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

Health Care Coverage of People with HIV/AIDS

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

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

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 ~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 ≈ 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

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

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 ¾ 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

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? (%)

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