Background Context

There is no cure for HIV/AIDS. However, through the use of ARVs — known for inhibiting viral replication and allowing for immune reconstitution — HIV-related morbidity and mortality can be prevented.

Medical Effectiveness

- Inconclusive evidence on the effect of cost sharing for ARVs on long-term adherence and viral suppression for people living with HIV.
- Insufficient evidence on the effects of cost sharing and utilization management for ARVs on healthcare utilization and health outcomes.

Benefit Coverage and Cost Impacts

At baseline, 98.9% of enrollees with DMHC- or CDI-regulated health insurance plans/policies have coverage for ARVs, and 38.6% of enrollees have coverage for ARV that is fully compliant with SB 427. Postmandate, 100% of enrollees with coverage subject to SB 427 would have coverage for ARV without cost sharing or utilization review requirements.

SB 427 would increase total net annual expenditures by $51,601,000 or 0.0352% for enrollees with state-regulated insurance, excluding DMHC-regulated Medi-Cal.

Public Health Impacts

CHBRP estimates an additional 1,402 enrollees would seek ARVs overall for the prevention or treatment for HIV/AIDS. Including an increase in the number of individuals who do not seroconvert due to PrEP (47) and PEP (22) access, an increase in the number of HIV-positive individuals who access ARV and sustain linkages to care (1,332), and a subsequent decrease in both short- and long-term adverse health outcomes.

The version of California Senate Bill (SB) 427 analyzed by CHBRP would require DMHC-regulated health plans and CDI-regulated health to cover all U.S. Food and Drug Administration (FDA)-approved or Centers for Disease Control and Prevention (CDC)-recommended antiretroviral drugs, products, and devices (ARVs) for HIV/AIDS with no cost sharing or utilization review requirements for enrollees in grandfathered and nongrandfathered plans and policies under the outpatient prescription drug benefit.