Protect Medicaid Funding Issue #9: People with HIV

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Introduction

Medicaid helps people live healthier and more economically secure lives. It increases the diagnosis and early treatment of chronic conditions, enhances educational achievement and future earnings for covered children, reduces health care inequities, and provides comprehensive, high-quality, and cost-effective care.[1] Medicaid coverage is tailored to the unique needs of individuals and families with low incomes, but still costs less per beneficiary than private insurance.[2] Medicaid's core beneficiary protections make the program work for enrolled populations, including children, parents, pregnant people, low-income workers, older adults, and people with disabilities. Despite Medicaid's proven success and efficient use of funds, detractors repeatedly seek to cut or cap funding for the program. These proposals seriously jeopardize the health and financial security of the over 80 million people who benefit from Medicaid and CHIP.[3]

This fact sheet explains why Medicaid is critical for people with HIV and examines how they would be harmed by Medicaid funding caps.

Why Medicaid is Important for People with HIV

Access to comprehensive and affordable health insurance coverage is critical to helping people with or impacted by HIV achieve their highest attainable standards of health. Access to HIV diagnoses, effective HIV preventive services (such as pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP)), and treatment (such as antiretroviral therapy) can dramatically reduce or eliminate transmission and improve health outcomes.[4] Moreover, coverage is important for treating HIV comorbidities. For example, people with HIV have increased risks of certain gynecological conditions, cervical cancer, and heart disease, needing access to comprehensive and affordable coverage.[5]

Medicaid is the largest source of health insurance coverage for people with HIV. It covers 40% of adults with the chronic condition.[6] Because Black and Hispanic/Latinx communities are disproportionately affected by HIV compared to other racial/ethnic groups, their communities especially benefit from the coverage, treatment, and care Medicaid provides.[7] Individuals with health insurance coverage are more likely to receive HIV testing and become aware of their HIV status.[8] People who know they are HIV-positive are also more likely to seek and retain care. As the largest source of insurance coverage for pregnant people, Medicaid enables access to treatments that can lower HIV viral loads to undetectable levels, virtually eliminating the risk of a pregnant person passing the condition on to their child.[9] Medicaid coverage also benefits the public's health by reducing the risk of transmission between sexual partners.

Medicaid expansion is a key component of ending the HIV epidemic. Medicaid expansion offers states the opportunity to cover more people with HIV. Under traditional Medicaid eligibility rules, many adults with HIV must wait until their condition progresses to an AIDS diagnosis before they are considered disabled and categorically eligible to receive Medicaid coverage, even if they have very low incomes. The ACA's Medicaid expansion created a new category of Medicaid eligibility that states can use to cover most adults with low incomes. Medicaid expansion has proven critical in the fight to end HIV. It is associated with an increase in HIV diagnoses, improvements in the knowledge of HIV status, and PrEP use.[10] Medicaid also allows states to use other optional categories or to seek approval for innovative pilot programs to provide coverage for people with HIV.

Medicaid covers many services that people with HIV need. State Medicaid programs must cover an array of mandatory services. These include inpatient and outpatient hospital services, physician visits, laboratory and x-ray services, family planning services and supplies, and pregnancy-related services.[11] Further, Medicaid programs must also cover many specialized services. For example, Medicaid covers long-term care, which is critical to people with HIV/AIDS who are at an increased risk of developing a permanent or episodic disability from their condition. It must also cover non-emergency medical transportation which helps beneficiaries with inadequate access to transportation get to appointments. States may also choose to cover many important optional services, such as the outpatient prescription drug benefit, which all states cover, and personal care services.

Medicaid expansion helps support other safety-net programs. The Ryan White AIDS Drug Assistance Program (ADAP) provides HIV-related drugs to individuals with limited or no prescription drug coverage. States that expand Medicaid are able to shift individuals enrolled in ADAP into Medicaid expansion, thereby freeing up ADAP funding for improved HIV/AIDS care

in the state. Medicaid also helps support community health clinics and reduces their uncompensated care costs.[12]

How Funding Caps Would Harm People with HIV and Thwart Efforts to End the HIV Epidemic

Funding caps threaten Medicaid coverage for HIV care. Funding caps reduce federal Medicaid funding and shift more of the costs onto states. States would likely respond to budget gaps by reducing Medicaid eligibility. For example, states that have already expanded Medicaid may consider reversing their expansions, and states that are considering expansion may halt their efforts.[13] It also would disproportionately affect certain communities. For example, in 2021, Black/African American individuals comprised only 12% of people in the U.S. yet 40% of people with HIV nationwide.[14] That same year, Hispanic/Latinx individuals comprised 18% of people in the U.S. yet 25% of people with HIV.[15]

Funding caps would likely result in states covering fewer HIV-related services. With less Medicaid funding under a funding cap, states would likely reduce coverage of Medicaid services. States could do this by cutting out optional services, particularly more expensive services such as the optional outpatient prescription drug benefit or home and community-based services (HCBS), or by imposing strict limits on the amount, duration, and scope of services. For example, states could reduce the number of prescriptions an individual can obtain.

Funding caps threaten access to essential HIV treatment. Under funding caps, states may also attempt to reduce costs by restricting the network of providers Medicaid beneficiaries are able to visit. People with HIV often depend on providers with specialized expertise in HIV care. Consequently, they would be greatly harmed by restrictive networks with limited access to specialists. States might also attempt to pass costs onto Medicaid beneficiaries, forcing low-income people with HIV to choose between life-saving medications and other necessities such as food, rent, and utilities.

Funding caps would leave states at risk for HIV/AIDS or other epidemics. Funding caps limit states to a preset amount of federal funding, regardless of how future health care costs actually increase. This means states would not be prepared to finance health-related epidemics, including surges in the number of HIV patients or in the cost of their care due to new effective but expensive treatments.[16]

ENDNOTES

[1] Robin Rudowitz et al., Kaiser Fam. Found., 10 Things to Know about Medicaid (Jun. 30, 2023), https://www.kff.org/mental-health/issue-brief/10-things-to-know-about-medicaid/; MACPAC, Access in Brief: Children's Experience in Accessing Medical Care (Nov. 2021), https://www.macpac.gov/wp-content/uploads/2016/06/Access-in-Brief-Childrens-Experiences-in-Accessing-Medical-Care.pdf.

[2] Heidi Allen et al., *Comparison of Utilization, Costs and Quality of Medicaid vs. Subsidized Private Health Insurance for Low-Income Adults*, 4 JAMA NETWORK OPEN (2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774583 (". . .overall health care spending was more than 80% higher among Marketplace-eligible adults than among Medicaid-eligible adults. This difference was no longer significant when claims were adjusted to Medicaid prices, indicating that the cost differences were driven by higher prices for the same services in the Marketplace compared with Medicaid."). *See also* Ark. Ctr. for Health Improvement, *Arkansas Health Care Independence Program ("Private Option") Section 1115 Demonstration waiver Interim Report* (Jun. 16, 2016), https://achi.net/wp-content/uploads/2018/10/Arkansas-Health-Care-Independence-Program-Section-1115-Demonstration-Waiver-Interim-Report-June-2016.pdf (noting a 78.3% difference between the commercial and Medicaid per patient per month payments).

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[4] Katie Huynh et. al, StatPerals, *HIV Prevention* (Jan. 10, 2024), https://www.ncbi.nlm.nih.gov/books/NBK470281/.

[5] *See* HIV.gov, *How Does HIV Affect Women Differently?* (June 15, 2022), https://www.hiv.gov/hiv-basics/Sstaying-in-hiv-care/other-related-health-issues/womens-health-issues/.

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[7] *See* HIV.gov, *Impact on Racial and Ethnic Minorities* (Dec. 18, 2023), https://www.hiv.gov/hiv-basics/overview/data-and-trends/impact-on-racial-and-ethnic-minorities/; Lindsey Dawson et al., Kaiser Fam. Found., *Insurance Coverage and Viral Suppression Among People with HIV, 2018* (Sept. 24, 2020), https://www.kff.org/hivaids/issue-brief/*insurance*-coverage-and-viral-suppression-among-people-with-hiv-2018/.

[8] *See* HIV.gov, *The Affordable Care Act and HIV/AIDS* (Oct. 7, 2022), https://www.hiv.gov/federal-response/policies-issues/the-affordable-care-act-and-hiv-aids/.

[9] Adam Searing et al., Georgetown U. Ctr. for Children & Families., *HIV and Medicaid Expansion: Failure of Southern States to Expand Medicaid Makes Elimination of HIV Infection in the United States Much Harder to Achieve* 2 (Nov. 2020), https://ccf.georgetown.edu/2020/11/29/hiv-and-medicaid-expansion-failure-of-southern-states-to-expand-medicaid-makes-elimination-of-hiv-infection-in-the-united-states-much-harder-to-achieve/.
[10] *See* Bita Fayaz Farkhad et al., *Effect of Medicaid Expansions on HIV Diagnoses and Pre-Exposure Prophylaxis Use*, 60(3) AM. J. PREV. MED. 335–342 (Jan. 2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7903489/.
[11] 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a). *See also* Leonardo Cuello, Nat'l Health Law Prog., *What Makes Medicaid, Medicaid: Five Reasons Why Medicaid is Essential to Low-Income People* (Jan. 14, 2015), https://healthlaw.org/resource/what-makes-medicaid-medicaid/; Madeline T. Morcelle, Nat'l Health Law Prog., *Closing The Medicaid Coverage Gap: Preventing a Separate and Unequal Result* 3–5 (June 28, 2021), https://healthlaw.org/resource/closing-the-medicaid-coverage-gap-preventing-a-separate-and-unequal-result/.
[12] *See* Corinne Lewis et al., The Commonwealth Fund, *The Role of Medicaid Expansion in Care Delivery at Community Health Centers* (April 4, 2019), https://www.commonwealthfund.org/publications/issue-briefs/2019/apr/role-medicaid-expansion-care-delivery-FQHCs; Jessamy Taylor, Nat'l Health Pol'y Forum, *Changes in Latitudes, Changes in Attitudes: FQHCs and Community Clinics in a Reformed Health Care Market* (2012), https://www.ncbi.nlm.nih.gov/books/NBK560333/.
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[14] HIV.gov, *supra* note 6.
[15] *Id*.
[16] Sarah Kaplan, *Indiana is Battling the Worst HIV Outbreak in its History*, WASHINGTON POST, (March 26, 2015), https://www.washingtonpost.com/news/morning-mix/wp/2015/03/26/indiana-is-battling-the-worst-hiv-epidemic-in-state-history/.