

HIV Treatment Access and Today's Medicare and Medicaid Challenges

The AIDS Institute and Title II Community AIDS National Network

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State of Health Policy Debate in 2006

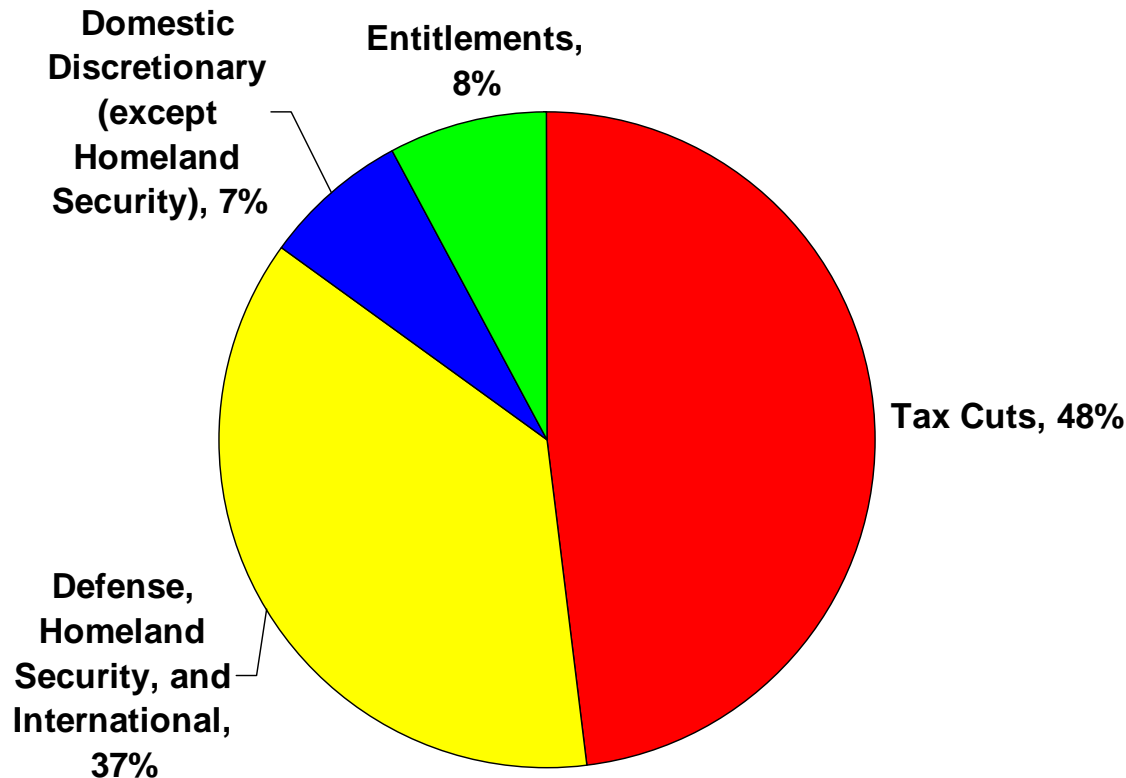
- **Broad split among political parties and stakeholders on goals and approaches:** Is universal coverage a goal?; Should we focus on public or private initiatives?; Should increased revenues be raised to pay for new initiatives?)
- **Concern over the cost of existing future obligations:** (Promises made through the entitlements to Medicare, Medicaid, Social Security, etc.)
- **Significant increases in numbers of uninsured Americans and increasing poverty:** 6.8 million more uninsured since 2000 and 5.4 million more people living in poverty since 2000
- **Increasing wealth disparities:** In 2005, for every wealthy family that received a tax cut due to 2001 and 2003 tax cuts, there are 160 uninsured Americans)



Figure 3

Tax Cuts and Defense Largely Responsible for the Federal Budget Crisis

Cost in 2005 of legislation enacted since January 2001



Source: Center on Budget and Policy Priorities calculations from Congressional Budget Office data. Reflects costs above an adjusted CBO current services baseline. Last revised February 3, 2005.



Medicaid as the Bogeyman

Medicaid's detractors and critics have selectively used facts to make claims that justify radical change:

- **Medicaid is broken**
- **Medicaid spending is out of control**
- **Medicaid is crowding out other state priorities—such as education**
- **Medicaid, in its current form, is unsustainable**



Most Current Challenges are Bigger than Medicaid (and Medicare)

The major financing issues facing Medicaid programs stem from problems that are bigger than Medicaid and call for broader national solutions. Unresolved issues include:

- **Controlling health costs (across all payers) that consistently rise faster than inflation**
- **Financing access to new medical technology**
- **Establishing a national system for financing long-term services (to take pressure off Medicaid)**
- **Adapting to demographic changes**



Consumer Reactions to the Deficit Reduction Act (DRA)

- **Deficit Reduction Act of 2005 (DRA):** Budget bill signed by President Bush in February 2006 (Public Law 109-171)
- **Increases Deficit:** Net impact of DRA and accompanying tax cuts leads to an increased, not decreased, deficit
- **Non-Solutions :** Did not resolve any of the health policy challenges facing the nation
- **Unnecessary Harm:** Senate bill would have achieved comparable savings without harmful benefits changes
- **Powerful Interests Win**
- **Consumer Advocacy Effective:** Could have been much worse



Key DRA Changes for Beneficiaries

- **Premiums:** Premiums permitted, without waiver, above 150% of poverty
- **Cost-Sharing:** Higher cost-sharing and people above poverty could be denied drugs or services for failure to pay
- **Flexible Benefits:** Most PWAs have a right to stay in regular Medicaid, but may not know it
- **Documentation Requirements:** Mandatory requirement for states to verify citizenship; process made less burdensome for most existing PWAs (who receive SSI), but still very troubling
- **Long-Term Services:** Major changes regarding asset transfers, partnership programs, self-direction, and options to provide community services



Key Themes in DRA and Recent Waivers

(Also applies to Medicare)

- **Personal Responsibility:** “Consumer choice” of plans; increased premiums and/or cost sharing; and behavior modification through incentives
- **“Tailored” benefits:** Varied benefits by population
- **Increased role of private marketplace:** Increased control to private for-profit plans to determine benefit packages
- **Increasing spending predictability:** Defined contribution approaches; aggregate caps on federal funding; and increased ability to limit/reduce coverage
- **More challenging advocacy environment:** Confusion about the rules of the game; limited public information; controversy; and loss of state legislative input



Needed: A Good Defense

- HIV community cannot focus on just federal or state levels; both environments important
- HIV community leadership is important, but working in broad-based coalitions essential
- Need to make the case that DRA flexibility doesn't solve the real problems — the problems with our health care system will not be resolved by charging beneficiaries higher cost-sharing, denying needed services, or hassling citizens
- Most recent reform efforts have not targeted HIV/AIDS, but have had major HIV/AIDS implications — Therefore, major goal needs to be to educate policymakers about HIV impacts



Needed: A Good Offense

The difficult political environment cannot last forever, we need to prepare to advance positive policy change.

- The HIV community needs to engage in efforts to push for universal coverage and long-term care reform
- In Medicare, without abandoning the current Part D system, we need to push for an option to receive drugs from a federal plan (as beneficiaries can select traditional Medicare or Medicare Advantage) — and other benefit improvements
- In Medicaid, we need to expand eligibility for more low-income people. My priorities:
 - Mandatory eligibility for all people under poverty (or all seniors and people with disabilities); ETHA-type expansion could be part of this
 - Mandatory access to medically needy coverage, and spenddown to a reasonable income level

