No. 11-400

In The
Supreme Court of the United States

STATE OF FLORIDA, ET AL., PETITIONERS,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR NATIONAL MINORITY AIDS COUNCIL; AMFAR, THE FOUNDATION FOR AIDS RESEARCH; HIV MEDICINE ASSOCIATION; NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS; AND TREATMENT ACCESS EXPANSION PROJECT AS AMICI CURIAE SUPPORTING RESPONDENTS

(Medicaid)

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The National Minority AIDS Council; amfAR, The Foundation for AIDS Research; the HIV Medicine Association; the National Alliance of State & Territorial AIDS Directors; and the Treatment Access Expansion Project respectfully submit this brief as amici curiae in support of respondents.[1]

INTEREST OF AMICI CURIAE

The **National Minority AIDS Council (NMAC)** is a nonprofit organization with the mission to develop leadership in communities of color to end the HIV/AIDS epidemic. Since its founding in 1987, NMAC has advanced this mission through a variety of public policy education programs, national conferences,

[1] Letters providing blanket consent to the filing of amicus briefs have been filed with the Clerk of the Court, pursuant to Rule 37.3(a). No counsel for a party authored this brief in whole or in part, and no party or counsel for a party made a monetary contribution intended to fund the preparation or submission of the brief. No person other than amici curiae, their members, or their counsel made a monetary contribution to the preparation or submission of this brief.

treatment and research programs and trainings, electronic and printed resource materials, and through its website. NMAC represents a coalition of close to 3,000 faith- and community-based and AIDS service organizations that deliver HIV/AIDS services in communities of color nationwide.

amfAR, The Foundation for AIDS Research, is one of the world's leading nonprofit organizations dedicated to the support of HIV/AIDS research, prevention, treatment education, and advocacy for evidence-based AIDS-related public policy. amfAR identifies critical gaps in our knowledge of HIV/AIDS, and supports promising early-stage studies that often lack the preliminary data required by more traditional funders. amfAR also strives to reduce worldwide rates of HIV infection in low- and middle-income countries by providing small grants to grassroots groups that help expand HIV education and prevention. amfAR aims to generate awareness of the need for better treatment and prevention methods, and publishes educational materials on important AIDS-related research, treatment, prevention, and policy issues.

The **HIV Medicine Association (HIVMA)** is a national organization representing more than 4,800 HIV medical providers, researchers, and scientists working in all 50 States and more than 50 countries. HIVMA is nested within the Infectious Diseases Society of America and was created in 2001 to promote access to quality HIV care and to advocate for federal policies that ensure a comprehensive and

humane response to the AIDS pandemic, informed by science and social justice. As an organization representing frontline medical providers caring for many uninsured and underinsured patients with HIV/AIDS, HIVMA has a strong interest in supporting sound healthcare financing policies that improve access to lifesaving care and treatment for people living with HIV/AIDS.

The **National Alliance of State and Territorial AIDS Directors (NASTAD)** represents the Nation's chief state health agency staff who have programmatic responsibility for administering HIV/AIDS and viral hepatitis healthcare, prevention, education, and supportive service programs funded by state and federal governments. NASTAD is dedicated to reducing the incidence of HIV/AIDS and viral hepatitis infections in the United States and its territories, providing comprehensive, compassionate, and high-quality care to all persons living with HIV/AIDS and viral hepatitis, and ensuring responsible public policies. NASTAD provides national leadership to achieve these goals, and to educate about and advocate for the necessary federal funding to achieve them, as well as to promote communication between state and local health departments and HIV/AIDS and viral hepatitis care and treatment programs. NASTAD supports and encourages the use of applied scientific knowledge and input from affected communities to guide the development of effective policies and programs.

Based in Washington, D.C. and Boston, Massachusetts, the **Treatment Access Expansion Project (TAEP)** is a national organization that has worked since 1996 to improve access to affordable, comprehensive, high-quality health care for poor and low-income people living with chronic medical conditions, including HIV/AIDS. TAEP plays a leadership role within the HIV/AIDS community in addressing emerging healthcare opportunities and challenges by coordinating and informing efforts of national, state, and local partners to expand access to care. TAEP specifically focuses on four goals: supporting HIV testing and linkage to care initiatives, reducing the number of people diagnosed late in their disease progression, promoting early access to care and treatment, and eliminating HIV-related stigma and discrimination. TAEP has been integrally involved in shaping and carrying out the national HIV/AIDS community's advocacy efforts related to healthcare reform and the Patient Protection and Affordable Care Act.

Amici have a strong interest in making treatment available for all persons living with HIV/AIDS. Nearly half of all persons living with HIV in the United States who are receiving regular care are enrolled in Medicaid. But because of Medicaid's eligibility requirements, most uninsured low-income adults with HIV are ineligible and therefore lack access to the recommended antiretroviral therapy. The Medicaid expansion provisions of the Patient Protection and Affordable Care Act will make critical

treatment available to many more low-income adults living with HIV/AIDS.

Amici submit this brief to demonstrate the real-world implications of the Affordable Care Act's Medicaid expansion provisions, not only on quality of life for low-income Americans, but also on ending the HIV/AIDS epidemic.

INTRODUCTION AND SUMMARY OF ARGUMENT

Under Medicaid law before the Patient Protection and Affordable Care Act, most low-income adults living with HIV do not qualify for Medicaid, even if they meet Medicaid's income limitations. That is because, to be eligible for Medicaid, a person must not only have income below a certain level, the person also must fall into one of several categories. Most non-disabled adults without dependent children are categorically excluded from Medicaid enrollment.

Disability is by far the most common category through which uninsured adults with HIV qualify for Medicaid. But the disability requirement sets a cruel trap. The standard of care for individuals with HIV is a regimen of highly active antiretroviral treatments, which successfully suppresses the progression of the virus and staves off disability. But most low-income individuals with HIV are unable to access the treatment regimen through Medicaid. That is because HIV infection, alone, is not a qualifying disability for Medicaid eligibility. Only once an individual's HIV has progressed to the point that he or she is unable to work or is diagnosed with AIDS does the individual qualify for Medicaid and for the very treatment that could have prevented disability in the first place.

The Affordable Care Act removes the disability requirement and makes Medicaid available to all adults who earn up to 133% of the federal poverty

level. That means that all income-eligible individuals living with HIV will have access to essential antiretroviral treatments.

The Medicaid expansion will have tremendous results in the fight against the HIV/AIDS epidemic. It will prolong life potentially by decades for literally hundreds of thousands of persons. It will also substantially improve quality of life for those who receive treatment. For most individuals with HIV who are on an antiretroviral treatment regimen, HIV is a chronic but manageable disease. Individuals can continue to work and go about their daily lives as productive members of society and can continue contributing to the U.S. economy.

Just as important, the Medicaid expansion has the potential to slow dramatically the spread of HIV infection in the overall population. Studies of places where HIV/AIDS treatment has been made universally available have shown transmission rates cut *in half*. HIV treatment can suppress the presence of the virus in the bloodstream to an extremely low—often undetectable—level, and thereby sharply reduce the chances of transmission. Epidemiologists have concluded that increased availability of antiretroviral treatment, combined with better health education and HIV screening, will successfully slow the spread of the disease.

Although the costs of care are substantial, treatment is very cost-effective. Better early treatment means less direct spending on acute and hospice care. Decreased transmission rates mean less spending

later on HIV/AIDS treatment. Earlier treatment means that individuals can stay productive for much longer during their working years. And that means less spending on other state services.

The judgment of the Eleventh Circuit upholding the Medicaid expansion provisions of the Affordable Care Act should be affirmed.

ARGUMENT

THE AFFORDABLE CARE ACT'S MEDICAID EXPANSION PROVISION WILL REDUCE HIV TRANSMISSION, IMPROVE QUALITY OF LIFE, AND PREVENT DEATHS, AND IT WILL DO SO COST-EFFECTIVELY

The Affordable Care Act's Medicaid expansion provisions will remove the single largest obstacle that keeps uninsured adults with HIV/AIDS who earn up to 133% of the federal poverty level from receiving treatment through Medicaid. That will be a critical step toward not only improving public health but ending the HIV/AIDS epidemic.

A. The Disability Requirement In Current Medicaid Law Makes Highly Effective HIV Treatment Unavailable For Most Uninsured Low-Income Adults

Under Medicaid law before the Affordable Care Act, most non-disabled low-income adults without dependent children are categorically excluded from

qualifying for Medicaid enrollment. That is because having income below a certain level does not, alone, make someone eligible for Medicaid. In addition to the income requirement, persons also must fall into one of several categories enumerated by statute. 42 U.S.C. § 1396a(a)(10)(A)(i). Those categories include children, parents with dependent children, pregnant women, and persons who receive Supplemental Security Income benefits due to a disability. 42 U.S.C. § 1396a(a)(10)(A)(i)(II), (III); *id.* § 1396d(a).

For persons living with HIV/AIDS, disability is by far the most common categorical eligibility pathway to qualify for Medicaid. Jen Kates, *Medicaid and HIV: A National Analysis,* KAISER FAMILY FOUNDATION at 1 (Sep. 30, 2011), http://www.kff.org/hivaids/8218.cfm. Seventy-four percent of persons living with HIV/AIDS who are enrolled in Medicaid qualify because of disability. *Id.* at 1, 17. Disability is the most likely eligibility pathway because individuals with HIV are more likely to be male and less likely to have dependent children than the overall population. *Id.* at 8. In contrast, only about a fifth of Medicaid enrollees who do not have HIV qualify on the basis of a disability. *Id.* at 1, 17. Although many participating States have expanded Medicaid eligibility beyond the federal minimums, the expansions primarily benefit children. Thus, for non-disabled adults, Medicaid eligibility is very limited. *Id.* at 4.

Yet having HIV—the virus that causes AIDS—is not considered a disability for Medicaid eligibility purposes. *Id.* at 4. Persons may live with HIV—and

may even be completely asymptomatic—for many years before they develop AIDS. Centers for Disease Control and Prevention, *Living with HIV/AIDS* (Jun. 21, 2007), http://www.cdc.gov/hiv/resources/brochures/livingwithhiv.htm [hereinafter CDC, *Living with HIV/AIDS*]. Persons with HIV qualify as disabled only once their disease progresses to the point that they are no longer able to work or when they are diagnosed with AIDS. Kates, *supra*, at 4.

But having to wait for Medicaid coverage until HIV progresses to AIDS deprives persons with HIV of the very care that might prevent that progression. The current recommended treatment for HIV involves a combination of three or more antiretroviral medications. This regimen is known as "highly active antiretroviral therapy," or "HAART." CDC, *Living with HIV/AIDS*, *supra*; Evan Wood et al., *Expanding Access to HIV Antiretroviral Therapy Among Marginalized Populations in the Developed World*, 17 AIDS 2419, 2419 (2003). Each HAART regimen must be tailored to each individual patient. CDC, *Living with HIV/AIDS*, *supra.* If the HAART regimen is followed closely, the progression of HIV into AIDS usually can be delayed for many years—even decades.

Without health insurance, HAART is prohibitively expensive for most HIV/AIDS patients. The cost of HAART medication alone amounts to as much as $16,000 per year. Center for Health Law and Policy Innovation of Harvard Law School, *Massachusetts HIV/AIDS Resource Allocation Project* 15 (Working

Paper, Dec. 13, 2011). That is simply unaffordable for most: a 1998 study revealed that 46% of persons receiving treatment for HIV/AIDS had annual household incomes of less than $10,000, and 72% had incomes of less than $25,000. Samuel A. Bozzette et al., *The Care of HIV-Infected Adults in the United States*, 339 New Eng. J. Med. 1897, 1900 (1998). Moreover, 68% lacked private health insurance. *Ibid*.

Thus, uninsured adults with HIV who otherwise meet the income eligibility requirements for Medicaid are trapped in a catch-22. Although there are highly effective treatments that can prevent HIV's progression to AIDS—as well as stave off a host of HIV-related opportunistic infections, keeping disability at bay—most uninsured low-income adults lack access to these treatments because they are ineligible for Medicaid. It is only once the disease has progressed to AIDS or has made the individual disabled that they become eligible for Medicaid and gain access to HAART. Indeed, despite the ability of HAART to prevent AIDS, the vast majority of people receiving treatment have already progressed to AIDS. *Id.* at 1903 (60% of patients receiving treatment for HIV/AIDS already have AIDS, even though only about one-third of persons with HIV has AIDS). Our Nation's healthcare system is failing to adequately provide care to those with HIV at a stage of the illness in which the treatments can have the most significant impact.

The Affordable Care Act eliminates that catch-22 for many. Beginning in 2014, the Affordable Care

Act will make Medicaid available for all persons under the age of 65 whose income does not exceed 133% of the federal poverty level. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). The Congressional Budget Office estimates that, by 2016, this Medicaid expansion alone will cover 16 million of the 50 million uninsured Americans. *CBO's Analysis of the Major Health Care Legislation Enacted in March 2010: Hearing Before the Subcomm. On Health of the H. Comm. on Energy & Commerce*, 112th Cong. 18 tbl.3 (2011) (statement of Douglas Elmendorf). By effectively ending the disability requirement, the Affordable Care Act will make many more low-income persons living with HIV/AIDS eligible for Medicaid. That will dramatically increase access to HAART.

B. The Affordable Care Act's Medicaid Expansion Will Improve Quality Of Life For Persons With HIV

The most obvious benefit from making Medicaid available to low-income individuals with HIV/AIDS is that it will improve their quality of life.

HIV causes a chronic viral infection that nearly universally progresses to a devastating and debilitating disease and, ultimately, to premature death. Centers for Disease Control and Prevention, *Vital Signs: HIV Prevention Through Care and Treatment—United States*, 60 Morbidity and Mortality Weekly Report 1618, 1618 (2011) [hereinafter CDC, *Vital Signs*]. Without treatment, most individuals

with HIV develop AIDS within 10 years of infection. *Ibid.*

The HAART regimen changes that dramatically. HAART is extremely effective at suppressing the amount of HIV in the bloodstream, often reducing it to undetectable levels. Over 75% of persons with HIV who follow the HAART regimen have suppressed viral load levels. *Id.* at 1619. Many people now can remain perpetually asymptomatic, not only preventing the disease's progression, but also staving off a number of HIV-related opportunistic infections. Apart from having to follow closely the HAART regimen and the possibility of side effects from the medication, HAART drastically improves quality of life. For those who have access to HAART, HIV is now essentially a chronic but manageable illness. *Wood* et al., *supra*, at 2419.

Since HAART was introduced in the 1990s, the number of deaths from AIDS has plummeted. Until 1994, the number of deaths steadily increased. Then from just 1995 to 1999, AIDS deaths dropped by 70% among men and 51% among women. Steep declines were seen in all demographic and risk groups. John M. Karon et al., *HIV in the United States at the Turn of the Century: An Epidemic in Transition*, 91 Am. J. of Pub. Health 1060, 1061-1064 (2001). Epidemiologists have concluded that the dramatic decrease in AIDS deaths was attributable primarily to HAART slowing the progression of the disease among people receiving treatment. *Id.* at 1065.

Despite the effectiveness of HAART, HIV/AIDS mortality persists in the United States. Although some HIV/AIDS deaths may be attributable to suboptimal adherence to the HAART regimen, the majority of deaths are due to limited access to HAART among disadvantaged or marginalized populations. Wood et al., *supra*, at 2420. These populations include many of the same groups that traditionally have had problems gaining access to quality health care, including individuals of lower socio-economic status, ethnic minorities, and users of intravenous drugs. *Ibid.* The Centers for Disease Control and Prevention (CDC) estimates that out of the 1.2 million people living with HIV in the United States, just 427,000 (36%) are on the HAART regimen, and only 328,000 (28%) have suppressed viral load. CDC, *Vital Signs*, *supra*, at 1621.

By making HAART available to many more low-income individuals living with HIV, the Affordable Care Act's Medicaid expansion is likely to save hundreds of thousands of lives. In addition to reducing the death rate, the Medicaid expansion will profoundly improve quality of life for those living with HIV—increasing not only their lifespan but also the number of years they will remain asymptomatic.

Indeed, where Medicaid expansion has been tested, these expected results have been proven. In 2001, Massachusetts received a waiver from the federal government to expand Medicaid coverage for people living with HIV/AIDS. Center for Health Law, *supra*, at 3. Under the State's Medicaid expansion,

all individuals under 65 years of age with an income up to 200% of the federal poverty level who tested positive for HIV became automatically eligible for Medicaid enrollment. *Ibid.* The program has been a marked success. "People with HIV in Massachusetts are living longer than people with HIV elsewhere." *Id.* at 7. The number of HIV deaths in the State remained steady at around 400 per year from 1999 to 2003, but then over the next five years—from 2004 to 2008—the number of HIV/AIDS deaths dropped each year to a low of 250. *Ibid.* While the rate of deaths from HIV/AIDS has been declining slowly nationwide—from 4.9% in 2002 to 3.7% today—the rate in Massachusetts has dropped nearly twice as fast—from 3.5% in 2002 to 2% today. *Id.* at 7-8.

C. The Medicaid Expansion Will Greatly Reduce HIV Transmission

While it is intuitive that providing treatment to individuals with HIV/AIDS will reduce mortality and morbidity and will improve quality of life, the Medicaid expansion will have another less obvious—but just as important—benefit: it will substantially reduce the transmission of HIV.

According to the CDC, "successful use of [HA]ART by enough infected individuals could substantially reduce the spread of HIV within a population." CDC, *Effect of Antiretroviral Therapy on Risk of Sexual Transmission of HIV Infection and Superinfection*, at 1 (2009), http://www.cdc.gov/hiv/topics/

treatment/resources/factsheets/pdf/art.pdf [hereinafter CDC, *Effect of Antiretroviral Therapy*]. That is because most individuals diagnosed with HIV who receive HAART are able to reduce the amount of the virus in the bloodstream to undetectable levels. Julio S. G. Montaner et al., *The Case for Expanding Access to Highly Active Antiretroviral Therapy to Curb the Growth of the HIV Epidemic*, 368 Lancet 531, 531 (2006). Individuals with undetectable levels of the virus are less infectious in general and less likely to transmit HIV through sexual contact. CDC, *Effect of Antiretroviral Therapy*, *supra* at 1. Indeed, the level of HIV virus in the bloodstream—referred to as "viral load"—is the single largest predictor of the risk of heterosexual transmission of HIV. Montaner et al., *supra*, at 531. By boosting viral load suppression among the population of people with HIV/AIDS, the number of individuals who are able to transmit the virus will fall dramatically.

Recent studies provide compelling evidence that making HAART available to all persons with HIV/AIDS cuts in half the transmission of the virus in the population as a whole. In a study from Taiwan, there was a 53% reduction in new HIV-positive tests after free access to HAART was made available. Montaner et al., *supra*, at 532. And in British Columbia, Canada, HIV transmissions fell by about 50% between 1995 and 1998 after the introduction of HAART. *Ibid.* The results are even more compelling when HAART is introduced immediately upon infection. In a model

of a program designed to control heterosexual HIV transmission through HAART initiation immediately upon testing positive for HIV, incidence of new HIV transmissions was reduced to less than 1 per 1000 persons per year. CDC, *Effect of Antiretroviral Therapy*, *supra*, at 5.

And a recent study among serodiscordant couples—couples in which one partner has HIV and the other does not—showed that early initiation of HAART led to a 96% reduction in HIV transmission to the uninfected partner. HIV Prevention Trials Network, *Initiation of Antiretroviral Therapy (ART) Prevents the Sexual Transmission of HIV in Serodiscordant Couples* (July 2011), http://www.hptn.org/web%20documents/HPTN052/HPTN%20Factsheet_InitiationART4Prevention.pdf. Another study showed that among heterosexual serodiscordant couples, transmission was reduced by 80% when the HIV-positive partner received HAART. CDC, *Effect of Antiretroviral Therapy*, *supra*, at 4.

Despite the effectiveness of HAART at reducing viral load, only about one fourth of all persons diagnosed with HIV in the United States are virally suppressed, mainly because only about half of individuals diagnosed with HIV are receiving regular care. CDC, *Vital Signs*, *supra*, at 1622. Making HAART more widely available, therefore, has tremendous potential to boost the number of persons living with HIV who are virally suppressed, and thereby substantially reduce rates of HIV transmission.

The results from Massachusetts's 2001 expansion of Medicaid are instructive. As a result of increased access to, and improved quality of, health care in Massachusetts, HIV/AIDS patients in that State have much higher rates of viral load suppression than the rest of the Nation. Center for Health Law, *supra*, at 10. By 2006, 65% of HIV/AIDS patients in Massachusetts had achieved total viral suppression, and 84% had viral loads under 400 (a key marker in HIV progression). *Ibid.* By expanding access to treatment nationwide, the Affordable Care Act is likely to achieve similar success at boosting viral load suppression and thereby substantially slowing the transmission of HIV.

In addition to reducing transmission through improved viral load suppression, the Medicaid expansion also is likely to stem HIV transmission through improved health care and health education among the non-infected population. "[S]ocioeconomic issues associated with poverty, including limited access to high-quality health care, housing, and HIV prevention education, directly and indirectly increase the risk for HIV infection and affect the health of people living with and at risk for HIV infection." CDC, *HIV Among African Americans* (Nov. 2011), http://www.cdc.gov/hiv/topics/aa/PDF/aa.pdf. Many of the population groups that are most at risk for new HIV infections are also the same groups that have limited access to health care. By making basic preventative health care widely available to many more low-income

adults, the Medicaid expansion will educate non-infected persons about how to prevent transmission.

Moreover, making regular HIV screening more widely available will substantially reduce transmission. It is estimated that 21% of all persons living with HIV in the United States are unaware that they are infected. Elisa F. Long et al., *The Cost-Effectiveness and Population Outcomes of Expanded HIV Screening and Antiretroviral Treatment in the United States*, 153 Annals of Intern. Med. 778, 778 (2010). The majority of cases of sexual transmission of HIV occur from those who are unaware of their HIV-positive status. Gary Marks et al., *Estimating Sexual Transmission of HIV from Persons Aware and Unaware That They Are Infected with the Virus in the USA*, 20 AIDS 1447, 1449 (2006). Indeed the transmission rate among the unaware is 3.5 times as high as among those who are aware. *Ibid.* The Medicaid expansion will provide access to HIV screening that will inform more individuals about their HIV status and will empower newly diagnosed individuals to receive treatment and take other precautions to stop transmission earlier. These are all critical steps toward stopping the HIV/AIDS epidemic, and the Affordable Care Act will make them a reality.

D. Expanding HIV/AIDS Treatment Through Medicaid Is Cost-Effective

To be sure, providing HAART to more uninsured low-income individuals with HIV will be expensive.

But doing so is extremely cost-effective and in many ways will save money for participating States.

Because the HAART regimen is, for most people, extremely effective at slowing or stopping the progression of HIV, making HAART more widely available will decrease HIV/AIDS-related healthcare expenditures on acute and hospice care. Numerous studies have proven that the HAART regimen is cost-effective on this basis alone—without even considering other, more indirect benefits. Montaner et al., *supra*, at 532; Kenneth A. Freedberg, *The Cost Effectiveness of Combination Antiretroviral Therapy for HIV Disease*, 344 New Eng. J. Med. 824, 830 (2001).

Moreover, because the HAART regimen reduces the number of new HIV cases, the short-term investment in making HAART more widely available will pay off in the long run by reducing the number of persons diagnosed with HIV and in need of HAART. The CDC estimates that if the HAART regimen is not made more widely available, there are likely to be 1.2 million new HIV infections in the United States over the next 20 years. CDC, *Vital Signs*, *supra* at 1622. Based on estimated treatment costs of $367,000 per person over each individual's lifetime, caring for these new infections could cost as much as $450 billion. *Ibid.* But it is estimated that HAART will reduce later HIV/AIDS treatment spending by tens of billions of dollars each year—based on studies that have shown that the universal availability of HAART reduces HIV-transmission rates by about 50%. Montaner et al., *supra*, at 532-533. In other words,

because HAART cuts transmission in half, it pays half its own way.

Expanding HIV treatment will also have economic benefits. Because the HAART regimen significantly extends the lifetime of persons with HIV/AIDS and staves off disability, persons with HIV who are receiving the HAART regimen have many more productive years than those not receiving therapy. Most persons who become infected with HIV do so in their younger and most productive years. Angela B. Hutchinson et al., *The Economic Burden of HIV in the United States in the Era of Highly Active Antiretroviral Therapy: Evidence of Continuing Racial and Ethnic Differences*, 43 J. Acquired Immune Deficiency Syndrome 451, 455 (2006). Thus, when AIDS cuts lives short, it does so with enormous costs to economic productivity. For example, the 40,000 new HIV infections in 2002 alone cost $30 billion in mortality-related productivity losses, measured by income forgone because of premature death. *Id.* at 453. That does not even include morbidity-related productivity losses, i.e., the income forgone because of disability. *Ibid.* Although the direct medical costs of expanding the HAART regimen to reach all persons living with HIV are estimated to be $1.2 billion, that investment actually would be cost-saving because it would reduce HIV/AIDS-related productivity losses by $3 billion. *Id.* at 454.

Those economic benefits will reduce States' expenditures on other public programs. Because the disability requirement in current Medicaid law

requires most uninsured low-income people to become unable to work before they are eligible for treatment, an HIV diagnosis traps a low-income person into a cycle of poverty and dependence upon government assistance. Without the Medicaid expansion, States still would bear costs associated with HIV infection, but they would be spent on other public welfare programs.

The Medicaid expansion will also relieve some of the direct costs, currently borne in part by the States, associated with treating HIV/AIDS through the Ryan White HIV/AIDS Program. With contributions from both the federal government and the States, the Ryan White Program is a payer of last resort and funds AIDS Drug Assistance Programs (ADAPs) in each State. ADAPs provide HIV-related prescription drugs to low-income persons who have limited or no insurance coverage for prescription drugs. ADAPs are not entitlement programs; the number of enrollees is dependent upon the amount of funding available. Henry J. Kaiser Family Foundation, *HIV/AIDS Policy Fact Sheet: AIDS Drug Assistance Programs (ADAPs)* (Apr. 2008), http://www.kff.org/hivaids/upload/1584_09.pdf; Health Resources & Services Administration, U.S. Dep't of Health & Human Servs., *Part B—AIDS Drug Assistance Program*, http://hab.hrsa.gov/abouthab/partbdrug.html. With the recent economic crisis, demand for ADAP services has ballooned, while funding has fallen short, which has spurred some States to reduce program eligibility and institute waiting lists. The Medicaid expansion will allow

States to provide treatment to income-eligible individuals through Medicaid rather than ADAPs. That will save States money because, unlike ADAP funding, 90% to 100% of the Medicaid expansion is paid for by the federal government.

The expansion will also allow States to make better use of their Ryan White HIV/AIDS Program funding. For example, since Massachusetts expanded its Medicaid eligibility, its Ryan White HIV/AIDS Program funds are now focused on early intervention, expanding access to care, and providing support services, rather than paying for acute medical care. Indeed, Massachusetts has been able to expand its ADAP coverage to 481% of the federal poverty level (treating 1,500 more people), while decreasing the amount it spends on medications and keeping overall costs and funding flat. And unlike most States, Massachusetts's ADAP has no waiting list. Center for Health Law, *supra*, at 14-15.

In sum, not only is it inhumane to wait until individuals become disabled—as all untreated individuals with HIV eventually will—before providing essential care, it also makes no sense from either a public health or economic perspective.

CONCLUSION

The judgment of the Eleventh Circuit upholding the Medicaid expansion should be affirmed.

Respectfully submitted,

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