HIV and Health Care Reform

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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

**Income <$10,000**
- US Population: 8%
- People with HIV/AIDS: 45%

**Unemployed**
- US Population: 5%
- People with HIV/AIDS: 62%

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

Uninsured: 29%
Medicaid: 36%
Private: 17%
Medicare: 4%
Duals: 14%

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

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

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

- In Care/HAART: 55%
- In Care/No HAART: 15%
- Not In Care: 30%

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)

- Medicare: 4.5 (39%)
- Medicaid (federal share only): 4.1 (35%)
- Ryan White: 2.2 (19%)
- Other: 0.8 (7%)

Total = $11.6 billion

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

Medicaid and HIV

- Largest provider of care to HIV population
  - Covers 1 in 4 persons with HIV receiving care
  - Covers $\approx$200,000
  - Estimated federal spending of $4.1$ billion in FY2009
- Covers $\approx$ 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 ≈ 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 are 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**

- **Enrollee Pays 5%**
- **Enrollee Pays 100%**
- **Enrollee Pays 25%**

**Plan Pays 15%; Medicare Pays 80%**

**$3,453 Coverage Gap (“Doughnut Hole”)**

**$2,700 in Total Drug Costs ($970 out of pocket)**

**$6,153 in Total Drug Costs ($4,350 out of pocket)**

**$364 Average Annual Premium**

**$295 Deductible**

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

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

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<thead>
<tr>
<th>MEDICAID:</th>
<th>MEDICARE:</th>
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<tr>
<td>Needs Based <strong>Entitlement</strong> Program</td>
<td><strong>Entitlement</strong> Insurance Program</td>
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<td>Eligibility for <strong>disabled</strong> w/ low-income, few assets, citizenship, state residency AND disability</td>
<td>Eligibility for <strong>disabled</strong> based on work history</td>
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<td>Program varies by state</td>
<td>2 year waiting period post eligibility</td>
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<td>Primary entry for PWHIVs is <strong>SSI</strong></td>
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*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
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
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

Andrea Weddle  
Executive Director  
HIV Medicine Association  
ph 703.299.0915  
aweddle@idsociety.org

Laura Hanen  
Director of Government Relations  
National Alliance of State and Territorial AIDS Directors  
Co-chair HIV Health Care Access Working Group  
Ph 202.434.8091  
lhanen@nastad.org