
Overview

Penelope L. Pine

This issue of the Health Care Financing Review features four articles on payment and service delivery for care of individuals with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). These articles focus on the following topics: the cost and financing of care for persons with HIV disease, Medicare utilization of beneficiaries with AIDS, HIV/AIDS drug assistance programs funded under Title II of the Ryan White Care Act, and health-based payment systems for HIV/AIDS.

This issue contains four papers relating to payment and service delivery for care of individuals with HIV or AIDS. The extent of the HIV/AIDS problem is well known, and the financing and service delivery problems have become more pronounced over time. New therapies and methods of organizing care can have significant effects. For instance, the rapid increase in use of new combination drug therapies has had a dramatic effect on the survival of persons with HIV (Centers for Disease Control and Prevention, 1997).

The financing burden for HIV/AIDS care is large. Medicaid¹ and Medicare² account for the largest proportion of Federal spending for care and assistance for persons with HIV/AIDS (Henry J. Kaiser Family Foundation, 1998). In Fiscal Year (FY) 1998, the Federal share of Medicaid spending for HIV/AIDS is expected to be \$1.9 billion, and Medicare will spend \$1.4 billion (22 and 16 percent,

respectively, of total Federal HIV/AIDS spending). In addition the State portion of Medicaid spending for HIV/AIDS care is \$1.6 billion, or 46 percent of the \$3.5 billion combined Medicaid spending.

Medicaid payments for HIV/AIDS care are projected to rise to \$2.6 billion (Federal) and \$2.2 billion (state), or a total of \$ 4.8 billion, by FY 2002. HCFA estimates that, nationally, Medicaid serves more than 50 percent of all persons living with AIDS and up to 90 percent of all children with AIDS (HCFA, Office of the Actuary, 1998).

Medicare's share of treatment costs for HIV/AIDS disease continues to rise as new medical technologies and drugs enable more persons to survive the 29-month waiting period for Medicare coverage under the Social Security Disability Insurance program. Medicare payments for HIV/AIDS care are projected to be \$2.1 billion by FY 2002 (HCFA, Office of the Actuary, 1998).

¹ Medicaid pays for health care services for eligible low-income individuals and, at the option of each State, those with high medical bills relative to their ability to pay. The program covers health care expenses for low-income families in which a parent is absent, deceased, incapacitated, or the principal wage earner is unemployed. In most States, the program covers the needy elderly, blind, and disabled who receive cash assistance under the Supplemental Security Income program. Coverage is also extended to certain low-income pregnant women and infants. States may extend Medicaid eligibility, only for the payment of group health insurance premiums, to certain individuals with low income and resources who are entitled to continue their employer-based policies after they have left employment.

² Medicare is a Federal health care insurance program for elderly persons, disabled persons, and persons with end-stage renal disease. The program has two separate and complementary parts: Hospital Insurance (Part A), with eligibility for workers and their dependents earned through the Social Security or Railroad Retirement programs, or in covered Government employment; and Supplementary Medical Insurance (Part B), which eligible individuals may choose to buy. State Medicaid agencies pay the Part B monthly premiums for certain low-income Medicare beneficiaries who are also eligible for Medicaid.

Penelope L. Pine is with the Office of Strategic Planning, Health Care Financing Administration (HCFA). The opinions expressed are those of the author and do not necessarily reflect those of HCFA.

The four papers on HIV/AIDS highlight important aspects of the changing care environment for persons with HIV/AIDS disease. In the first article on this theme, Hellinger provides an overview of the available health services research on costs and financing of care for persons with HIV/AIDS. This study focuses on the impact of the diffusion of new combination drug therapies on the cost and financing of HIV/AIDS. The proportion of treatment costs attributable to drugs has increased significantly since the diffusion of new combination drug therapies, and the proportion of costs attributable to hospital inpatient care has decreased. The number of persons living with HIV has increased, and persons with HIV have been starting antiretroviral therapies earlier in their illness. Changes in treatment regimens as well as in the demographic characteristics of persons living with HIV affect the cost and financing of HIV/AIDS care. Increasingly, persons with HIV in Medicaid are being enrolled in managed care plans, which affects payments. At this time, the major difficulty in analyzing the impact of these changes on cost and financing of care for persons with HIV is the lack of timely data.

The second article, by Fasciano, Cherlow, Turner, and Thornton, presents an analysis of Medicare utilization using administrative claims data for the period 1991-93. The article describes an AIDS case-finding process for use with claims files and discusses its potential accuracy. Using this method, the authors estimate that, at the end of 1993, 12 percent of AIDS cases in the United States were covered by Medicare. The more than 37,000 Medicare beneficiaries with AIDS were older than the general population of people with AIDS and were more likely to be female.

Medicare expenditures averaged \$2,400 per month for this group, with inpatient care accounting for about two-thirds of the expenditures.

In the future, this picture may be affected by changes in drug therapies. Greater use of protease inhibitors appear to reduce the use of inpatient care while increasing outpatient care and prescription drug utilization (Torres and Barr, 1997). The nature of insurance coverage, however, may affect this substitution. The HIV Outpatient Study found that patients with HIV on public insurance were less likely than persons who have private insurance to be prescribed protease inhibitors (Palella et al., 1998).

In the third article, Buchanan and Smith present results of a 1997 survey of how 48 States implemented HIV/AIDS drug assistance programs (HADAPs) funded under Title II of the Ryan White Care Act. HADAPs provide access to medications for people who lack health insurance coverage for medications. Considering combination drug therapies to fight HIV infection and medications to treat opportunistic infections, the number of drugs needed by persons with HIV can be extensive. As more persons with HIV seek care, public programs are faced with a growing demand for drug-related benefits. This study reports that even before the new protease inhibitors were approved by the Food and Drug Administration, budget constraints forced HADAPS in many States to reduce the number of drugs included in their formularies and to restrict eligibility for program benefits, with some programs implementing waiting lists. The respondents to this survey reported that they expect that the number of people needing HADAP benefits will increase and the number of

drugs on their formulary will also increase during the next year, putting more financial demand on this payment mechanism.

Recently, chronically ill patients in the Medicaid program, including persons with HIV/AIDS, have been more likely to be in managed care. In the fourth article relating to HIV/AIDS financing, Convisir, Gamliel, and Honberg present issues—including access, cost, equity, and quality concerns—raised at a May 1997 conference on risk adjustment of capitation payments for HIV. This article also describes AIDS-specific capitation rates that have been adopted in several State Medicaid waiver programs. It examines comprehensive risk adjustment systems and suggests further areas of study.

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Reprint Requests: Penelope L. Pine, Office of Strategic Planning, Health Care Financing Administration, 7500 Security Blvd., C-3-19-07, Baltimore, MD 21244-1850, E-Mail: PPine@hcfa.gov