Doubled Risk of Death Among Publicly Insured People With HIV in U.S.

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For people living with HIV and relatively healthy CD4 counts on public health insurance, the risk of dying is about twice that of those who have private health insurance, according to a sobering new report from the HIV Outpatient Study (HOPS) published online ahead of print by the journal *AIDS*. According to the report, HIV-positive individuals with CD4 counts above 200 were more likely to die of non-AIDS-related health problems—many of them modifiable with appropriate guidance and medical care—if they were covered by a public health insurance plan compared with a private health insurance plan.

Public insurance programs—notably Medicare and Medicaid—have long played a critical role in HIV care since the epidemic began. According to The Henry J. Kaiser Family Foundation, Medicare covers about one fifth of people with HIV receiving care in the United States, whereas Medicaid covers about four in 10 American residents living with the virus. While these programs are an undeniable lifeline for hundreds of thousands of HIV-positive people in the United States, the potential disparities in the care they receive haven't been fully explored in terms of comparing them with similarly situated people receiving care made possible with private health insurance.

To investigate this long-standing question, Frank Palella, MD, of Northwestern University in Chicago, and his HIV Outpatient Study colleagues evaluated mortality rates according to race and insurance categories among 3,754 people living with HIV, all of whom had been followed for at least six months from 1996 to 2007 and had been receiving antiretroviral (ARV) treatment at least 75 percent of the time.

Most study participants were male (84 percent) and white (60 percent)—roughly 29 percent were black and 12 percent were Hispanic. The majority of the study participants were privately insured (57 percent); 32 percent were publicly insured for much of the time they were followed in the HOPS study and were on ARV treatment.

There were 331 deaths over an average follow-up period of 4.7 years.

Death rates, in patients with CD4 counts above 200, were significantly higher among people with public health insurance. More precisely, Palella's group noted a greater than two-fold mortality rate compared with similar patients whose health care costs were paid by private insurance plans. Race was not believed to be a factor, as there were no statistically meaningful differences in

mortality rates between whites, blacks and Hispanics who died with a CD4 count above 200.

Among patients who died with a CD4 count below 200, mortality rates were generally no different in analyses limited to insurance status or race. Low CD4 counts, older age and high viral loads were the only factors associated with death in this group.

Causes of death were available for 248 of the participants who died. Compared with privately insured patients, publicly insured participants had proportionately more deaths related to cardiovascular disease (30 versus 15 percent) and liver disease (24 versus 12 percent). More publicly insured people were also more likely to have preventable and often treatable chronic non-AIDS diseases such as cardiovascular disease, kidney disease, hepatitis C and hepatitis B.

Palella's group urged caution in interpreting its findings. "We believe it would be improper to consider these findings as evidence that the quality of publicly funded health care provided was inferior and that it was primarily this inferiority that contributed to the greater mortality observed among publicly insured persons."

That said, the authors stressed the need for additional clarification, particularly as the United States undergoes health care reform. "[W]e need to better understand how health care delivery and its financial reimbursement affect quality of care (including routine well-health screening and pre-emptive care) and mortality risk, particularly among groups of persons who have higher prevalence of illnesses that ultimately contribute to mortality regardless of insurance status.

"In the interim," they add, "screening for and addressing modifiable health risks associated with preventable and treatable medical conditions should guide clinical practice and inform public health measures in our efforts to further improve survival and enhance overall health for all patients."
