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NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS

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Early Treatment for HIV Act
(S 860)

To increase access to care and treatment for persons living with HIV/AIDS, Senators Gordon Smith (R-OR) and Hillary Clinton (D-NY) have introduced the "Early Treatment for HIV Act" (ETHA). The legislation gives states the option of adding HIV infection as an eligible category for Medicaid coverage. ETHA will allow income-eligible individuals living with HIV to qualify for Medicaid coverage earlier in the course of their disease and eliminate the need for states to apply for an 1115 waiver. A House companion bill will be reintroduced in the coming months.

Need for an HIV-Specific Medicaid Eligibility Category

To qualify for Medicaid, individuals must meet an income requirement (percent of Federal Poverty Level) and categorical requirements. The categorical requirements are aimed to reach three groups of low-income individuals: parents and children, the elderly, and the disabled. Unfortunately, childless adults generally do not meet the categorical requirements unless they are disabled. Most people living with HIV who qualify for Medicaid only do so when their immune systems decline to an AIDS diagnosis and therefore meet the disability requirement. Medicaid defines "disability" as the point at which an individual is unable to engage in "substantial gainful activity by reason of a medically determined physical or mental impairment expected to result in death, or that has lasted or can be expected to last for a continuous period of at least 12 months." At this point, the individual is much sicker than the federal guidelines recommend for beginning antiretroviral (ARV) therapy, limiting the efficacy of the life-prolonging anti-HIV drugs that are available through the Medicaid program. In order to stay healthy, and to realize the full benefit of HIV treatments, a person living with HIV needs early access to these essential drug therapies.

The precedent is set for a disease-specific Medicaid categorical expansion. In 2000, Congress passed legislation that allows states to extend the full Medicaid benefit package to women screened through the National Breast and Cervical Cancer Early Detection Program, run by the Centers for Disease Control and Prevention, and found to need treatment for breast or cervical cancer. As of November 2004, 50 states and the District of Columbia have taken up this option despite state fiscal challenges.

Need for Care and Treatment Financing Options Beyond the Ryan White Program

The federal government and states have a proven track record of partnering to respond to the unmet care and treatment needs of low-income, underinsured, and uninsured people living with HIV/AIDS, particularly through the Ryan White Program. The Ryan White Program receives the majority of its funding through the discretionary federal appropriations process. Although this funding has grown over the past ten years, federal and state funding has not kept up with the growth in the number of uninsured and underinsured people needing access to HIV treatments. In times of economic hardship, as presently experienced by the states and federal government, significant increases in discretionary funding necessary to meet

the needs of the growing number of persons living with HIV are unlikely. ETHA provides a long-term solution by providing access to Medicaid for these individuals. Without long-term financing solutions, the sustainability of care and treatment for people living with HIV/AIDS will be in jeopardy.

1115 MEDICAID WAIVER NOT A VIABLE OPTION FOR MANY STATES

Currently, states may pursue 1115 waivers, which allow states to create innovative programs to cover additional non-mandatory populations, as long as the state can demonstrate that the program is budget neutral to Medicaid over five years. States often experience difficulty demonstrating budget neutrality within a five-year time period, and only to the Medicaid program, as early access to Medicaid often results in initial increased costs to cover antiretroviral therapy. The narrow definition of budget neutrality overlooks the savings that early treatment of HIV has on other federal and state programs, such as Medicare, Social Security Disability Insurance, Supplemental Security Income, or other direct service programs such as the Ryan White Program. Furthermore, this strict definition of budget neutrality discounts the benefits society reaps as persons with HIV who receive care and treatment have a higher quality of life, are healthier, and remain in the workforce, paying taxes. Finally, the cost-effectiveness and health care cost-savings associated with early treatment of HIV are well documented.[1,2]

ETHA'S COST TO THE FEDERAL GOVERNMENT IS LOW

A PricewaterhouseCoopers analysis shows that over ten years, ETHA saves the federal government $31.7 million. It also concludes that ETHA reduces the death rate for persons on Medicaid living with HIV by 50 percent, and that disease progression significantly slows and health outcomes improve.[3] Researchers at the University of California, San Francisco, using a published model that serves as the basis for assessing Medicaid expansion in several states, estimate that the five-year net federal costs to the Medicaid program of expansion for low-income individuals (100 percent FPL) with HIV prior to disability are $490 million. Such an expansion extends coverage to 18,000 people by the end of the five-year period, at an average annual federal Medicaid cost of approximately $5,600 per person. Over a ten-year period, national implementation of ETHA would result in significant cost savings, particularly when savings outside of Medicaid are considered.

SUPPORTING ETHA IS THE FAIR THING TO DO

HIV/AIDS treatment, such as highly active antiretroviral therapy, successfully delays the progression from HIV infection to AIDS. These advances, along with access to comprehensive health care, improve both the health and the quality of life for many people living with HIV. Without access to early intervention health care and treatment through Medicaid, these advances remain out of reach to thousands of low-income people living with HIV. The federal government must ensure that the standard of care for HIV treatment, which calls for early intervention and is endorsed by its own agencies, is accessible to those who have no other way to obtain it.

[1] Shackman, et al., *The Lifetime Cost of Current Human Immunodeficiency Virus Care in the United States*, Medical Care, 2006.

[2] Chen, et al., *Distribution of Health Care Expenditures for HIV-Infected Patients*, Clinical Infectious Diseases, 2006.

[3] Rodgers, et al., *An Analysis of the Early Treatment for HIV Act*, Prepared by PricewaterhouseCoopers, May 27, 2003.