

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

Lindsey Dawson and Jen Kates

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 15%) and people with HIV are much less likely to be covered by private insurance than the population overall (34% compared to 68%).
- 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

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%).^{7,8} 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 2012.⁹

Medicaid remains the single most important source of coverage for nonelderly people with HIV, reaching 40% of in 2015,¹⁰ more than twice the rate of the general population (15%). 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 two thirds (68%) 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%).

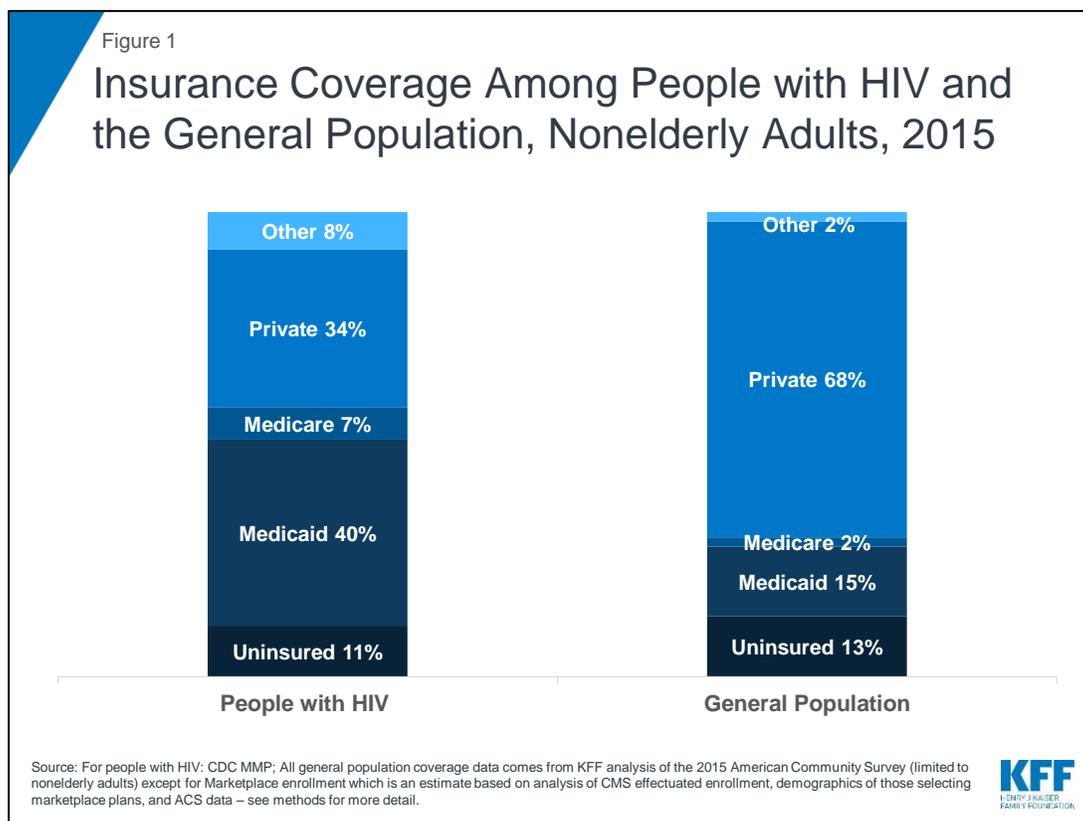


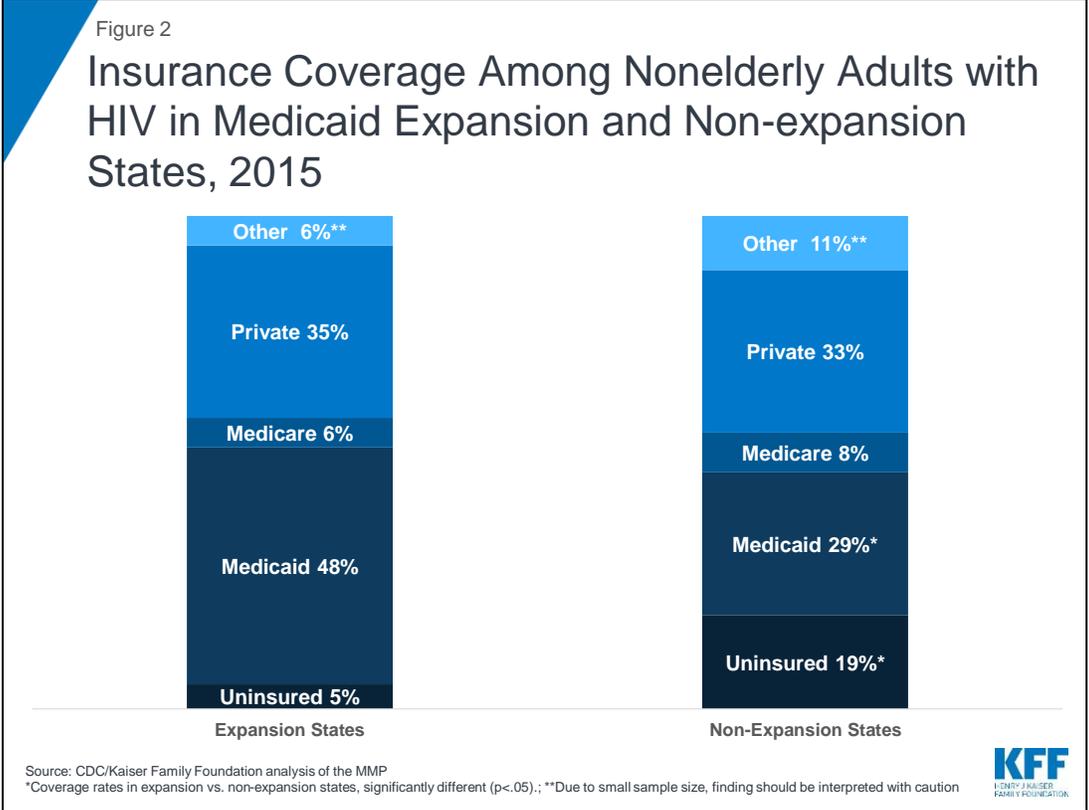
Table 1: Insurance Source Among Nonelderly Adults with HIV and Nonelderly Adults in the General Population, 2015

	People with HIV	General Population
Uninsured	11%	13%
Medicaid	40%	15%
Medicare	7%	2%
Private – overall	34%	68%
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 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.¹¹ 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%).



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%
<i>Private – ESI</i>	26%	23%
<i>Private – Marketplace</i>	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.¹² 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.

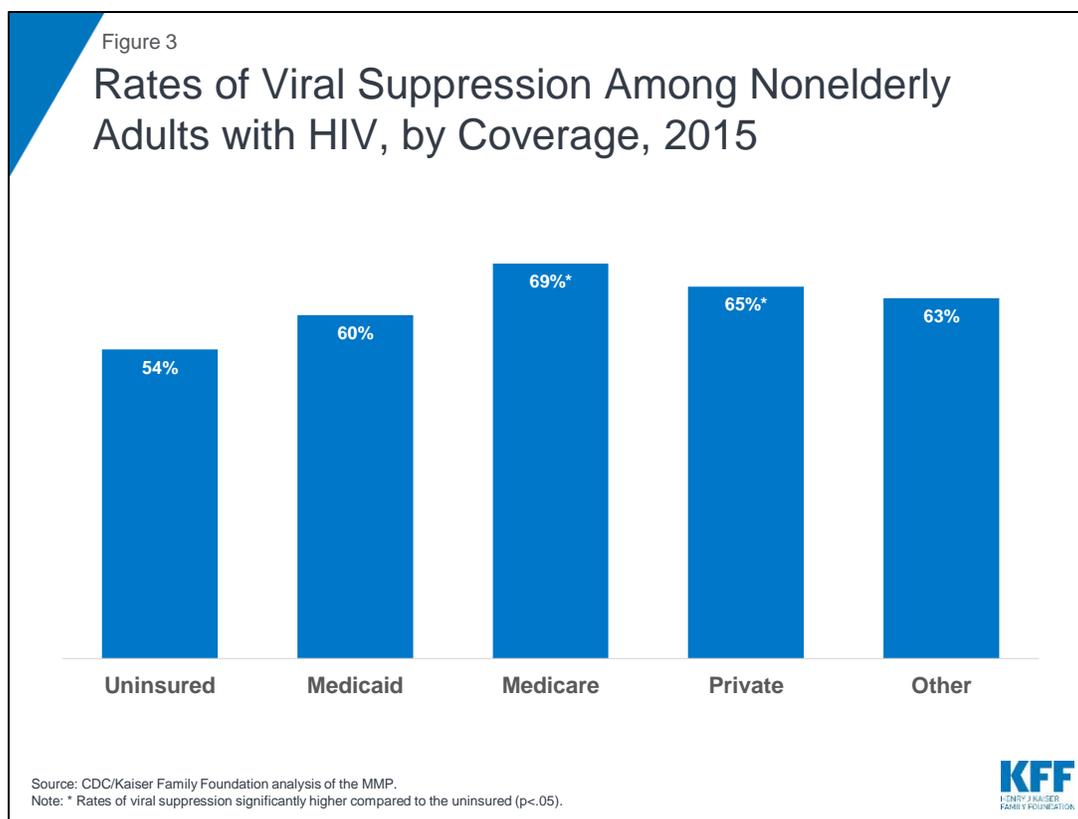


Table 3: Sustained Viral Suppression Among Nonelderly People with HIV, by Insurance	
Overall	62%
Uninsured	54%
Medicaid	60%
Medicare	69%*
Private – overall	65%*
Private - ESI	63%
Private - Marketplace	66%
Other	63%

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%
<i>Private – ESI</i>	65%	62%
<i>Private – Marketplace</i>	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 9,949,079.¹³ 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 18.¹⁴ 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.¹⁵

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 classifies individuals according to the coverage source that serves as their primary payer. People who do not report any of the sources of insurance coverage above are classified as uninsured. 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

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/>

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/>

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/>; 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.

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/>

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>

⁶ U.S. Dept. of Health and Human Services (HHS). "Ending the HIV Epidemic: A Plan for America." [Press release.] February 5, 2019. <https://www.hhs.gov/blog/2019/02/05/ending-the-hiv-epidemic-a-plan-for-america.html>

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

8 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/>

9 2015 data are not directly comparable to 2012 and 2014 data due to a methodological change in data collection.

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

11 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/>

12 U.S. Department of Health and Human Services. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV. Available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>.; Cohen MS, Chen YQ, McCauley M, et al. Prevention of HIV-1 infection with early antiretroviral therapy. *N Engl J Med* 2011;365:493-505.; Cohen MS, Chen YQ, McCauley M, et al. Antiretroviral therapy for the prevention of HIV-1 transmission. *N Engl J Med* 2016;375:830-9.; CDC. HIV Treatment as Prevention; updated November 2017. <https://www.cdc.gov/hiv/risk/art/index.html>; INSIGHT START Study Group. Initiation of antiretroviral therapy in early asymptomatic HIV infection. *N Engl J Med*. Jul 20 2015.; Rodger, A., et al. *Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study*. *The Lancet*. May 2, 2019.

¹³ U.S. Department of Health and Human Services. Center for Medicare and Medicaid Services. June 30, 2015: Effectuated Enrollment Snapshot. September 2019. <https://www.cms.gov/newsroom/fact-sheets/june-30-2015-effectuated-enrollment-snapshot>

¹⁴ U.S. Department of Health and Human Services. Center for Medicare and Medicaid Services. 2015 Marketplace Open Enrollment Period Public Use Files. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2015_Open_Enrollment.html

15 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.