Published in final edited form as:

Sex Transm Dis. 2018 April ; 45(4): 283–286. doi:10.1097/OLQ.0000000000000727.

Improving insurance and healthcare systems to ensure better access to sexually transmitted disease testing and prevention

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Keywords

insurance; cost; co-pays; deductibles; HIV; STD; PrEP

INTRODUCTION

Despite ongoing national efforts and advances in testing and treatment, sexually transmitted diseases (STDs) including human immunodeficiency virus (HIV), chlamydia, gonorrhea, and syphilis remain a significant public health challenge in the United States.¹

Approximately 20 million cases of STDs and 40,000 cases of HIV are diagnosed annually, ^{2,3} contributing an estimated \$15.6 billion in total direct healthcare costs each year.⁴ As of 2015, new cases of syphilis, gonorrhea, and chlamydia are at the highest peak in the past decade.¹ STDs and HIV infections continue to disproportionately impact historically marginalized individuals, including African American/Black, Hispanic/Latino, and sexual minority groups.^{1,5} Improved efforts are needed to address HIV/STD prevention, including facilitating testing and treatment approaches while minimizing barriers.

There are a number of barriers to HIV/STD testing and prevention, including pre-exposure prophylaxis (PrEP) for reducing risk of HIV infection,^{6–9} that may be effectively addressed through reduced costs, elimination of unnecessary prior authorization requirements, and enhanced privacy in electronic medical records (EMRs). Cost and privacy barriers to STD care have historically been addressed by public STD clinics that, unlike traditional primary care or private sector settings, have provided anonymous services at no or minimal costs.¹⁰ However, declining public health funds, rising healthcare costs, and increased numbers of insured individuals following Medicaid expansion have pushed many settings to implement payment structures, including billing insurance for services.^{7,10–12} Thus, clinics previously

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All authors report no conflicts of interest.

providing services free of charge regardless of insurance status have adopted insurance use requirements that, while offsetting the burden of decreasing public health dollars, present a new set of challenges to patients. Paramount among these barriers is the out-of-pocket cost of services in the form of insurance copayments, coinsurance, and deductibles. Studies on patient willingness to use insurance at publicly funded STD clinics found that patients consistently report out-of-pocket costs as a major impediment to using insurance for STD services.^{7,13} Furthermore, patients with insurance may not want to use their insurance due to confidentiality concerns.^{7,13} In this commentary, we describe how insurance policies and currently employed EMRs deter patients, especially those from disadvantaged groups, from engaging in HIV/STD testing and prevention. We conclude with potential solutions that can aid healthcare practices, health information technology experts, and policymakers in improving access to these services.

INSURANCE COVERAGE AND PRIVACY LIMITATIONS

Since 2010, implementation of The Patient Protection and Affordable Care Act (ACA) has resulted in a dramatic increase in the number of newly insured individuals, especially among young adults less than 26 years old and low-income adults in Medicaid expansion states.^{14,15} Despite these significant coverage gains, many in the country remain uninsured or underinsured.^{16,17} An estimated 24 million adults continue to be uninsured largely due to the 19 states that have opted not to expand Medicaid eligibility and the exclusion of undocumented immigrants from ACA coverage.¹⁶ Importantly, such disparities in coverage affect groups that are disproportionately impacted by HIV and STDs, with African American/Black and Hispanic/Latino individuals more likely to remain uninsured or to forgo needed medical care due to out-of-pocket costs. Out-of-pocket health expenses, including copays, coinsurance, and deductibles, have been documented as a prominent concern for utilizing insurance for STD testing and services, with nearly a third of patients at STD clinics citing cost sharing concerns as the reason why they did not want to use insurance.^{7,13} Studies of STD clinics in Colorado and Massachusetts have found that the introduction of patient fees for STD services previously offered free of charge are associated with immediate and substantial declines in the volume of clinic visits.^{11,12} Whereas these studies evaluate the impact of clinic flat fees on service utilization, they may indicate more broadly the extent to which out-of-pocket expenses of any type impede access to HIV and STD services. Furthermore, recent work corroborates the role of insurance coverage as a key predictor of engagement in PrEP for HIV prevention.^{9,18}

In addition to cost sharing barriers and disparities in coverage, insurance practices pose unique privacy concerns for individuals, especially youth, heterosexual-identifying men who have sex with men (MSM), and racial and ethnic minorities,^{6,19} whose decision to obtain testing and care occurs in a larger social context of HIV and STD-related stigma.²⁰ Patients frequently cite the desire for privacy, including a preference not to disclose STD care and treatment to their other providers, as one of the primary motivators for seeking services at public STD clinics that offer anonymous testing over primary care settings.²¹ Concerns about anonymity have been documented as the most commonly reported barrier to insurance use for STD care, with approximately two-thirds of insured patients citing privacy as the main barrier to using their insurance for services.^{7,13} Despite patient preferences for stricter

confidentiality of STD services as well as studies linking patient concerns over stigma and confidentiality to delays in engaging in STD testing and care,⁶ insurance companies do not have a reliable mechanism for addressing these concerns. For example, insurance companies may send a detailed Explanation of Benefits (EOB) statement to the primary policyholder with a summary of charges for services received, which may expose individuals who are covered under a parent's or spouse's insurance plan.^{6,7} Especially for youth and young adults, such practices are a major deterrent to engaging in HIV and STD testing. In a 2016 national study of youth ages 15–25 years old, approximately half of respondents reported deferring STD testing due to confidentiality concerns, including not wanting their parents to find out about the testing.⁶

INSURANCE PRIOR AUTHORIZATION REQUIREMENTS

Insurance carriers have been increasingly instituting prior authorization policies to control the escalating cost of prescription drugs.²² Such policies, which require a prescriber to obtain advance approval for a medication from the insurer, consume significant staff time and resources while complicating and delaying access to services. In 2017, United Healthcare (UHC), one of the largest health insurers in the United States, briefly implemented a prior authorization requirement for PrEP due to “significant growth in prevention use,”²³ only to rescind the requirement following public outcry and pushback from HIV advocacy groups.²⁴ Despite public controversy, several insurance providers still require prior authorization for PrEP. In 2017, a coalition of healthcare organizations that includes the American Medical Association released guidance against instituting utilization management programs and prior authorizations based solely on cost containment aims, in light of the negative impact that these requirements have on timely engagement in care.²⁵ In the context of HIV treatment, prior authorization requirements routinely result in interruptions and delays in accessing medications.⁸ Prior authorization for PrEP, which has been prescribed to over 13,000 individuals in the United States,²⁶ will likely have the same impact. The decision to enforce a utilization review process should not be based on growing costs alone, especially in the case of HIV prevention services that are intended to address both the health of the patient and transmission risk to the public.

ELECTRONIC MEDICAL RECORDS AND PRIVACY LIMITATIONS

EMRs are now ubiquitous across United States medical systems and provide the basis for medical documentation and billing in most clinical settings.^{27,28} With the introduction of EMRs, the purpose of medical documentation has shifted away from patient-centered medical documentation towards data captured for billing and reimbursement.²⁸ EMRs now largely exist as tools for automated coding and billing processes, with exhaustive documentation requirements to justify services billed to third-party insurers.²⁹ Such interdependent documentation and insurance reporting practices, while beneficial for meeting financial priorities, are in direct conflict with patient preference for anonymous testing, especially among youth, heterosexual-identifying MSM, and other patient groups uniquely impacted by HIV and STD-related stigma. Currently, few reliable options exist in EMRs to sequester sexual health data or information on prescription medications such as PrEP from the rest of the medical record, outside the purview of coding and billing to third-

party payers, or to have sexual health visit notes protected from access by individuals who are not directly involved in the visit, including primary care providers, parents, and spouses. Patients across numerous studies report a desire for greater control over sharing sensitive health information selectively across providers, and even stricter control over what is seen by non-providers such as insurance companies and family members.³⁰ Additionally, EMR visit summaries that are typically given out in some clinical settings may include medications and problem lists that expose patients seeking HIV and STD services to undue confidentiality risks in the event that these are seen by others. EMRs and documentation policies should support patient preferences for greater privacy and confidentiality, especially in the context of HIV and STD testing and prevention where these remain predominant patient concerns.

FUTURE CONSIDERATIONS

Key structural factors, ranging from gaps in insurance coverage to inflexible EMR systems, are significant barriers to accessing HIV/STD testing and prevention services (Figure 1). We suggest several considerations for healthcare practices, health information technology experts, and policymakers to inform future changes. First, there is a need to minimize out-of-pocket costs for services. While cost-sharing mechanisms exist to mitigate potential overutilization, these are known barriers to HIV and STD services that serve to benefit both the patient and public health. Reducing cost-sharing barriers has the potential to ultimately decrease insurer costs through prevention of sequelae from untreated infections in patients who delay care due to financial concerns. Sustainable models for offering affordable HIV and STD services using insurance reimbursement mechanisms should be explored. Although ACA policies require insurers to fully cover screenings recommended by the United States Preventive Services Task Force, current guidelines for chlamydia and gonorrhea screening do not extend to most sexually active men, leaving certain at-risk subgroups to bear additional costs for screenings. Insurance companies and healthcare systems must work together to limit out-of-pocket expenses for all individuals at increased risk for HIV and STDs, in order to ensure timely and consistent access to HIV and STD care.

Second, insurers must also work to address confidentiality concerns related to billing and payment, as existing practices do not sufficiently protect patients from unintended disclosures to parents and spouses who are listed as primary or joint policyholders. To better ensure confidentiality for dependents, select insurers and states have extended exceptions to EOBs, including not requiring them to be mailed when no balance is due, and allowing dependents to request confidential communications from their insurers.³¹ Similar workarounds may be implemented across insurers to improve confidentiality protections for all patients receiving sensitive services.

Third, insurance companies should eliminate prior authorizations for effective and evidence-based services relating to HIV/STD prevention. Current prior authorization requirements for PrEP are without appropriate clinical justification and are intended to curb utilization based on cost reasons alone. Whereas insurers cite concerns about medically necessary and appropriate prescribing to defend prior authorizations, such concerns should rather be

addressed through improved education and ongoing provider feedback rather than restrictive practices.

Fourth, EMR databases must address patient desire for privacy in the context of HIV and STD testing and prevention services, including patient preference for more granular and selective control over which providers have access to sensitive records containing sexual health information.³⁰ Potential solutions may take the form of additional safeguards or an option for documenting sensitive information, including prescription medications such as PrEP, in secure electronic records that are kept separate from billing processes and accessible only by providers participating directly in the patient's HIV and STD care. In maintaining EMRs that prioritize documenting and billing for services rendered, healthcare practices continue to overlook a frequently cited barrier to accessing HIV and STD services.

More research is needed to better understand acceptability of insurance use, including acceptable co-pay thresholds and deductible amounts for HIV and STD services, and how these costs are linked to risk of infection. Furthermore, additional research is needed on the cost effectiveness of insurance interventions implemented upstream, including the impact of reduced cost-sharing requirements and improved confidentiality protections on patient uptake of HIV and STD prevention services and healthcare savings downstream. On the national level, improving access to HIV and STD testing and prevention hinges on both access to insurance coverage that minimizes cost-sharing burdens for critical prevention services and increased public health funding for safety-net HIV and STD services for individuals who remain uninsured or underinsured.

Acknowledgments

Dr. Chan is supported by NIH grants R34DA042648, R34MH110369, R34MH109371, R21MH113431, and R21MH109360. Dr. Dean is supported by the National Cancer Institute grant K01CA184288; the Sidney Kimmel Cancer Center grant P30CA006973; Johns Hopkins University Center for AIDS Research grant P30AI094189, and National Institute of Mental Health grant R25MH083620. Dr. Patel is supported by NIH grant KL2TR00045. Dr. Raifman is supported by National Institute of Allergy and Infectious Disease grant T32AI102623 and National Institute of Mental Health grant R25MH083620.

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Figure 1. Key barriers (electronic health record systems, insurance policies, and cost of services) disrupt patient access to HIV and STD prevention services.