transition period
  – Only eligible for “cost average plans” unless extra premium is paid
  – Beneficiaries currently being auto-enrolled into plans
  – Allowed to change plans once a month
  – State Medicaids can cover drugs that are excluded from part D coverage and still receive federal match
Medicare and HIV – Benefit Implementation

• All antiretrovials must be included on all plan formularies
  – No such guidance for OIs or other HIV-related medications
• Spending by ADAPs not counted towards True Out-Of-Pocket (TrOOP) costs
• Concern that clients will fall through cracks when dual-eligibles transition
• May increase pressure on ADAPs and PAPs during transition
• As payer of last resort ADAPs can coordinate with PDPs and Medicare Advantage plans
• Coordination between ADAPs and PDPs is extremely difficult
• Will be a cost savings for ADAP
Ryan White - Outlook

• Funding for FY2006
  – An across the board cut is likely
  – Could be 1 - 2.5% or $11 - 41 million

• Reauthorization
  – President’s principles change the focus of the program to care and treatment
    • 75% of funds for core services
  – Potential for destabilization if principles implemented
    • SNCSI
    • Hold harmless
    • Double counting
    • Incorporation of HIV into formula
  – Congressional action is slow
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