COSTS AND BENEFITS OF THE EARLY TREATMENT FOR HIV ACT

Background:

The Early Treatment for HIV Act (ETHA) creates a state option to provide Medicaid access to uninsured, low-income people living with HIV before they would otherwise qualify for Medicaid assistance though a disability diagnosis of AIDS. ETHA addresses a critical problem that exists under current Medicaid rules: most people must become disabled by AIDS before they become eligible for Medicaid, which provides access to care and treatment that could have prevented HIV disease from progressing into AIDS. ETHA is a cost-effective, prevention-based approach to reducing AIDS-related deaths and improving both individual and public health outcomes through early access to comprehensive care.

Prevention Benefits of ETHA

ETHA is in large part aimed at preventing the spread of HIV and the onset of AIDS.

- **Preventing HIV transmission** – Early access to HIV medications often reduces viral levels in the blood to undetectable levels, reducing the potential for HIV transmission by as much as 60%.

- **Preventing progression into AIDS** – Early access to care delays, if not altogether prevents, progression from HIV to AIDS and greatly reduces AIDS-related deaths.

- **Preventing the development of drug resistant strains** – Ensuring continuous access to HIV medications minimizes the development and possible transmission of drug resistant strains of HIV. Thus, continuous access to medication, and clinicians who supervise adherence to complex drug regimens, not only improves individual health outcomes, it is ultimately a public health imperative that decreases the spread of virulent new drug resistant HIV.

Savings of ETHA

In addition to its prevention benefits, ETHA results in significant cost-savings.

- **Lowering annual treatment costs** – Early treatment is cost-effective, as the average cost of treating a person with HIV is $13,000 per year, while treatment for a person with AIDS is nearly three times that amount, at an average of $36,000 per year.

- **Reducing high-cost medical interventions** – Early access to care and treatment significantly lowers the cost of patient hospitalizations, community care and terminal care, and the costs of treating opportunistic infections and cancers.

- **Reducing reliance on government programs** – Early treatment produces cost savings beyond health care, as it also reduces reliance on government disability and income-support programs.

- **Productivity benefits** – Early access to care keeps people healthy, allowing them to remain productive, working and paying taxes.
PricewaterhouseCoopers Analysis of the Early Treatment for HIV Act:

In 2003, the Treatment Access Expansion Project hired PricewaterhouseCoopers (PwC) to prepare a cost/savings analysis of ETHA. The PwC study analyzed the true costs and benefits of ETHA over five and ten year periods, considering the costs and savings in all federal programs. It equalized the death rates in the early intervention and non-early intervention scenarios to factor out the savings associated with the death of individuals not receiving early intervention health care. Finally, the study considered the costs/savings of those that entered the program in year one over five and ten-year periods to reduce the problem of savings associated with later entrants not being accounted for within the time frame analyzed. The PwC study demonstrates that ETHA delays the progression of HIV disease, increases life expectancy and is highly cost-effective.

- Over ten years, ETHA reduces the death rate for persons on Medicaid living with HIV by 50%.
- Over ten years, ETHA slows disease progression and improves health outcomes for thousands of individuals living with HIV.
- Over five years the net cost of providing early intervention health care and treatment under ETHA is $55.2 million. The savings realized through ETHA increase over time, resulting in savings of $31.7 million over ten years.

The CBO Cost Analysis:

In 2000, the Congressional Budget Office (CBO) estimated the cost of ETHA at approximately $1.4 billion over 5 years. The CBO analysis differs from the PwC estimates because the CBO employed strict budget analysis rules -- it only considered the costs and savings associated with providing early intervention health care within the Medicaid program over a set five-year period. While the CBO budget estimate demonstrates that ETHA is highly cost-effective, in light of the established benefits it provides in reducing HIV-related deaths, improving health outcomes and preventing the further spread of HIV, there are significant cost savings not recognized under the strict CBO budget model.

Savings created by late entrants

- The strict five-year CBO budget neutrality requirement is weighted toward recognizing costs. It counts the costs of providing care to those who enter the program late in the 5-year analysis, but excludes the savings of providing access to care to these later entrants because they are only realized after the 5-year budget time frame.

Savings realized by programs other than Medicaid

- The CBO budget analysis rules do not account for the savings realized in other federal programs such as SSI, SSDI, Medicare and Food stamps that result from providing early access to care and keeping people healthier. Early HIV coverage also increases federal tax revenues as individuals stay healthy and productive longer.

Benefits of improved health outcomes

- Early intervention reduces AIDS-related deaths by approximately 50-60%. Under strict budget rules, this results in increased costs to Medicaid, as reducing AIDS-related deaths means that more people are living longer and receiving health care. Therefore, when comparing the costs and savings of early intervention, strict budget neutrality rules recognize the costs associated with keeping people healthy and alive, but not the benefits of improved health outcomes and reduced deaths.

Prevention benefits

- Strict budget neutrality rules do not recognize the benefits provided by early access to HIV care in reducing HIV infectivity, the number of newly infected individuals, and ultimately the number of people living with HIV and AIDS who would otherwise end up on the Medicaid program.
Conclusion:
Early access to care delays progression from HIV to AIDS and reduces preventable high-cost medical interventions. As demonstrated through both the PricewaterhouseCoopers and the Congressional Budget Office budget analyses, access to early HIV care and treatment is cost-effective. Medicaid is the largest single payer of direct medical services for persons living with AIDS, but it is not currently managing HIV/AIDS expenses in the most cost-effective manner. Early treatment programs represent an exceptional opportunity to capitalize on the major progress that has been made in both treating and preventing the further spread of HIV disease. ETHA saves lives and money, prevents or postpones the development of AIDS, and reduces infectivity and transmission of HIV.


7 A Stanford/RAND study, funded by the federal Agency for Healthcare Research and Quality and published in the *Journal of Health Economics* (2003) confirms these results. The study found that expanding Medicaid coverage for HIV/AIDS patients could reduce HIV/AIDS-related deaths by up to 66%.

8 The PwC budget analysis differs from the CBO score as the PwC study found that traditional budget scoring, such as that used by the Congressional Budget Office, recognized all federal budgetary costs but failed to recognize many of the benefits and savings of ETHA.

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