RISKY BUSINESS?
FINANCIAL PROTECTION FOR PEOPLE LIVING WITH HIV/AIDS
A REVIEW OF INTERNATIONAL EXPERIENCES
Mission

The Health Systems 20/20 cooperative agreement, funded by the U.S. Agency for International Development (USAID) for the period 2006-2011, helps USAID-supported countries address health system barriers to the use of life-saving priority health services. Health Systems 20/20 works to strengthen health systems through integrated approaches to improving financing, governance, and operations, and building sustainable capacity of local institutions.

Date

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Health Systems Division
Office of Health, Infectious Disease and Nutrition
Bureau for Global Health
United States Agency for International Development

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### ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AAR</td>
<td>African Air Rescue</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>BPL</td>
<td>Below Poverty Line</td>
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<tr>
<td>CBO</td>
<td>Community-based Organization</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
</tr>
<tr>
<td>CMS</td>
<td>Council for Medical Schemes</td>
</tr>
<tr>
<td>DMP</td>
<td>Disease Management Program</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GEMS</td>
<td>Government Employees Medical Scheme</td>
</tr>
<tr>
<td>HICP</td>
<td>Health Insurance Continuation Program</td>
</tr>
<tr>
<td>HIVREF</td>
<td>HIV Risk Equalization Fund</td>
</tr>
<tr>
<td>HOPWA</td>
<td>Housing Opportunities for Persons with HIV/AIDS</td>
</tr>
<tr>
<td>IRDA</td>
<td>Insurance Regulatory and Development Authority</td>
</tr>
<tr>
<td>NAMAF</td>
<td>Namibian Association of Medical Funds</td>
</tr>
<tr>
<td>NAMFISA</td>
<td>Namibian Financial Institutions Supervisory Authority</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental Organization</td>
</tr>
<tr>
<td>OOP</td>
<td>Out-of-Pocket</td>
</tr>
<tr>
<td>PLHA</td>
<td>People Living with HIV/AIDS</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
</tr>
<tr>
<td>PPP</td>
<td>Public-private Partnerships</td>
</tr>
<tr>
<td>PSEMAS</td>
<td>Public Service Employee Medical Aid Scheme</td>
</tr>
<tr>
<td>RSBY</td>
<td>Rashtriya Swasthya Bima Yojana</td>
</tr>
<tr>
<td>TPA</td>
<td>Third Party Administrator</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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</table>
EXECUTIVE SUMMARY

India is at a crossroads in how it addresses HIV/AIDS. Despite great advancements in resources for HIV/AIDS services, critical gaps in the health system disproportionately affect people living with HIV/AIDS (PLHA). They face high out-of-pocket expenses and great financial burden due to their disease, yet are often excluded from benefits offered to others suffering from a chronic health condition.

The sustainability of public HIV/AIDS prevention and treatment programs cannot rely solely on external donor funds; additional, complementary approaches, such as health insurance, are required to ensure availability and accessibility of HIV services over the long-term and mitigate the impact of HIV in India.

However, integrating HIV/AIDS into health insurance and allowing the participation of PLHA in health insurance schemes is not an easy task. Fortunately for India, there are several countries that have been down this road and overcome some of the challenges and concerns that stakeholders in India face.

This paper provides international experiences in providing health insurance coverage for HIV/AIDS services and for PLHA. Key observations from other countries include:

- **Policy and regulatory environment:** Many countries have a specific regulation around the provision of health insurance to PLHA ranging from prohibiting insurance companies from excluding PLHA from health insurance schemes, to requiring health insurance plans to cover HIV/AIDS-related services, to requiring all individuals to have health insurance. India lacks definitive guidance from the IRDA or any other government agency around financing HIV/AIDS-related services.

- **Financing and cost experience:** Routine data collection is critical to managing costs and ensuring premiums are accurate. Careful consideration around voluntary versus compulsory insurance is also critical: there need to be sufficient safeguards to protect beneficiaries, but also safeguards to protect insurance companies from adverse selection. International experience suggests that the best approach is to integrate HIV/AIDS services into existing insurance schemes, as well as not inhibit PLHA from joining. For this to be effective, the keys to covering PLHA are: knowing the costs, accounting for the costs in premium estimates, managing the costs (such as through disease management programs), spreading the costs across the risk pool, and preventing adverse selection.

- **Insurance model:** International experience suggests that covering PLHA and HIV/AIDS services is not dependent on the model of insurance used. A variety of models are used to extend coverage to PLHA – what is most important is that the model pays attention to the key elements that determine success, such as size and diversity of risk pool, accurate risk analysis, incentives, and cost containment.

- **Beneficiaries:** International experience suggests that it is feasible from an operational and financial perspective to integrate services and PLHA into health insurance, without focusing on a specific beneficiary group. Focusing on a specific beneficiary group (i.e., the poor, or just PLHA) risks financial insolvency or a higher reliance on funding to subsidize the scheme. Further, countries have taken intentional steps to make PLHA autonomous, protecting their HIV-status from employers, and others. This has helped facilitate a more diversified risk pool, as well as protects consumers and beneficiaries from potential stigma and discrimination.
• Benefit package: It is possible to leverage government-provided services, thereby reducing some costs of the insurance scheme; but consideration needs to be made when those services are not available. Access to ART and continuity of care for PLHA is critical to reduce the long-term costs associated with the disease. Therefore ensuring that beneficiaries have access to ART and services when they need it will be an important cost containment mechanism. Most countries reviewed do include ART, as well as other HIV/AIDS-related prevention and treatment services. The introduction of disease management programs can help ensure PLHA have access to the right services, while also protecting the payer to ensure PLHA are managing their illness, which will also reduce costs in the long-run.

With growing health insurance coverage and increasing variety of insurance models, there is great potential to extend health insurance coverage to Indians living with HIV. India has the luxury of benefitting from successes and lessons learned from other countries that have previously traveled this road.
I. INTRODUCTION

India is experiencing exponential growth – both positive and negative – in many areas of its society. The population is living longer, there is greater investment in both basic and secondary education, GDP is growing, and India is considered a major international player in the marketplace. Unfortunately, the prevalence of HIV in India undermines the positive impact of India’s growth.

India is at a crossroads in how it addresses HIV/AIDS. Despite great advancements in resources for HIV/AIDS services, critical gaps in the health system disproportionately affect people living with HIV/AIDS (PLHA). They face high out-of-pocket expenses and great financial burden due to their disease, yet are often excluded from benefits offered to others suffering from a chronic health condition. The sustainability of public HIV/AIDS prevention and treatment programs cannot rely solely on external donor funds; additional, complementary approaches, such as health insurance, are required to ensure availability and accessibility of HIV services over the long term and mitigate the impact of HIV in India. With growing health insurance coverage and increasing variety of insurance models, there is great potential to extend health insurance coverage to Indians living with HIV. India has the luxury of benefitting from successes and lessons learned from other countries that have previously traveled this road.

The purpose of this paper is to provide international experiences in providing health insurance for PLHA and identify critical factors that have affected the provision of insurance to PLHA. The paper is organized as follows: there is a brief overview of the HIV epidemic in India, followed by the current insurance industry, and the context around healthcare and insurance for people living with HIV in India. This background is followed by an overview of critical factors for the provision of insurance to PLHA–policy environment; insurance model; beneficiaries; enrollment and uptake; benefit packages; and financing and cost-containment mechanisms–drawing on examples from other countries.

This document is meant to serve as a stepping stone for a more extensive and thorough analysis of international experiences of HIV and health insurance. While few countries have analyzed and researched the effects of health insurance coverage and HIV/AIDS, the lessons learned are highly relevant to India as it explores options for moving forward.
2. HEALTH INSURANCE IN INDIA

High out-of-pocket (OOP) healthcare expenditures are the single largest contributor to indebtedness in low-income households in India. It is estimated that nearly 72% of India's per capita annual healthcare expenditures is OOP, with less than 20% coming from the government. Health insurance is one mechanism that can help spread the costs of healthcare, redistributing the sources of funds to pay for health.

FIGURE 1: SOURCES OF FUNDS FOR HEALTH CARE IN INDIA 2004-05

Health insurance has seen exponential growth in the past several years in India, as illustrated in Table 1. The health insurance market is also quite diverse, allowing the industry to expand its reach to several corners of society with various models. Social schemes provide coverage for certain government employees and to indigent population. Micro insurance schemes provide coverage for those that enroll, which tend to be the poor or rural population. Private insurance schemes provide coverage for individuals or families that purchase a policy, employer-based schemes provide coverage for employees and their families, and some cooperative/mutual health organizations provide coverage to their members. There has been an explosion of pro-poor health insurance schemes in India, including the central and state co-funded RSBY scheme, Rajiv Arogyashree in Andhra Pradesh, Kalaignar in Tamil Nadu, and Vajpayee Arogyashree in Karnataka.

2 Insurance Regulatory and Development Authority, Annual Report.
TABLE 1: INDIA'S INCREASING HEALTH INSURANCE COVERAGE

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of policies</th>
<th>No. of members</th>
<th>Avg. no. of persons /policy</th>
<th>No. of claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003-4</td>
<td>22,65,451</td>
<td>83,61,629</td>
<td>4</td>
<td>3,60,088</td>
</tr>
<tr>
<td>2004-5</td>
<td>20,59,449</td>
<td>89,87,239</td>
<td>4</td>
<td>5,55,273</td>
</tr>
<tr>
<td>2005-6</td>
<td>38,28,495</td>
<td>1,63,45,575</td>
<td>4</td>
<td>10,16,785</td>
</tr>
<tr>
<td>2006-7</td>
<td>31,10,475</td>
<td>1,79,07,430</td>
<td>6</td>
<td>10,60,047</td>
</tr>
<tr>
<td>2007-8</td>
<td>37,90,838</td>
<td>2,41,21,625</td>
<td>6</td>
<td>14,36,998</td>
</tr>
<tr>
<td>2008-9</td>
<td>45,75,725</td>
<td>3,27,10,604</td>
<td>7</td>
<td>20,81,297</td>
</tr>
<tr>
<td>2009-10</td>
<td>68,84,687</td>
<td>5,48,93,453</td>
<td>8</td>
<td>32,63,597</td>
</tr>
</tbody>
</table>

Source: Insurance Information Bureau 2010, IRDA

One group that has consistently been excluded from health insurance programs in India are those living with HIV/AIDS.
3. HEALTH INSURANCE AND HIV/AIDS IN INDIA

UNAIDS estimates approximately 2.27 million PLHA in India\(^3\), a prevalence of approximately 0.3%—though actual numbers are likely to be higher, given India’s large and diverse population and the complexity of estimating HIV incidence/prevalence and AIDS-related deaths. The low prevalence rate can be misleading: India ranks third in the world in terms of greatest number PLHA after South Africa and Nigeria\(^4\). With its population of more than 1 billion, a mere 0.1% increase in HIV prevalence in India would increase the estimated number of people living with HIV by more than half a million. Currently, HIV/AIDS is the fifth most common cause for life-years lost and the eighth most common cause of mortality in India, as illustrated in Tables 2 and 3\(^5\). The relatively high mortality due to HIV/AIDS is indicative of poor access to care and treatment services. Even a small increase in HIV prevalence, without concomitant increases in access to care and treatment services, has the potential to dramatically and very negatively impact the country’s health and economic sector.

**TABLE 2: LEADING CAUSES OF MORTALITY**

<table>
<thead>
<tr>
<th>Cause</th>
<th>% of deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Ischemic heart disease</td>
<td>15%</td>
</tr>
<tr>
<td>2 Lower respiratory infections</td>
<td>11%</td>
</tr>
<tr>
<td>3 Cerebrovascular disease</td>
<td>7%</td>
</tr>
<tr>
<td>3 Perinatal conditions</td>
<td>7%</td>
</tr>
<tr>
<td>5 Chronic obstructive pulmonary disease</td>
<td>5%</td>
</tr>
<tr>
<td>6 Diarrheal diseases</td>
<td>4%</td>
</tr>
<tr>
<td>6 Tuberculosis</td>
<td>4%</td>
</tr>
<tr>
<td>8 HIV/AIDS</td>
<td>3%</td>
</tr>
<tr>
<td>9 Road traffic accidents</td>
<td>2%</td>
</tr>
<tr>
<td>9 Self-inflicted injuries</td>
<td>2%</td>
</tr>
</tbody>
</table>

**TABLE 3: LEADING CAUSES OF DISABILITY**

( measured in disability adjusted life years)

<table>
<thead>
<tr>
<th>Cause</th>
<th>% of years of life lost</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Lower respiratory infections</td>
<td>13%</td>
</tr>
<tr>
<td>1 Perinatal conditions</td>
<td>13%</td>
</tr>
<tr>
<td>3 Diarrheal diseases</td>
<td>8%</td>
</tr>
<tr>
<td>4 Ischemic heart disease</td>
<td>7%</td>
</tr>
<tr>
<td>5 HIV/AIDS</td>
<td>4%</td>
</tr>
<tr>
<td>5 Tuberculosis</td>
<td>4%</td>
</tr>
<tr>
<td>7 Cerebrovascular disease</td>
<td>3%</td>
</tr>
<tr>
<td>7 Self-inflicted injuries</td>
<td>3%</td>
</tr>
<tr>
<td>9 Chronic obstructive pulmonary disease</td>
<td>2%</td>
</tr>
<tr>
<td>9 Road traffic accidents</td>
<td>2%</td>
</tr>
</tbody>
</table>

Lacking access to insurance or social security systems, most PLHA in India face serious obstacles in obtaining treatment for various types of opportunistic infections they contract in the course of their illness. On average, India’s PLHA face much higher OOP healthcare costs—approximately five times

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\(^3\) UNAIDS, WHO, and UNICEF. 2008. Epidemiological Fact Sheet on HIV and AIDS: Core data on epidemiology and response.


\(^5\) WHO Death and DALY estimates by cause, Country Fact Sheet 2006.
more than the general population. Higher OOP costs create a financial barrier to accessing needed healthcare services. It also means that PLHA are disproportionately affected by rising healthcare costs, and thus more likely to become indigent due to healthcare expenses.

There is increasing demand from PLHA and others for health insurance coverage, which includes HIV/AIDS-related services. For example, employers are increasingly interested in providing insurance coverage for all employees, regardless of HIV status and are willing to pay for this coverage for their employees. Further, PLHA themselves drive demand for insurance products to protect their assets and improve access to healthcare.

Providing coverage for HIV/AIDS through health insurance can improve access to care and reduce the financial burden on PLHA and their families by decreasing OOP costs. In addition, the improved health status resulting from increased access to care and treatment services will also have an economic benefit for PLHA and their employers and reduce the strain on India’s healthcare system and economy overall.

However, despite the obvious need and demand for healthcare insurance, PLHA are typically excluded from traditional health insurance policies in India, regardless of their ability to pay, health status, or employment status. No HIV-related services are offered under employer-based schemes and PLHA employees are excluded from such schemes. A number of government-sponsored health insurance plans such as Rashtriya Swasthya Bima Yojana (RSBY), Andhra Pradesh’s Arogyasri Scheme and the Kalaignar critical illness scheme in Tamil Nadu do not expressly exclude PLHA. However, these schemes do not cover out-patient treatment, which for PLHA, can contribute to a large portion of healthcare needs. (Reportedly, hospitalization costs are covered for opportunistic infections of HIV/AIDS such as pneumonia, TB, etc., if such ailments are included in a list of covered illnesses under the benefit package of these plans. However, this is not clearly confirmed by the insurer or the implementing agency.)

Resources for the healthcare system are already scarce, with the government contributing less than 20% of total health expenditure for health. Increases in HIV prevalence, along with high rates of HIV-TB co-infection (approximately 55%), further add to the burden on the fragile healthcare system. At the same time, uptake of antiretroviral therapy (ART) is low, stigma and discrimination of PLHA continues, and there is a great deal of misunderstanding about the potential productivity of PLHA.

There are several barriers to including PLHA in health insurance schemes. There is a lack of information on the burden of financing and health-seeking behavior of PLHA. The insurance industry assumes that costs associated with extending health insurance to PLHA are high, meaning higher utilization rates and claims ratios. India has a nascent health insurance industry with low penetration rates, high loss ratios and lack of regulatory definition, and there is limited data available on healthcare utilization and costs for PLHA, which makes it difficult or near impossible to appropriately cost a benefit package inclusive of HIV-related services.

However, using an assets-based approach to determine poverty, one can see that India has a strong foundation upon which to build a solvent insurance industry for PLHA. There is strong economic growth, rising awareness of the need for health insurance in India, and significant opportunities for

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7 Based on discussions with some private and public sector employers.
8 Loss ratio is the ratio between the premiums paid to an insurance company and the claims settled by the company.
9 Asset-based approach is an approach for poverty measurement that considers well-being as a function of what one possesses and the value of those possessions.
shaping the growth and path for health insurance in India. There are government health insurance packages for below-poverty line (BPL) families in several states enabling access to tertiary care (e.g., Rajasthan Life Security Fund provides for PLHA). There is a strong presence of NGOs and CBOs, enabling an expansion of health coverage and access at policy and grassroots levels. The pharmaceutical industry in India (Cipla, Ranbaxy) has enabled availability of antiretroviral medication at significantly lower costs compared to other medications.
4. INTERNATIONAL EXPERIENCES OF COVERING HIV/AIDS-RELATED SERVICES INTO HEALTH INSURANCE

While the experience from other countries is not vast, there are examples and lessons learned from which India can learn. We organized the experiences around six components: 1) policy environment, 2) insurance models, 3) beneficiaries, 4) enrollment and uptake, 5) benefit packages, and 6) financing and costing methods. Each is described in more detail in the following sections.

These components were selected as they are critical factors that can determine whether a health insurance scheme succeeds or fails. The **policy and regulatory environment** guides industry practice and sets the precedent on how health insurance will be implemented in a country, including also the benefits and products offered, outreach and enrollment practices, and financing. The **financing and costing methods**, combined with the beneficiaries' uptake of these services and their claims against the policies, determine the overall effectiveness and solvency of the insurance scheme. The **insurance model** utilized is very important to understand, as not every model is appropriate for every beneficiary population. For example, in countries with a low tax base, it becomes very difficult to sustainably implement national or social health insurance models, as there are not sufficient resources to finance the scheme for everyone. With high BPL populations, private health insurance is also difficult as the poor are unable to afford the premium contribution (without the inclusion of subsidies). So how a health insurance model is designed is critical to the success and viability of a scheme.

**Beneficiaries** are those that receive benefit from the scheme. For India to be able to learn from other countries, we need to understand who is covered so that the lessons learned can be taken in context. **Enrollment and uptake** is how people are enrolled and the experiences of insurance schemes vis-à-vis getting people to join. Enrollment practices can be a critical factor in the success and sustainability of a scheme. Finally, the benefits package refers to what benefits are included in the scheme and can be an attraction or deterrent from enrolling in a health insurance scheme.

When all these variables are working in alignment and effectively, one would expect: improved health indicators, as beneficiaries have greater access to health services; reduced financial strain on households of PLHA; and increased financial viability of insurance companies, as they are able to increase market share, offer insurance products that meet the needs of their target populations, and reduce financial risk through risk pooling and informed rate adjustment.

4.1 POLICY AND REGULATORY ENVIRONMENT SURROUNDING HIV/AIDS AND HEALTH INSURANCE COVERAGE

A prudent policy and regulatory environment is critical to the success of any health insurance program. It is no different for the issue of extending health insurance to PLHA. The policy and regulatory
environment includes laws and directives around insurance in general and insurance for PLHA in particular. It guides industry practice, levels the playing field, and sets the precedent on how health insurance will be implemented in a country, including also the benefits and products offered, outreach and enrollment practices, financing modalities, and consumer protections. Laws and regulations of an insurance industry are complex and interrelated.

This section provides examples of some regulatory and legal approaches that have been tried; however, with each approach, there are advantages and disadvantages, as well as other related regulations that may have to be dealt with. Regulations and laws do not change in a vacuum, so careful attention and due diligence are always required when dealing with the laws and regulations in a country. For example, in addition to policies and regulations that can help PLHA obtain health insurance coverage, it is important to also address policies and regulations that protect insurance schemes from problems such as adverse selection.

Many countries that have had success in providing coverage to PLHA have supportive and very specific policies that have paved the way for inclusion of HIV/AIDS-related services. In South Africa, HIV/AIDS has special protection within the health insurance industry. The Medical Schemes Act (No. 131 of 1998) was implemented in 2000, which introduced the principles of guaranteed acceptance, community rating, and prescribed minimum benefits (PMBs), which provide protection to vulnerable individuals, including those living with HIV/AIDS.

Alternatively, in other countries although there may be no specific provisions for PLHA, the issue of insurance coverage for PLHA is subsumed in a broader policy. For example, in the United States, the American Disability Act protects all people with disabilities, including PLHA, from getting different treatment in an employment situation and entitles them to the same health insurance benefits at the same rate offered to those that do not have HIV or other disability.

Policy can direct inclusion/exclusion criteria, and affect financing and costing methods of insurance models. The Namibian Financial Institutions Supervisory Authority, the body that oversees and regulates health insurance, specifically prohibits the exclusion of HIV/AIDS in insurance plans. Under South Africa’s Medical Schemes Act, medical schemes are not allowed to:

- Exclude members with HIV or insist on an HIV test prior to acceptance
- Charge higher contributions based on risk; or
- Restrict benefits available for members with HIV that are provided as part of the PMB.

Similarly, under the United States’ recently enacted Patient Protection and Affordable Care Act, there is a “guaranteed issue” clause that will prohibit insurance companies from denying coverage to anyone with a pre-existing condition, which includes HIV/AIDS. And the U.S. Congress allocated $5 billion for the establishment of “high-risk pools” across the country. The group insurance plans will provide coverage for people with pre-existing conditions, including HIV/AIDS, who are unable to find insurance through other avenues.

And while specific policies significantly contribute to accessibility of healthcare coverage of PLHA, countries like Rwanda and Uganda have demonstrated that it is not absolutely necessary. In Rwanda, for example, most insurance plans provide coverage for HIV/AIDS-related services without any mandate from a regulatory body. Similarly, even without a policy explicitly mentioning anything about HIV/AIDS, most private health insurance policies in Uganda have coverage for HIV/AIDS.
The lack of explicit policy, health regulation, or regulatory body to monitor the activities of health insurance in the country can create uncertainty for players currently in this space and for those wanting to enter the market. It further results in a lack of beneficiary protection and oversight in underwriting practices and ensuring that individuals are not discriminated against, particularly as it relates to HIV/AIDS. However, it also allows innovation and flexibility for developments within the health insurance industry. For example, Namibia does not prescribe the minimum benefit package of HIV-related services. This has resulted in more flexibility and innovation in the types of plans and models that are on the market. New “risk equalization funds”\(^{10}\) are being explored, as are new low-cost schemes that have generous HIV-related benefits, but limited inpatient coverage. In South Africa, where the policy is more directive and regulations more strict, the insurance industry is less able to respond to market demands with innovative products.

### 4.2 FINANCING AND COST EXPERIENCE WITH COVERING PLHA

If a health insurance scheme is not financially viable, the scheme will fail. When health insurance schemes fail, people lose access to needed services, lose the financial risk protection against catastrophic healthcare costs, and lose trust in the system, thereby increasing the chance they will not enroll in a new scheme. For these reasons, it is critical that utilization and cost data are analyzed and actuarial analysis is done to ensure premium amounts are sufficient for paying the claims that will arise within the scheme.

Due to the fact that many countries do not know exactly which health insurance beneficiaries are HIV-positive, it is hard to also determine the financial experience of the schemes that provide coverage for PLHA. In countries that utilize disease management programs, such as Namibia and South Africa, some data is being generated around the costs and utilization rates of PLHA and the effects these services are having on the cost of the health insurance scheme. In particular, data shows that early Enrollment on disease management programs enables the achievement of improved health outcomes which in turn result in lower healthcare costs for hospitalization.\(^{11},^{12}\)

The other variable in financing for HIV/AIDS through health insurance is the role of donors. Donors are the predominant source of HIV/AIDS funding in many countries, and as a result, health insurance products have often not been as innovative to provide coverage for these needed services. In some countries, insurance schemes have linked with donor- or government-financed services to expand coverage. For example, Nigeria and Namibia have utilized donor funds to help extend health insurance to PLHA.

Some schemes have employed cost-containment mechanisms to help defray the costs of health insurance coverage that includes HIV/AIDS-related services, as well as minimize moral hazard. In Rwanda, for example, most mutuelles require copayments to be made at the point of service for all services, not just HIV/AIDS-related services.

In South Africa where they employ the PMB, they have conducted an analysis of the community-rated PMB prices, which was calculated by the Risk Equalization Technical Advisory Panel. The analysis shows that of the R340.95 (2010) per beneficiary per month, the cost of the HIV/AIDS portion is

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\(^{10}\) Risk equalization is a way of balancing or spreading the financial risk of insurance members across groups in order to avoid loading premiums on the insured group.


\(^{12}\) Rahaman, Sultan. 2010. Chronic Disease Management: Key to Reducing Healthcare Costs.
approximately R20.46, or about 6%, with this cost differing significantly by age and gender. The proportional share of HIV-related costs is expected to increase as the HIV prevalence of medical scheme beneficiaries increases. Those that are HIV-positive are identified through DMPs and those that are HIV-positive transition into more advanced stages of the disease.

For many chronic conditions, medical schemes can make benefits conditional on beneficiaries obtaining preauthorization or joining a benefit management program/DMP. In Uganda and South Africa, benefit management programs/DMPs have been set up to help educate members about the nature of their disease and equips them to manage it in a way that helps them stay as healthy as possible and help keep costs down in the long run. There are DMPs for people living with HIV/AIDS. There is no requirement to participate in Namibia; in South Africa, participation in DMPs is at the discretion of each medical scheme; however, membership cannot be terminated for nonparticipation.

4.3 INSURANCE MODELS USED TO PROVIDE HIV/AIDS COVERAGE

There is great variation in the types of insurance models that countries are utilizing to provide insurance coverage for HIV/AIDS-related services. These range from membership models to private medical schemes, publicly funded programs, to employer-based models. In general, health insurance works best when risk pools are large and when the health risks associated with the covered population are diversified – in essence, when the healthy can subsidize the sick. In some insurance models, cross-subsidization from the wealthy to the poor may be an additional goal. Health insurance can look very different in each setting and with each scheme, with variations on how it is financed and managed – which are the two variables that can help define the model of insurance being implemented.

**TABLE 4: FOUR MAJOR TYPES OF HEALTH INSURANCE**

<table>
<thead>
<tr>
<th>Insurance model</th>
<th>Financing</th>
<th>Management</th>
<th>Illustrative countries using model</th>
</tr>
</thead>
<tbody>
<tr>
<td>National health insurance</td>
<td>General taxes</td>
<td>Public sector</td>
<td>Canada, Costa Rica, France, Great Britain</td>
</tr>
<tr>
<td>Social health insurance</td>
<td>Payroll taxes from employers and employees</td>
<td>Social security agency, health fund, sickness fund(s)</td>
<td>Colombia, Germany, Japan, Korea, USA (Medicare), India</td>
</tr>
<tr>
<td>Private voluntary insurance, commercial insurance</td>
<td>Premium payments from individuals or employers/employees</td>
<td>Commercial insurance company, for-profit or not-for-profit</td>
<td>South Africa, USA, India</td>
</tr>
<tr>
<td>Community-based health insurance/ mutuelles</td>
<td>Premium payments from individuals and/or community</td>
<td>Community or association</td>
<td>China, India, Philippines, Rwanda, Senegal</td>
</tr>
</tbody>
</table>

It is important to note that health insurance schemes rarely fit neatly into just one category. Not all models are appropriate in any situation and choosing the right model depends largely on the revenue sources (for premium contribution), as well as the beneficiary population that you would like to cover. Without proper incentives (such as subsidies or an attractive benefits package), the type of insurance
model utilized may not achieve its objectives. However, what is also critical to point out is that the health insurance model employed can affect access to care and costs of the insurance scheme. So what is the most effective model for providing coverage for HIV/AIDS-related services? Unfortunately, there is not one answer to that question and each country reviewed has taken a different approach to cover HIV/AIDS services. However, each country and model has had some successes in covering PLHA as summarize in Table 5.

**TABLE 5: SUMMARY OF HEALTH INSURANCE MODELS AND HIV/AIDS COVERAGE**

<table>
<thead>
<tr>
<th>Model</th>
<th>Where it is used to cover HIV</th>
<th>Potential Strengths/Weaknesses</th>
</tr>
</thead>
</table>
| National health insurance          | Brazil                        | • Equitable access to coverage across population  
• Limited adverse selection with everyone covered  
• Financing can be difficult, depending on tax base |
| Social health insurance            | USA, Namibia                  | • Equitable access to coverage across covered group  
• Limited adverse selection with all those in group covered |
| Private voluntary insurance,      | South Africa, USA, Uganda     | • Equitable access to services among the covered group (however, inequitable access across population, as not all can afford)  
• Anyone can join if they can afford premium payment  
• With employer-based insurance, guaranteed risk pool with reduced adverse selection  
• With open, voluntary schemes, increase chance for moral hazard  
• Generally, poor are left out |
| Community-based health insurance/  | Rwanda, South Africa          | • Close oversight of utilization practices  
• Solidarity can help ensure beneficiaries have access to needed services  
• Small group can facilitate “disease management” approach to ensure PLHA are following treatment regimen  
• CBHI often lack management capacity to manage risk effectively  
• Potential risk of moral hazard |

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Rwandans are predominantly covered through community-based health insurance, or mutuelles, which are governed by members. Solidarity has helped ensure that beneficiaries have access to needed services, including HIV/AIDS. This model has also allowed for closer oversight of overutilization by subscribers who are hasty to solicit health services. This can be useful when providing coverage for HIV/AIDS, as it can act as a disease management program providing oversight to those that are infected, ensuring they are following the treatment regimen. On the other hand, mutuelles often lack management capacities and the ability to properly manage risk, making them insolvent. Further, there is great variation between the different mutuelles, which means variations in effective coverage and in access to care.

In South Africa, diagnosis, treatment, and care for people infected with HIV/AIDS are covered through private medical schemes, which are either “open” or “restricted” schemes. Open schemes are open to anyone who can afford the contributions; restricted schemes tend to be employer-based schemes, which are limited to certain employees or professions. Medical schemes in South Africa are mutual or not-for-profit organizations that are managed by a Board of Trustees, with at least 50% of the Board being elected or appointed from the members themselves. Contributions from members are pooled for the payment of healthcare and non-healthcare (e.g., administration) costs, with any surplus made remaining in the scheme trust.

There is a new generation of medical schemes in South Africa, which combine the traditional functions of a mutual membership organization with a medical savings account. The savings account allows members to pay for costs that are “controllable,” such as outpatient visits, reserving the risk pool for “uncontrollable” costs. However, PMBs may not be paid from savings accounts.

Namibia also utilizes open and closed medical schemes to provide coverage for HIV/AIDS-related services. Each scheme is managed by a nonprofit organization, with administrative functions being maintained by third-party administrators (TPAs), which are for-profit. Providers are contracted by the medical schemes and are paid on a fee-for-service basis. Namibia also utilizes Disease Management Programs (DMPs) to help monitor and manage HIV/AIDS-related beneficiaries and associated claims.

Government employees in Namibia are covered by the Public Service Employee Medical Aid Scheme (PSEMAS), which provides coverage for the full spectrum of HIV/AIDS-related care, including antiretroviral drugs. To better control expenses, PSEMAS began contracting out the claims administration function to a third party.

PharmAccess Foundation has been working in Namibia and is supporting the launch of several medical schemes aimed at low- and middle-income workers. For example, “Health is Vital” is a risk equalization fund for HIV/AIDS that was set up in 2006. “Health is Vital” is essentially a reinsurance fund for AIDS-related medical costs, which enables individual health insurance providers to share the costs associated with HIV. To equalize the risk between employment groups, NAD20 per month is taken from each existing policy issued and paid into a reinsurance policy; claims for AIDS-related costs were reimbursed from this fund. The program allows both low- and higher-income people to be covered.

Uganda has a mix of insurance models. In the health insurance arrangements, employers or individuals purchase health insurance plans from the insurance company. Some companies have their own healthcare facilities where members can avail of services. Others partner with private providers to deliver services. In other instances, insurers can combine traditional health insurance and third-party payment arrangements that can be extended to cover HIV/AIDS. In this case, the client firm (or individual) buys the insured basic benefit package for its employees and then provides a separate fund from which the insuring organization/third party pays for services excluded from the basic benefit.
package. Some companies, for example, have supplementary coverage for hospitalization as a result of HIV/AIDS up to a certain amount.

The third model of coverage found in Uganda is essentially self-insurance, with use of a TPA. In this model, the company arranges coverage for HIV services, including ART through the TPA, passing the costs through to the employer. In each model, the employer is “blind” to the identity of the individual employees that are HIV-positive and may be receiving HIV services.

In the United States, the health insurance programs that cover PLHA and HIV/AIDS-related services are a mix of private and public health insurance options. Private health insurance options are available for those that are above the poverty line and are not disabled (mostly employer-based schemes). For some employers, particularly small- to medium-size businesses, employers will contract with an insurance company to provide coverage for their employees. Larger businesses often self-insure, sometimes utilizing a TPA to implement the health insurance scheme.

For some poor or disabled U.S. citizens, there is a public health insurance option called Medicaid. Medicaid is the single largest source of care and coverage for PLHA. Medicaid is a state-administered health insurance program for the poor; however, poverty alone does not necessarily qualify an individual for Medicaid. State participation in Medicaid is voluntary, although all states participate and have since 1982. In some states, Medicaid is subcontracted to private health insurance companies to manage the enrollment, provider empanelment, and claims processing for members. In other states, the state Medicaid offices contract with and pay providers directly. Still in others, states have set up public-private partnerships (PPP) where they use private companies to administer portions of the Medicaid benefits. These are typical managed care arrangements, where private insurance companies or health maintenance organizations contract directly with a state Medicaid department at a fixed price per enrollee. The states are responsible for monitoring the contract and ensuring that beneficiaries are receiving the services needed.

The international experience suggests that covering PLHA and HIV/AIDS services is not dependent on the model of insurance used. A variety of models are used to extend coverage to PLHA – what is most important is that the model pays attention to the key elements that determine success, such as size and diversity of risk pool, accurate risk analysis, incentives, and cost containment.
Experience of Levis Strauss & Co in India: A Global Reimbursement Scheme

The Levi Strauss & Co. is a global employer with large operations in India. Their aim is to ensure employees have access to HIV/AIDS prevention, treatment and care worldwide – regardless of location. When possible, the company integrates HIV/AIDS coverage in local health plans. When it cannot, the company offers the global Employee HIV/AIDS Benefit Plan - a plan offered in many locations, including India.

Given the difficulty of finding an insurer in India who will offer HIV/AIDS as part of the benefits package, Levis in partnership with a third party administrator, created a global schedule of benefits for HIV/AIDS services. The services are based on international standards and have been used by other global organizations and benefit plans. In India, the scheme operates in parallel to their regular health insurance scheme that is provided to the employees (with a local Indian insurance company). While the regular insurance services are cashless, the HIV/AIDS scheme is reimbursable. All service costs are provided for 100%.

Levi Strauss & Co. continues to update the list of services covered by the Employee HIV/AIDS Benefit Plan, and continues to negotiate with local insurance providers to include HIV/AIDS services as part of larger plans. The intention of this global reimbursement plan is to serve as a stop gap, not parallel program, to replace for local insurance.

### TABLE X: EXAMPLE OF HIV/AIDS SERVICES INCLUDED IN LEVI STRAUSS & CO. EMPLOYEE HIV/AIDS BENEFIT PLAN

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Design</strong></td>
<td></td>
</tr>
<tr>
<td>Maximum overall benefit limit</td>
<td>Based on negotiated estimates with TPA</td>
</tr>
<tr>
<td>Annual benefit limits</td>
<td>Based on negotiated estimates with TPA</td>
</tr>
<tr>
<td>General limits</td>
<td>Plan covers medically justified treatments. Outpatient and inpatient services are only covered for the pathologies related to HIV (see diseases covered)</td>
</tr>
<tr>
<td>Co-payment</td>
<td>None</td>
</tr>
<tr>
<td>Deductibles/excess</td>
<td>None</td>
</tr>
<tr>
<td>Stop-loss clause</td>
<td>None</td>
</tr>
<tr>
<td>Employer/employee contributions</td>
<td>Employer financing</td>
</tr>
<tr>
<td>Eligible population</td>
<td>Levi Strauss &amp; Co employees and legal dependents</td>
</tr>
<tr>
<td><strong>Preventative Treatment</strong></td>
<td></td>
</tr>
<tr>
<td>Voluntary counseling and testing for routine and necessary HIV tests</td>
<td>Immunizations/vaccines</td>
</tr>
<tr>
<td>PMTCT</td>
<td></td>
</tr>
<tr>
<td><strong>Diseases Covered</strong></td>
<td></td>
</tr>
<tr>
<td>Pneumocystis jirovecii/Pneumocystis carinii</td>
<td>Aspergillus sp.</td>
</tr>
<tr>
<td>Candida albicans</td>
<td>Kaposi’s Sarcoma</td>
</tr>
<tr>
<td>Staphylococcus aureus</td>
<td>HIV encephalitis</td>
</tr>
<tr>
<td>Streptococcus pyogenes</td>
<td>NHL lymphoma</td>
</tr>
<tr>
<td>Pseudomonas aeruginosa</td>
<td>Mycobacterium</td>
</tr>
<tr>
<td>Acinetobacter baumannii</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Toxoplasma gondii</td>
<td>Avium or Kansasii</td>
</tr>
<tr>
<td>Cytomegalovirus</td>
<td></td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td></td>
</tr>
<tr>
<td>Drugs, including prophylactic (Rx required)</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
<td></td>
</tr>
<tr>
<td>General practitioner consultations</td>
<td>Specialist consultations</td>
</tr>
<tr>
<td><strong>Examinations</strong></td>
<td></td>
</tr>
<tr>
<td>Lab tests</td>
<td>MRIs, CT scans</td>
</tr>
<tr>
<td>Xrays</td>
<td>Diagnosis procedures</td>
</tr>
<tr>
<td><strong>Hospitalization</strong></td>
<td></td>
</tr>
<tr>
<td>Hospital charges</td>
<td>Physician, surgeon and anesthetist fees</td>
</tr>
<tr>
<td>Room charges, semi private room</td>
<td>Emergency care2 In-patient services</td>
</tr>
</tbody>
</table>

4.4 **BENEFICIARIES OF INSURANCE SCHEMES THAT PROVIDE COVERAGE FOR HIV/AIDS**

HIV/AIDS transcends boundaries within a population group and is not found in one demographic or socioeconomic group. While this is true, the poor and vulnerable are often disproportionately affected by the hardship of HIV/AIDS as they are the least likely to be able to cover the healthcare expenses resulting from HIV infection. Therefore, it is important to look at different avenues to ensure that health insurance that is inclusive of HIV/AIDS services transcends geographic, socioeconomic, and gender divides.

One issue that becomes very important is that of confidentiality of HIV status. With stigma and discrimination still pervasive, countries and health regulations need to consider how HIV will be treated within the context of health information. Many countries do not have laws around the issue of health information in general and around HIV health insurance in particular. So it is a larger issue than just HIV. However, HIV (as well as other health conditions) is often subject to discrimination, so protecting people’s health information becomes critically important – especially if the goal is to increase insurance coverage of PLHA.

This section looks at both demographics of who is covered in the schemes we reviewed, as well as the overall numbers of PLHA covered by health insurance.

Of the schemes that we reviewed, the beneficiaries tend to be middle- to upper-income wage earners. This is probably explained by the fact that in many countries and situations, it can be easier to extend health insurance to the formal sector, which is often middle or upper income. For example, in South Africa, Namibia, Uganda, and the United States, where private, employer-based schemes are present, beneficiaries of health insurance where HIV/AIDS services are included tend to be middle to upper income. The United States and Rwanda are two countries where they have been able to provide health insurance coverage (inclusive of HIV/AIDS services and for PLHA) successfully to the poor.

There are exceptions to this; efforts to change the demographic of beneficiaries to be more pro-poor have been intentional and have been met with mixed success. For example, in the United States, Medicaid (which includes HIV services) has successfully been providing coverage to the poor and other groups; however, there are strict guidelines on who is eligible for Medicaid, which leaves a lot of poor people out. In Namibia, there are many efforts to provide health insurance coverage to low-income workers. These pilot schemes have had variable success. The HIVREF, in particular, has opened the door for health insurance to many more people in the low-income groups, in addition to the middle/high-income group. In Nigeria, there is a very small number of PLHA covered by health insurance, through a World Bank-financed pilot project. This pilot provides coverage for a diverse risk pool by enrolling households, rather than individuals. The project targets 27,000 low-income small business employers and households, as well as employees and their households.

In Rwanda, beneficiaries of the mutuelles tend to be rural, low-income populations. With no exclusion of PLHA, and with the majority of the country covered by health insurance (around 90%), it is estimated that many, if not most, of the PLHA have health insurance coverage, including many poor.

It is very difficult to get the actual numbers of PLHA who are covered by health insurance. Given confidentiality of health information, as well as concern around stigma and discrimination, many countries prohibit HIV testing prior to enrollment, and prohibit sharing of data that could identify someone as HIV-positive. In many employer-based schemes that use a third-party to administer the scheme, the PLHA are not even identifiable to the employers or insurance companies.
With the advent of disease management programs to help control costs of health insurance, as well as help beneficiaries manage their illness, some countries have estimates about the number of PLHA that are covered with health insurance. For example, in the United States, estimates suggest that Medicaid provides health insurance coverage for approximately 40% of people with HIV that are receiving care in the United States. While this figure seems high, this makes up only a small fraction of the overall Medicaid population (<0.01%).

4.5 ENROLLMENT AND UPTAKE FOR HIV-INCLUSIVE HEALTH INSURANCE

Health insurance can only improve health outcomes and protect against financial risk if people enroll and utilize the benefits offered through the schemes. Therefore, enrollment practices can be a critical factor in the success and sustainability of a health insurance scheme. Enrollment is an important opportunity to educate the beneficiary about what is covered in the scheme, educate about what the rights of the beneficiary are with regard to the scheme and accessing services, and to ensure beneficiaries understand how to use and access their benefits. It can also be an opportunity for health education, which can help beneficiaries make the right health-seeking behavior. Different enrollment practices are needed for different demographic groups and need to be culturally appropriate. Good enrollment practices will have a direct effect on the uptake of insurance products and utilization of insurance benefits.

Enrollment of health insurance for PLHA does not seem to be that different than enrollment for those that are HIV-negative. There is understandable concern that insurance companies would put their marketing efforts into enrolling individuals who are HIV-negative. However, of the countries that were reviewed most have a policy that prohibits the discrimination of PLHA, as well as prohibits HIV testing of individuals who are enrolling in a scheme. Therefore, it is difficult for insurance companies to target people who are HIV-negative. Because of this, we also have little information about the uptake of insurance and utilization of services of PLHA.

In Namibia, a study examined the efficacy of HIV workplace surveys as a tool to increase uptake of the risk equalization fund insurance schemes. Of 8,500 targeted employees, 6,521 were anonymously screened for HIV. Out of 6,205 previously uninsured employees, 61% enrolled in private health insurance; 78% of which enrolled in the HIV/AIDS REF. The study suggested that anonymous HIV workplace surveys can serve as a tool to motivate private companies to provide health insurance to their workforce and can help alleviate the burden on the public sector.

In South Africa, anyone who can afford medical scheme coverage can enroll, regardless of HIV status. Participation in medical schemes tends to be voluntary, except for employer-based schemes which can be mandatory. As a result, beneficiaries tend to be those who can afford to pay and tend to leave out the poor. Since 1998, total membership of all medical schemes has been approximately seven million beneficiaries, which accounts for about 16% of the population in South Africa. The Government Employees Medical Scheme (GEMS), which covers government employees, has been successful in attracting hundreds of thousands of previously uncovered lives into the medical scheme risk pool and thus being the largest vehicle for membership growth in the past few years. Other initiatives to expand the risk pool such as the 'Low Income Medical Scheme' and the introduction of low-cost options have been slower to enroll and increase the numbers of covered lives.

Figure 2 shows the age distribution of beneficiaries registered in medical schemes. The figure shows a dip in coverage among those in the 20-to 40-year-old bracket, which is similar to other countries whose young, healthy population feel risk adverse and therefore do not enroll in health insurance. The
distribution of beneficiaries is mapped against the distribution of HIV prevalence by age, which illustrates the implicit health needs and HIV risks of this segment of the population.\textsuperscript{14,15}

**FIGURE 2 AGE DISTRIBUTION OF BENEFICIARIES REGISTERED IN MEDICAL SCHEMES**

![Figure 2](image)

This table is a very vivid demonstration of the need to improve enrollment practices, and therefore demand for health insurance among different demographic groups. The messaging for the 20- to 40-year-old bracket could be crafted to speak to the needs and concerns of this demographic group.

### 4.6 BENEFIT PACKAGE: HIV-RELATED SERVICES THAT ARE COVERED BY HEALTH INSURANCE

Designing an appropriate benefits package can be a determining factor of whether people enroll in health insurance or not. If the benefits offered are not appealing to the consumer, there is no incentive to enroll. Further, needed and desired benefits are not going to be equal across different demographic groups. The poor may want greater access to primary healthcare services, while the higher-income groups may want better access to high-cost, chronic conditions or access in higher-cost private facilities.

In addition, access to ART is critical to the health of PLHA as well as to the health of an insurance scheme. ART reduces healthcare costs in the long run by reducing the chance for opportunistic infections, which can lead to expensive hospitalizations and treatment.\textsuperscript{16,17,18} ART can prolong life

\textsuperscript{14} Da Silva, op cit.
\textsuperscript{15} As da Silva and Wayburne note, this is a crude comparison, which is not adjusted for risk factors such as race and access to health services. However, it illustrates the distribution of beneficiaries relative to HIV risk.
expectancy, allowing PLHA to be productive members of society for an extended period of time. There is often fear that inclusion of ART in a benefits package will be cost-prohibitive. But in reality, the increased availability of ART has resulted in decreased costs for the drugs. The price of antiretrovirals for low- and middle-income countries has continued to fall. Between 2004 and 2008, first-line antiretroviral regimens in lower- and middle-income countries declined by 30%-68%. The most widely used drug combination (d4T+3TC+NVP) is available for $U.S. 88 per person per year.19 In addition, many governments including India subsidize ART making it even more affordable.

We did not find much demographic or socioeconomic variance across the types of HIV/AIDS-related services offered through health insurance. Most schemes that include HIV/AIDS services under the health insurance plan provide the full range of care and treatment of services. In some countries, the health insurance benefits are linked to other social benefits that are offered from the government, for example ART.

In South Africa, the Medical Schemes Act mandates coverage for 270 diagnosis and treatment pairs, including chronic conditions, such as HIV/AIDS and maternity. Collectively, this is referred to as the PMBs. These benefits must be paid in full by the medical scheme to the provider, with no copayment, deductible or coinsurance passed on to the beneficiary. The PMBs include hematological, infectious, and miscellaneous systemic conditions, such as HIV/AIDS and TB (inpatient and outpatient), and also include PMTCT. Medical schemes also provide coverage for ART.

South Africa, as well as Namibia, have implemented disease management programs to help monitor treatment given by providers and screen ART prescriptions for consistency with accepted treatment guidelines. Enrollment on a disease management program is often compulsory in order to access benefits.

In the United States, states have flexibility in which Medicaid services are offered to beneficiaries. However, there are some mandatory services that all states must provide. The mandatory services include inpatient and outpatient hospital services, physician and laboratory services, and long-term care, regardless of diagnosis. PLHA can avail of these services as well. Medicaid is also a larger purveyor of prescription drugs, an optional benefit that all states have chosen to provide to the Medicaid population.

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India has many of the pieces upon which to build a solvent insurance industry for PLHA. However, there are lessons and experiences from other countries that can be leveraged to help move India into a situation where PLHA are offered the same social security and risk management options as other chronic conditions in India.

Below, we attempt to synthesize the experiences from other countries and identify issues that are relevant to India. They are organized by the variables that are discussed above.

**Policy and Regulatory Environment Surrounding HIV/AIDS and Health Insurance Coverage**

- India lacks definitive guidance from the IRDA or any other government agency around financing HIV/AIDS-related services. Many countries have had success because of a strong policy, which requires health insurance to provide coverage for HIV-related services and prohibits the exclusion of PLHA. India has yet to take a stand regarding these issues, which has hindered advancement in sustainable financing for PLHA.

**Financing and Cost Experience with Covering PLHA**

- There is a paucity of data in India around health insurance costs in general and utilization rates. Actuarial analysis is not routinely done to monitor the costs. This data is more scarce when it comes to HIV/AIDS. Through USAID’s support, PSI has been able to collect data on health insurance for PLHA, which will provide a starting point for insurance companies to actuarially price a product that is inclusive of HIV/AIDS services. But this needs to be done routinely to monitor how utilization patterns may shift over the course of coverage.

- Depending on the goals of health insurance and HIV/AIDS, there will need to be careful consideration of how to finance schemes that are inclusive of HIV/AIDS-related services. In many group policies, this may not be an issue. While not recommended, many schemes target a specific beneficiary group (such as the poor or, in India, PLHA). In these schemes, decisions need to be made about how to subsidize the insurance products for this population group in a sustainable way. A better approach is to integrate HIV/AIDS services into existing insurance schemes, as well as not inhibit PLHA from joining.

- For this to be effective, the keys to covering PLHA are: knowing the costs, accounting for the costs in premium estimates, managing the costs (such as through disease management programs), spreading the costs across the risk pool, and preventing adverse selection.

- As with the example from Levis, there are other financing arrangements that can be offered to integrate HIV into health insurance. This could be a separate package of services that are offered to those that want to purchase. While this is not a long-term, cost-effective way to proceed, it could provide interim coverage while the larger policy issues are being resolved.
Insurance Models Used to Provide HIV/AIDS Coverage

- India utilizes a variety of models of health insurance in the country. It will be important for India to identify their goals with regard to HIV and health insurance and utilize the model that is most likely to succeed. For example, if the target will be on the BPL population, there are a large number of BPL covered either through RSBY, community-based health insurance initiatives, or other state-sponsored health insurance schemes. It would make sense to leverage these schemes already existing to achieve their goals.

- If the goal is to integrate HIV/AIDS-related services into the schemes offered to the formal sector, India will need to consider employer-based schemes, as well as Social Health Insurance schemes that are providing coverage to government employees. With each model, careful consideration will need to be made to reduce adverse selection, moral hazard, and that the risk pool is large enough to absorb the risks of an expanded risk pool.

Beneficiaries of Insurance Schemes that Provide Coverage for HIV/AIDS

- Similar to above, India will need to clarify the goals they have for health insurance and HIV/AIDS. Will the goal be to integrate fully into all health insurance schemes? Target a specific beneficiary group to ensure access to health? Each of these potential goals will determine how India can move forward.

- There also needs to be a conscious decision about the use of health information regarding PLHA and health insurance. Many countries do not fully understand the number of PLHA that are covered by health insurance, as it is illegal to require HIV-testing. This helps facilitate a more diversified risk pool, as well as protects consumers and beneficiaries from potential stigma and discrimination.

Enrollment and Uptake for HIV-inclusive Health insurance

- Enrollment practices in India vary, with some people getting the information they need to make an informed choice about the health insurance policy they are purchasing, and with others not receiving the necessary information to understand where they can access services, etc. With coverage of HIV/AIDS, it will be important to strengthen Enrollment practices and ensure all are informed about their benefits. Education about the inclusion of HIV will not only be an issue for PLHA, but will also be an issue for those that are HIV-negative, who may not want to be in a group policy with PLHA. Careful consideration will need to be made about the benefits of extending insurance to PLHA and about including HIV/AIDS-related services in general.

Benefit Package: HIV-related Services that Are Covered by Health Insurance

- Decisions need to be made about which services will be covered under the health insurance schemes. With the influx of donor funding in India, as well as the Government of India’s contribution to thwart HIV/AIDS, there are many services that are already available free or at low cost to PLHA. However, the quality and consistency of those services may be variable. It may be possible to leverage government-provided services, but consideration needs to be made when those services are not available.

- Establishing criteria against which government-sponsored care can be evaluated is one strategy to determine what services to cover. If the public health system offers appropriate and quality care, the need for supplementary insurance coverage is less critical, thereby freeing purchasers to focus effort on other services. However, if government-sponsored HIV/AIDS services do not meet quality standards, then the need for supplemental coverage becomes more critical.
• Access to ART and continuity of care for PLHA is critical to reduce the long-term costs associated with the disease. Therefore ensuring that beneficiaries have access to ART and services when they need it will be an important cost-containment mechanism.

• The introduction of disease management programs can help ensure PLHA have access to the right services, while also protecting the payer to ensure PLHA are managing their illness, which will also reduce costs in the long run.
ANNEX A: INTERNATIONAL EXPERIENCES: CASE STUDIES

The desire to provide health insurance coverage to PLHA, as well as the subsequent challenges that hinder expanded coverage, is not unique to India. Many countries have incorporated HIV-related services into health insurance benefits packages with variable success. The lessons and experiences of other countries can help India determine how to take the best step forward in expanding coverage to PLHA in a sustainable way. The case studies presented here provide more depth examples of strategies other countries have used to expand coverage to PLHA.

COUNTRY EXAMPLE: UNITED STATES

Background

According to the Center for Disease Control and Prevention, there are approximately 1.1 million people living with HIV/AIDS in the United States. This figure is expected to increase slightly over time as PLHA are living longer with HIV and new infections remain stable. In 2006, there were approximately 56,300 new HIV infections and, in 2007, approximately 14,561 AIDS-related deaths. In 2007, nearly three-quarters of HIV/AIDS diagnoses among adolescents and adults were for males. HIV-related mortality rates have declined significantly from the mid-1990s: HIV was the sixth leading cause of death for those ages 25-44, down from number one in 1994 and 1995.

According to the Kaiser Family Foundation, U.S. federal funding to combat HIV totaled $24.8 billion in FY 2009. Of this, 50% was for care, 11% for research, 10% for case and housing assistance, 4% for prevention, and 25% for the international epidemic. There are a few key programs that provide services and health insurance to PLHA. These include: Medicaid, Medicare, the Ryan White Program, and the Housing Opportunities for Persons with HIV/AIDS Program (HOPWA). Social Security’s income programs for those disabled are also important sources of support. Further, some PLHA are covered by health insurance through private health insurance (mostly employer-based health insurance schemes). Of these programs, Medicaid is the largest single source of care and coverage for PLHA in the United States.

Policy Environment

The policy environment surrounding HIV/AIDS and health insurance in the United States has been fragmented. There has not been an overarching policy that provides guidance to health insurance companies, employers, or individuals about how HIV/AIDS should be managed within health insurance. The Americans with Disabilities Act (ADA) is a labor law protecting individuals considered to have a

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“disability,” as defined as a person with a physical or mental impairment that limits one or more major life activities\textsuperscript{26}. PLHA, both symptomatic and asymptomatic, are considered to have impairments that limit one or more major life activity and are therefore protected by the law.

ADA protects people who are discriminated against. In the area of health insurance, ADA protects individuals from getting different treatment in an employment situation and entitles PLHA with the same health insurance benefits offered to those that do not have HIV at the same rates.

Medicaid, which is the nation’s main safety-net health insurance program implemented through the states. Medicaid is a federally mandated, state-implemented health insurance program that provides health insurance coverage for those with disabilities and those in poverty. As such, Medicaid provides coverage for PLHA and has played a critical role in HIV care since the epidemic began. It is the single largest source of coverage for PLHA in the United States\textsuperscript{27}.

More recently, the Patient Protection and Affordable Care Act, which is the new health reform bill that was passed by U.S. Congress, allocates $5 billion for the establishment of “high-risk pools” across the country. The group insurance plans will provide coverage for people with preexisting conditions, including HIV/AIDS, who are unable to find insurance through other avenues. The law not only provides coverage for PLHA, but also requires that insurance companies take all eligible applicants and cannot charge more than the standard rate for health insurance policy. Further, there is a “guaranteed issue” clause of the Act, which when it begins in 2014, will prohibit insurance companies from denying coverage to anyone with a preexisting condition.

Insurance Model
The health insurance coverage that exists for the general population of PLHA tends to be through the private health insurance market, which is more often than not, employer-based insurance. However, in the United States, Medicaid actually is the single largest source of care and coverage for PLHA.

Medicaid is a state-administered health insurance program for the poor; however, poverty alone does not necessarily qualify an individual for Medicaid\textsuperscript{28}. The Centers for Medicare and Medicaid Services (CMS) monitors the state-run programs and establishes requirements for eligibility, service delivery, quality, and funding. There are certain portions of Medicaid that are mandatory and that each state must implement (such as certain benefits). However, each state has some flexibility in services they offer and how they package the benefits.

State participation in Medicaid is voluntary; however, all states participate in Medicaid and have done so since 1982. In some states, Medicaid is subcontracted to private health insurance companies. In other states, the state Medicaid offices pay providers directly. In other states, some have set up a PPP, where the state uses private companies to administer portions of their Medicaid benefits. These PPPs are typically managed care arrangements, where private insurance companies or health maintenance organizations contract directly with a state Medicaid department at a fixed price per enrollee. The health plan enrolls eligible individuals into their programs and become responsible for assuring Medicaid benefits are delivered to eligible beneficiaries. The states are responsible for monitoring the contract and ensuring that beneficiaries are receiving the services needed.


\textsuperscript{28} There are specific eligibility requirements to receive Medicaid coverage.
**Beneficiaries**

There is little empirical data about the number of PLHA that are covered through private health insurance programs. This is due to the confidentiality of data and HIV status that exists. With Medicaid, there is more analysis and estimates that have been made (although the integrity and confidentiality of data exists for Medicaid beneficiaries as well). Estimates suggest that Medicaid provides health insurance coverage for approximately 40% of people with HIV that are receiving care in the United States, which makes up only a small fraction of the overall Medicaid population (<0.01%).

Most PLHA that are on Medicaid qualify for coverage because they are both low income and permanently disabled (approximately 70%). PLHA are three to four times more likely to be covered by Medicaid than the U.S. population overall, given that HIV remains a disabling condition for many. Women who are HIV-positive in particular have benefitted Medicaid coverage, as they are more likely to be covered by Medicaid than men.

**Enrollment and Uptake**

Enrollment for Medicaid is driven by the individual needing and qualifying for coverage. To be eligible, individuals must be both low income, with limited assets or belong to various eligibility groups (some eligibility groups are mandated by the federal government; some are determined by the states).

<table>
<thead>
<tr>
<th><strong>TABLE 6: ELIGIBILITY FOR MEDICAID</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Eligibility Pathways for People with HIV/AIDS</td>
</tr>
<tr>
<td><strong>Category</strong></td>
</tr>
<tr>
<td>Supplemental Security Income (SSI) beneficiaries</td>
</tr>
<tr>
<td>Parents, children, pregnant women</td>
</tr>
<tr>
<td>Medically needy</td>
</tr>
<tr>
<td>Disabled workers</td>
</tr>
<tr>
<td>Poverty level expansion</td>
</tr>
<tr>
<td>State-supplemental payment (SSP)</td>
</tr>
</tbody>
</table>

Source: KFF, 2009

Being HIV-positive does not automatically qualify a person for Medicaid. While there are many pathways to qualify for Medicaid coverage, many PLHA have difficulty meeting the eligibility requirements...

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29 KCMU. Fact Sheet: The Medicaid Program at A Glance; November 2008
32 Kaiser Family Foundation, Op Cit.
33 Urban Institute & KCMU estimates based on Census Bureau’s March 2007 and 2008 CPS.
34 Bozzette, Op cit.
particularly with the advent and success of ART: they are not permanently disabled and they are not pregnant. In fact, the eligibility policy within Medicaid presents a conundrum for PLHA: they are not eligible for Medicaid until they are considered permanently disabled, even though there are medications available through Medicaid that can prevent disability.\textsuperscript{36}

There are some efforts to rectify this: legislation has been proposed to allow states the option to cover low-income people with HIV prior to disability under Medicaid; and some states have used other labor policies to extend some coverage to PLHA that do not quite fit the Medicaid eligibility criteria.\textsuperscript{37}

**Benefit Package**

States have flexibility in determining which Medicaid services are offered to beneficiaries; however, there are some mandatory services that must be covered to enable states to participate in implementing Medicaid. These include inpatient and outpatient hospital service, physician and laboratory services and long-term care, regardless of diagnosis (i.e., PLHA can avail of these services as well)\textsuperscript{38}. States may cover optional services as well and receive federal matching funds. One of Medicaid’s most important roles for people with HIV is its provision of prescription drugs, an optional Medicaid benefit that all states have chosen to provide to their Medicaid populations.

States also have the option of providing community-based, long-term care services to enable individuals to remain independent and live in their communities.\textsuperscript{39}

**Financing and Cost Containment**

In regard to private health insurance schemes, the costs of coverage are the responsibility of employers and individuals covered through the schemes. Insurance companies and employers will utilize varying cost-containment mechanisms at their discretion. This can include co-payments, co-insurance, waiting periods, and limits on coverage. These cost-containment mechanisms are not specific to HIV-related services, but rather when applied, are applied across the spectrum of services offered.

Some states have specific programs to help cover the costs of health insurance premiums if one can no longer work. For example, the New Jersey Health Insurance Continuation Program (HICP) is a special program for New Jersey residents with HIV or AIDS. This program allows PLHA to keep health insurance when that person can no longer work or can only work part time. If someone qualifies for it, HICP will pay the monthly premiums for health insurance, including family insurance that covers any dependants, including spouse or children\textsuperscript{40}. New York State also has a similar program where premiums will be paid for a reasonable policy that provides coverage for PLHA.\textsuperscript{41}

Medicaid is a means-tested entitlement program, financed jointly by the federal and state governments. The federal government matches state Medicaid spending, ranging from 50%-76%.\textsuperscript{42} In FY2008, total Medicaid spending for HIV totaled $7.5 billion, making it the largest source of public financing for HIV/AIDS care in the United States \textsuperscript{43}, \textsuperscript{44}, \textsuperscript{45} Over time, Medicaid spending on HIV has increased, reflecting

\footnotesize
\begin{itemize}
  \item \textsuperscript{36} Kaiser Family Foundation, Op cit.
  \item \textsuperscript{37} Specifically the “Ticket to Work / Work Incentives Improvement Act.”
  \item \textsuperscript{38} KCMU. 2008. Fact Sheet: The Medicaid Program at A Glance.
  \item \textsuperscript{39} Kaiser Family Foundation, Op cit.
  \item \textsuperscript{40} http://www.state.nj.us/health/aids/keepins.shtml
  \item \textsuperscript{41} http://www.health.state.ny.us/diseases/aids/resources/adap/
  \item \textsuperscript{42} KCMU. Fact Sheet: The Medicaid Program at A Glance; November 2008.
  \item \textsuperscript{43} OMB, CMS Office of the Actuary, HHS Office of Budget, 2008.
  \item \textsuperscript{44} CRS. AIDS Funding for Federal Government Programs: FY1981–FY2009; April 2008.
\end{itemize}
the increasing numbers of beneficiaries with HIV and the rising cost of healthcare; however, HIV spending through Medicaid represents less than 2% of total Medicaid spending.⁴⁶,⁴⁷,⁴⁸,⁴⁹,⁵⁰

Each state, within some parameters, determines their own Medicaid benefit package and cost-containment mechanisms. For example, some states limit the inpatient days allowable, the number of physician visits allowed per month, or the number of prescriptions. Other states utilized managed care programs, particularly for PLHA, to help manage services and costs more efficiently, ensuring that PLHA maintain a healthy lifestyle and drug regimen.⁵¹

**COUNTRY EXAMPLE: NAMIBIA**

**Background**

Namibia is faced with a generalized HIV epidemic, with an estimated prevalence of 17.8% in adults.⁵² While HIV prevalence rates have decreased among younger populations (ages 15–29) since 2002, Namibia has witnessed a higher prevalence among older populations during the same time period. In part, the increase in prevalence is due to the increased availability of ART through both government and private sector sources.

Namibia's large medical scheme industry is mainly composed of nonprofit contributory health insurance plans managed by for-profit companies. Models include the government-based public employees' medical scheme (PSEMAS), employee-based private insurance schemes, and Community-Based Health Insurance (CBHI) schemes. At present, insurance is not mandatory in Namibia. Approximately 12.5% of Namibians (250,000) were covered by health insurance in 2004; those medical schemes covered 22.5% of total Namibian health costs. Those who are insured are primarily higher income, formal sector workers who obtain coverage through their employer. Less than half of formal sector workers belong to a medical scheme. Even when partial employer support for premiums was available, lower-income workers found the costs of the existing schemes too high, and instead relied on the government and out-of-pocket payments for medical care.⁵⁴

Since the beginning of the decade, some Namibian medical schemes have covered the cost of HIV-related benefits, including ART, making treatment available to public sector workers and others with higher-paying formal sector jobs. Over the past several years, with the help of donor organizations and the Namibian Business Coalition on AIDS, medical schemes in Namibia are now introducing low-cost health insurance products for indigent populations. During 2006 and 2007 three new health insurance packages, including HIV treatment, became available providing >13,500 previously uninsured Namibians

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⁵⁰ CBO. The Budget and Economic Outlook: An Update; September 2008.
access to private health insurance and a full range of HIV care and treatment services: monitoring, first or second line antiretrovirals, laboratory tests, consultation and counseling, treatment of opportunistic infections and hospital care for complications. Participation of HIV-positive individuals in insurance schemes has increased since the introduction of these schemes in 2004. By late 2007, more than 40,000 individuals shared in the REF for HIV/AIDS and more than 83,000 people benefited from its shared administration and disease management program.

Policy Environment

The Namibian Financial Institutions Supervisory Authority (NAMFISA) oversees the insurance industry and regulates medical schemes, as part of their regulation of the general financial sector. This government agency receives quarterly and annual reports from medical schemes and enforces requirements for financial solvency. New medical scheme products are subject to prior approval by NAMFISA, which reviews both the benefits of the plan and the proposed price to assure that the premiums are fair and does not endanger the solvency of the scheme.

Namibia’s regulatory requirements are not as stringent as seen in some countries. Namibia prohibits the exclusion of HIV/AIDS in insurance plans; however, it does not prescribe the minimum benefit package of HIV-related services in a particular plan. As a result, Namibia has been able to move ahead quickly, with the approval of new schemes that are innovative and attempt to expand coverage to a greater number of people. For example, new “risk equalization funds” are being explored, as are new low-cost schemes that have generous HIV-related benefits, but limited inpatient coverage. The approvals are consistent with the Namibia Ministry of Health’s aim to increase access to health to low-income populations and informal sector workers, who will benefit most from low-cost schemes.

Insurance Models

The Namibian medical scheme market has witnessed a variety of schemes to extend coverage, including HIV/AIDS coverage, to various segments of the population. Namibia distinguishes between a medical scheme and medical insurance. A medical scheme is a nonprofit entity that pays benefits directly to medical providers in proportion to the services rendered to the beneficiary. In Namibia, medical insurance is usually issued by profit making multiline insurers that pay cash benefits to the individual insured in the event of illness or accident. The insured may then use these payments to purchase medical care.

Namibia has both closed schemes (those that cover only a particular firm or industry) and open schemes (those sold to any employer and some individuals). Each open or closed scheme is a separate nonprofit organization with its own Board of Trustees. Each maintains separate financial statements, reporting results to NAMFISA, which imposes financial solvency rules on the scheme. The administrative functions of all schemes – both open and closed – are maintained by TPAs, which are for-profit.

With a few exceptions, providers (including pharmacies) bill the medical scheme for covered services rendered to an insured and are paid directly by the scheme on a fee-for-service basis. Each year,

NAMAF 57 (the Namibian Association of Medical Funds) and provider groups negotiate a fee schedule to determine prices paid to physicians and clinics. However, many providers charge more than the NAMAF fee, requiring a co-payment from the insured.

To manage HIV/AIDS care and claims specifically, most schemes contract with disease management programs (DMPs) which approve HIV/AIDS care reimbursements to private and public providers. DMPs develop protocols and review patient data to determine provider compliance. Prior approval from the DMP is often required for the purchase of antiretroviral drugs. DMPs also run an outreach program to encourage testing and monitoring of members who are HIV-positive, and to improve patient adherence to treatment.58

PSEMAS is the government scheme and is open to all government employees who elect to join. Participants pay a monthly fee of NAD 60 (about $8 U.S.). The rest of the scheme’s costs are covered by funds from the Namibian Treasury, so that the scheme is not forced to demonstrate “solvency” in the same manner as closed and open schemes. The full spectrum of AIDS care, including antiretroviral drugs, is available to PSEMAS beneficiaries. Inpatient benefits are unlimited, but available only in the private units of government hospitals. Outpatient benefits—including prescription drugs—are generous and can be obtained from any licensed private sector provider. In fact, PSEMAS pays above the “standard tariff” for various medical procedures, which is set by NAMAF59. To better control expenditures, PSEMAS began contracting out the claims administration function to a third party.

Since 2004, there has been an influx of donor funds in Namibia to support publicly provided HIV care and treatment. While this has made services much more accessible, it has also caused concern that private funding would be “crowded out,” thereby leading to a reduction in the overall resources used to treat patients.60 In response, PharmAccess Foundation has been working in Namibia and is supporting the launch of several medical schemes aimed at low- and middle-income workers. For example, “Health is Vital” is a risk equalization fund for HIV/AIDS that was set up in 2006. “Health is Vital” is essentially a reinsurance fund for AIDS-related medical costs, enabling individual health insurance providers to share the costs associated with HIV. HIV infection rates vary considerably between insured groups. To equalize the risk between employment groups (for example, truck drivers and fishermen are at a much higher risk than bank tellers), NAD20 per month is taken from each existing policy issued and paid into a reinsurance policy. Claims for AIDS-related costs are reimbursed from this fund.61 The program allows both low- and higher-income people to be covered. Crowding out valuable private resources has been avoided and the quality of HIV/AIDS services has improved from this scheme.

57 NAMAF was established in terms of the Medical Aid Funds Act, 1995 (Act 23 of 1995) to control, promote, encourage and coordinate the establishment and functioning of medical aid funds in Namibia.
61 The REF began as a internal program in the open and closed schemes administered by Prosperity Health. Paying for AIDS-related costs of the fund, therefore, proved to be relatively simple, as all the claims processed were by Prosperity Health, or by Methealth under a subcontract to Prosperity.
The Health is Vital program also introduced a stand-alone “AIDS insurance,” which is available to companies enrolling all uninsured employees at a rate of $4.25 per employee per month. The coverage provides physician visits, ARVs, lab tests, and inpatient care up to a maximum annual limit.

**Beneficiaries**

Beneficiaries of health insurance in Namibia tend to be higher-income workers, as well as government employees. This is because premium rates tend to be out of reach for lower-income employees outside of the government. Data are not readily available to determine market penetration of health insurance by socioeconomic level; however, it is estimated that less than half of private sector employees have medical scheme coverage.

Because of the nature of how medical schemes are managed in Namibia, it is difficult to determine how many beneficiaries are HIV-positive and their subsequent experience within medical schemes.

More recently, however, there have been greater efforts to expand health insurance coverage to low-wage workers. Although schemes have had variable success, the market penetration efforts are having some success in reaching many individuals who fall into the low-wage category, particularly PLHA.

**Enrollment and Uptake**

One recent study examined the efficacy of HIV workplace surveys as a tool to increase uptake of REF insurance schemes by employees in the Namibian formal business sector. Of 8500 targeted employees, 6521 were screened for HIV. Out of 6205 previously uninsured employees, 61% enrolled in private health insurance; the majority of these new insurances (78%) covered HIV/AIDS only. This suggests that anonymous HIV workplace surveys can serve as a tool to motivate private companies to provide health insurance to their workforce and can help alleviate the burden on the public sector. After presentation of survey results to the company management, 18 of the 19 companies that did not yet provide health insurance for employees expressed a willingness to do so.

**Benefit Package**

The “Health is Vital” risk equalization fund is available to companies enrolling all uninsured employees at a rate of $4.25 per employee per month. The insurance covers physician visits, ARVs, laboratory tests, and inpatient care up to a maximum annual benefit of $14,000, which is sufficient to cover first- or second-line ART and treatment of most opportunistic infections.

PSEMAS covers the full spectrum of AIDS care, including antiretroviral drugs. Inpatient benefits are unlimited, but available only in the private units of government hospitals. Outpatient benefits – including prescription drugs – are generous, and can be obtained from any licensed private sector provider.

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Financing and Cost Containment

While most medical scheme offer a wide range of benefits, costs are contained by imposing overall limits on annual payouts along with sublimits on various services. In instances where providers charge a fee greater than that set by NAMAF, participants must pay a co-pay for services received. Policies also vary in the extent to which they cover services beyond hospital care, physicians, and drugs.

For example, the overall annual benefit limit of the Namibia Medical Care Sapphire policy is NAD1,000,000 per family and NAD500,000 per beneficiary. Physician consultations are limited to 40 visits and NAD12,500 per year per family. The limit for drugs for chronic conditions, which includes ART, is NAD21,500 per year per family. For a lower cost product (Protector Health) in this same scheme (NMC), the overall annual limit drops to NAD165,000 per family and NAD65,000 per beneficiary. Physician consultations are limited to 8 visits per beneficiary and an annual total of NAD 3,350 per family. Drug payments are limited to NAD 5,000 per family—clearly insufficient if two family members needed ART. Policies also vary in the extent to which they cover services beyond hospital care, physicians, and drugs. Limiting or excluding services such as dentistry or opticians lowers the premium.

In 2004, Diamond Health introduced two new cost-containment mechanisms: exclude inpatient hospital services and provide outpatient services through a limited network of providers that are paid a capitation for each insured who enrolls, rather than being paid a fee for each service rendered.

Like many African countries, Namibia’s HIV prevention, care, and treatment programs are highly subsidized by donors. For example, to make access to private healthcare more affordable PharmAccess, through a grant from the Dutch, Stop AIDS Now! provided subsidies for more than 9,500 low-income employees.

Premiums have been rising faster than general inflation, with annual medical inflation running at 11%, while prices generally have increased by only 6% per year. Medical scheme managers attribute this high rate of inflation to a small community of qualified providers that have been effective in bargaining for higher rates. Other factors driving up costs are increasing utilization (including the impact of AIDS, the import of expensive medical technology, and – as is seen in developed countries – the aging of the insured population, with a concomitant increase in the prevalence of costly chronic diseases.

COUNTRY EXAMPLE: SOUTH AFRICA

Background

In 2009, the United Nations estimated that 5.7 million people were living with HIV/AIDS in South Africa, more than in any other country. National prevalence is around 11%, with some age groups being particularly affected. Almost one-in-three women aged 25-29, and over a quarter of men aged 30-34, are living with HIV. HIV prevalence also varies by province with the Western Cape (3.8%) and Northern

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69 Ibid.
70 UNGASS (2010, 31st March) ‘South Africa UNGASS Country Progress Report’

Cape (5.9%) being least affected, and Mpumulanga (15.4%) and KwaZulu-Natal (15.8%) at the upper end of the scale.

Healthcare in South Africa is financed through mixed models. The government provides public healthcare through the public health system, which is predominantly accessed by the poor. There is private health insurance that is financed either through employer-based health insurance models, where members can access services free of charge after making membership contributions. However, only people from the higher and middle socioeconomic segments of society are able to afford access to the health insurance mechanisms.

The total membership of all medical schemes is around 7 million beneficiaries since 1998, which represents approximately 16% of the South African population.72

Policy Environment

HIV/AIDS has special protection within the health insurance industry in South Africa, which was not always the case. South African mutual health insurers (Medical Schemes73) have existed for more than 100 years and were regulated under a specific act since 1967. Until 1989, medical schemes were required by law to not exclude high-risk enrollees from coverage and to community rate their premiums, which spread the costs of healthcare across a group regardless of the health risks. In 1989, the medical schemes industry was deregulated, which allowed health insurers to risk-rate the coverage provided to beneficiaries and allowed the exclusion of “medically uninsurable”74.

Unsurprisingly, vulnerable groups were being excluded from medical schemes and premium costs were rising too high for many people (including the elderly and those with chronic conditions) to pay to participate in the schemes75. In the 1990s, concern was raised about the effects of deregulations and in response; the Medical Schemes Act (No. 131 of 1998) was implemented in 2000, which was instrumental in protecting the rights of South Africans, as well as instilling safeguards and regulations on the medical schemes in the country. This Act further reintroduced the principles of guaranteed acceptance, community rating, and PMBs, which provided protection to vulnerable individuals, including those living with HIV/AIDS.

Since implementation of the Medical Schemes Act, medical schemes are not allowed to:

- Exclude members with HIV or insist on an HIV test prior to acceptance
- Charge higher contributions based on risk
- Restrict benefits available for members with HIV that are provided as part of the PMBs (PMBs; discussed further below)

73 Medical schemes are mutual funds that are governed by boards of trustees and must be registered in country. There are two types of medical schemes: open schemes, in which membership is open to anyone who wishes to join and can afford contributions and employer-based schemes, which are restricted to a certain group of employees or professions and are not open to the public.
75 Most models showed that risk rating of premiums was consistently associated with higher premiums, after adjustment for risk, quality, scale and other environmental differences between insurers. Likely explanations include the additional costs required for marketing and underwriting risk-rated policies, insufficient incentives to use cost-control techniques, and higher levels of moral hazard associated with diminished risk-pooling.
With the Act, also came the establishment of the Council for Medical Schemes (CMS), which received authority from the Minister of Health to monitor and regulate the medical schemes industry. CMS is entrusted with the responsibility of regulating the activities of the industry and protecting consumers against deceptive and unfair practices.

**Insurance Model**

The medical schemes in South Africa are not-for-profit funds, which fall into two categories: open or restricted. In open scheme, anyone who can afford the contributions can join. Restricted schemes tend to be employer-based schemes, which are limited to certain employees or professions.

Medical schemes are managed by a Board of Trustees. At least 50% of the Board must be elected or appointed from the membership pool. The Board must ensure that the interests of members are protected and that the scheme is properly administered. If they are found guilty of misconduct, they may be held accountable for losses incurred.

Contributions from members are pooled for the benefit of members. Medical schemes are nonprofit organizations and belong to the members themselves. Therefore, any surplus made remains in the scheme trust for the benefit of members and their dependents.

As a membership organization, members have the opportunity to voice their views and concerns during annual meetings. Medical schemes maximize member participation by holding frequent meetings where members can be heard.

In traditional medical schemes, all medical expenses covered in the plan are paid in full with money from the medical schemes account (money from a risk pool). There is a new generation of medical schemes which combine a risk pool with a medical savings account. The risk pool covers uncontrollable expenses or major claims, such as a major surgery. The medical savings account covers those expenses which are “controllable”, such as primary care, visits to the general practitioner, and over-the-counter medicines. Savings accounts are not to exceed more than 25% of the annual contributions; however, some medical schemes give members the option of what percentage they would like in their savings account (not to exceed 25%).

**Enrollment of Beneficiaries**

Anyone who can afford the medical scheme can enroll in the scheme, regardless of HIV or general health status. In addition, upon enrollment, medical schemes are unauthorized to require an HIV test to identify those members who are HIV-positive. In this way, PLHIV are not discriminated against at the point of enrollment or utilization of services.76

Participation in medical schemes tends to be voluntary, except in employer-based schemes, which can be mandatory. Therefore, beneficiaries tend to be those who can afford to pay and tend to exclude the poor.

Since 1998, total membership of all medical schemes has been approximately 7 million beneficiaries, which accounts for about 16% of the population in South Africa.

76 One drawback of this is that medical schemes do not know which members are HIV positive or negative and therefore data on PLHIV is not easily collected, nor is it easy to analyze the effects of insurance on HIV.
The figure below shows the age distribution of beneficiaries registered in medical schemes. The figure shows a dip in coverage among those in the 20-to 40-year-old bracket, which is similar to other countries whose young, healthy population perceive them to be risk-adverse and therefore do not enroll in health insurance. The distribution of beneficiaries is mapped against the distribution of HIV prevalence by age, which illustrates the implicit health needs and HIV risks of this segment of the population.\textsuperscript{77,78}

**FIGURE 3: AGE DISTRIBUTION OF BENEFICIARIES REGISTERED IN MEDICAL SCHEMES**

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**Benefit package**

As articulated in the Medical Schemes Act, every registered medical scheme is mandated to cover the PMBs for their beneficiaries. Benefits included in the PMB must be paid in full through designated service providers, without any co-payment or deductible.

There are 270 conditions that qualify for PMB coverage. The conditions are diagnosis-specific and can be categorized into 16 groupings.\textsuperscript{79}

\textsuperscript{77} Da Silva, op cit.
\textsuperscript{78} As da Silva and Wayburne note, this is a crude comparison, which is not adjusted for risk factors such as race and access to health services. However, it illustrates the distribution of beneficiaries relative to HIV risk.
### TABLE 7: PMB COVERAGE

<table>
<thead>
<tr>
<th>PMB Category</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brain and nervous system</td>
<td>Stroke</td>
</tr>
<tr>
<td>Eye</td>
<td>Glaucoma</td>
</tr>
<tr>
<td>Ear, nose, mouth, and throat</td>
<td>Cancer of oral cavity, pharynx, nose, ear, and larynx</td>
</tr>
<tr>
<td>Respiratory system</td>
<td>Pneumonia</td>
</tr>
<tr>
<td>Heart and vasculature (blood vessels)</td>
<td>Heart attacks</td>
</tr>
<tr>
<td>Gastro-intestinal system</td>
<td>Appendicitis</td>
</tr>
<tr>
<td>Liver, pancreas and spleen</td>
<td>Gallstones with cholecystitis</td>
</tr>
<tr>
<td>Musculoskeletal system (muscles and bones); Trauma NOS</td>
<td>Fracture of the hip</td>
</tr>
<tr>
<td>Skin and breast</td>
<td>Treatable breast cancer</td>
</tr>
<tr>
<td>Endocrine, metabolic, and nutritional</td>
<td>Disorders of the parathyroid gland</td>
</tr>
<tr>
<td>Urinary and male genital system</td>
<td>End-stage kidney disease</td>
</tr>
<tr>
<td>Female reproductive system</td>
<td>Cancer of the cervix, ovaries and uterus</td>
</tr>
<tr>
<td>Pregnancy and childbirth</td>
<td>Antenatal and obstetric care requiring hospitalization, including delivery</td>
</tr>
<tr>
<td>Haematological, infectious, and miscellaneous systemic conditions</td>
<td>HIV/AIDS and TB</td>
</tr>
<tr>
<td>Mental illness</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Chronic conditions</td>
<td>Asthma, diabetes, epilepsy, hypothyroidism, schizophrenia, glaucoma, hypertension</td>
</tr>
</tbody>
</table>

5tIn 2000, the regulations stipulated that schemes must provide treatment for HIV-related opportunistic infections, the costs of hospitalization as part of the PMBs, and coverage for HIV-associated diseases including diagnosis and medical and surgical management of opportunities infections. As such, medical schemes have provided coverage for HIV/AIDS-related hospitalization and the broader spectrum of HIV-related services, such as treatment for the prevention of mother-to-child transmission (PMTCT), voluntary counseling and testing (VCT), and treatment for common opportunistic infections. There are no specific exclusions as it relates to HIV/AIDS in the medical schemes coverage plan.

**Coverage of Drug Benefits**

In South Africa, ART is available through four main channels: medical schemes, outsourced HIV disease management services for beneficiaries enrolled in a HIV disease management program, government public sector clinics, and company clinics. In 2003, it was noted in the CMS’ annual report that several complaints had surfaced about the accessibility of ART. CMS investigated further to understand the complaints and as a result the Minister of Health accepted recommendations by CMS to further expand the PMB package to provide payment by schemes of clinically appropriate treatment with ART⁸⁰. By January 2005, ART was also included as part of the PMBs and was to be administered according to national guidelines, which specifies treatment initiation at a CD4 count of 200 or less. However, medical schemes have subsequently adopted treatment guidelines with treatment initiation at a CD4 count of 350 or less.

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Disease Management

In addition to services being offered to cover HIV-related conditions, most medical schemes have taken it a step further and introduced HIV disease management programs (DMPs) for their beneficiaries. The DMPs help monitor treatment given by providers and screen ART prescriptions for consistency with accepted treatment guidelines. Through the DMPs, more data has become available to analyze the patterns and outcomes of HIV treatment and coverage.

One of the biggest challenges of DMPs is that beneficiaries are not enrolling in HIV DMPs at an early stage of HIV and rather delay access until they are seriously ill with opportunistic infections. There is strong correlation between early initiation of ART, survival rates, and treatment costs. Therefore, DMPs are confronted with trying to ensure that HIV-positive beneficiaries enroll in their DMP early enough to initiate ART at the clinically optimal time.

Financial Experience with Covering PLHA

As noted previously, beneficiaries are not required to display their HIV status, nor are any beneficiaries required to test for HIV upon enrollment. Through DMPs, however, medical schemes are beginning to have a better understanding of the costs and utilization patterns of those members living with HIV. However, with only a small percentage of members participating in DMPs, these are underestimated.

The cost of PMBs, however, has been studied. An analysis of the community-rated PMB prices, which was calculated by the Risk Equalization Technical Advisory Panel, shows that of the R340.95 (2010) per beneficiary per month, the cost of the HIV/AIDS portion is approximately R20.46, or about 6%.

The proportional share of HIV-related costs is expected to increase as the HIV prevalence of medical scheme beneficiaries increases, those that are HIV-positive are identified through DMPs and those that are HIV-positive transition into more advanced stages of the disease.

Cost-containment

South Africa’s medical schemes have limited cost-containment mechanisms for PMBs. Medical Schemes are unable to charge a co-payment or levy on a PMB, if the beneficiary follows the scheme formulary and protocol. The one caveat is if beneficiaries use a provider other than a designated service provider (DSP), in which medical schemes are able to charge the beneficiary the difference in service cost.

For many chronic conditions, medical schemes can make benefits conditional on beneficiaries obtaining preauthorization or joining a benefit management program/DMP. The benefit management programs/DMPs help educate members about the nature of their disease and equips them to manage it.

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82 As noted earlier, beneficiaries are not required to acknowledge HIV status upon enrolment. Therefore, DPM utilization is completely voluntary and upon the discretion of the individual.
84 Cowlin, op cit.
85 Da Silva, op cit.
87 Da Silva, Op cit.
in a way that helps them stay as healthy as possible. There are DMPs for people living with HIV/AIDS; while in theory, there are no requirements to participate, it is highly encouraged.

**COUNTRY EXAMPLE: UGANDA**

**Background**

Uganda has a total population of 31 million people, with approximately 87% of the population living in rural areas and a growth rate of 3.2%. It is estimated that 38% of healthcare is paid for out-of-pocket, with the government only contributing approximately 10% of the total health expenditure.

Uganda has suffered greatly from HIV/AIDS issues. According to UNAIDS, there are almost 1 million people in Uganda living with HIV/AIDS. The total prevalence of HIV in the country (of adults over 15) is about 5.4% and 0.7% among children.88 With the availability of ART, more people are receiving continuous treatment for HIV/AIDS. In 2007, 88% of HIV-positive adults and children were known to be on treatment for at least 12 months after initiation of ART.89

There are three main health financing schemes in Uganda to help improve access to healthcare services:

- Free healthcare policy for all
- Community-based health financing
- Private sector medical schemes

The **Free Healthcare Policy** for All was started in 2002 and was intended to be able to provide comprehensive healthcare package to the total population. However, lack of funds has understandably meant that the healthcare is not really free (in fact a recent analysis of health expenditures has shown that out-of-pocket expenditures have actually increased since implementing the “free” healthcare policy).

Some Ugandans do find some financial respite from **community-based health insurance** schemes that are operational in the country. Started in 1996, there are approximately 33 schemes that are operating in the country. Each scheme is autonomous with its own management structure, but is coordinated by the national level Uganda Community Based Health Financing Association (UCBHFA). Benefits generally include outpatient and inpatient delivery services, but exclude, chronic diseases as well as other items. Low management capacity, low ability to contribute financially to the schemes and the scale-up of the Free HealthCare Policy has meant that only a small number of people are covered with these schemes: approximately 120,000 beneficiaries, or less than 0.5%, are covered by these schemes.

In addition to these mechanisms, there has been a growing private health insurance industry, which includes a mix of health maintenance organizations and more traditional health insurance companies. Approximately 250,000 people are covered with private health insurance, or 0.8% of the population. Services are comprehensive and include access to HIV-related care and treatment.

**Policy environment**

The Free Healthcare for All Policy has meant that the demand for health insurance products has been relatively low. That being said, given the lack of funding to truly operationalize this policy and make

88 Government of Uganda (2010, March) 'UNGASS country progress report: Uganda.'
89 Government of Uganda, Op Cit.
healthcare services free, there is increasing demand from the population to establish stronger health insurance mechanisms to spread the financial risks of healthcare across the population.

As such, there has been a slow, but increasing trend in private health insurance, the policies of which tend to be comprehensive and include HIV/AIDS related services.

Health insurance is regulated by the Insurance Regulatory Body. The Ministry of Health is represented in this body with regard to health insurance. The Ministry’s role is to help oversee quality issues, ensuring beneficiaries are not being exploited and ensuring standards of care are being upheld (guidelines on ART, treatment of opportunistic infections, and PMTCT).

With the relatively nascent health insurance industry in Uganda, there is no explicit health regulation to monitor the activities of health insurance in the country. This has had both positive and negative effects. On the negative side, it has created uncertainty for players currently in this space and for those wanting to enter the market. It further results in a lack of beneficiary protection and oversight in underwriting practices and ensuring that individuals are not discriminated against, particularly as it relates to HIV/AIDS. On the positive side, it has allowed innovation and flexibility for developments within the health insurance industry. Interestingly enough, even without a policy explicitly mentioning anything about HIV/AIDS, most private health insurance policies in Uganda have coverage for HIV/AIDS.

**Insurance Model**

As HIV/AIDS prevalence increased over the past decades, there were different ways that companies responded to this phenomenon. In most cases, companies offered medical benefits to employees directly reimbursing employees for HIV/AIDS-related medical bills, usually up to a maximum amount. However, this resulted in little confidentiality, and as such, employees were reluctant to come forward for HIV treatment through these schemes. The employee reimbursement plans were also subject to substantial discretion and inequity among the managers of the scheme, with the company reimbursing more HIV-related medical costs for influential or highly valued staff, more so than other staff.

Shift is moving from reimbursement programs to health insurance or TPA arrangements, which offer more uniform application of rules governing medical benefits. In addition, health insurance offers the company more predictable annual health expenditure.

In the health insurance arrangements, employers or individuals purchase health insurance plans from the insurance company. Some of the companies (for example, International Medical Group) have their own healthcare facilities where members can avail services. Others partner with private providers to deliver services. In this circumstance, services and rates are negotiated between the insurance company and the provider based on the agreements between the employer (client) and the insurance company.

In other instances, insurers can combine traditional health insurance and third-party payment arrangements that can be extended to cover HIV/AIDS (for example, African Air Rescue). In this case, the client firm (or individual) buys the insured basic benefit package for its employees, and then provides a separate fund from which the insuring organization/third-party pays for services excluded from the

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basic benefit package. AAR, for example, has supplementary coverage for hospitalization as a result of HIV/AIDS up to a certain amount.\(^{92}\)

Another model of coverage that is used is essentially self-insurance, with use of a TPA. In this model, the company arranges coverage for HIV services, including ART through the TPA, passing the costs through to the employer.

In both the insurance and the TPA arrangement, the employer is “blind” to the identity of the individual employees that are HIV-positive and may be receiving HIV services.

**Beneficiaries**

The number of people covered by private health insurance is low relative to the number of people in Uganda and relative to the prevalence of HIV/AIDS. It is estimated that 250,000 people are covered with private health insurance (that which provides coverage for HIV/AIDS services), or 0.8% of the population. With a population of 31 million and an HIV prevalence of 5.4%, there is potential for growth and demand for health insurance among a greater number of people.

Because of the mechanism by which claims are being paid for HIV/AIDS-related services (transparent), there is little data available on the number of PLHA that are covered by health insurance. Further, there remain high levels of stigma around HIV/AIDS in Uganda, with even President Museveni supporting the policy of dismissing or not promoting members of the armed forces who test positive for HIV.\(^{93}\) Discrimination has also been reported in the private sector, including mandatory HIV testing for new employees.\(^{94}\) This may result in a low number of PLHA actually being covered by private health insurance, as there may be few employees who are HIV-positive. But as data is lacking in this area, it is difficult to ascertain.

**Enrollment and Uptake**

Enrollment is managed by the insurance company. Insurance companies are directly contracted by the employers to provide coverage for the beneficiaries; so there is no formal enrollment process or issues of uptake.

There is a small individual health insurance market as well in Uganda, where individuals purchase health insurance directly from the insurance company. However, this market is very small and is not all that common to see.

Anecdotal evidence suggests that those that have health coverage through health insurance, particularly those living with HIV/AIDS, are happy with the amount of coverage and services offered to them through the insurance scheme.\(^{95}\)

**Benefit Package**

There are several different policies of private health insurance that provide some kind of coverage for HIV/AIDS. Below are two different examples.

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\(^{95}\) Personal correspondence with Paul Bukuluki, Health Advisor, Uganda.
International Air Ambulance is a managed care organization that provides health insurance coverage for employers and individuals. There are different types of policies and subsequent benefits based on the level of coverage purchased. For example, a family of four can pay $750/year to receive the following benefits:

**TABLE 8: HIV COVERAGE OF INTERNATIONAL MEDICAL GROUP, UGANDA**

<table>
<thead>
<tr>
<th>Medical Services – Unlimited</th>
<th>Hospitalization at International Hospital, Kampala</th>
</tr>
</thead>
<tbody>
<tr>
<td>General consultations</td>
<td>The contractor will provide hospitalization in the 4-bedded ward at IHK up to the cost of US$ 4000 for the following services:</td>
</tr>
<tr>
<td>Approved X-rays</td>
<td>General surgery</td>
</tr>
<tr>
<td>Ultrasound scans</td>
<td>Gynecology</td>
</tr>
<tr>
<td>12-lead ECGs</td>
<td>Pediatrics</td>
</tr>
<tr>
<td>Standard drugs</td>
<td>Internal medicine</td>
</tr>
<tr>
<td>Laboratory investigations</td>
<td>Physiotherapy</td>
</tr>
<tr>
<td>UNEPI immunizations</td>
<td>Room upgrades may be obtained with cash payment subject to availability.</td>
</tr>
<tr>
<td>Family planning incl.</td>
<td></td>
</tr>
<tr>
<td>Contraceptive pills, IUDs,</td>
<td></td>
</tr>
<tr>
<td>Norplant</td>
<td></td>
</tr>
<tr>
<td>Treatment of HIV opportunistic infections</td>
<td></td>
</tr>
<tr>
<td>Ordinary medical check-ups</td>
<td></td>
</tr>
<tr>
<td>such as physical examinations by an IMG doctor, HIV testing, blood pressure</td>
<td></td>
</tr>
</tbody>
</table>

Source: http://www.img.co.ug/services/medicalinsurance.php

African Air Rescue (AAR) provides supplementary benefits as part of their health insurance package. Supplementary benefits for HIV include: Hospitalization arising out of HIV/AIDS-related complications limited to UGX. 2,745,000.96

Jubilee, which is a private insurance company in Uganda offering companies’ medical insurance plans, has an “enhanced benefits” option, which includes HIV/AIDS services. Specifically, Jubilee will provide coverage for HIV/AIDS including treatment for opportunistic infections and administration of ART. Further, there is an option for a disease management program administered specifically for PLHA. 97

**Financing and Cost Containment**

Paying for private health insurance in Uganda is the responsibility of the individual or the employer. There are no subsidies provided by the government to enable the poor or more vulnerable people to access coverage. However, the Government of Uganda has been strategizing how to expand health insurance coverage to a greater number of people and one of the considerations is building on the experiences and success of the private health insurance industry.

Some cost-containment mechanisms are being employed with health insurance in Uganda. For example, many of the schemes have disease management programs specifically around chronic conditions, including HIV/AIDS. In some cases, if there is noncompliance with the member on the disease management regimen, the member will become subject to a co-payment for all treatment costs.98

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