2019-20 Service Category Definition
Ryan White Part B and DSHS State Services

Local Service Category:	**Health Insurance Premium and Cost Sharing Assistance**
Amount Available**:**	**To be determined**
Budget Requirements or Restrictions **(TRG Only)**:	Contractor must spend no more than 20% of funds on disbursement transactions. The remaining 80% of funds must be expended on the actual cost of the payment(s) disbursed. ADAP dispensing fees are not allowable under this service category.
Local Service Category Definition:	**Health Insurance Premium and Cost Sharing Assistance:** The Health Insurance Premium and Cost Sharing Assistance service category is intended to help people living with HIV continue medical care without gaps in health insurance coverage or disruption of treatment. A program of financial assistance for the payment of health insurance premiums and co-pays, co-insurance and deductibles to enable eligible individuals with HIV disease to utilize their existing third party or public assistance (e.g. Medicare) medical insurance. Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement that requires the insured to pay a percentage of costs for covered services/prescription Deductible: A cost-sharing requirement that requires the insured pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy. Advance Premium Tax Credit (APTC) Tax Liability: Tax liability associated with the APTC reconciliation; reimbursement cap of 50% of the tax due up to a maximum of $500.
Target Population (age, gender, geographic, race, ethnicity, etc.):	All Ryan White eligible clients with 3rd party insurance coverage (COBRA, private policies, Qualified Health Plans, CHIP, Medicaid, Medicare and Medicare Supplemental plans) within the Houston HSDA.
Services to be Provided:	Contractor may provide assistance with: • Insurance premiums, • And deductibles, co-insurance and/or co-payments.
Service Unit Definition **(TRG Only)**:	A unit of service will consist of payment of health insurance premiums, co-payments, co-insurance, deductible, or a combination.
Financial Eligibility:	Affordable Care Act (ACA) Marketplace Plans: 100-400% of federal poverty guidelines. All other insurance plans at or below 400% of federal poverty guidelines. Exception: Clients who were enrolled prior to November 1, 2015 will maintain their eligibility in subsequent plan years even if below 100% or between 400-500% of federal poverty guidelines.
Client Eligibility:	People living with HIV in the Houston HSDA and have insurance or be eligible (within local financial eligibility guidelines) to purchase a Qualified Health Plan through the Marketplace.

Agency Requirements **(TRG Only)**:	Agency must: • Provide a comprehensive financial intake/application to determine client eligibility for this program to insure that these funds are used as a last resort in order for the client to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace. • Clients will not be put on wait lists nor will Health Insurance Premium and Cost Sharing Assistance services be postponed or denied due to funding without notifying the Administrative Agency. • Conduct marketing in-services with Houston area HIV/AIDS service providers to inform them of this program and how the client referral and enrollment processes function. • Establish formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance abuse provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance abuse provider site. (i.e. No need for client to physically present to Health Insurance provider.) • Utilizes the RW Planning Council-approved prioritization of cost sharing assistance when limited funds warrant it (premiums take precedence). o **Priority Ranking of Requests (in descending order)**: ▪ HIV medication co-pays and deductibles (medications on the Texas ADAP formulary) ▪ Non-HIV medication co-pays and deductibles ▪ Co-payments for provider visits (eg. physician visit and/or lab copayments) ▪ Medicare Part D (Rx) premiums ▪ APTC Tax Liability ▪ Out of Network out-of-pocket expenses • Utilizes the RW Planning Council –approved consumer out-of-pocket methodology.
Special Requirements **(TRG Only)**:	Must comply with the **DSHS Health Insurance Assistance Standards of Care** and the **Houston HSDA Health Insurance Assistance Standards of Care** ~~and, pending the most current DSHS guidance, client must:~~ ~~• Purchase Silver Level Plan with formulary equivalency~~ ~~• Take advance premium credit~~ • ~~No assistance for Out of Network out-of-pocket expenses without prior approval of the Administrative Agent.~~ ~~Must comply with DSHS Interim Guidance.~~ Must comply with updated guidance from DSHS. Must comply with the Eastern HASA Health Insurance Assistance Policy and Procedure ~~(HIA-1701)~~.

FY 2021 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/11/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/04/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/19/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #2**	Date: **04/21/2020**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

FY 2020 Houston EMA Ryan White Part A/MAI Service Definition Health Insurance Co-Payments and Co-Insurance Assistance	
HRSA Service Category Title:	**Health Insurance Premium and Cost Sharing Assistance**
Local Service Category Title:	**Health Insurance Co-Payments and Co-Insurance**
Budget Type**:**	**Hybrid Fee for Service**
Budget Requirements or Restrictions:	Agency must spend no more than 20% of funds on disbursement transactions. The remaining 80% of funds must be expended on the actual cost of the payment(s) disbursed.
HRSA Service Category Definition**:**	***Health Insurance Premium & Cost Sharing Assistance*** is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.
Local Service Category Definition:	A program of financial assistance for the payment of health insurance premiums, deductibles, co-insurance, co-payments and tax liability payments associated with Advance Premium Tax Credit (APTC) reconciliation to enable eligible individuals with HIV disease to utilize their existing third party or public assistance (e.g. Medicare) medical insurance. Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement that requires the insured to pay a percentage of costs for covered services/prescription Deductible: A cost-sharing requirement that requires the insured to pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy. APTC Tax Liability: The difference paid on a tax return if the advance credit payments that were paid to a health care provider were more than the actual eligible credit.
Target Population (age, gender, geographic, race, ethnicity, etc.):	All Ryan White eligible clients with 3rd party insurance coverage (COBRA, private policies, Qualified Health Plans, CHIP, Medicaid, Medicare and Medicare Supplemental) within the Houston EMA.
Services to be Provided:	Provision of financial assistance with premiums, deductibles, co-insurance, and co-payments. Also includes tax liability payments associated with APTC reconciliation up to 50% of liability with a $500 maximum.
Service Unit Definition(s): **(RWGA only)**	1 unit of service = A payment of a premium, deductible, co-insurance, co-payment or tax liability associated with APTC reconciliation for an HIV-infected person with insurance coverage.

Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	HIV-infected individuals residing in the Houston EMA meeting financial eligibility requirements and have insurance or be eligible to purchase a Qualified Health Plan through the Marketplace.
Agency Requirements:	Agency must: • Provide a comprehensive financial intake/application to determine client eligibility for this program to insure that these funds are used as a last resort in order for the client to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace. • Ensure that assistance provided to clients does not duplicate services already being provided through Ryan White Part B or State Services. The process for ensuring this requirement must be fully documented. • Have mechanisms to vigorously pursue any excess premium tax credit a client receives from the IRS upon submission of the client's tax return for those clients that receive financial assistance for eligible out of pocket costs associated with the purchase and use of Qualified Health Plans obtained through the Marketplace. • Conduct marketing with Houston area HIV/AIDS service providers to inform such entities of this program and how the client referral and enrollment processes function. Marketing efforts must be documented and are subject to review by RWGA. • Clients will not be put on wait lists nor will Health Insurance Premium and Cost Sharing Assistance services be postponed or denied without notifying the Administrative Agency. • Establish formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance abuse provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance abuse provider site. (i.e. No need for client to physically present to Health Insurance provider.) • Utilize RWGA approved prioritization of cost sharing assistance, when limited funds warrant it. • Utilize consumer out-of-pocket methodology approved by RWGA.
Staff Requirements:	None
Special Requirements:	Agency must: • Comply with the Houston EMA/HSDA Standards of Care and Health Insurance Assistance service category program policies.

FY 2021 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/11/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/04/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/19/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #2**	Date: **04/21/2020**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

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FY 2018 PERFORMANCE MEASURES HIGHLIGHTS
RYAN WHITE GRANT ADMINISTRATION
HARRIS COUNTY PUBLIC HEALTH (HCPH)

TABLE OF CONTENTS

HCPH is the local public health agency for the Harris County, Texas jurisdiction. It provides a wide variety of public health activities and services aimed at improving the health and well-being of the Harris County community.

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Ryan White Part A
HIV Performance Measures
FY 2018 Report

Health Insurance Assistance
All Providers

HIV Performance Measures	FY 2017	FY 2018	Change
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	1,252 (76.1%)	1,421 (81.0%)	**4.9%**

An Update on Insurance Coverage Among People with HIV in the United States

Lindsey Dawson (https://www.kff.org/person/lindsey-dawson/) and

Jennifer Kates (https://www.kff.org/person/jennifer-kates/) (https://twitter.com/jenkatesdc)

Published: May 20, 2019

Key Facts

- Health insurance and access to care improve health outcomes, including viral suppression, for people with HIV in the United States. Our prior research documented an increase in insurance coverage between 2012 and 2014 among people with HIV, after implementation of the Affordable Care Act (ACA).[1] In this update, based on analysis of nationally representative data, we find that by 2015, just 1 in 10 (11%) nonelderly people with HIV were uninsured, on par with the rate in the general population (13%), which had fallen to historic lows due to the ACA.
- At the same time, there are important differences in coverage for people with HIV, compared to the general population. Medicaid represents the single largest source of coverage for people with HIV, much more so than for the general population (40% compared to 13%) and people with HIV are much less likely to be covered by private insurance that the population overall (34% compared to 71%).
- A main factor driving increased coverage for people with HIV has been the ACA's Medicaid expansion.[2] Among expansion states sampled, the share of people with HIV who are uninsured is significantly lower (5% v. 19%) and rates of Medicaid coverage significantly higher (48% v 29%), compared to non-expansion states.

  The Ryan White HIV/AIDS Program plays a major role in providing outpatient care and support services to people with HIV, regardless of insurance coverage. Almost half of all people with HIV (46%) rely on Ryan White, as do more than eight in ten (82%) of those who are uninsured. Among those with insurance coverage, 41% rely on Ryan White, including a greater share of those with marketplace coverage (60%).

  We looked at rates of viral suppression by insurance coverage as well as reliance on Ryan White. While overall viral suppression rates did not vary by coverage type, sustained viral suppression (that is, having an undetectable viral load over the preceding 12 months) was significantly higher among those with private insurance and Medicare, compared to the uninsured. In addition, those who relied on Ryan White were significantly more likely to have sustained viral suppression, driven in particular by those with both Ryan White and Medicaid.

Introduction

Nearly half (46%) of people with HIV rely on the #RyanWhite program for outpatient care and support services. This includes most (82%) of the uninsured as well as many (41%) with health insurance.
(http://twitter.com/share?text=Nearly+half+%2846%25%29+of+people+with+HIV+rely+on+the+%23RyanWhite+program+for+outpatient+care+and+support+services.+This+includes+most+%2882%25%29+of+the+uninsured+as+well+as+many+%2841%25%29+with+health+insurance.&url=https%3A%2F%2Fwww.kff.org%2Fe6cfde8%2F)

Health insurance improves access to care and, ultimately, health outcomes, including viral suppression, for people with HIV in the United States.[3] Based on analysis of data from the Centers for Disease Control (CDC) and Prevention's Medical Monitoring Project (MMP), our prior research documented an increase in insurance coverage between 2012 and 2014 among nonelderly people with HIV in care, after implementation of the Affordable Care Act's (ACA) major coverage reforms.[4] This data note provides updated MMP data for 2015, drawing on the MMP's expanded sample compared to previous years.[5] It also examines the role of the Ryan White HIV/AIDS Program and looks at rates of viral suppression by coverage. Such findings can help to inform the Administration's Ending the HIV Epidemic Initiative, a new effort to reduce HIV infections by 90% by 2030 which depends, in part, on engaging people with HIV in care and treatment and achieving viral suppression.[6]

FIndings

In 2015, just 1 in 10 (11%) nonelderly people with HIV were uninsured, on par with the share in the general population that year (13%).[1,2] In addition, while not directly comparable to the earlier MMP sample, this appears to have continued a downward trend that began in 2014, after ACA implementation. In 2014,14% of nonelderly people receiving HIV care were uninsured, down from 18% pre-ACA, in 2012.[3]

Medicaid remains the single most important source of coverage for nonelderly people with HIV, reaching 40% of in 2015,[4] about three times the rate of the general population (13%). While private insurance also plays an important role in coverage for people with HIV, rates are substantially lower than in the general population; just one third (34%) of people with HIV are privately insured compared to nearly three-quarters (71%) of the general population. As is the case with the general population (see Table 1), much larger shares of people with HIV get private coverage through an employer compared to the marketplace (25% v 6%).

Population, Nonelderly Adults, 2015

Table 1: Insurance Source Among Nonelderly Adults with HIV and Nonelderly Adults in the General Population, 2015

	People with HIV	General Population
Uninsured	11%	13%
Medicaid	40%	13%
Medicare	7%	1%
Private – overall	34%	71%
Private – ESI	*25%*	*59%*
Private – Marketplace	*6%*	*5%*
Other	8%	2%

Notes: Data on people with HIV includes those 18-64 and general population data includes those 19-64; Those with Medicaid include those covered by Medicaid and another type of coverage, including those dually eligible for Medicare and Medicaid.
Source: For people with HIV: CDC MMP; All general population coverage data comes from KFF analysis of the 2015 American Community Survey (limited to nonelderly adults) except for Marketplace enrollment which is an estimate based on analysis of CMS effectuated enrollment, demographics of those selecting marketplace plans, and ACS data – see methods (https://www.kff.org/report-section/an-update-on-insurance-coverage-among-people-with-hiv-in-the-united-states-methods) for more detail.

Medicaid Expansion

In our earlier analysis, we found that the main driver of coverage gains under the ACA among people in HIV care was Medicaid expansion.[5] Similarly, in 2015, this continues to hold true. Among the states sampled, uninsurance rates were significantly lower in states that had expanded their Medicaid programs compared to non-expansion states (5% v 19%) and rates of Medicaid coverage were significantly higher (48% v 29%).

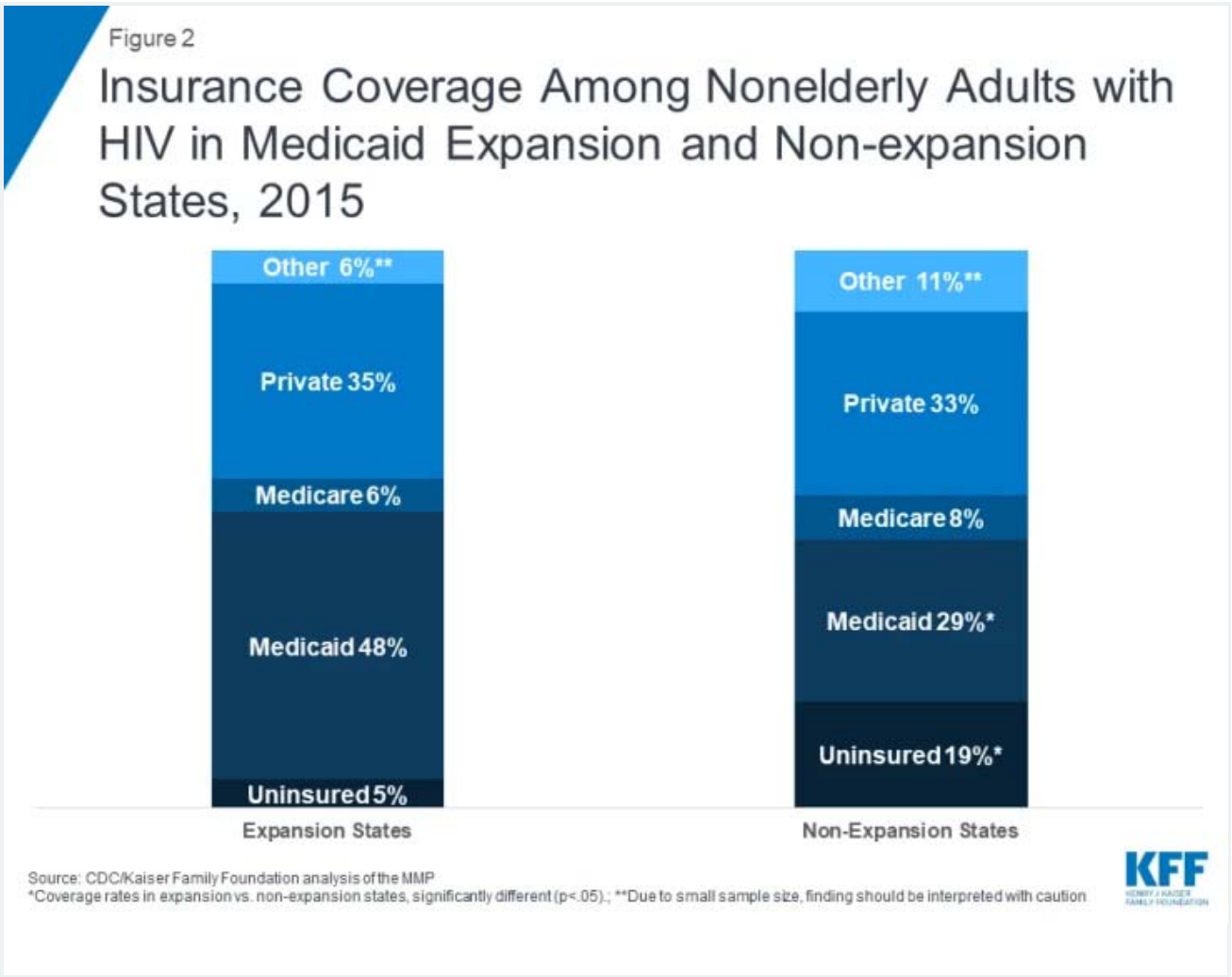

Figure 2: Figure 2: Insurance Coverage Among Nonelderly Adults with HIV in Medicaid Expansion and Non-expansion States, 2015

While overall rates of private coverage did not differ significantly between expansion and non-expansion states for this population, non-expansion states did see significantly higher rates of marketplace participation (8% v 5%), potentially from those individuals who would have been Medicaid eligible, if their states had expanded. Coverage rates of other insurance sources were similar between expansion and non-expansion states.

Table 2: Insurance Source Among Nonelderly People with HIV, by State Expansion Status		
	Expansion States	**Non-Expansion States**
Uninsured	5%	19%*
Medicaid	48%	29%*
Medicare	6%	8%
Private – overall	35%	33%
Private – ESI	*26%*	*23%*
Private – Marketplace	*5%*	*8%**
Other	6%**	11%**

Source: CDC/Kaiser Family Foundation analysis of the MMP
* Coverage rates in expansion vs. non-expansion states, significantly different (p<.05).
**Due to small sample size, this finding should be interpreted with caution

Ryan White

The nation's Ryan White HIV/AIDS Program provides outpatient HIV care, treatment, and support services to people with HIV who are underinsured and uninsured. The program also assists with purchasing insurance on behalf of clients with access to coverage. Overall, in 2015, about half (46%) of non-elderly people with HIV received assistance from Ryan White. Ryan White plays an especially important role for the uninsured, 82% of whom received assistance through the program (e.g. direct medical care, medications, insurance purchasing, and/or support services). Ryan White also plays a meaningful role for those with insurance coverage, supporting 41% in 2015 by addressing gaps in coverage and assisting with insurance and out-of-pocket drug and medical costs related to HIV care and treatment. A much higher percentage of those with marketplace coverage relied on Ryan White (60%) than those with employer sponsored insurance (31%), potentially reflecting the role of Ryan White in helping clients purchase insurance, especially among a group likely to have lower incomes relative to those with employer coverage.

Viral Suppression

Viral suppression (defined as having an undetectable viral load at the time of last available laboratory data) is a critical health indicator and a goal of successful HIV treatment. Viral suppression affords optimal health outcomes at the individual level and, because when an individual is virally suppressed they cannot transmit HIV, also has significant public health benefit.[6] However, because viral suppression can change over time, especially depending on treatment adherence, it is also useful to look at sustained viral suppression (defined as having an undetectable viral load over all tests in the preceding 12 months), a stronger indicator of long-term successful antiretroviral treatment and its associated preventive benefits. We looked at both measures but focused our analysis on sustained viral suppression. As expected, overall rates of sustained viral suppression (62%) were lower than viral suppression at last test (70%).

While rates of viral suppression at last test did not vary by insurance coverage, rates of sustained viral suppression were significantly higher among those with private insurance and Medicare, compared to the uninsured.

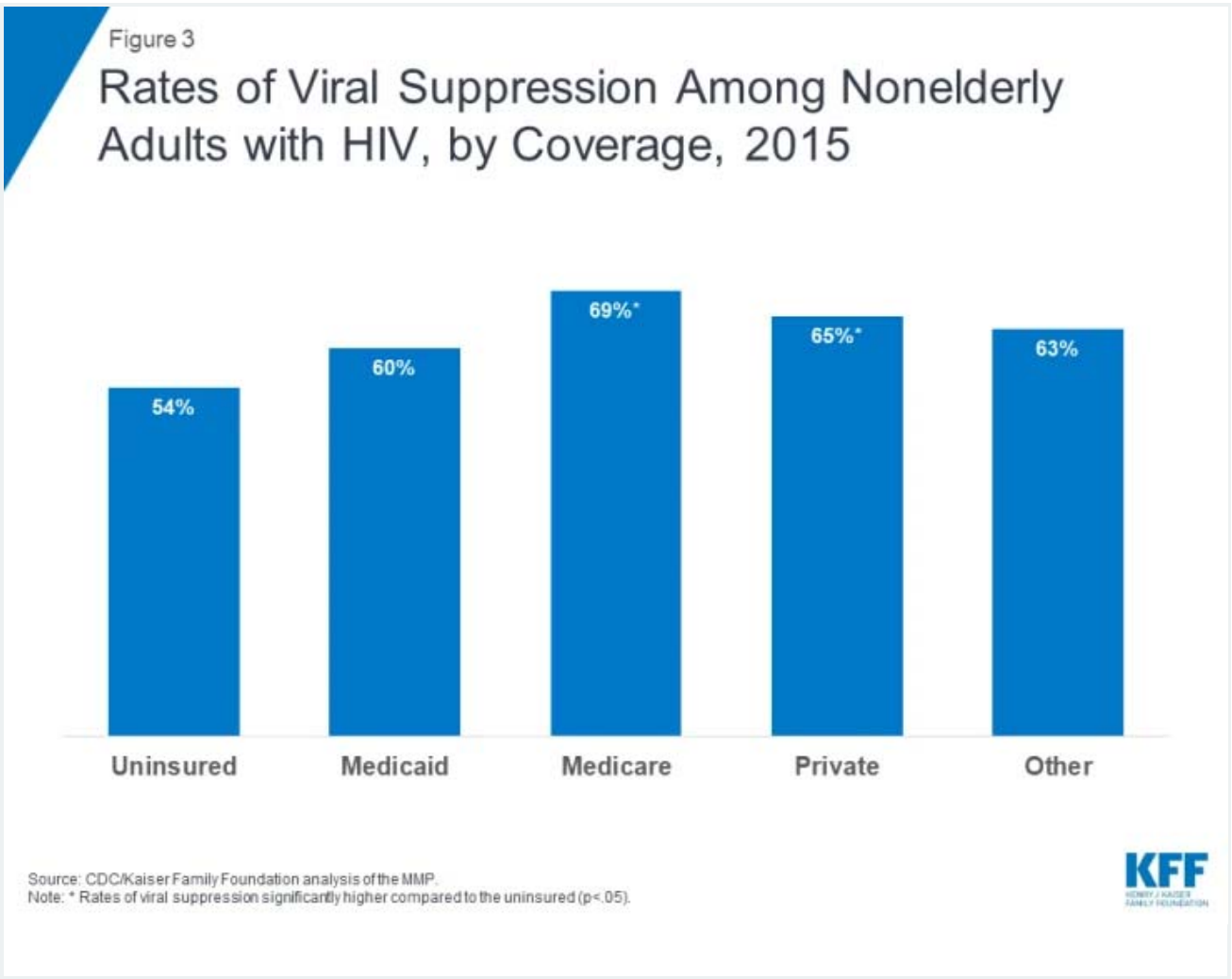

Figure 3: Rates of Viral Suppression Among Nonelderly Adults with HIV, by Coverage, 2015

Table 3: Sustained Viral Suppression Among Nonelderly People with HIV, by Insurance	
Overall	62%
Uninsured	54%
Medicaid	60%
Medicare	69%*
Private – overall	65%*
Private – ESI	*63%*
Private – Marketplace	*66%*
Other	63%

Source: CDC/Kaiser Family Foundation analysis of the MMP
***** Rates of viral suppression significantly higher compared to the uninsured (p<.05).

Ryan White support appears to make a significant difference in sustained viral suppression. Overall, those with Ryan White support were significantly more likely to have sustained viral suppression than those without Ryan White (66% v. 58%). This trend was driven by those with both Medicaid and Ryan White, a group who saw higher rates of viral suppression than those with Medicaid but without Ryan White (65% v 57%). While the viral suppression estimates for the uninsured without Ryan White are unstable due to a small sample size, uninsured persons with Ryan White had much higher rates of sustained viral suppression compared with uninsured persons without Ryan White (62% v. 16%). Differences were not significant (or estimates were unstable) across the remaining insurance categories (i.e. Medicare, private insurance, and other types of insurance).

Table 4: Ryan White Coverage and Sustained Viral Suppression Among Nonelderly People with HIV, by Insurance		
	Coverage & Ryan White	**Coverage & No Ryan White**
Overall	66%	58%*
Uninsured	62%	16%**
Medicaid	65%	57%*
Medicare	74%	61%
Private – overall	69%	63%
Private – ESI	*65%*	*62%*
Private – Marketplace	69%	*61%*
Other	67%**	58%**

Source: CDC/Kaiser Family Foundation analysis of the MMP
* Rates of viral suppression significantly different between those with coverage and Ryan White and those with coverage and no Ryan White, (p<.05).
**Due to small sample size, this finding should be interpreted with caution

Discussion/Looking Ahead

The ACA has played a significant role in increasing insurance coverage for people with HIV, particularly through Medicaid in those states that expanded coverage. As of 2015, the uninsurance rate among nonelderly people with HIV was similar to that of the public at large. We also find that the Ryan White HIV/AIDS Program remains a critical source of care, treatment, and support for people with HIV, especially for those who are uninsured but also for a substantial share of those who do have coverage. Both insurance coverage and Ryan White were associated with higher rates of sustained viral suppression, a crucial indicator of optimizing the individual and public health benefits associated with antiretroviral treatment.

The future of the U.S. healthcare landscape continues to be a source of significant debate, with some parties seeking to repeal the ACA or certain aspects of the law and others aiming to move towards even more expansive coverage options. Either approach would stand to significantly impact coverage, and likely care outcomes, for people with HIV, as well as the success of the new Ending the HIV Epidemic Initiative. Looking ahead, it will be important to continue to monitor access to care and coverage among people with HIV, particularly given the importance of engagement in care and treatment in optimizing the individual and public health benefits of treatment.

Acknowledgments

The authors wish to thank Dr. Sharoda Dasgupta and Dr. Linda Beer of the CDC and Wen Zhou of ICF International, Inc., who were instrumental in this work in providing access to data, guidance, and conducting statistical analysis.

Methods

Data Sources:

Coverage Data on General Population

Table 1 in this data note presents health insurance coverage data for the general nonelderly adult population (those 19-64). All general population coverage data comes from KFF analysis of the 2015 American Community Survey (limited to nonelderly adults) except for Marketplace enrollment. Marketplace enrollment is an estimate based off the number of nonelderly adults with effectuated marketplace enrollment at mid-year in 2015. Overall mid-year marketplace enrollment in 2015 was 9,949,079.[1]

The share estimated to be nonelderly adults was based off data on characteristics of individuals who selected a marketplace plan, whereby 8% of marketplace plan selectors were under 18.[2] We assumed that age characteristics of those with effectuated marketplace enrollment were similar to those who had selected plans and subtracted 8% from the effectuated enrollment total to obtain an estimated adult marketplace enrollment of 9,153,153 or 5% of the ACS population (190,278,654).

Data on People with HIV

This analysis relies on data from the Medical Monitoring Project (MMP), a CDC surveillance system designed to produce nationally representative estimates of behavioral and clinical characteristics of adults (aged 18 and older) with diagnosed HIV in the United States. During 2015–2016, MMP employed a two-stage, complex sampling design in which US states and territories were sampled, followed by adults (aged 18 years and older) with diagnosed HIV sampled from the National HIV Surveillance System (NHSS), a census of US persons with diagnosed HIV.

Data used in this analysis were collected via telephone or face-to-face interviews and medical record abstractions between June 1, 2015 and May 31, 2016. All sampled states and territories participated in MMP.[3]

In 2015, of 9,700 sampled persons, 3,654 participated. The overall adjusted response rate was 40%. Data were weighted based on known probabilities of selection at state or territory and patient levels. In addition, data were weighted to adjust for non-response using predictors of person-level response. Although characteristics associated with nonresponse varied among states and territories, the weighting classes for the national data were informed by sex at birth, HIV exposure category, and the person's frequency of receipt of care (as indicated by NHSS records). This analysis includes information on 3,654 participants who represent all adults with diagnosed HIV in the United States and Puerto Rico.

Analysis:

For all respondents in MMP, we examined self-reported insurance coverage by using responses to the following question "I'd like to ask you about all of the types of insurance and other coverage you have to pay for healthcare, medicines, and supportive services like case management, transportation, or mental health services. During the past 12 months, have you had any of the following types of insurance or other coverage for any type of healthcare?" Response options included insurance programs (Medicaid, Medicare, private insurance – employer and marketplace -, Ryan White HIV/AIDS Program – Ryan White or the AIDS Drug Assistance Program-, Veteran's Administration, Tricare or CHAMPUS coverage, other public insurance, and other unspecified insurance). "Other specify" responses were extensively recoded to reflect the most accurate coverage type when possible. It is important to note that patients may not be aware of all the services they receive that are paid for by the Ryan White

HIV/AIDS Program (the program provides funding directly to service organizations in many cases) and therefore, the estimates of the number of individuals who receive Ryan White HIV/AIDS Program services is likely an underestimate.

We estimated weighted percentages of individuals with the following types of health care coverage: no coverage (uninsured), private insurance (with breakouts for employer coverage and marketplace coverage), Medicaid, Medicare, and other (specified). Because respondents in MMP may indicate more than one type of coverage, we relied on a hierarchy to group people into mutually exclusive coverage categories. Specifically, the hierarchy groups people into coverage types in the following order:

- Private coverage (with breakouts for employer coverage and marketplace coverage)
- Medicaid coverage, including those dually eligible for Medicare
- Medicare coverage only
- Other public coverage, including Tricare/CHAMPUS, Veteran's Administration, or city/county coverage

In most cases, this hierarchy classified individuals according to the coverage source that served as their primary payer. People who did not report any of the sources of insurance coverage were classified as uninsured. (The same categories and order was applied to ACS data to develop a comparable coverage hierarchy for the general population.) We separately assess weighted percentages of persons receiving assistance through the Ryan White HIV/AIDS Program by health coverage type.

We assessed distributions of health coverage type in 2015, overall and by whether the participant lived in a Medicaid expansion or non-Medicaid expansion state. We also examined receipt of Ryan White assistance by coverage group and viral load suppression by coverage group. Statistical comparisons were made using Rao-Scott chi-square tests and prevalence ratios with predicted marginal means.

Limitations:

MMP only allows for extrapolation to the national level when using the full sample. Similar extrapolation is not possible when examining coverage changes in and contrasting Medicaid expansion states and non-expansion states. The Medicaid expansion and non-expansion coverage data presented here are representative only of the subset of states sampled that fell into each group.

Endnotes

Key Facts

1. Kates, J and Dawson, L. Insurance Coverage Changes for People with HIV Under the ACA. Kaiser Family Foundation. 2017. https://www.kff.org/health-reform/issue-brief/insurance-coverage-changes-for-people-with-hiv-under-the-aca/ (https://www.kff.org/health-reform/issue-brief/insurance-coverage-changes-for-people-with-hiv-under-the-aca/)

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2. Kates, J and Dawson, L. Insurance Coverage Changes for People with HIV Under the ACA. Kaiser Family Foundation. 2017. https://www.kff.org/health-reform/issue-brief/insurance-coverage-changes-for-people-with-hiv-under-the-aca/ (https://www.kff.org/health-reform/issue-brief/insurance-coverage-changes-for-people-with-hiv-under-the-aca/)

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3. Kates, J and Dawson, L. Insurance Coverage Changes for People with HIV Under the ACA. Kaiser Family Foundation. 2017. https://www.kff.org/health-reform/issue-brief/insurance-coverage-changes-for-people-with-hiv-under-the-aca/ (https://www.kff.org/health-reform/issue-brief/insurance-coverage-changes-for-people-with-hiv-under-the-aca/); Bradley, et al. "Health Care Coverage And Viral Suppression Pre- And Post-ACA Implementation." Conference on Retroviruses and Opportunistic Infections (CROI) March 4–7, 2019.

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4. Kates, J and Dawson, L. Insurance Coverage Changes for People with HIV Under the ACA. Kaiser Family Foundation. 2017. https://www.kff.org/health-reform/issue-brief/insurance-coverage-changes-for-people-with-hiv-under-the-aca/ (https://www.kff.org/health-reform/issue-brief/insurance-coverage-changes-for-people-with-hiv-under-the-aca/)

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5. See description of MMP sampling in methods and the CDC Surveillance Report: https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-special-report-number-20.pdf (https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-special-report-number-20.pdf)

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FIndings

1. A difference that was not statically significant overall but was significant in expansion states sampled

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2. Kates, J and Dawson, L. Insurance Coverage Changes for People with HIV Under the ACA. Kaiser Family Foundation. 2017. https://www.kff.org/health-reform/issue-brief/insurance-coverage-changes-for-people-with-hiv-under-the-aca/ (https://www.kff.org/health-reform/issue-brief/insurance-coverage-changes-for-people-with-hiv-under-the-aca/)

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3. 2015 data are not directly comparable to 2012 and 2014 data due to a methodological change in data collection.

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4. Throughout this data note, the Medicaid category includes those dually eligible for both Medicaid and Medicare.

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3. A total of 23 areas were funded to conduct data collection for the 2015 cycle: California (including the separately funded jurisdictions of Los Angeles County and San Francisco), Delaware, Florida, Georgia, Illinois (including the separately funded jurisdiction of Chicago), Indiana, Michigan, Mississippi, New Jersey, New York (including the separately funded jurisdiction of New York City), North Carolina, Oregon, Pennsylvania (including the separately funded jurisdiction of Philadelphia), Puerto Rico, Texas (including the separately funded jurisdiction of Houston), Virginia, and Washington.

← Return to text

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The Lifetime Cost of HIV

Balancing the Relationship Between Cost and Quality Care

By James Myhre and Dennis Sifris, MD | Medically reviewed by a board-certified physician
Updated on February 14, 2020

A number of studies have not only looked into the lifetime cost of HIV therapy but its cost-effectiveness during different states of infection.

One such study from the U.S. Centers of Disease Control and Prevention (CDC) aimed to estimate the average lifetime cost of HIV—both for individuals starting antiretroviral therapy (ART) early (CD4 count of 500 cells/mL or less) and those starting late (200 cells/mL or less).

The results confirmed what many smaller studies have long suggested: that early initiation of ART correlates to far lower lifetime costs.

According to the research, for those starting treatment at higher CD4 counts, the estimated average lifetime cost is roughly $250,000. By contrast, those starting at 200 cells/mL or less were likely to spend twice that amount—from anywhere between $400,000 and $600,000.

Among the reasons cited for the higher costs are the increased risk of both HIV-related and non-HIV-related illnesses in those with compromised immune systems. Moreover, the likelihood that a person will be able to restore immune function to near-normal levels (i.e., CD4 counts of 500-800 cells/mL) becomes less likely the later one starts treatment.

Retrospective analyses from Weill Cornell Medical College further supported the conclusions. tracking individuals with HIV from the age of 35 until death. While the cost of treatment for those who started treatment on diagnosis ($435,200) was significantly higher than those who delayed therapy ($326,500), the saving in terms of disease and hospitalization avoidance was considered substantial.

The investigators were further able to conclude that the lifetime cost savings of avoiding HIV infection in a single person was between $229,800 to $338,400.

Putting Lifetime Cost of HIV Into Perspective

While the lifetime cost of treatment may, on the surface, appear exorbitant—suggesting inflated HIV drug prices or American healthcare costs—it's important to look at the costs in relation to other attributable health concerns.

Consider, for example, that the average lifetime cost of smoking for a 24-year-old male is $183,000, while a 24-year-old female can expect to spend an average of $86,000. Beyond the cost of the cigarettes themselves, the social costs to Medicare, Medicaid, Social Security, and health insurance are seen to be far seen to be far greater—whether due to smoking cessation, emphysema, lung cancer, etc.

(These figures are exacerbated by the fact that smoking, as an independent factor, is known to reduce life expectancy by as much as 12.3 years in people with HIV.)

Meanwhile, the lifetime cost of drinking three alcoholic beverages a day comes to a startling $263,000 over a lifetime, which correlates to a 41% increased risk of cancer in men, whether HIV-positive or HIV-negative.

Cost Containment Strategies

None of this, of course, is meant to diminish the financial impact of HIV, both on the individual and the healthcare system as a whole.

From an individual perspective, the cost of HIV care directly relates to how well a patient is retained in care and how effectively that person can adhere to a prescribed therapy. In their May 2014 revision of the U.S. HIV treatment guidelines, the Department of Health and Human Services (DHHS) addressed these concerns by recommending that clinicians "minimize patients' out-of-pocket drug-related expenses whenever possible."

This includes the use of generic drug alternatives whenever possible or reasonable. However, the decision should be accompanied by a careful assessment as to whether the reduced costs might increase the pill burden for the patient. In such cases, the use of generics may reduce overall costs but at the expense of patient adherence. Furthermore, the generic components of a multi-drug regimen could lead to higher insurance co-pay, increasing rather than decreasing out-of-pocket expenses.

In a similar vein, the DHHS has recommended a reduction in the frequency of CD4

monitoring for patients who have been on ART for at least two years and have had consistent, undetectable viral loads. While this is seen to be less impactful in terms of actual cost containment, associated tests such as CD8 and CD19 are, in fact, costly; have virtually no clinical value; and are not recommended as a course of managed HIV care.

For those who have exhibited long-term viral suppression on ART, the DHHS currently recommends that:

- CD4 monitoring be performed every 12 months for those with CD4 counts between 300 and 500 cells/mL, and;
- CD4 monitoring is considered optional for those with CD4 counts over 500 cells/mL.

According to the guidelines, CD4 counts direct when to start or stop prophylactic therapy designed to prevent opportunistic infections, or to assess whether the patient's immunological response to ART is adequate. (An "adequate" response is defined as an increase in the CD4 count by 50 to 150 cells during the first year of therapy, with similar increases every year until a steady state is achieved.)

By contrast, viral load testing should be considered the key barometer for treatment success. As such, the DHHS recommends viral load monitoring every 3-4 months for patients with consistent, stable viral suppression.

Article Sources

Verywell Health uses only high-quality sources, including peer-reviewed studies, to support the facts within our articles. Read our editorial process to learn more about how we fact-check and keep our content accurate, reliable, and trustworthy.

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