Estimated Cost of Eliminating Medicaid Prior Authorizations for Antiretrovirals in Washington State

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BACKGROUND

- Approximately 80% of the cost of HIV medical care is attributable to antiretroviral drugs (ARVs).
- Medicaid is the largest source of insurance for nonelderly adults with HIV in the United States.
- Many state Medicaid programs use prior authorizations to promote the use of less costly ARVs.
- In 2023, the Washington State Legislature passed legislation requiring Washington's Medicaid program to cover all ARVs without prior authorization.
- We estimated the impact of the new law on Medicaid expenditures on ARVs. To place that cost in context, we estimated how new ARV expenditures might be used to fund housing for people living with HIV (PLWH) or new sexual health clinics.

METHODS

- ARV costs based on Medicaid claims 2021-2022 using net costs inclusive of statutory and supplemental rebates.
- Costs estimated for 5-year period, 2023-2027
- Housing costs based on local Ryan White budget data inclusive of housing case management, 2022
- Sexual health clinic (SHC) operational costs based on budget data from a public health SHC in Seattle, 2022

Major assumptions in different models of changing ARV use following elimination of prior authorizations

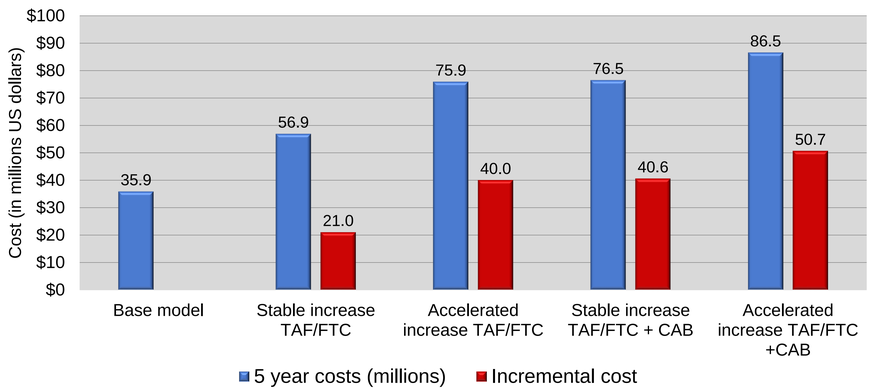
PrEP Models	
Base	PrEP use increases 10% per year. Proportion of people using TDF/FTC and TAF/FTC remains at 2022 levels with no use of CAB.
Stable increase	PrEP use increases 10% per year. Proportion of PrEP users on TDF/FTC decreases 3.5% annually from 87% in 2022 to 72% in 2027 and TAF/FTC increases from 13% to 28%. Percent change in TDF/FTC based on change 2021 to 2022. No use of CAB.
Accelerated increase	PrEP use increases 10% per year. Proportion of PrEP users on TDF/FTC decreases 7% per year from 87% in 2022 to 60% in 2027 and TAF/FTC increases from 13% to 40%. No use of CAB.
Stable increase plus CAB	PrEP use increases 10% per year. TAF/FTC use increases as in model 1 (13% in 2022 to 28% in 2027). CAB use increases 1% per year to 5% by 2027.
Accelerated increase plus CAB	PrEP use increases 10% per year. TAF/FTC use increases as in model 2 (13% in 2022 to 40% in 2027). CAB use increases 1% per year to 5% by 2027.
HIV Treatment Models	
Base Model	Number of people on treatment increases 2% per year. No change in the proportion of people receiving each antiretroviral regimen
No PA Model	Number of people on treatment increases 2% per year. Number of people on BIC/TAF/FTC - relative increase of 18% per year from 26% in 2023 to 50% in 2027 – Based on change 2021 to 2022. CAB/r increases 1% per year from 1% to 5% in 2027. Darunavir/cobicistat use unchanged. Relative increase of 9% per year in use of TAF/FTC co-formulated tablet among persons on either TAF/TDF or TDF/TFC. This increases TAF/FTC use among persons on either TAF/TDF or TDF/TFC from 52% to 74%. (Excludes tenofovir containing single dose tablet regimens). All other regimens decline at rates proportional to their use in 2022.

TDF/FTC= tenofovir disoproxil and emtricitabine, TAF/FTC=tenofovir alafenamide and emtricitabine, CAB= cabotegravir, BIC=bictegravir

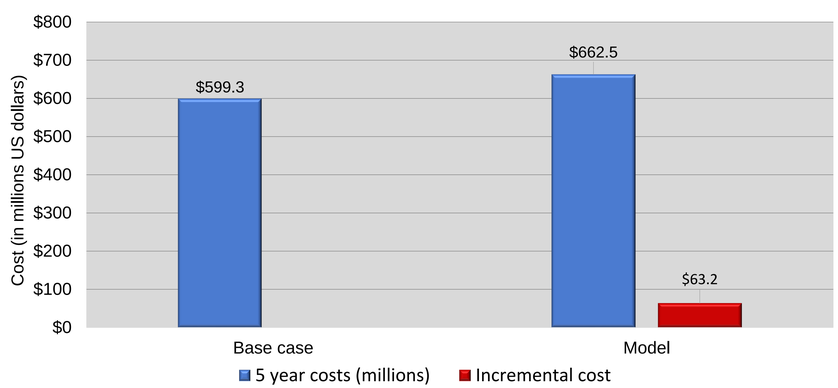
Elimination of prior authorizations for antiretroviral drugs will cost WA state Medicaid $84-$114 million over 5 years. These funds could house approximately 50% of unstably housed PLWH in WA State.

RESULTS

Estimated Total and Incremental Costs Associated with Eliminating Prior Authorizations for ARVs Used for HIV PreP Over 5-Years



Estimated Total and Incremental Costs Associated with Eliminating Prior Authorizations for ARVs Used for HIV Treatment Over 5-Years



- Elimination of prior authorizations for ART will cost the WA Medicaid program $84.2-$113.9 million over 5 years.
- Based on an estimated 5-year cost to house someone in King County, WA of $148,090, new ARV expenditures would be sufficient to house 569-769 people, or 43-58% of all unstably housed persons living with HIV in Washington state.
- Alternatively, new ART expenditures would be sufficient to fund at least 3-5 new sexual health clinics capable of providing care, including PrEP, to tens of thousands of state residents.

CONCLUSIONS

- Elimination of prior authorizations will likely result in substantial new Medicaid expenditures on ARVs.
- Prior cost-effectiveness analyses suggest that newer ARVs are often not cost-effective for either PrEP or HIV treatment*.
- The use of public funds to eliminate prior authorizations come with substantial opportunity costs. The same funds could have an important impact on HIV prevention and/or homelessness among PLWH.

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