HIV and Health Care Reform

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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

10 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

11 Standard Medicare Prescription Drug Benefit, 2009

12 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

13 Medicaid and Medicare

14 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.

15 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

16 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

17 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

18 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

19 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

20 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

21 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

22 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

23 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

24 □ Stigma

25 □ 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

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

27 □ 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

28 □ 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

29 □ Contact Information
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