



Overcoming Barriers to Expanding CARE/HIPP Enrollment

Background: As the number of persons living with HIV (PLH) in California expands and antiretroviral drug prices continue to increase, the funding needed for the AIDS Drug Assistance Program (ADAP) grows. One proposal for easing the financial demands on ADAP is to increase enrollment in The Comprehensive AIDS Resources Emergency/Health Insurance Premium Payment Program (CARE/HIPP) program. CARE/HIPP is funded by the Ryan White Program and administered by the California Department of Public Health, Office of AIDS. The goal of CARE/HIPP is to subsidize private insurance premiums for low income Californians who are disabled and unable to work because of HIV/AIDS. Since many of these PLH would otherwise be eligible to receive medication through ADAP, CARE/HIPP relieves the fiscal pressure on the ADAP budget and at the same time, provides the full medical coverage that the recipient had access to while employed. The duration of CARE/HIPP eligibility is limited (currently to 36 months), because the program was initially designed to allow individuals disabled by HIV to use COBRA continuation health insurance coverage until they could qualify for Medicare disability coverage.

Question:

“Aligning eligibility requirements for ADAP and CARE/HIPP would reduce ADAP costs.”

Methods: To examine the cost-effectiveness of the current CARE/HIPP program and the potential to expand the program, a UCLA research project funded by CHR, then known as UARP, first estimated the numbers and characteristics of then-current CARE/HIPP recipients. The study calculated the state’s cost of using CARE/HIPP to maintain enrollment in the individual’s private insurance plan and contrasted that with the estimated cost of providing antiretroviral drugs to these same individuals through the ADAP program. The expected costs and benefits of expanding the program to additional beneficiaries were then calculated.

To identify barriers to expanding CARE/HIPP insurance purchase to

additional enrollees in California, we conducted key informant interviews with benefits counselors, Ryan White case managers, and program managers at AIDS service organization (ASO) and HIV healthcare clinics in Los Angeles.

Findings: The current CARE/HIPP program is highly cost-effective, costing the state less than half of what it would otherwise spend to provide antiretroviral drugs (and other drugs on the ADAP formulary) to the same set of individuals. It is not only less costly to provide antiretrovirals through CARE/HIPP than directly through ADAP, but CARE/HIPP also provides clients with coverage for physician visits, other medications, and hospital services.

Although it would be cost-beneficial to expand the CARE/HIPP program, interviews with ASOs and medical providers in Los Angeles identified several eligibility and implementation barriers to CARE/HIPP enrollment:

- CARE/HIPP has more restrictive eligibility requirements than ADAP. Income criteria for eligibility are identical for full coverage under the two programs (income less than 400% of the



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federal poverty level; although persons with incomes up to \$50,000 are eligible for ADAP with a co-pay) Further, the ADAP program does not require that clients be disabled, while CARE/HIPP does. PLH who separate from a job for reasons other than disability are not eligible for help from the CARE/HIPP program and may turn to ADAP for assistance with drug costs.

- CARE/HIPP caps the premium for which it can pay at \$700. This cap may not adequately reflect recent increases in premium costs. Further, the state can not pay just the portion of the premium that is below the cap.
- CARE/HIPP is not able to pay for policies purchased through the Major Risk Medical Insurance Board.
- Potential clients lack awareness of the CARE/HIPP program and community-based case managers and benefits counselors lack information about eligibility for CARE/HIPP. While ADAP enrollment experts in the local health jurisdictions receive training for enrolling their clients in ADAP, comparable training and information about CARE/HIPP is not provided.
- Using ADAP enrollers to also enroll for CARE/HIPP results in a mismatch between enrollment

outreach and the target population. ADAP enrollers are deployed primarily at sites serving low-income HIV-infected individuals, few of whom have private insurance policies that could be extended by participation in CARE/HIPP. However, enrollers lack a presence at the types of medical facilities that treat persons with private insurance that could be eligible for CARE/HIPP continuation. The system is not structured in a way that facilitates enrollment because a potential CARE-HIPP enrollee needs to be aware of the program and proactively search out an enrollment opportunity.

- The CARE/HIPP enrollment process is more time consuming and burdensome to both enrollers and clients than ADAP enrollment. Reimbursement rates for CARE/HIPP enrollment are not sufficient to incentivize ASOs to participate.

Our analysis determined that CARE/HIPP would also be cost-effective for likely expansion populations, including the non-disabled, those whose private insurance premiums exceed the cap and HIV positive persons without health insurance who could enroll in the state's high risk insurance pool.

Policy Implications: The CARE/HIPP program should be expanded in order to reduce ADAP program expenditures and provide additional benefits to PLH by adopting the following policies:

- Aligning the eligibility requirements of the CARE/HIPP and ADAP programs, particularly removing the disability requirement for CARE/HIPP.
- Raising or eliminating the premium cap.
- Increasing awareness of CARE/HIPP among potential clients.
- Improving training of ADAP outreach workers in screening, referral, enrollment and recertification procedures for CARE/HIPP.
- Encouraging CARE/HIPP enrollment at sites that have more potential clients with private insurance coverage.
- Allowing CARE/HIPP to pay less than the full amount for premiums that exceed the cap.
- Removing budget barriers that prevent flexible allocation of funds between the two programs.
- Expanding options for private insurance for PLH, including use of the new high risk pool.