AAHIVM POSITION PAPER: THE EARLY TREATMENT FOR HIV ACT (ETHA)

(Last Updated August 2003)

The science of HIV medicine is clear. Treatment of HIV patients before their immune systems have been severely damaged by HIV will greatly delay or even prevent the disabling effects of HIV disease. This is now recognized as the clinical standard of HIV health care—preserving an immune system is much more effective than rebuilding one already destroyed. However, while admirably providing states the option for early treatment for breast and cervical cancers under Medicaid, the federal government does not yet provide this option for HIV-infected patients. Instead, Medicaid provides access to quality medical care only in the later stages of HIV disease. Federal Medicaid statutes are outdated and must be amended in order for patients to benefit from advances in science and medicine. Fortunately, the opportunity to apply the scientific advances that reduce HIV-related mortality and illness to Medicaid requirements – critical for the realization of such advances - is before us now in the form of ETHA.

The Medicaid program is the single largest payer of health care to persons living with AIDS in the United States. To qualify for coverage under Medicaid, Americans not only must meet low income requirements, but also must be among the groups specifically designated to receive Medicaid funds.[1] Currently, HIV-positive individuals must meet the Supplemental Security Income (SSI) definition of disability,[2] which requires diagnosis of a manifest symptom (e.g., an opportunistic infection), a CD4 count below 200 combined with documented functional effects, or other overt symptoms of AIDS.[3] In other words, one must be *fully disabled* by AIDS before receiving care under Medicaid.

Current guidelines on antiretroviral therapy from the Centers for Disease Control and Prevention (CDC), however, recommend initiating treatment of HIV infection well *before* CD4 counts fall below 200. These guidelines recommend considering treatment when CD4 counts fall below 350, to avoid complications from AIDS.[4] Moreover, treating patients with higher CD4 counts, before they develop AIDS, is more cost-effective than treating the more serious, and more expensive, complications of AIDS.[5-8] Yet, these recommendations conflict with the current standards of eligibility under Medicaid,[3] highlighting a significant policy conflict between two arms of the U.S. Department of Health and Human Services, but offering an opportunity to integrate science and policy.

LEGISLATIVE ACTION

The "Early Treatment for HIV Act of 2003" (S. 847) (ETHA), introduced by Senators Gordon Smith (R-OR), Hillary Rodham Clinton (D-NY), and several others, amends Title

XIX of the Social Security Act to permit states the *option* of providing Medicaid coverage for people with HIV who have low incomes.[9] ETHA would give states the opportunity to provide care to people living with HIV *before* they are disabled, bringing Medicaid eligibility in step with the accepted, and more cost-effective, clinical standard of health care. The passage of ETHA would parallel the Bush Administration's commitment to follow public health science data, including the recent CDC initiative, *Advancing HIV Prevention: New Strategies for a Changing Epidemic*, a stated goal of which is to increase "availability of sustained treatment and prevention services for those infected [with HIV]."[10]

ETHA is successfully modeled after the Breast and Cervical Cancer Prevention and Treatment Act signed into law in October of 2000 (PL106-354).[11] This law gives states the option to expand Medicaid to eligible women screened through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and found to have breast or cervical cancer, including precancerous conditions.[12] NBCCEDP provides free breast and cervical cancer screening and follow-up diagnostic services to women with low incomes and to racial/ethnic minorities.[13] To date, 48 states and the District of Columbia have adopted this policy despite the difficult budgetary situations currently facing the nation.[14]

WHY ETHA MAKES SENSE

Passage of the Early Treatment for HIV Act will save lives, increase the length and quality of life for people living with HIV/AIDS, help ensure their medical coverage, and save money over time. Implementation of ETHA:

Saves Lives

- Over ten years, the death rate of those accessing Medicaid coverage is estimated to be cut in *half*, from 12% under current Medicaid guidelines down to 6% under the proposed ETHA.[15]

Increases the Quality and Length of Life

- Early treatment would delay the onset of AIDS in many eligible patients. The CDC guidelines for antiretroviral treatment in adults recommend early intervention (when the CD4 count drops below 350 or the viral load rises above 55,000 copies) as a sound treatment strategy, to delay the onset of AIDS.[4]
- ETHA would encourage and extend continuity of care by engaging HIV-positive individuals earlier in the disease process, providing earlier access to a broader range of health care services.[16]
- ETHA would reduce breaks in HIV treatment, which can compromise health and invite drug resistance, by supplying reliable, consistent treatment under Medicaid, an entitlement program, and reducing reliance on the AIDS Drug Assistance Programs (ADAPs),[15] which are, unfortunately and increasingly, subject to inconsistent funding and thus varying restrictions to access.[17]

Reduces New Infections

- Increased care and more effective treatment decrease a patient's circulating plasma viral load, which has been linked to decreased HIV transmission.[18] Therefore, treated populations may be less likely than untreated populations to transmit the virus.
- Increased access to health care encourages patients to maintain regular health care, thus lowering viral loads,[16] and to use more effective prevention measures.[19]

Ensures Coverage

- As an entitlement program, Medicaid does not depend on yearly federal appropriations of discretionary funds. Under Medicaid, ETHA would increase our ability to keep pace with the HIV epidemic, currently growing at approximately 40,000 per year,[20] and to maintain access to continuing advances in treatment.

Saves Money

- ETHA would be cost-effective for the Medicaid program by limiting costly hospital admissions and reducing *unnecessary*, preventable illness.[15]
- ETHA would provide cost savings to a number of other federal programs, including Medicare, SSI, and Social Security Disability Insurance (SSDI)[15]—programs already overextended by escalating caseloads.
- ETHA would increase federal tax revenue by helping patients who are in care to remain in or return to the workforce.[15]
- ETHA would lift some of the burden from Ryan White CARE Act, ADAPs, and other AIDS programs,[15] which could then turn resources to other clients or services.

According to the CDC, "every HIV-infected person should have the opportunity to be tested and have access to state-of-the-art medical care."[10] ETHA would help create this opportunity by fashioning continuity across federal health policies and equanimity across the HIV patient community.

In conclusion, federal Medicaid requirements must be amended to reflect the scientific fact that HIV-infected individuals benefit by initiation of therapy before HIV has progressed to disabling illnesses. We, as providers, know how and when to treat our patients. The decision as to when to intervene with medical treatment for HIV infection should be left in the hands of the medical provider and the patient, and should be appropriately supported by the policies of the federal government. Outdated restrictions suspend our ability to provide lifesaving treatment to those who need us the most. We value every human life, and we urge that this bill be quickly enacted into law. The American Academy of HIV Medicine (AAHIVM) encourages its members to support S. 847, The Early Treatment for HIV Act of 2003, by contacting their Members of Congress and urging their leadership on this issue.

ABOUT THE ACADEMY

The American Academy of HIV Medicine is an independent organization of HIV Specialists and others dedicated to promoting excellence in HIV/AIDS care. Through

advocacy and education, the Academy is committed to supporting health care providers in HIV medicine and to ensuring better care for those living with AIDS and HIV disease.

Our 1,600 members provide direct care to more than 275,000 HIV patients. This is more than half of the patients in active treatment for HIV disease. The Academy has a professionally diverse membership, primarily composed of ID, IM, FP, and GP specialists. In addition, 10 percent of the Academy's primary voting members are frontline NPs and PAs. More than 40 percent of the Academy's members receive Ryan White CARE Act funding, with 17 percent of the Academy's members practicing in community clinics.

NOTES AND REFERENCES

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