

**Briefing: Public Financing and Delivery of HIV/AIDS Care:  
Securing the Legacy of Ryan White  
May 13, 2004**

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**CHRISTINE STENCEL:** Good morning everybody. My name is Christine Stencel I'm the Media Officer of the Institute of Medicine and on behalf of the National Academy I'd like to welcome you here today for the release of a new report from the Institute of Medicine, Public Financing and Delivery of HIV/AIDS Care: Securing the Legacy of Ryan White. This will be a one hour public briefing that is being recorded and web cast live and the audio files will be posted along with links to the report and other materials on the National Academy's home page, which is [www.nationalacademies.org](http://www.nationalacademies.org). Because this discussion is being recorded and audio web case live, we ask that the members of the panel state their names when they are answering questions for the benefit of listeners. In a moment I will turn the podium over to Harvey Fineberg, the President of the Institute of Medicine. He will provide some brief opening remarks on this report and introduce the members of the panel who are with us today. The Committee Chair will then read an opening statement and the floor will be opened to your questions. When we get the question and answer period, those of you who are in the room, please note that there are microphones on the floor on either side of the room. We'd ask you to please go to one of those microphones to ask your questions and we ask both those in the room and those listening to the web cast to please identify yourself by your name and

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affiliation before asking your question. With that, let me introduce Dr. Harvey Fineberg.

**DR. HARVEY FINEBERG:** Thank you very much and good morning everyone. It's a pleasure, on behalf of the Institute of Medicine to welcome you to this briefing and to be able to express my appreciation to the Chair and members of the Committee who labored so diligently to produce the report that we are releasing today. We're entering the third decade of the HIV pandemic. A pandemic that has afflicted millions of people around the world and many, many thousands within the borders of the United States. In two decades we've made remarkable progress. Moving from a disease that was previously totally mysterious to a condition that was recognized by its cause where available treatments were originally developed and finally where effective treatment got to the point that what had been a death sentence, could be converted into a manageable chronic disease. We've made advances in understanding and we've made advances in caring. But, we have not really done enough to deal with the problem. We've recognized globally some of our responsibilities as a nation and the task that was set to this Committee, was to take a look for the United States to those who were living and burdened by HIV, what could be done to improve our ability to get effective treatment to those in need. Each year, still, about 40,000 people become newly infected and between 15,000 and 16,000 Americans succumb to

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HIV. Most telling, according to some reports, is that only about half of those individuals who are eligible for the most effective combination treatment currently, are actually receiving it in the United States. The Committee on the Public Financing and Delivery of Health Care, established in the fall of 2001, came to grips with a very complicated and difficult task. How to find the best solution for our nation to finance and deliver care to low income individuals who had HIV infection. I'm very pleased to have the privilege to introduce to you the Chair and some members of the Committee, who in turn will introduce a summary of the key ideas and then be available for your questions. Sitting just about in the middle of the panel, Dr. Lauren Leroy, was Chair of the Committee. She is the President and CEO of Grantmakers in Health, which is a non-profit educational organization serving trustees and staff of foundations and corporate giving programs in the health field. Dr. David Holtgrave, on the panel, is a professor in the Department of Behavioral Sciences and Health Education at the Rollins School of Public Health at Emory University. He previously served as Director of the Division of HIV/AIDS prevention and intervention research and support at the Centers for Disease Control. Dr. Jim Kahn. He is professor at the University of California San Francisco in their Institute for Health policy studies, the Department of Epidemiology and Biostatistics and the AIDS Research Institute. Dr. David

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Nerenz is the Senior Staff Investigator in the Center for Health Services Research at the Henry Ford Health System in Detroit. Next to him, Andy Schneider is the principal of Medicaid Policy, which is a consulting firm he founded in Washington, specializing in issues related to Medicaid eligibility benefits and financing. Previously he served on positions that included council to the Subcommittee on Health and Environment of the House, Energy and Commerce Committee. And at the end, at the far side, Dr. Paul Volberding. He is Professor and Vice Chair of the Department of Medicine at the University of California in San Francisco and has been a principal investigator, leading researcher and clinician in the care of patients with AIDS for many years. It's a pleasure now for me to call upon the Chair of the Committee, who will introduce the key findings. Dr. Leroy.

**DR. LAUREN LEROY:** Thanks Harvey. I also want to welcome you here today on behalf of our entire Committee on Public Financing and Delivery of HIV Care. The report that we're issuing today, the Public Financing and Delivery of HIV/AIDS Care: Securing the Legacy of Ryan White, is a report that comes after two years of serious work and deliberation among the various Committee members. I have several of those members with me today as Harvey said, who will be available when I finish this brief statement to help answer your questions and guide you through the report. As part of the

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2000 reauthorization of the Ryan White Care Act, the Congress directed the Health Resources and Services Administration or HERSA to commission a study by the Institute of Medicine that would provide guidance on a number of issues related to public financing and delivery of HIV/AIDS. Specifically the Committee was asked to do several things. First, to examine the feasibility of creating a publicly funded system of HIV care that is acceptable, equitable, cost effective, of high quality, comprehensive and easily negotiable. Second, we were asked to consider extending Medicaid coverage to people in early stages of HIV infection as one of the options that we would look at. And third we were asked to assess the costs stemming from the current barriers to care, as well as, the cost and savings to any programs affected by the proposed changes that we would recommend. In reviewing this broad scope, and the Congressional language that guided us, the Committee concluded that it's charged directed it to focus on low income individuals affected with HIV/AIDS. This is the target population we focused on. And also, on public sector financing of HIV/AIDS care. It noted that the charge also allowed us to consider a broad spectrum of possible financing and delivery options while specifically having to take a look at the option of modifying the Medicaid program to include eligibility for those in the early stages of HIV infection. With these points in mind, the Committee interpreted its charge of the following.

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A challenge to us to articulate a vision for financing and delivery of HIV/AIDS care that would provide the standard of care for low income individuals with HIV. In conducting our work, we tried to pursue a very rigorous approach that is consistent with the standards of the Institute of Medicine. We reviewed the literature, we gathered and analyzed information from a variety of sources wherever we could find useful information, including holding public meetings at which we heard from individuals with HIV/AIDS, advocates, researchers and federal and state policy officials. We also conducted a series of structured interviews with a sample of providers regarding their experiences with Medicaid and the Ryan White Care Act program. And with the help of Jim Kahn and David Holtgrave, who are with us today, in particular, we developed a number of models that allowed us to assess the financial and health impacts of our recommendations, as well as, their cost effectiveness. And we'll talk a little bit about that in a minute. I want to just pause to say that we believe that these models make a major contribution to the analysis of potential public policies. This one in particular, but more broadly as well. And we encourage you, when you have a chance to look at the report, to really look closely at the details of that work, in addition to your consideration to the recommendations that we make because we think that they're both extremely important. After the careful review of the information that we were able

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to obtain, the Committee concluded a number of things. Among them, significant inequities exist in access to the standard of care for HIV across geographic and demographic populations. Much of this disparity is related to the patchwork of financing mechanisms across the country and the programs widely disparate, eligibility requirements and benefit packages under current programs. And all of this results in fragmentation of coverage and significant variations in the types of services available to people with HIV from state to state. For many people, the current system doesn't allow sustained access to Highly Active Antiretroviral Therapy or HAART and the services that support adherence to the treatment. This lack of sustained access to HAART in the view of the Committee is a clear indicator of poor quality care. Without this treatment individuals face increased illness, disability and death. Furthermore, the Committee noted that the current federal, state partnership for financing HIV care is unresponsive to the fact that HIV/AIDS is a national epidemic with consequences that spill across state borders. At the same time, the Committee believes that the substantial federal funding for HIV care that we have today provides a strong incentive and an opportunity to finance and deliver care more effectively and so we try to take that into consideration in our recommendations. Given these conclusions, we asked ourselves if we were to design a better financing and delivery system for people with

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HIV, what would the goals of that system be? We needed a set of goals to guide our deliberation. And our primary goals were the following; to improve the quality and duration of life for those with HIV and to promote effective management of the epidemic by providing access to comprehensive care to the greatest number of individuals with HIV infection. The Committee considered seven different approaches for how these goals might be achieved. Most of these approaches build on the existing financing programs. One approach considered expanding the Ryan White Care Act. Another would expand Medicare coverage to low income individuals with HIV infection. Three approaches would give states options for expanding Medicaid to cover low income individuals with HIV infection who are not currently eligible. One of those approaches would facilitate Medicaid coverage through the Section 1115 demonstration waivers. The other two would create a new optional Medicaid category for individuals with HIV, but with different federal matching rates, one with at the regular rate and one in the enhanced rate. We also considered developing a federal block grant to states so that they could purchase services for individuals with HIV. As well as an approach that would establish a federally funded state administered entitlement to care for low income individuals with HIV. The Committee assessed these approaches against a series of criteria that we had developed. Such as, whether a low income individual with

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HIV would have the same eligibility for services no matter what state he or she lived in, whether the benefit package meets the standard of care for HIV/AIDS or whether the approach provides adequate reimbursement to encourage providers to participate in the program and care for these individuals. Based on this assessment, the Committee chose to recommend that the federal government should establish and fully fund a national program for treatment of individuals with HIV infection that would be administered by the states. Under this new HIV Comprehensive Care Program, coverage would be extended to HIV infected individuals with incomes below 250% of the federal poverty level, or about \$23,000 a year for an individual. Each individual would be entitled to a science-based, uniform, federally designed benefit package that reflects the standard of care. And the benefits would include HAART and other medications, obstetric and reproductive health services, treatment for mental health and substance abuse programs, case management services, HIV prevention services and primary care along with specialty services to which patients are referred. From the literature, we know that health care providers with experience treating individuals with HIV are critical to providing quality care and we're very concerned about provider participation in this new program. Low provider reimbursement rates have been identified as an important factor that may limit provider participation. And given the high participation

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rates in the Medicare program, the Committee chose to set its proposed programs, provider reimbursement rates at the same level at the Medicare program. It's always important that the federal government use its resources wisely. And in this case, we recommend that the program be a prudent purchaser of drugs. This is not a new recommendation. The Office of the Inspector General and the General Accounting Office have made similar recommendations. Also drawing from the research in the areas of chronic care and quality care, we recognize that an infusion of funds alone, will be insufficient to try to achieve the goals that we have set out and so we also need to look at redesigning the delivery system. The Committee identified the concept of Centers of Excellence as a model that should be tested for improving the integration, coordination and quality of care provided to those in the program through a national demonstration. And finally we recognize that this program would necessitate substantial changes in the Ryan White Care Act. Because many of the services that are currently provided under the act, would be available through the HIV Comprehensive Care Program, particularly medical services and drugs. However, not all HIV infected individuals will be served via this new program and there will continue to be needs that go unfulfilled. Ryan White would continue in this plan that we lay out to meet those needs as it has since the inception of the program with nearly two-thirds of its funding going for

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those purposes. We envision refocused Care Act programs that we continue to assist the most vulnerable and those ineligible to participate in the HIV Comprehensive Care Program. Other parts of the Care Act, such as the AIDS education and training centers would continue and there would be new rules under the Ryan White Care Act such as outreach and enrollment to help support those who are eligible for the HIV Comprehensive Care Program to actually become enrolled and take advantage of its benefits. We recommended this new national program because it appropriately expands federal responsibility for controlling the national HIV epidemic. The program would relieve state budgets from the majority of costs they currently assume for financing HIV care. Another very important aspect of this approach is that the federal funds for HIV care follow the eligible individual no matter what state or locality he or she resides in. And this is a significant departure from what occurs today. The Committee estimated that in the first year of the new program, almost 59,000 HIV infected individuals will gain access to HAART. Over ten years this would result in a 56% decrease in mortality among these individuals. Bringing more people into the system overall provides opportunities to increase their quality of life and productivity and to disseminate prevention information, which is critical to the management of the epidemic and the protection of the public's health. We also estimate that around 3,000 new HIV infections

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would be averted each year. With an estimated cost care savings to the system of \$140 million over ten years and over \$500 million over 30 years. And we estimate that this program would prevent 20,000 deaths over ten years. We also assess the cost of the program. For those 59,000 individuals, newly on HAART, the cost of HAART over ten year would be \$2.65 billion. If we look at the incremental cost of the comprehensive package of the benefits beyond HAART. Those incremental costs, the total costs over ten years would be \$5.56 billion, that's the ten year number. We also estimated the cost offsets to the program if the government were to purchase drugs at the federal ceiling price. The program's costs would be reduced by up to \$419 million a year if the drugs were purchased at the federal ceiling price. The Committee recognized and took very seriously the potential disincentives to the pharmaceutical industry to continue to invest in research and development in HIV/AIDS therapy with an approach that would actually set a ceiling on the prices for drugs. And we conducted analyses to try to better understand what the impact would be. Our analyses indicate that any discount of less than 27% would allow manufacturers to retain current profit levels for antiretroviral drugs. The Committee also conducted a cost effectiveness analysis to assess whether the proposed program's outcomes and the costs of the interventions are an efficient use of federal resources, which is obviously a concern to

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federal policymakers. And our answer is yes, the program is cost effective. The cost for quality adjusted life year gained from implementing this program is \$42,972 in 2002 dollars. Which is an amount that is comparable to other widely accepted health care investments and is considered a good buy using this type of analysis. After its detailed and extensive review, the Committee feels strongly that having the tools in our midst to save people's lives, to benefit from the continuing contributions that many of them can make to our society and to help manage the epidemic to protect the public's health, having those tools that can accomplish those goals and not making them available to those who need them, is imprudent social policy and is indefensible. With that, I would like to turn to you and your questions and to welcome the panel members to participate in answering them. As Christine mentioned, if you want to walk up to the microphones, and please introduce yourself and tell us what organization you're affiliated with, we can get those questions started. Yes?

**CHARLTON FREELANS:** Charlton Freelans [spelling?], correspondent from [inaudible]. I would like to know what the current status of the so-called new HIV/AIDS Center of Excellency. I think this should be the first priority of the Institute of Medicine.

**DAVID NERENZ:** I think we, excuse me, I'm David Nerenz, we proposed this concept as a general organizing scheme for

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service delivery for HIV. It's not a new concept in general, there are already Centers of Excellence that exist. Cancer centers, heart surgery, for women's health, for stroke and to some extent, for HIV and AIDS. We recognize that the specific organizational structure for Centers of Excellence may vary appropriately from location to location, depending on geography, depending on the organizations available to work together to provide services. So we did not make the specific recommendation about the precise organizational form of these Centers of Excellence, but we recognize that that is a vehicle for accomplishing three very important things. One is the bringing in of the experience providers so that the best available knowledge can be applied to individuals with HIV and AIDS. It's a vehicle for coordination of care so that the services that are provided are done in an integrated and coordinated way. And it provides a vehicle for accountability, meaning that quantifiable parameters of quality of care can be identified and there can be a defined organization capable of measuring and then being held accountable for achieving those levels of quality. So we're drawing on models and concepts that have been in place in other places and suggesting that this be applied here in the context of the demonstration so that the effects and the contents of this program can be assessed.

**CHARLTON FREELANS:** [inaudible]

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**DAVID NERENZ:** I'm sorry, could you repeat that last question again? Or the last part of it.

**CHARLTON FREELANS:** [inaudible]

**DAVID NERENZ:** If the question was should this be a first priority of the Institute of Medicine, I guess I would say that it is an important part of our recommendations, but it's part of a larger package and includes recommendations about financing and we didn't single it as the first priority, but it's clearly an important part of what we have to say here.

**MARCIA MARTIN:** Good morning, Marcia Martin, Executive Director of AIDS Action and AIDS Action is a membership organization that represents community health centers and AIDS service organizations, local health departments and the AIDS Education and Training Centers and first I want to commend the Committee for very boldly saying that the response to HIV is a federal government obligation and, therefore, should indeed expect resources and funds from the federal government. It's a very important message to communicate that it is largely a federal program and I appreciate that the findings support and reinforce that. We look forward to reading the entire report and I just would ask the Committee if you would speak a little bit about why not, through the Ryan White Care Act, and why and how to think about expanding to create a, for what some might appear to be a parallel entitlement program. And I say that only because folks have clearly come to know the Ryan Care Act

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and I appreciate, this is wonderful, bold new step to try to make uniform, the U.S. response to HIV, which I hope at some point we can have be part of a global response to HIV. But if you would speak a little bit about, sort of, why not or why and at least in the pieces that I read, at least would consider and we appreciate it would have been a challenge to put for this bold initiative and again I want to be very clear, we commend you for taking this bold step, because the principals and the messages in it are important messages today about truly controlling this epidemic, truly financing the care, standardizing our approach in our program and coming up with a uniform response as opposed to the patchwork that we have before us. On the other hand, the resources to do it and the integration and the apparatus and the management and administration of it and the monitoring of it is a whole new ballgame. So, could you speak to that? Thank you.

**LAUREN LEROY:** Well, I'll start it off and others can join in. One of the issues that concerned us from the beginning was the issue of variation from state to state, locality to locality and we were looking for a solution to that problem, and obviously with the Ryan White Care Act, we have that issue for a variety of reasons and circumstances. Also because the Ryan White Care Act is not an entitlement as the source of funding, the discretionary nature of the funding, means that there's less security to ensure achievement of the

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goals that we also set for this program. And I think that because of the importance of the Ryan White Care Act and the programs that have developed and the experience that's developed under the Ryan White Care Act. We took it very seriously in developing this new comprehensive program and thought very seriously about the roles that it would continue to play. So, we felt that because of these primary goals, of trying to have national uniformity and to eliminate the type of variation that challenges people so seriously now that we needed to move to a broader, federally funded entitlement program. Anything else, people want to answer that?

**DAVID HOLTGRAVE:** I would just add maybe, that you'll see in the report we did an analysis looking at approximately \$1.9 billion that's in the Ryan White Care Act and think that at least two-thirds of that money would still remain in Ryan White. There would be some cost shifting perhaps with ADAP and other pieces, but that it would sort of refocus and redefine the roles of Ryan White so that we have the entitlement program that would be an important center piece, but that Ryan White planning counsels and the Ryan White services could address the needs of communities not eligible under the recommended program and also focus on some services that might not be covered. For instance, making people aware of how to become enrolled in the program, transportation services and other kinds of activities. So we think there'd still be that important, important roles as

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well. And it's David Holtgrave for the record for our audio conference.

[LAUGHTER]

**JESSIE TRY:** I'm Jessie Try [spelling?] with the AIDS Institute. Ms. Leroy, do you, when you were laying out the components of the plan you mentioned HIV prevention, and also primary care and referrals to specialists. I wonder if you could expand on those two components a little bit, specifically with reference to the primary care referral to specialists. Would that include coverage for those referrals and would it cover things like co-infection issues like Hepatitis B and Hepatitis C?

**LAUREN LEROY:** I'm looking at my fellow Committee members that I would say yes to all of those. Yes. Because they all are part of the standard of care for people with HIV/AIDS.

**JESSIE TRY:** --kind of glossed over the question about HIV intervention [inaudible]

**LAUREN LEROY:** Yes.

**PAUL VOLBERDING:** And if I could just, this is Paul Volberding, if I could add to that, I think we have a good sense and we talked to a number of experienced providers in the course of our deliberations and clearly what we want to do is we want to take the best of current comprehensive programs that do deliver both primary and specialty care for the full range

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of problems that affect people with HIV and we felt also that that, as the report said, should definitely go to the [inaudible] of conditions of substance use, mental health and other conditions that really get in the way of affective primary care of HIV.

**LAUREN LEROY:** And by covering the preventive services, given that we have the opportunity to bring more people into care. We should do everything we can to cease that opportunity for preventive purposes.

**DAVID HOLTGRAVE:** And just one thing to add about prevention as well too, it's David Holtgrave, in the report, we estimate that 2,000 to 3,000 HIV infections might be prevented because of those prevention counseling services and we also estimate that well over \$100 million could be saved over the course of ten years because of the medical costs diverted by those preventions and those analyses are included in the report as well.

**VENA VINE:** Excuse me.

**LAUREN LEROY:** Yes.

**JESSIE TRY:** Vena Vine [spelling?], [inaudible] office here at the Academies. I have two questions from one of our web listeners, Bill Tideman [spelling?] from the city of Cleveland, Cleveland's Department of Public Health. He says, "Please respond to the comment you made regarding drug companies and their profit margins. Can you explain how we can

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ensure that future drug breakthroughs will continue under your proposed plan. It would seem that drug companies might be less interested in seeking high level solutions." That's the first question.

**LAUREN LEROY:** Okay. I'm going to let Jim Kahn answer that.

**JIM KAHN:** This is Jim Kahn. That's a really important consideration in our discussion of the recommendation that it might be possible to seek discounts in drug prices to help cover the cost of this program and so we did an analysis where we looked at the increase in utilization of antiretroviral drugs, about 60,000 more people would be using them. That, of course, would bring in substantially more income for the manufacturers and at the same time, some people would shift, obtaining their medications from existing public programs and prices to potentially a discounted price and we said well, if you have the increase in revenue from more people using HAART and a potential loss in the revenue from more people getting a discount, how big could that discount be and still leave the drug companies with an absolute increase in profits because of this program? And that cutoff point is 27%. So in other words, any discount less than 27% leads to an increase in profits for the drug manufacturers as a result of this program and while this isn't a definitive analysis, we think it sends the right message that we are advocating a program that

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increases the profits and, therefore, should increase the incentive for the development of medications.

**JESSIE TRY:** And his second question, again this is Bill Tideman from the city of Cleveland's Department of Public Health. "You had mentioned that this project will impact prevention and disease," I'm sorry, "impact prevention and decrease HIV infections. Could you explain how this might happen?"

**DAVID HOLTGRAVE:** Sure, this is David Holtgrave. What we estimated was we looked at the size of the population of persons who had newly received services as a function of this program and assumed that additional counseling and prevention services could be provided. We also looked at the literature on how effective those services might be in terms of reducing HIV transmission and based on a number of different assumptions about the exact level of effectiveness, came to the conclusion that we would probably avert, somewhere between 2,000 and 3,000 HIV infections a year. Then we multiplied that by the annual cost of HIV care and looked at that over a ten year period as well as a 30 year period and even in our most conservative analysis, found that we were averting, or saving over \$100 million in medical care costs as a function of those preventive HIV infections as well.

**BRENDA WILSON:** Yes, Brenda Wilson, National Public Radio. A fairly rudimentary question and that is, you say it's

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a fully funded federal program and I just want to make sure I understand that meaning that the federal government would share the cost with the states or assume all of the costs. I mean, does it work like Medicaid.

**LAUREN LEROY:** No.

**BRENDA WILSON:** You said match 100%, but it isn't quite clear to me.

**LAUREN LEROY:** The federal government would assume the costs and also pay the necessary administrative costs to the state agency that was administering the program in each state. So it's fully federally funded.

**BRENDA WILSON:** So--

**LAUREN LEROY:** No state participation.

**BRENDA WILSON:** Alright, so therefore, many of the southern states where you have really high rates of infection--

**LAUREN LEROY:** Right.

**BRENDA WILSON:** You know, would not consider this one of those sort of optional programs that it might opt out of.

**LAUREN LEROY:** Right. Exactly. It's not, it's a voluntary program, but because it's 100% federally funded, our assumption is that states would have an interest in participating.

**BRENDA WILSON:** Okay. Sort of political question. Which, you may feel free to answer or not. Which is given what some state administrators and federal folks feel about, for

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example, a program like the in stage, I think the renal In Stage Disease program some say, that would never ever be another disease specific program, what do you think the chances are of Congress ever accepting this and, sort of a dual question, anybody can take it, some are concerned about the "hegemony" of certain diseases that you create this aura around AIDS which people are going to be resistant and react against.

**LAUREN LEROY:** I, you know, the Committee discussed this. I think in the case of HIV/AIDS, there is already a precedent. Congress has already made a decision that this is a disease that merits special programs and special attention. The Committee didn't make a decision that this one somehow had higher priority than a number of other diseases that may be equally serious and significant, but this was, we were basically following our charge and following the fact that the Congress has already made a decision to focus in on this particular disease and to treat it differently in some cases than other diseases.

**PAUL VOLBERDING:** If I could add, this is Paul Volberding, that one of the things that we grappled with in this report was that the real problem of the disparity of services available in some parts of the country versus those in others and felt that the approach in having a federally funded and a set of benefits that were defined at a federal level was the only way we could see of helping decrease that very real

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problem, and we would expect, as you heard, that we've tried to identify those reasons that would lead a state not to participate and so by participating, this would increase access to care. And by the models that we did, we think the argument is strong that this would, while requiring some additional dollars, a program that would really reduce the death rate from this epidemic and justified on that and many other levels.

**MARCIA MARTIN:** Marcia Martin from AIDS Action. I ask you to speak a little bit about the infrastructure and the care system that I think we're talking about expanding or actually overlaying this onto or are we assuming that some of the resources are going to go into truly building out the capacity to really respond to this epidemic as a national model. And then, I'd also like to ask you to speak a little bit about some of the discrepancies and inadequacies and then ultimately classified as disparities in care that you observed and the relationship between that and our current resistance kind of dynamic in HIV care. Because there is some concern we have about bringing a care up to a standard and then having everybody being available for it and then trying to understand what that means in terms of long term implications for HIV care, treatment, research, resistance, outcomes, mortality, etc. So, I know several of you who do a lot of work in this area and if you would speak to that. This is truly a bold initiative and could be used, as what I would describe as shoe

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horn to change a whole lot of other things that don't fit. But at the same time there would need to be care into understanding what it really means to roll it out, what the infrastructure looks like or doesn't, what the care system looks like, where the current state of knowledge is in clinical care, what it really all means. And if you could speak to that a little bit, it would be helpful.

**LAUREN LEROY:** Maybe David Nerenz can start and then Paul Volberding?

**DAVID NERENZ:** Yes, Dave Nerenz here. I think I can address your first question a bit better than the second, others may speak to the second. In terms of the infrastructure, again, we did not recommend a specific organizational form for the Center of Excellence concept, recognizing that there may be no single form that is universally applicable or even possible. We did, though, presume a couple of things. One is that since the program would be administered at the state level, the state would have an entity, it could be the current Medicaid infrastructure, it could be a new one, that would define for its state what the characteristics of the Center of Excellence could be and which existing entities might be best qualified to step up and take on that role. We also presumed that there are models in place of comprehensive programs that would almost certainly qualify and be able to go as a Center of Excellence. So we did not

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presume that existing programs and services would have to be replaced in all instances. We presumed that existing programs and services might find new ways to relate to each other under the Center of Excellence concept. But again, the precise way in which that would be done in any particular locality, is a bit beyond our view, or beyond the science base from which we could make recommendations. I think that's why we're led to the concept of a demonstration or demonstration projects, plural, as a way to examine these relationships and learn more about how they could best work and in the context of this financing model, which would create a novel environment for these organizations to work.

**PAUL VOLBERDING:** If I could just, this is Paul Volberding, if I could just continue that response. One of the things that we found in our deliberation and collecting information were examples where there might be excellent physician level care, but where that wasn't connected with substance use services or mental health services and the patient, therefore, had to really work very hard, sometimes on his or her own to find those other services. So we think that a comprehensive, that providing the support for that and bringing that into a comprehensive center would seem inherently to make sense in that issues such as adherence, which are really important, especially in people that have other social problems that they're dealing with that might get in the way of

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adherence that by bringing this together, by funding it, and by funding expert physician care as well, that we would hope that this system would, and we would hope to prove that it would, decrease non-adherence, increase sustained benefits and treatment and decrease the resistance that is the problem that we all face. So, again, I think that seeing different models, and clearly there are existing models in various parts of the country that are responsive to their own local epidemic, we would see that probably as the way these demonstration centers would roll out.

**JENNIFER KATES:** Good morning, Jennifer Kates from the Kaiser Family Foundation. Could you speak to the relationship of this newly proposed program and the current Medicaid eligibles, costs and those kinds of issues?

**JIM KAHN:** If I understood your question, this is Jim Kahn, if I understood your question, and please feel free to follow up if I didn't quite get it. We looked at the current distribution of public use of public, in terms of enrollment in public insurance and estimated that there are approximately 335,000 people with HIV/AIDS in the public [inaudible] system which is predominantly Medicaid. And many of those are not in care, despite being covered, not in regular care and then many of them would enroll in this program. And in terms of the dollar amounts, it's instructive to look at what would happen in the first year. Right now we estimate that the federal

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share, oh this is table, for those of you who will eventually look at the report, this is in table 6-7, oh, you have it. Okay. You don't have it.

**LAUREN LEROY:** They have it. There is this page, right?

**PAUL VOLBERDING:** You may have this page, I think we printed it up, I think Rose Martinez will hand those around. In this table 6-7, we portray what's happening in the first year of the program. Currently, the federal share of Medicaid and Medicare is estimated at \$3 billion, the state's share of Medicaid at \$2 billion, which leads to a subtotal for the CMS contribution of about \$5 billion. In the first year of the program that we're proposing, that would increase from \$5 billion to about \$6.6 billion. At the same time, care for the uninsured, which includes some Ryan White funds as well as state and county indigent care funds, those costs would go down. So as a result, the net effect of the program would be that there would be an increase of 2.6 billion in the federal share of Medicaid and Medicare, a decrease in the state contribution of 1.1 billion. An overall increase in the CMS portion of Medicaid and Medicare of 1.45 billion and a savings for care for the uninsured including some savings from Ryan White of about 900 million and that overall leads to a savings, excuse me, an increased net cost of about \$570 million. Does that answer your question? Good.

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**LAUREN LEROY:** We have another question coming up.

**JESSIE TRY:** Another question from a web listener.

Edna Thompson in Chicago. "Please describe what changes in the administrative overhead would remain for the Ryan White Care Act Title 1 program. It seems like your proposed for [inaudible] will provide great cost savings from, by decreasing the high level of administrative costs for Ryan White's program."

**DAVID NERENZ:** David Nerenz here. I, we did not specifically attempt to model or estimate this. We presume as does the listener, that there could be some administrative savings by creating organized entities that do a little smoother job of coordinating care and we recognize that administrative can costs, can come at several levels. It can come at the sort of high level of program administration, but can also come in the more local level of billing and scheduling and what goes on in physician offices and other offices. It's a very complex set of figures. In general we presume that by making the arrangements simpler, more complicated, there can be savings, but I don't believe we attempted to make a formal estimate of those.

**LAUREN LEROY:** More questions?

**FEMALE SPEAKER:** [inaudible] again, and we are coming up near the end of the allotted time we had for this public hearing things that we pause real quick to make sure if there

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is anybody with a last minute question that they want to get in before we bring this briefing to a close? And if not, just as a reminder, ah, I think we might have another question.

**FEMALE AUDIENCE MEMBER:** [inaudible] are these sort of Committee reports and this might be in the report itself, were there any dissenting members? And who were they and were there--

[LAUGHTER]

--because sometimes those are included fair assessment of the approach that was adopted.

**LAUREN LEROY:** I would say that we had very lively conversations and exchanges of view and in the end, everyone agreed to the recommendations.

**FEMALE AUDIENCE MEMBER:** Okay, thank you.

**CHRISTINE STENCEL:** Okay. With that, I will bring this public briefing to a close and just a brief reminder that the report will eventually be posted on the National Academy's website. There will be a link from our homepage at [nationalacademies.org](http://nationalacademies.org) and I'd like to thank all of the members of the Committee who joined us today and I'd like to thank you all for coming and for listening.

[INAUDIBLE]

**CHRISTINE STENCEL:** I think I see an indication that it is posted as of now.

[END RECORDING]

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