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## The Health Insurance and Financing Landscape for People with and at Risk for HIV

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### HIV Insurance Coverage and Care Landscape in the United States

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Insurer/Payer	Background	Eligibility	Benefits: HIV Care, Treatment, and Prevention	Federal Contributions	Prescription Drug Pricing and Access	Enrollee/Client Costs
<b>Medicaid</b>	<p>Medicaid, the largest public health insurance program in the United States, covering health (medical, behavioral and prescription drug) and long-term care services for many low-income individuals. It is also the largest payer of care for people with HIV and its role grew further due to the program's expansion under the ACA. States operate their Medicaid programs within federal standards (e.g., covering certain groups and benefits), with a wide range of state options, in exchange for federal matching funds. As a result, Medicaid coverage and benefits vary across the country. A detailed review of the coverage Medicaid provides for people with and at risk for HIV is available <a href="#">here</a>.</p> <p>An estimated 43% of people with HIV were enrolled in Medicaid in 2020.</p>	<p>Traditional Medicaid (all states): There are multiple eligibility pathways for the program and enrollees must meet eligibility criteria. States must cover certain mandatory groups and may also cover optional groups. Mandatory groups include: individuals who meet disability and income criteria of the SSI program, low-income children, parent or caretaker relatives, and pregnant women. Optional groups/programs include: the medically needy program and some low-income working individuals with disabilities. States have flexibility to expand coverage beyond federal minimum criteria.</p> <p>Medicaid expansion (41 states, including DC): Adults under 65 years of age with an income up to 138% of the federal poverty limit (FPL) are eligible.</p>	<p>Medicaid benefits are offered on a fee-for-service basis, through capitated managed care organizations (MCOs), or through a combination of these benefit designs.</p> <p>Traditional Medicaid: States must cover a set of mandatory benefits and may also cover optional benefits. Mandatory benefits include: inpatient and outpatient hospital care, physician and nurse practitioner visits, laboratory (e.g. HIV and STI testing) and x-ray services, family planning services, nursing facility services, home health, and long-term care. Optional benefits include: prescription drugs - including antiretrovirals for care and prevention - (a benefit all states elect to cover), case management, dental services, personal care services, rehabilitation services, and home and community-based services.</p> <p>Medicaid expansion: Expansion programs must include ACA's ten "EHB" categories. These include a broad range of services including ambulatory care, laboratory services (e.g. HIV and STI testing), women's preventive services, and prescription drugs (e.g. ARVs for treatment and prevention). However, benefits are largely defined through a state-based benchmarking process using a plan of the state's choosing from several options or from an alternative plan selected through a waiver. Most states use a waiver to select the traditional state Medicaid plan as the benchmark, aligning traditional and expansion benefits.</p>	<p>Medicaid is a jointly financed federal-state program. In FY2022, federal Medicaid spending on people with HIV was estimated to be \$13 billion (states spent another \$5.4 billion) before rebates.</p> <p>In FY23, the federal government matches traditional state Medicaid spending at rates ranging from 56-84%, varying by state.</p> <p>Medicaid expansion: the federal government's contribution for the expansion population began in 2014 at 100% of the cost and has been phased down to 90%, where it remains with states covering the rest.</p>	<p>Drug manufacturers must participate in the Medicaid Drug Rebate Program if their drugs are to be covered by Medicaid (and Medicare Part B). Under the program, manufacturers are generally required to pay a statutory rebate of 23.1% (13% for generics) of AMP or the difference between AMP and "best price," whichever is greater. Additional rebates are paid if this confidential AMP increases faster than the CPI-U rate of inflation and supplemental rebates, negotiated between states and manufacturers, are common. (The extent of the rebates is unclear.)</p>	<p>States are permitted to require nominal cost-sharing for medical and pharmacy benefits for some beneficiaries, although many do not use them. Preventive services with a USPSTF rating of A or B must be covered at no cost by expansion programs, including routine HIV and STI screening, PrEP, and a range of immunizations. Traditional programs are incentivized to cover these services without cost-sharing. Enrollees are not denied services based on inability to pay, though they may be held liable for unpaid copayments.</p>

<p><b>Medicare</b></p>	<p>Medicare, the federal health insurance program for people age 65 and older and for younger adults with long-term disabilities, plays an important role in delivering health coverage to people with HIV. A detailed review of Medicare's coverage for people with HIV is available <a href="#">here</a>.</p> <p>An estimated 28% of people with HIV were enrolled in Medicare in 2020. Some people are dually covered by both Medicare and Medicaid.</p>	<p>There are three eligibility pathways: Individuals aged 65 and older with sufficient work history; individuals younger than 65 years with permanent disability and sufficient work history; and individuals with end-stage renal disease or ALS of any age</p>	<p>Medicare covers a range of services that are important to people with and at risk for HIV, including prescription drugs, inpatient and outpatient care, and preventive services. Medicare benefits are organized and paid for in different ways, separated into four parts:</p> <ul style="list-style-type: none"> <li>• Part A: Covers inpatient hospital stays, SNF stays, some home health visits, and hospice care.</li> <li>• Part B: Covers physician visits, outpatient services, preventive services, and some home health visit, prevention services, and most physician-administered drugs. Preventive services include, annual HIV testing for people aged 15–65 (regardless of risk), annual screening for those younger than 15 or older than 65 who are at increased risk, and up to three tests during pregnancy. It also covers STI screening for people at risk and pregnant people and covers injectable PrEP (see section on prescription drugs).</li> <li>• Part C: Medicare advantage or private plans, which are primarily HMOs and PPOS through which enrollees receive Part A and B benefits, and typically Part D.</li> <li>• Part D: Part D is the outpatient prescription drug benefit which is delivered through private plans that contract with Medicare as stand-alone plans or through Medicare Advantage plans with drug coverage. Part D plans cover most ARVs used for care and prevention (see section on prescription drugs).</li> </ul>	<p>Medicare is a federal program and in fiscal year 2022, Medicare spending on people with HIV was <a href="#">estimated</a> to be \$11.28 billion (including both traditional Medicare and Medicare Advantage) for all care and treatment costs prior to any manufacturer rebates.</p>	<p>Prescription drugs are covered under both Parts B and D. ARVs are one of six protected classes under Part D. As a result, Part D plans must provide access to all, or substantially all, FDA-approved ARVs (excluding those covered under Part B). Part D plans (or pharmacy benefits managers on their behalf) negotiate rebates on outpatient drug costs with manufacturers (the extent of the rebates is unclear). Most physician-administered drugs and biologics are covered under Part B (including some ARVs). HHS does not negotiate prices for most drugs covered under Medicare Part B. However, under the Inflation Reduction Act, the federal government is <a href="#">required</a> to negotiate prices for some high-spending drugs covered under Medicare Parts B and D and drug manufacturers are required to pay rebates to Medicare if prices increase faster than inflation, which has the potential to impact ARV drugs.</p> <p>In addition, for drugs covered under Part D utilization management (prior authorization, step therapy, higher cost-sharing) is possible as cost-containment measures, including for drugs in the protected classes.</p>	<p>Premiums and cost-sharing might be substantial for both services and prescription drugs. There is no cap on out-of-pocket spending under Part A and Part B. However, subsidies and supplemental coverage are offered to low-income beneficiaries, including for the 61% of beneficiaries who are dually eligible for Medicaid. Part D (outpatient prescription drug) costs can be high, especially given the cost of ARVs, though there are protections through the LIS, for which 74% of beneficiaries with HIV are eligible. Additionally, a cap on Part D out-of-pocket costs will be introduced in 2025. Part B preventive services with a USPSTF A or B grade that have been approved under a Medicare NCD are covered without cost-sharing, including routine HIV and STI screening, and a range of immunizations. Medicare is currently conducting an NCD for injectable PrEP covered under Part B. Cost-sharing support is available in some cases from the Ryan White Program, and other sources, on the basis of financial eligibility criteria but manufacturer co-pay assistance programs cannot be applied to Medicare costs.</p>
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<p><b>Private Insurance</b></p>	<p>As with the population overall, most people with HIV who are privately insured obtain coverage through an employer. However, a smaller share obtain coverage in the individual market, especially through ACA health insurance marketplaces.</p> <p>An estimated <b>40%</b> of people with HIV were covered with private insurance in 2020.</p>	<p>Medicaid expansion (41 states, including DC): Adults under 65 years of age with an income up to 138% of the federal poverty limit (FPL) are eligible.</p>	<p>ACA-compliant individual and employer-based plans generally cover a broad range of benefits. Most individual and small group plans are required to cover <b>ten EHB categories</b>, one of which is prescription drugs. Additionally, these plans cover HIV and STI testing, PrEP, <b>women’s health services</b> (e.g. contraceptives), immunizations, and other prevention services. Non-ACA compliant plans, such as short-term limited duration or grandfathered plans, may have more restricted benefits (e.g., no drug or behavioral health coverage) and <b>may not even cover</b> people with HIV.</p>	<p>The federal government contributes to premium assistance support for people purchasing coverage in the health insurance marketplaces with incomes between 100–400% of the FPL (spending estimate not available for people with HIV).</p>	<p>Private insurance plans (or pharmacy benefits managers on their behalf) negotiate rebates on inpatient and outpatient drug costs with manufacturers but the extent of rebating is unclear. Formulary restrictions and utilization management (prior authorization, step therapy, higher cost-sharing) are commonly used as cost-containment measures. The ACA envisioned that several sets of preventive services be covered without cost-sharing by most private plans. In April 2023, a district court judge ruled that one such set of services (those services with A or B USPSTF grades since March 2010) are <b>no longer required</b> to be covered without cost-sharing. This could impact PrEP costs and coverage, among other services. An appeal is pending.</p>	<p>HIV care and treatment costs in the private market (e.g., premiums and cost-sharing) can be highly variable, depending on plan generosity and subsidy eligibility. Pharmaceutical manufacturers assistance programs/coupons may be available to offset drug costs for those with low to moderate incomes, but these might not count towards annual cost-sharing limits or deductibles. Cost-sharing support is available through Ryan White (though with some limitations and differences by location), and other sources based on financial eligibility criteria.</p> <p>In general, HIV and STI screenings are covered without cost-sharing. PrEP is generally covered but the no cost-sharing element envisioned by the ACA has recently been called into question (see section on prescription drug pricing and access for more information). <b>Women’s Preventive Service</b>, including contraceptives, are covered without cost-sharing as are most major immunizations.</p>
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<p><b>Veteran Affairs (VA)</b></p>	<p>The Department of Veteran Affairs offers medical coverage for people who served in the active military, naval, or air service.</p> <p>An estimated 3% of people with HIV received health benefits through the VA in 2020.</p>	<p>Those who enlisted or entered active duty in the military, naval, or air service may be <a href="#">eligible for VA health care benefits</a>, if they met minimum service and discharge requirements. Current and former members of the National Guard or Reservist members who had active duty by federal order and completed the full period of active duty are also eligible</p>	<p>The VA provides primary and specialty care, prescription drug coverage (includes all top recommend HIV initial treatment regimens, among other ARVs) mental health care, home health care, geriatrics and extended care, among other services. Some benefits under the VA vary, such as dental care, based on need and <a href="#">priority group</a>. HIV testing, PrEP (with a facility level prior-authorization restriction), STI screening, immunizations and other prevention services are covered.</p>	<p>In FY 2022, federal VA spending on HIV care and prevention services was <a href="#">estimated</a> to be \$1.6 billion.</p>	<p>Prescription drug coverage includes all top recommend HIV initial treatment regimens, among other ARVs.</p> <p>The FCP, the maximum price manufacturers may charge the "Big Four" federal purchasers, including the VA, includes a 24% discount off of a drug's AMP paid by non-FAMP. Additional discounts occur if non-FAMP prices increase faster than CPI-U. Big Four drug prices may be <a href="#">40% to 50%</a> below list prices. VA may negotiate further price reductions using its preferred formulary.</p>	<p>Many veterans qualify for health care without cost-sharing. For those that do face cost-sharing, it is nominal compared to the private market and Medicare but slightly higher than Medicaid. Treatment and medications are not withheld from those who cannot afford copayment.</p>
<p><b>Indian Health Service (IHS)</b></p>	<p>The <a href="#">Indian Health Service</a> is an agency, within the Department of Health and Human Services, responsible for providing federal health services to American Indians and Alaska Natives. Its mission is to raise the physical, mental, social and spiritual health of these communities.</p> <p>An estimate for the number of people with HIV served through IHS is not available.</p>	<p>The most common eligibility pathway is membership in a federally recognized tribe (as well as non-Indian children, spouses, and some other family members) and, in some cases, is limited to those who live on or near federal reservations.</p>	<p>The IHS primarily provides primary care and prevention services, but also some ancillary and specialty services. Prevention services include: HIV surveillance, risk assessment, education, HIV testing and counseling, provider HIV training and technical assistance, as well as PrEP.</p>	<p>In FY2022 the IHS is estimated to have spent \$6.3 million on HIV (details on estimate available upon request).</p>	<p>IHS is a "Big Four" federal purchaser subject to FCP protections. (Additional information about the "Big Four" pricing under the VA). There are three IHS formulary types:</p> <ul style="list-style-type: none"> <li>• Agency level, NCF.</li> <li>• Some Areas (e.g. Oklahoma City) have regional formularies.</li> <li>• Additionally, each local site has a local formulary and exceptions process for non-formulary drugs.</li> </ul>	<p>Traditional IHS services are provided without cost-sharing. Services provided through the Urban Indian Program are offered on a sliding scale. The <a href="#">Urban Indian Program</a> contracts with the IHS to provide services to American Indians and Alaskan Natives living in urban areas.</p>

<p><b>Ryan White HIV/AIDS Program (Ryan White)</b></p>	<p>The Ryan White HIV/AIDS Program is the largest federal program designed specifically for people with HIV in the United States. Functioning as the "payer of last resort," Ryan White helps fill the gaps for those who have no other source of coverage or face coverage limits or cost barriers. A detailed overview of the services Ryan White provides for people with HIV is <a href="#">here</a>.</p> <p>An estimated <a href="#">54%</a> of people with HIV received support from Ryan White in 2020.</p>	<p>Ryan White serves uninsured and underinsured individuals with HIV. Income and other eligibility criteria are set by grantees (e.g. state, county, CBO, etc.) but the program is typically limited to those with low and moderate incomes. The program is divided into five major parts which operate and are funded independently:</p> <ul style="list-style-type: none"> <li>•Part A: Funds counties/cities most severely affected by HIV.</li> <li>•Part B: Funds all states, territories, Puerto Rico, Washington D.C. and includes ADAP - the prescription drug and insurance program.</li> <li>•Part C and Part D: Fund public and private community-based organizations providing medical care and support service with Part D focused on serving women and children.</li> <li>•Part F: Has multiple funding components for 1) dental schools and community programs, 2) technical assistance and training (AETCs) and development of innovative models of care (SPNS), and 3) the MAI.</li> </ul>	<p>Ryan White provides a range of outpatient HIV "core medical" and "support" services, which vary by Part and grantee. Parts A-C must spend at least 75% of funds on core services, unless they receive a <a href="#">waiver</a>.</p> <ul style="list-style-type: none"> <li>• Core medical services may <a href="#">include</a>: ADAPs (insurance assistance, ARVs, and many other HIV-related medications are covered), pharmaceutical assistance, early intervention services, health insurance premium and cost sharing assistance, home and community-based services, home health care, hospice, medical case management, medical nutrition therapy, and mental health, oral health, outpatient and ambulatory medical, and substance use outpatient care.</li> <li>• Support services may <a href="#">include</a>: Child care services, emergency financial assistance, food services, health education, housing, legal and linguistic services, medical transportation, non-medical case management, other professional and outreach services, permanency planning and psychosocial support, referral services, rehabilitation services, respite care and residential substance use services.</li> </ul> <p>Primary prevention services are generally not provided as the program is intended to serve people with HIV but the program does support risk reduction counseling and targeted testing and some partner services. Existing program <a href="#">infrastructure</a> can be used to support PrEP programming, but Ryan White funds cannot be used directly for PrEP. Many CHCs receive both federal CHC and Ryan White funding and provide both prevention and treatment services using the two streams.</p>	<p>In FY2023, federal funding for Ryan White was <a href="#">\$2.6 billion</a>. This includes federal contributions from the <a href="#">EHE initiative</a>.</p>	<p>Many Ryan White clinics are enrolled in the 340B Drug Pricing Program, which allows for discounted drug purchasing using a formula. 340B discounts start at 23.1% of AMP, with additional discounts if AMP increases higher than CPI-U. Additionally, ADAPs receive significant voluntary discounts (&gt;50% off list prices) on most ARVs, as negotiated by the ADAP Crisis Task Force. Program grantees can generate 340B revenue when a drug is purchased at a discounted 340B rate and grantee is reimbursed by insurance at a higher rate. The revenue (i.e. the spread) is then used to support provision of services, including funding HIV care and support services.</p>	<p>Cost-sharing in Ryan White programs is typically low and often on a sliding scale basis. Ryan White grantees, including state ADAP programs, can also assist with offsetting private or public insurance costs (e.g. premiums, and cost-sharing).</p>
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<p><b>Community Health Centers (CHCs)</b></p>	<p>Community health centers are a national network of safety-net primary care providers serving low-income and medically underserved communities, including people with and at risk for HIV.</p> <p>In 2021, CHCs treated <a href="#">more than 200,000 people with HIV</a> (who may also have a primary payer and/or be receiving Ryan White support), <a href="#">over 3 million visits included a test for HIV reaching 2.8 million patients</a>, and <a href="#">provided PrEP to 79,163 patients</a>.</p>	<p>There is no eligibility requirement. Health centers primarily serve low-income individuals, including uninsured or underinsured individuals and families, as well as those with Medicaid and private insurance.</p>	<p>CHCs provide primary care, prescription drugs, dental, mental health, substance use services, and support services. Offerings may vary by site. Prevention services may vary depending on the site, but generally, HIV testing and screening, STI screening, PrEP, and other services are offered.</p>	<p>Total CHC spending on HIV is not available. However, in FY23, CHCs directly received \$157 million as part of funding for the federal <a href="#">EHE initiative</a>. Dually funded CHCs also receive funding from the Ryan White program (see section on Ryan White), <a href="#">totaling \$87 million from Part C in FY2021</a>.</p>	<p>CHCs are eligible for the 340B Drug Pricing Program, allowing discounted drug purchasing using formula similar to Medicaid Drug Rebate Program. Discounts start at 23.1% off AMP, with additional discounts if AMP increases higher than CPI-U. Many health centers received both CHC and Ryan White funding. (See further discussion of 340B under the Ryan White section).</p>	<p>Cost-sharing in CHCs is first determined by payer source. Insurance is billed for patients with coverage and, depending on coverage and services, individuals may face cost-sharing. For the uninsured, cost-sharing is typically based on a sliding scale, if required.</p>
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NOTE: ABP=alternative benefit plan. ACA = Affordable Care Act. ADAP = AIDS Drug Assistance Program. AETC = AIDS Education and Technical Assistance Centers. ALS = amyotrophic lateral sclerosis. AMP = average manufacturer price. ARVs = antiretrovirals. CHC = community health centers. CPI-U = consumer price index for all urban consumers. EHB = Essential Health Benefits. EHE = Ending the HIV Epidemic. FCP = federal ceiling price. FDA = Food and Drug Administration. FPL = federal poverty limit. HMO = health maintenance organization. IHS = Indian Health Service. LIS = low-income subsidy. MAI = Minority AIDS Initiative. NCD = national coverage determination. NCF = National Core Formulary. Non-FAMP = average manufacturer price paid by non-federal purchasers. PPOS = preferred provider organization. PrEP = pre-exposure prophylaxis. Ryan White = Ryan White HIV/AIDS Program. SPNS = Special Programs of National Signific. SSI = Supplemental security income. STI = sexually transmitted infection. USPSTF = United States Preventive Services Task Force. VA = Veteran Affairs.

