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HIV and Health Care Reform

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U.S. Population and People with HIV/AIDS: Income & Unemployment

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Health Care Coverage of

People with HIV/AIDS

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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**

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

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Federal Funding for HIV/AIDS Care by Program,

FY 2008 (in billions)

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

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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

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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 <u>disability</u> 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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