until it's over AIDS ACTION POLICY FACTS

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Early Treatment for HIV Act

Introduction

The Early Treatment for HIV Act (ETHA) is proposed legislation that, if passed, will provide states the option of expanding Medicaid coverage to individuals living with HIV. The proposed legislation is modeled after the Breast and Cervical Cancer Prevention Treatment (BCCPT) Act of 2000, which amended Title XIX of the Social Security Act giving states the option of expanding Medicaid coverage to women who were found, through early intervention programs, to have breast or cervical cancer. In a similar manner, ETHA would provide resources to pay for early intervention, treatment and health care for people living with HIV. Currently, most individuals with HIV/AIDS who qualify for Medicaid do so because they are certified as disabled. Usually, this certification comes after an individual has received an AIDS diagnosis. This means that many of these people are too sick to benefit from current therapies by the time they qualify for Medicaid. Successful passage of ETHA would allow more HIV positive people to receive treatment at earlier stages of the infection.

Medicaid and HIV/AIDS

Created in 1965 under Title XIX of the Social Security Act, Medicaid is an entitlement program that is jointly funded and administered by the federal government and the states. Medicaid covers three main groups of low-income Americans: the elderly, the disabled, and parents and children. All states provide Medicaid coverage to individuals in these three groups who meet specific income and asset requirements. Although Medicaid benefits vary from state to state, all Medicaid programs cover some level of hospital, physician, nursing home, prescription drug, and long-term care services.

Medicaid is a vital source of healthcare for people with HIV. It is estimated that the program covers at least 40 percent of all people living with AIDS and 90 percent of all children living with AIDS who are receiving medical care.[1,2] In fiscal year 2001 (FY 01), the federal government spent $3.7 billion on HIV/AIDS care through the Medicaid program.[3] As the largest direct payer for medical care for people with HIV/AIDS, Medicaid is a critically important program. Yet despite its importance, the structure of the Medicaid program is often ill-suited to meet the needs of people living with HIV/AIDS. Further, not all poor Americans with HIV are currently eligible for health care under the Medicaid program, since income is only one test for Medicaid eligibility.

Most people living with HIV/AIDS who qualify for Medicaid do so because they meet the definition of disability, as put forth by the Social Security Administration. This Social Security disability definition means that individuals living with HIV will not be eligible for services until their immune systems have declined to the point of an AIDS diagnosis and/or they are no longer able to work. This requirement results in a dilemma for most people living with HIV who are often too sick to benefit from Medicaid. Current federal guidelines call for early access to medical care and treatment, including the use of combination antiretroviral therapy, but advancements in treatment along with the use of antiretroviral therapies come at a high price.[4] Treatment with antiretroviral therapy costs between $10,000 and $12,000 annually, and the cost of monitoring patients and other services related to antiretroviral therapy rises to $18,500.[5] Low-income individuals, many of whom are uninsured or underinsured, are simply unable to pay for these life-prolonging medications without help from Medicaid, which often comes too late.

ETHA Legislation

In both the 106th and 107th Congresses, ETHA was introduced in an attempt to provide treatment earlier in the course of HIV disease progression for low-income Americans living with HIV. The bill is

expected to be reintroduced in the first session of the 108th Congress with even broader support.

ETHA would allow non-disabled individuals access to Medicaid by creating another category of eligibility based solely on HIV status, and thus ultimately eliminate some of the barriers that low-income, uninsured individuals living with HIV face in accessing health care and prescription drugs. By creating an additional Medicaid eligibility category, ETHA would offer substantial health care benefits at an affordable cost for people living with HIV. Further, ETHA could serve as an early intervention program by encouraging people to seek health care and by delaying the progression from HIV to AIDS. In this way, ETHA could improve the quality of life for individuals living with HIV and save on treatment costs.

Researchers at the University of California, San Francisco have calculated that expanding Medicaid coverage to low-income individuals with HIV prior to disability would amount to an additional federal expense of $393 million over a five-year period. Yet such an expansion would extend coverage to 18,000 people by the end of the five-year period.[6] This expansion is quite cost-effective when compared to the $10,000 to $12,000 it costs annually to pay for antiretroviral therapy and the $34,000 it can cost annually to treat someone with advanced AIDS.[7] In addition, under ETHA, Medicaid could provide treatment that would offset costs associated with non-drug services related to an AIDS diagnosis. Further cost savings beyond health care would also be possible under ETHA. Tax revenues would be maintained and SSI and disability insurance costs would be reduced since individuals could continue to work.

Concerns

If and when ETHA becomes law, it could alleviate many of the challenges faced by low income individuals. However, concerns arise regarding the legislation's limitations and its ability to have a positive impact on health care for individuals with HIV/AIDS.

- The passage of ETHA by Congress would not guarantee or ensure that non-disabled individuals living with HIV would receive Medicaid in all states. State matching dollars are required for Medicaid, and the availability of money for Medicaid expansion is limited, due to state budget constraints. Many states therefore are being forced to reduce their Medicaid benefits in order to balance their budgets. Opening the Medicaid rolls to individuals living with HIV would place further pressure on already-burdened state budgets.
- The reliance of HIV care on antiretroviral therapy is an increasing concern for state Medicaid programs. Prescription drug benefits under Medicaid are severely limited. Given that many HIV positive individuals require four or more prescriptions in combination each month, these limitations pose serious difficulties.
- ETHA cannot replace the Ryan White Care Act because individuals living with HIV often require case managers to assist with adherence to drug regimens, psychosocial support, and other concerns. Medicaid programs act solely as a health care benefit and do not directly provide ancillary services; whereas the Ryan White CARE Act does.

Conclusions

In accessing health care through Medicaid, the greatest challenge for low-income individuals living with HIV is meeting the program's limited eligibility requirements. The only avenue of eligibility that is currently available for many HIV positive people—no matter what their poverty level—is total disability status, as determined by the Social Security Administration. This requirement, which forces people to wait until they are disabled by AIDS to get help, robs many low-income individuals of the benefits provided by advances in HIV treatment. These advances prevent the decline of the immune system and the infections that result from this decline. Medicaid has been and will continue to be a vital part of this nation's ability to care for impoverished individuals with HIV/AIDS; however, long term strategies to improve the public health system must be incorporated into the plan.

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[1] Bozette, S. et al. (1998). *The care of HIV infected adults in the United States.* New England Journal of Medicine (336) no. 26.
[2] Foster. S. et al. (1999). *Federal HIV/AIDS spending: A budget chartbook.* The Henry J. Kaiser Family Foundation.
[3] Foster, S. et al. (2002). *Federal HIV/AIDS spending: A budget chartbook, 4th Ed.* The Henry J. Kaiser Family Foundation.
[4] U.S. Department of Health and Human Services. (2000). *Guidelines for the use of antiretroviral agents in HIV-infected adults and adolescents* (Web page). http://www.hivatis.org [Retrieved: October 28, 2000].
[5] Bartlett, J. & Finkbeiner, A. (1998). The Guide to Living with HIV Infection. *4th Ed.* Baltimore, MD: The Johns Hopkins University Press.
[6] National Alliance of State and Territorial AIDS Directors. (2002). *Early treatment for HIV act of 2001 (S 987/HR 2063).*
[7] Feig, Kristy. (2002). *Study explores high cost of HIV care in U.S.* (Web page). http://www.cnn.com/2002/HEALTH/conditions/07/10/aids.costs/ [retrieved January 22, 2003].