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Catch-22: Medicaid and HIV

Antiretroviral therapy keeps people living with HIV healthy. But the costs of HIV care can impoverish anyone, and people living with HIV are already disproportionately low-income. Antiretroviral therapy alone costs approximately \$10,000 – \$12,000 annually, making it virtually impossible for low-income people to access life-prolonging medications without health insurance. People living with HIV are often unable to afford to pay for antiretroviral therapy that would allow them to live longer, healthier lives.

Medicaid plays a critical role in financing AIDS care by providing a comprehensive benefit package that includes prescription drugs. For most people living with HIV, Medicaid eligibility is dependent on both income and disability status (or other categorical eligibility), and therefore Medicaid often does not cover people living with HIV until they are quite sick. Without medication, people living with HIV will progress more quickly to an AIDS diagnosis. People living with HIV only qualify for Medicaid once they become severely ill. This presents a catch-22: people living with HIV cannot access drugs through Medicaid to stay healthy until they are very sick.

Discretionary vs. Mandatory Programs

The federal government pays for health care and related social services for people living with HIV/AIDS through a variety of different programs. Medicaid, a public insurance program, is the largest public payer of AIDS care in the U.S. The Ryan White CARE Act (Ryan White) is also a significant public payer of AIDS care. But there is a critical distinction between these two programs: Medicaid is funded with mandatory dollars and entitles people to all the necessary medical services provided in the state Medicaid program.

Ryan White is a discretionary program that provides fixed dollar grants that are not tied to clients or need.

Discretionary programs are subject to an annual political process that determines how much money the program will receive. Discretionary programs are not assured that they will be funded at the same financial levels each year nor do they automatically receive increases to account for inflation. Discretionary programs also cannot keep up with increases in the number of people needing services without congressional approval. In contrast, mandatory government programs are always fully funded each year and do not require annual appropriations.

In an era of deficit spending, discretionary programs are particularly vulnerable as the federal government seeks to balance the budget and limit spending. As more people living with HIV live longer lives as a result of antiretroviral therapy, they depend on services funded through the Ryan White CARE Act. Mandatory programs like Medicaid are more financially stable from a federal perspective and provide comprehensive health insurance for people living with HIV and/or AIDS.

Medicaid

Medicaid is an entitlement program run jointly by the federal government and the states that provides health insurance to low-income people. Low-income women, children, elderly and disabled populations are most likely to qualify for Medicaid. Over 50 percent of the people living with AIDS in this country depend on Medicaid to pay for their medical services and prescription drugs.

Eligibility for Medicaid is dependent on meeting both financial and disability criteria. Consequently,

all people living with HIV/AIDS are not eligible for Medicaid. For example, many people living with HIV who would benefit from antiretroviral therapy do not qualify for Medicaid because they are not considered disabled. Yet current federal treatment guidelines indicate that an individual living with HIV should begin antiretroviral therapy before they are disabled.

Eight other states are either considering applying for waivers or have submitted proposals to the CMS.

To stay healthy, a person living with HIV needs access to expensive drug therapies. Yet this same person living with HIV cannot access Medicaid to pay for those drugs until they are severely ill enough to be considered disabled. There are a number of policy options that states and the federal government can use to expand Medicaid eligibility for people living with HIV/AIDS.

Medicaid HIV Waivers

One option to alleviate the catch-22 described above is through the use of Medicaid's 1115 waiver process. States can seek a waiver of federal law to create innovative programs as long as these programs do not cost the federal government any more than they would have already spent providing Medicaid services. This concept is known as budget neutrality.

Budget neutrality is tremendously complicated and involves complex negotiations between states and the federal government. Ultimately, the high cost of antiretroviral therapy means that a state seeking an HIV 1115 waiver needs to find significant Medicaid savings as a result of later onset of disability and subsequent health care costs. The U.S. Office of Management and Budget has been unwilling to allow states to consider savings to other federal programs, such as Medicare and Social Security, which would result from delaying disability.

The 1115 waiver process involves significant state resources in order to develop a budget neutral proposal and to engage in lengthy negotiations with the Centers for Medicare and Medicaid Services (CMS). Three HIV 1115 waivers have been approved in the District of Columbia, Maine, and Massachusetts. To date, Massachusetts is the only state that has implemented an HIV waiver.

The Early Treatment for HIV Act

The Early Treatment for HIV Act is legislation that has been introduced in the U.S. Congress that would allow states to create a Medicaid eligibility category specifically for people living with HIV. This would give states the option to extend Medicaid to uninsured low-income people living with HIV.

In 1999, the U.S. Congress expanded Medicaid to give states the option to cover women with breast and cervical cancer. This program has been widely successful: forty-four states have expanded Medicaid to provide women with access to life-prolonging cancer treatment. Unlike other Medicaid eligibility categories, women with breast and cervical cancer in states that have picked up this option are not required to be disabled or low-income.

Researchers at UCSF, using a published model that has served as the basis for assessing Medicaid expansion in several states, estimate that the five-year net federal costs to the Medicaid program of Medicaid expansion for low-income individuals with HIV prior to disability, at state option, are \$393 million. Such an expansion would extend coverage to 18,000 people by the end of the five-year period at an average annual federal Medicaid cost per person of approximately \$5,600.

Providing early access to antiretroviral therapy for low-income people living with HIV through Medicaid would also reduce the burden on Ryan White CARE Act programs, including the AIDS Drug Assistance Program. If Medicaid is available to pay for primary care and expensive prescription drugs, the Ryan White CARE Act's resources can be used to finance supportive services that facilitate access to medical care.

Conclusion

Federal legislation has been proposed that would enable people living with HIV to qualify for Medicaid on the basis of an HIV diagnosis rather than waiting for a person to become disabled. Giving states the option to cover people living with HIV would be much simpler than utilizing the 1115 waiver process. Expanding Medicaid eligibility

would also relieve some of the fiscal pressures on the Ryan White CARE Act and ultimately, provide more care to more people living with HIV/AIDS.