

Does Medicaid Allow Doctors to Practice Sound HIV/AIDS Care and Treatment?

Introduction

Medicaid has played a critical and cost-effective role in HIV/AIDS care in the U.S. It has improved long-term outcomes for those living with the disease and prevented further spread of infection through sound medical management and counseling. But while current recommendations for medical care urge early treatment of HIV to maximize positive patient and community outcomes, Medicaid does not cover treatment until individuals meet a narrow definition of “disability.” Simple changes at the federal and state level can “fix” that service gap—and potentially *reduce* long-term Medicaid costs related to HIV/AIDS care and treatment.

The Critical Importance of Medicaid in HIV/AIDS Care and Treatment

Serving over 55 million people, Medicaid is the largest public health program in the U.S.¹

- Jointly funded by federal and state governments, the program is designed to serve eligible low-income families and individuals with disabilities.
 - ✓ To be automatically eligible for Medicaid, Ohio parents must earn below 90 percent of the federal poverty level (\$19,080 for a family of four), while single Ohioans with disabilities require an income below 64 percent of the line (\$6,656).²

Upwards of 50 percent of HIV+ patients rely on Medicaid coverage.^{3,4}

- With life-preserving highly active anti-retroviral therapy costing as much as \$13,000 per year, adequate coverage is essential to ensure the health of HIV+ patients, and to prevent the spread of drug-resistant strains of HIV.⁵
 - ✓ One study found that providing Medicaid for HIV/AIDS patients could reduce mortality rates by as much as 66 percent.⁶
- Spending cuts that result in higher co-pays or further limit access to essential services for poor Ohioans needlessly endanger lives and put entire communities at risk for the spread of drug-resistant strains of HIV if medication is not consistently available.

Currently, Medicaid “Waits” for HIV/AIDS to “Disable” Low-Income Ohioans

An unmarried HIV+ Ohioan earning less than \$6,656 per year is not automatically eligible for Medicaid to cover the cost of his or her treatment.

- Even for Ohioans living below 64 percent of the poverty line, testing positive for HIV does not automatically establish Medicaid eligibility because of the U.S. government’s narrow definition of “disability” (“having a physical or mental impairment that prevents one from working for a year or more or that is expected to result in death.”⁷)
 - ✓ In turn, the system excludes the very Ohioans who often need treatment the most to maintain community independence and *avoid* becoming fully “disabled” by AIDS.

**Medicaid and HIV:
Saving Lives and Resources**

¹ Kaiser Commission on Medicaid Facts. *Fact Sheet: The Medicaid Program at A Glance*, October 2006. Available at <http://www.kff.org/hiv/aids/7172.cfm>. (Accessed May 2008).

² To qualify for the “Buy-In for Workers with Disabilities” program, a single individual must earn less than 250 percent of the federal poverty level, though must pay monthly premiums if making over 150 percent of the line.

³ AIDS Action. (March 2002). Policy Facts: Medicaid and HIV. Available at <http://www.aidsaction.org>. (Accessed May 2008).

⁴ Fleishman, J.A., Gebo, K.A., Reilly E.D., Conviser, R., Matthews, C.W., Korthuis, T.P., Hellinger, J., Rutstein, R., Keiser, P., Rubin, H., Moore, R.D. (September 2005). Hospital and outpatient health services utilization among HIV-infected adults in care 2000-2002. *Medical Care*, 43 (9 Supplement), 40-52.

⁵ Goldman, D., Bhattacharya, J., McCaffrey, D., Duan, N., Leibowitz, A., Joyce, G., Morton, S. (2001). The effect of insurance on mortality in an HIV+ population in care. *Journal of the American Statistical Association*. 96 (405), 883-894.

⁶ Bhattacharya, J; Goldman, D; Sood, N. (2003). The link between public and private insurance and HIV-related mortality. *Journal of Health Economics*. 22, 1105-1122.

⁷ U.S. Social Security Administration. (June 2006). Disability Evaluation under Social Security. Available at <http://www.ssa.gov/disability/professionals/bluebook/listing-impairments.htm>. (Accessed June 2008).

To offset this dangerous catch-22, states may apply for “Section 1115” Medicaid waivers to start demonstration projects that cover otherwise eligible individuals living with HIV.⁸

- Massachusetts has successfully implemented a program to cover HIV+ individuals living below 200 percent of the poverty level.⁹ Maine provides for those living below 250 percent of the line.¹⁰
 - ✓ These waivers require that states demonstrate “budget neutrality”—covering HIV+ individuals must not cause long-term Medicaid spending to grow any faster than it would without the expanded coverage.
- To join the nine other states considering application for a Section 1115 waiver, Ohio should study the benefits of such a waiver and its capacity to provide medical treatment for poor HIV+ Ohioans.
 - ✓ Those benefits include preventing the spread of infection and drug-resistant forms of HIV, as well as treating individuals before they are fully “disabled” by AIDS and reliant upon more costly emergency care.

Possible Reform at the Federal Level: The Early Treatment for HIV Act (ETHA)

ETHA addresses the catch-22 built into Medicaid policy governing HIV/AIDS and the federal definition of “disability”.

- Passage of ETHA would allow, though not require, states to define uninsured, low-income individuals with HIV as Medicaid-eligible.
 - ✓ This would open the door to innovative and cost-effective programming presently available only through the Section 1115 waiver process.
 - ✓ ETHA is modeled after the successful Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) implemented by all 50 states, which provides women with breast cancer early access to Medicaid for treatment before becoming officially “disabled.”¹¹

Research indicates significant positive effects on the health of patients and overall cost savings from ETHA.

- A 2003 study by PricewaterhouseCoopers found that passage of ETHA would actually reduce Medicaid costs by 70 percent by decreasing infectiousness and treating eligible HIV+ individuals immediately after diagnosis.¹²
 - ✓ Passage of ETHA would yield *net governmental savings* in state and federal budgets after just 10 years.

Moving Forward

To protect the health and well being of *all* Ohioans and permit doctors to adequately serve their patients’ needs, future Medicaid cuts must be avoided.

As Governor Strickland’s “Ohio Anti-Poverty Task Force” works to reduce the number of Ohioans living below 200 percent of the federal poverty line, Ohio should pursue a cost-effective Section 1115 Medicaid waiver to treat all HIV+ individuals that would otherwise be eligible for Medicaid. This will thereby ensure that they are not “disabled” by AIDS solely by virtue of their current economic situation.

Finally, state leaders should continue to advocate for federal reform to expand treatment for individuals living with HIV through the Early Treatment for HIV Act (ETHA).

- **Ohio should apply for a Section 1115 Medicaid waiver to ensure early access to essential HIV care**
- **Policymakers should step forward to support passage of ETHA**

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⁸ Centers for Medicaid and Medicare Services. (2008). *Medicaid Waiver and Demonstrations List*. Available at <http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/List.asp>. (Accessed May 2008).

⁹ Ibid.

¹⁰ Ibid.

¹¹ Centers for Medicaid and Medicare Services. (2005). *Breast and Cervical Cancer: Prevention and Treatment*. Available at http://www.cms.hhs.gov/MedicaidSpecialCovCond/02_BreastandCervicalCancer_PreventionandTreatment.asp. (Accessed June, 2008).

¹² Rodgers, J. & Yip, R. (2003). An analysis of the Early Treatment of HIV Act. Prepared by PricewaterhouseCoopers. Available at http://www.taepusa.org/documents/PwC_ETHA_Report.pdf. (Accessed June 2008).