LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave, 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-4748
HIVCOMM@LACHIV.ORG • https://hiv.lacounty.gov

VIRTUAL MEETING AGENDA
TUESDAY, JANUARY 7, 2025
1:00 PM – 2:30 PM

TO JOIN BY WEBEX, CLICK:
https://lacountyboardofsupervisors.webex.com/lacountyboardofsupervisors/j.php?MTID=m45f7078cf5885c4b547aa915a1858c71
Password: AGING (Case sensitive/All capital letters)
Meeting Number and Access Code: 2535 508 3511
Join by phone: +1-213-306-3065 United States Toll (Los Angeles)

1	**Welcome & Introductions**	1:00pm-1:10pm
2	**Co-Chairs' Report** a. Purpose of the Aging Caucus b. Co-Chair Nominations and Elections c. October 1, 2024 Meeting Debrief d. Meeting Frequency Review	1:10pm-1:20pm
3	**Discussion: 2025 Strategic Priorities Draft Review**	1:20pm – 1:35pm
4	**Medicare Basics (Center for Healthcare Rights),** Rie Fishman, MPH, CHES| Community Education Coordinator | Health Insurance Counseling and Advocacy Program (HICAP)	1:35pm -2:05pm
5	**Division of HIV and STD Programs (DHSP) Report**	2:05pm – 2:10pm
5	**Executive Director/Staff Report** a. Commission 2025 Workplan	2:10pm- 2:15pm
6	**Next Steps and Agenda Development for Next Meeting**	2:15-2:20pm
7	**Public Comments & Announcements**	2:20pm-2:30pm
8	**Adjournment**	2:30pm

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AGING CAUCUS (AC) VIRTUAL MEETING SUMMARY
TUESDAY, OCTOBER 1, 2024
MEETING PACKET: CLICK HERE.

I. Co-Chairs' Report

a. **Addressing Social Isolation and Loneliness in Black, Indigenous and People of Color (BIPOC) Women 50+ Educational Event Debrief**

Dr. P. Nash reported that the event, held on September 23, was well attended with approximately 50 people in attendance. Participants appreciated the space dedicated to discussing loneliness and isolation among older women living with HIV. Staff from Gilead Sciences attended and were impressed by the quality of the discussion and interested in supporting a follow-up activity. Dr. Nash will report back on the outcome of his meeting with Gilead staff.

The event summary, slides and resources are available on the Commission's website.

The Caucus suggested the following topics for future educational events:

- Continue collaboration with other caucuses.
- Story telling as a tool for empowerment, education, advocacy and breaking down stigma; focus on people of color, transgender voices and women living with HIV.
- Self-advocacy and awareness of health issues and understanding lab work.
- Information on Medicare and the population it covers.

b. Introductory Partnership Meeting with Dr. Gary Tsai, Director, Substance Abuse Prevention and Control (SAPC), Los Angeles County Department of Public Health

Aging Caucus Co-Chairs, K. Donnelly and P. Nash, held a brief introductory virtual meeting with Dr. Gary Tsai, Director of SAPC, on September 20 to explore partnership opportunities with SAPC. Dr. Tsai noted that SAPC works with Senior Community Centers and has participated in Senior Health & Wellness Fairs in the past, but there is undoubtedly more work they could be doing to support older adults living with HIV. Some ideas discussed during the call included presentations at COH meetings on braiding HIV and substance use programs to prevent and treat HIV, special events and summits focused on the impact of substance use on older adults living with HIV, and more data sharing with HIV stakeholders.

II. Collaboration in Care Conference: Empowered Aging, Thriving Beyond HIV | Key Takeaways

Arlene Frames reported that she facilitated a session for caregivers; the conference was excellent and highlighted the lack of attention paid to the needs of older adults; many face stigma and lack support to navigate services.

M. McFadden shared that the conference was of high quality and highlighted the need for workforce development focused on specialized skills needed to serve older adults. Additionally, he underscored the need to think creatively and thoughtfully how care could financed for older adults such as collaborating with other aging resources and Medicare coverage.

III. **Division of HIV and STD Programs (DHSP) Report**

a. **Solicitations –** P. Ogata noted that DHSP has released the Ambulatory Outpatient Medical/Medical Care Coordination/Patient Support RFP. They are also planning to release an RFP for prevention services in an effort to be more strategic and impactful in the way to fund HIV/STD prevention services in the County. Lastly, DHSP submitted the Ryan White Part A application to HRSA.

IV. **Executive Director/Staff Report:** C. Barrit reminded attendees about the Commission's Annual Conference on November 14 at the MLK Behavioral Health Center from 9am to 4pm.

V. **Announcements and Public Comments –** Dr. Nash mentioned the upcoming public comment period for the CDC HIV testing guidelines. He recommended members of the Caucus to read the proposed changes to the guidelines and advocate for the removal of the upper age limit for HIV testing.

V. Next Steps and Agenda Development for Next Meeting

- Next Meeting: December 3, 2024 @ 1pm to 2:30pm (hybrid)

Meeting was adjourned at 2:30pm.

LOS ANGELES COUNTY COMMISSION ON HIV 2025 AGING CAUCUS KEY STRATEGIES

Goal: Raise awareness of ageism and its impact on older adults living with HIV.

DATA SPECIFICITY

Advocate for specific age breakdowns for older adults to better understand the needs older adults. Secure HIV continuum of care data broken by specific age groups for older adults.

ENHANCE AND EXPAND SOCIAL SUPPORTS

Leverage all funding sources to expand the network of social support services for older adults living with HIV.

CA STATE PLAN ON AGING

Participate in the State of CA townhalls and provide feedback on the CA State Plan on Aging (Due July 2025). Highlight the needs of older PLWH.

CROSS-CAUCUS COLLABORATIONS

Partner with all Commission on HIV Caucuses to address ageism and HIV.

EXPAND HIV TESTING TO OLDER ADULTS

Provide public comments to the CDC to remove upper age limits for HIV/STI testing. Promote multi-agency, regional and statewide approach to remove upper age limits to HIV/STI testing.

WHITE PAPER ON AGEISM AND HIV

Develop a white paper on ageism and HIV and its impact on older adults.

PARTNERSHIP WITH DEPARTMENT OF AGING AND DHSP

Assist DHSP in establishing a relationship with the LAC DOA and create a process for referring eligible clients to DOA-funded services.

ONGOING EDUCATION

Provide educational information on ageism and HIV at COH meetings via the Aging Caucus Co-Chairs' Reports.

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VIA ELECTRONIC SUBMISSION — https://www.regulations.gov/commenton/CDC-2024-0100-0001
Centers for Disease Control and Prevention [Docket No. CDC–2024–0100]

Cecily Campbell Associate Director for Policy National Center for HIV, Viral Hepatitis, STD, and TB Prevention Centers for Disease Control and Prevention 1600 Clifton Road NE Atlanta, Georgia

RE: Draft CDC's Recommendations for HIV Screening in Clinical Settings

Dear Associate Director Campbell,

The Los Angeles County Commission on HIV (COH) serves as the local planning council for the planning, allocation, coordination and delivery of HIV/AIDS prevention and care services. The COH is composed of 51 members appointed by the Board of Supervisors and represent a broad and diverse group of providers, consumers, and stakeholders. Thirty-three percent of the members are individuals living with HIV and consumers of services funded by the Ryan White Program.

The COH is committed to supporting collective efforts to reduce HIV stigma, increase HIV prevention and awareness, and rapidly link individuals to care and social services to ensure optimal health. The COH applauds the recommendation to remove the upper age limit for an HIV test and concurs with the other good practice statements enumerated in the draft recommendations.

In an effort to support the national goals of the Ending the HIV Epidemic (EHE), we strongly urge the CDC to maintain the lower age limit of 13 years for testing. Some studies show early sexual initiation in young adolescents occur before 13 years of age. We believe that maintaining the lower age limit at 13 supports and facilitates access to comprehensive sexual health education and care for young adults.

Additionally, while the CDC recommends "at least one HIV test in a lifetime for all persons 15 years of age or older" to ensure a minimum standard for clinical practice, this language may promote a false of sense of safety and may present missed opportunities for diagnosing HIV across the lifespan. Sexual behaviors and exposures to risks are not static and change due to multitudes of factors that affect an individual's life. We ask for a reconsideration of this statement and consider a more frequent cycle of testing. Lastly, we recommend a more frequent national review and updates of the guidelines to three to five years to keep pace with evolving best practices in clinical settings.

We thank you for your consideration of these comments and commend your tireless leadership in fostering thriving and healthy communities across the nation. Feel free to contact Cheryl Barrit, Executive Director, at cbarrit@lachiv.org or 23-618-6164 should you have any questions.

Sincerely,

Los Angeles County Commission on HIV

2025 COMMISSION ON HIV WORKPLAN
Ongoing 12-26-24

#	DUTY/ROLE	LEAD (S)	NOTES/TIMELINE
1	Conduct ongoing needs assessments	PP&A Shared task with DHSP	• Review, analyze and hold data presentations (Feb-August COH meetings)
2	Integrated/Comprehensive Planning Comprehensive HIV Plan Development	PP&A Shared task with DHSP	• Review CDC/HRSA guidance • Develop project timeline based on CDC/HRSA guidance • CHP Due June 2026 • Plan dedicated status-neutral and/or prevention-focused planning summit in collaboration with DHSP.
3	Priority setting	PP&A	• July-September
4	Resource allocations/reallocations	PP&A	• July-September • Receive and review expenditure data – quarterly
5	Directives	PP&A	• Complete by February 2025; secure COH approval by March 2025
6	Development of service standards	SBP Shared task with DHSP	• Housing services • Transitional case management
7	Assessment of the Efficiency of the Administrative Mechanism	Operations	• PY 33 & PY 34 AEAM recipient and subrecipient surveys will be disseminated in January/February 2025. Reports completed by April 2025
8	Planning Council Operations and Support	Operations	• Membership training • Membership recruitment and retention • Fill vacancies • Mentorship program • Bylaws and policies update

9	Complete restructuring framework and key principles and align with bylaws/ordinance updates.	Executive and Operations	• January- April 2025
10	MOU with DHSP	Co-Chairs and Executive Committee	• Complete by March 2025 (awaiting DHSP feedback)
11	Ongoing community engagement and non-member involvement of PLWH	Consumer Caucus and Operations	

Engage all caucuses, committees and subgroups in all functions.

CENTER FOR HEALTH CARE RIGHTS

Medicare 101

Presented by: Rie Fischman, Community Education Coordinator

This project was supported, in part by grant number 90SAPG0094-03-02 from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration for Community Living policy.

Center for Health Care Rights

- A non-profit organization that provides free Medicare and health insurance counseling and advocacy services to Los Angeles County residents.

- CHCR's services are funded by the California Department of Aging Health Insurance Counseling and Advocacy Program (HICAP).

HICAP Statewide number: 1-800-434-0222

Visit our website: www.healthcarerights.org

Center for Health Care Rights

Have you seen us?

Center for Health Care Rights

Services provided:

One-on-one counseling and advocacy for Medicare beneficiaries

- Over the phone, or
- In-person at sites throughout LA County, often by volunteer HICAP counselors

SHIP
State Health Insurance Assistance Program
Navigating Medicare

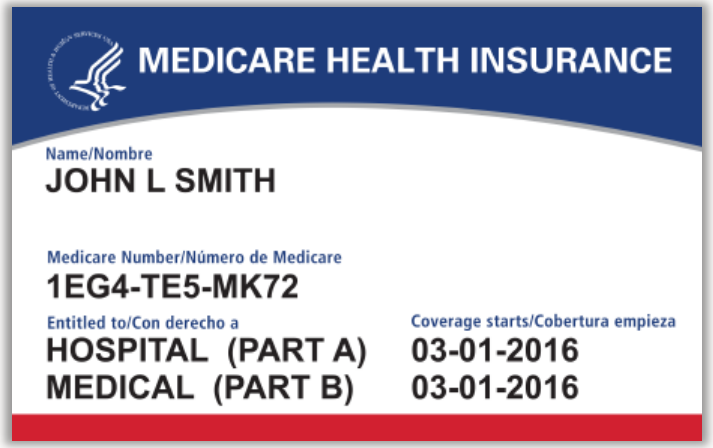
Community Education and Outreach

- Medicare workshops and trainings for beneficiaries, caregivers, and social service and health care professionals
- In-person and online
- In partnership with community-based organizations, senior centers, and other agencies

What is Medicare?

- A federal health insurance program that provides health benefits to people who are age 65 and older and people under the age of 65 who have a permanent disability.

- Eligibility for Medicare is **NOT** based upon income or resources.



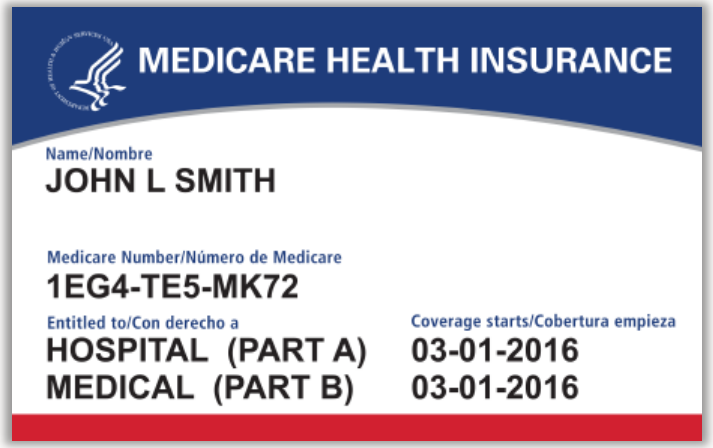
Who is Eligible for Medicare?

People who are 65 or older and,

- A US Citizen, or
- A legal permanent resident with at least five years of continuous residency in the US

People under the age of 65 with a permanent disability who have:

- Received Social Security Disability Insurance (SSDI) benefits for 24 consecutive months.
- Amyotrophic Lateral Sclerosis (ALS), also known as Lou Gehrig's Disease, or End Stage Renal Disease (ESRD).



Medicare Benefits

Part A

- Hospital Services
- Home Health Care
- Skilled Nursing Care in a Skilled Nursing Facility
- Hospice Care

Part B

- Doctor Services
- Ambulance Services
- Labs, X-Rays, Diagnostic Tests
- Durable Medical Equipment
- Preventive Care
- Outpatient Therapy
- Mental Health Services

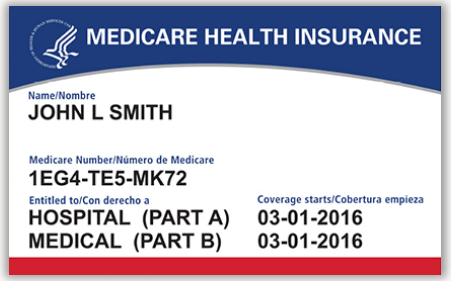
Part C

- Known as “Medicare Advantage,” typically combines Parts A, B, and D

Part D

- Prescription Drugs

Medicare Part D Coverage Options



Original Medicare

Enroll in a Prescription Drug Plan

Or

Medicare Advantage Plan
(typically covers Parts A, B, and D)

Medicare Part D Drug Plan Choices

Prescription drug plan (PDP)

- Obtain Medicare Part D drug coverage by enrolling into a PDP plan
- Continue to use Original Medicare to obtain Part A and B services
- Plan premiums vary

Medicare Advantage drug plan (MAPD) = Part C

- You assign your all Medicare benefits to the plan
- You obtain all your medical care from plan providers
- Plan premiums vary

Gaps in Medicare Coverage

Medicare Costs:

- **Medicare Part A and B:**
  - Premiums
  - Copayments
  - Deductibles
- **Medicare Part D**
  - Premiums
  - Copayments
  - Deductibles

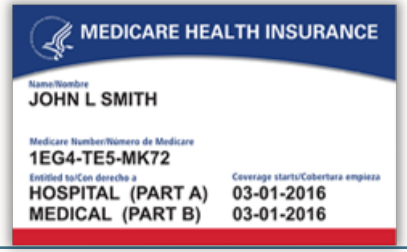
Benefits not covered by Medicare:

- Dental Care
- Routine Podiatry
- Eyeglasses
- Hearing Aids
- Incontinence supplies
- Transportation to medical services
- Custodial Nursing Home or Personal Care Services at Home (IHSS)

Options for Supplementing Your Medicare

Decide how you want to get your coverage

Original Medicare



You enroll in a stand-alone Part D plan and can see any provider that accepts Medicare.

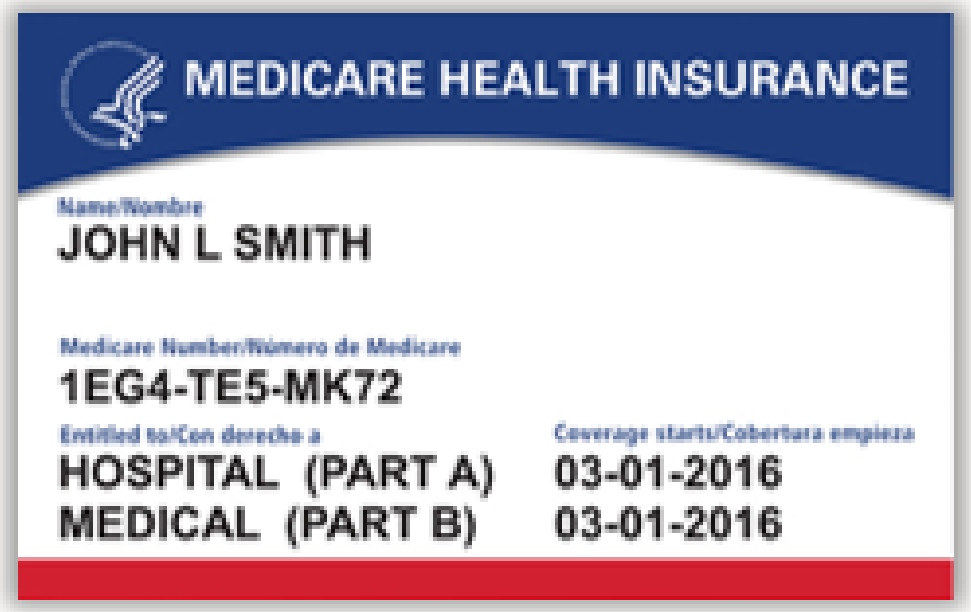
Supplemental/secondary coverage is recommended.

or

Medicare Advantage

You enroll in a Medicare Advantage HMO or PPO that may reduce your medical costs and add benefits like dental and vision services, with a specific provider network.

Supplementing Your Medicare



Options to supplement Original Medicare:

- Medicare Supplement Policy (Medigap)
- Medi-Cal
- Retiree Coverage

Medicare Supplement Insurance

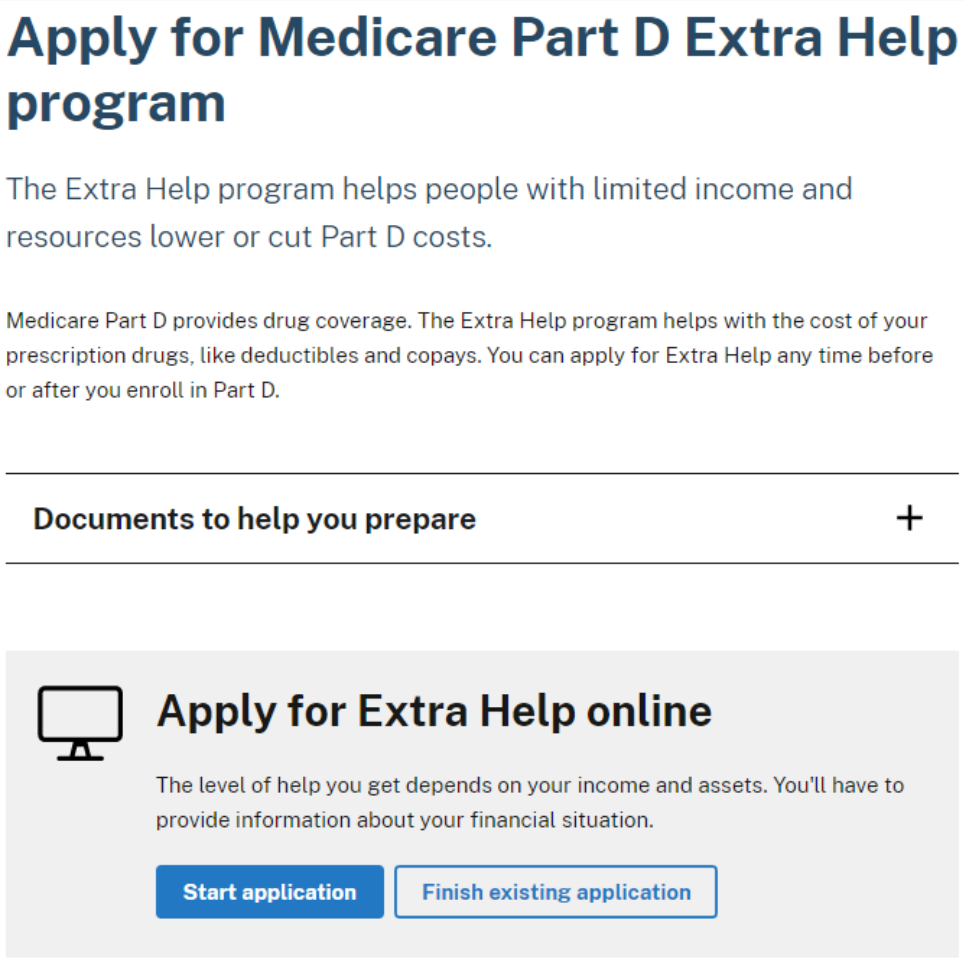
"Medigaps"

- Private insurance policies that cover some or all of Original Medicare's co-payments and deductibles.
- Must meet specific state and federal requirements and are standardized. Each policy must contain a package of benefits that match one of 10 plans, labeled A through N.
- Some Medigaps have a foreign travel benefit that covers medical care received outside the U.S.
- In California, Medigap Insurance is regulated by Calif. Dept. of Insurance (CDI) www.insurance.ca.gov

When Can I Enroll in a Medigap?

- Generally, you have a 6-month open-enrollment period when you first get Medicare Parts A and B.
- During the Medigap open enrollment period, you have a guaranteed issue right to Medigap coverage and cannot be denied due to a pre-existing medical condition.
- Medigap policies can require a 6-month waiting period for pre-existing health conditions.
- Federal and California laws provide additional guaranteed access rights based on specific qualifying events.

Financial Help with Part D Costs



- **You may qualify for help with Part D expenses.**
- **The program is called the Low-Income Subsidy Program or Extra Help Program.**

Low-Income Subsidy “Extra Help” Program

Full Subsidy	Monthly Income Limit	Asset Limit*
Single	$1,903	$17,600
Married	$2,575	$35,130

Part D costs in 2025:

- Drug plan premium and deductible: $0
- Set prescription copays ($4.90 generic/$12.15 brand name in 2025)

*Limits include $1,500/person for burial expenses. The home you live in, cars & life insurance are not counted

Gaps in Medicare Coverage

Medicare Costs:

- **Medicare Part A and B:**
  - Premiums
  - Copayments
  - Deductibles
- **Medicare Part D**
  - Premiums
  - Copayments
  - Deductibles

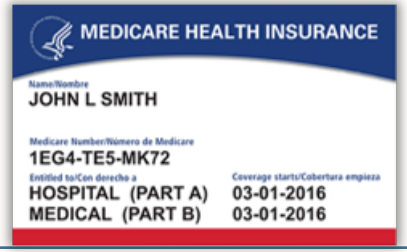
Benefits not covered by Medicare:

- Dental Care
- Routine Podiatry
- Eyeglasses
- Hearing Aids
- Incontinence supplies
- Transportation to medical services
- Custodial Nursing Home or Personal Care Services at Home (IHSS)

Options for Supplementing Your Medicare

Decide how you want to get your coverage

Original Medicare



You enroll in a stand-alone Part D plan and can see any provider that accepts Medicare.

Supplemental/secondary coverage is recommended.

or

Medicare Advantage

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Medi-Cal Aged, Blind and Disabled Federal Poverty Level Program (ABD FPL)

	Income Limit	Asset Limit
Single	**$1,732**	**None**
Married	**$2,352**	**None**

- Medicaid rules vary from state to state.
- These income guidelines change every year.
- The asset limit was eliminated starting 1/01/2024.

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

dpss
DEPARTMENT OF PUBLIC SOCIAL SERVICES

How Medicare and Medi-Cal Work Together

- Medicare is primary and Medi-Cal (Medicaid) is secondary.
- If a person has full Medi-Cal with no Share of Cost, Medi-Cal pays the Medicare Part B premium ($185.00).
- A person with Medicare and full Medi-Cal cannot be billed for their Part A and B copayments or deductibles.
- The beneficiary automatically gets Extra Help with low prescription drug copays.

Medicare Fraud

- Beware of telemarketers and door-to-door solicitors
  - Do not respond to offers for “free” medical equipment or services, such as COVID-19 testing kits.
  - Check your medical statements routinely for services that were not provided.
  - Do not share your Medicare card or ID with anyone other than your doctor.

Medicare Marketing Violations and Enrollment Fraud

- Medicare marketing scams target people with Medicare year-round.
- Patients need to beware of insurance agents pressuring them to switch plans. Agents cannot:
  - Conduct marketing or sales activities at an educational event
  - Approach people in public common areas, or sell door-to-door
  - State they are calling on behalf of Medicare
  - Make unsolicited calls for potential enrollees
  - Provide inaccurate or misleading information

Need Help Understanding Medicare?

Call Center for Health Care Rights
We are here to help you!

1-800-434-0222 | www.healthcarerights.org

CENTER FOR
HEALTH CARE
RIGHTS

2025 Medicare Benefits and Costs

- Who is eligible for Medicare
- 2025 Medicare Part A and B premiums
- When to enroll in Medicare
- Medicare Part A and B benefits and costs
- How Medicare coordinates with employer health insurance

Need information about Medicare?
Call Center for Health Care Rights at 800-434-0222 or visit www.HealthCareRights.org

The Center for Health Care Rights (CHCR) is a California nonprofit organization that provides free information and help with Medicare. CHCR is the Health Insurance Counseling and Advocacy Program (HICAP) for Los Angeles County. HICAP can be reached statewide at 800-434-0222.

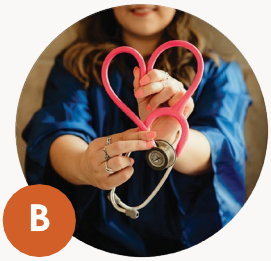
What is Medicare?

Medicare is a national health insurance program for people age 65 and older and people under the age of 65 who have a permanent disability.

What does Medicare cover?

Medicare has 3 parts:

Part A Hospital Insurance pays for hospital services, skilled nursing facility services, hospice and home health.



Part B Medical Insurance
pays for doctor services and other outpatient medical care.

Part D Prescription Drug Benefit
pays for prescription drugs.

Medicare does not cover:

Dental care, hearing aids, eyeglasses, or personal care services at home or in a nursing home

Who is eligible for Medicare?

People age 65 or older who:

- Are U.S. citizens, or permanent U.S. residents who have lived in the U.S. continuously for five years prior to applying.

People under age 65 who:

- Have received Social Security Disability benefits for 2 years; or
- Are eligible for Social Security Disability benefits and have ALS (Lou Gehrig's disease) or End Stage Renal Disease (ESRD).

When do I enroll in Medicare ?

Initial Enrollment Period — When you first become eligible for Medicare

This is a **7 month** period. It starts 3 months before your month of eligibility and ends 3 months later.

Example: John will be eligible for Medicare when he turns age 65 in June. His Initial Enrollment Period starts March 1 and ends September 30.

General Enrollment Period — January 1 to March 31 of every year

If you missed your Initial Enrollment Period, you can enroll during this period. Your Medicare benefits will start the first day of the following month after enrollment.

Special Enrollment Period — When your employer insurance stops

If you or your spouse are working and have employer group health plan coverage, you may be able to delay your Medicare enrollment. When your employer health plan coverage ends, you will have an **8-month** special enrollment period to enroll in Medicare with no late enrollment penalty.

You may qualify for a special enrollment period if either of these apply:
- You are 65 or older and you have group health coverage;
- You are under 65 and your employer has 100 or more employees.

However, the size of your or your spouse's employer determines whether Medicare or your employer group health plan is the primary insurance coverage. If you delay your Medicare enrollment, your employer health plan will continue as your primary health insurance coverage as long as the employer has at least 20 employees (100+ if you are under 65).

If you enroll in Medicare before your employer health plan coverage ends, Medicare will typically be your secondary health insurance. It is a good idea to confirm with your benefits department whether your group health plan will continue to be your primary insurance coverage.

How do I apply for Medicare?

Apply online at the Social Security website www.ssa.gov

Call the Social Security Administration at 800-772-1213.

Visit a local Social Security office.

2025 Medicare Part A premiums, benefits and copayments

2025 Medicare Part A premiums

Most people do not pay for Medicare Part A. If you have earned 40 or more work quarters, you pay no premium for Medicare Part A hospital insurance. You earn work quarters when you (or your spouse) have paid Social Security and Medicare payroll taxes for at least 10 years (or 40 quarters) while working.

Number of earned work quarters	Part A premium cost
You have less than 30 earned work quarters	**$518 per month**
You have 30-39 earned work quarters	**$285 per month**

If you do not have enough earned work quarters, you can purchase Medicare Part A if you are:

- Age 65 or older;
- A U.S. Citizen, or
- A legal resident and have lived in the U.S for at least 5 continuous years.

Medicare Part A benefits

Medicare coverage of hospital and skilled nursing facility days is based on a **benefit period.**

What is a benefit period?

- A benefit period begins when you are admitted to the hospital;
- The benefit period ends when you have been out of the hospital or have not received skilled care in a skilled nursing facility for 60 consecutive days.

Hospital Care

Medicare covers up to 90 days of hospital care in a benefit period. If you use all 90 days, you can use your lifetime reserve days. You have 60 lifetime reserve days to use over your lifetime.

Skilled Care in a Skilled Nursing Facility (SNF)

Medicare pays for up to 100 days of skilled nursing care in a benefit period if you meet all of these requirements:

- You go to a Medicare-contracted skilled nursing facility after a 3-day inpatient hospital stay;
- Your doctor orders your skilled nursing facility stay;
- You need skilled nursing and/or therapy (physical, speech, and occupational) services at least 5 days a week.

Most people who use the Medicare SNF benefit are receiving rehabilitation services.

Home Health Care

Medicare pays for home health if you meet all of these requirements:

- Due to an illness or injury, you have difficulty leaving your home;
- You need skilled nursing or therapy (physical, speech, and occupational) on a part time basis;
- The home health provider contracts with Medicare;
- Your doctor has prescribed Medicare home health services for you.

Hospice Care

This Medicare benefit is for people who have a life-threatening illness and are not expected to live longer than 6 months. The purpose of hospice care is to provide comfort and manage pain.

Medicare patients who participate in a hospice program do not receive treatment for their life-threatening illness.

Medicare hospice services include: palliative care by doctors and nurses, medical equipment, physical, speech and occupational therapy, respite care and grief counseling.

2025 Medicare Part A Copayments and Deductibles

Part A Benefits	Time Frame	Your Out-of-Pocket Cost
Hospital Benefit	Days 1-60	$1,676 hospital deductible
	Days 61-90	$419 per day
	Days 91-150 **Lifetime reserve days**	$838 per day
Skilled Nursing Facility	Days 1-20	$0
	Days 21-100	$209.50 per day

2025 Medicare Part B medical insurance premiums, benefits and copayments

2025 Standard Part B premium: $185.00 per month

You pay a higher Part B monthly premium if you are single with an annual income of $106,000 or more. If you are married, you pay a higher Part B premium if you have a joint income of $212,000 or more.

Part B late enrollment penalty

Medicare may charge you a monthly penalty if you do not sign up for Part B at the right time. The penalty is 10% for each 12-month period that you delayed your enrollment into Part B. You pay the penalty for the rest of your life.

2025 Medicare Part B benefits include:

- Physician services
- Ambulance services
- Mental health services
- Preventive care (example – flu shot)
- Outpatient therapy (physical, speech and occupational)
- X-rays and lab tests
- Diagnostic tests (example – MRI, CT scan)
- Medical equipment (example – wheelchair, walker, hospital bed)

2025 Medicare Part B out-of-pocket costs
$257 annual Part B deductible
20% coinsurance

Medicare Part D Prescription Drug Coverage

Medicare Part D pays for prescription drugs. **There are 2 types of Medicare Part D drug plans:**

- **Medicare Prescription Drug Plans** (PDPs) only provide prescription benefits;
- **Medicare Advantage Prescription Drug Plans** provide prescription drug and medical care services. These plans provide all your Medicare A, B and D benefits. Also known as Medicare Part C.

For more information about Medicare Part D plans, see our 2025 Medicare Part D Drug Coverage factsheet.

Need information about Medicare?

Call Center for Health Care Rights at 800-434-0222 or visit www.HealthCareRights.org

SHIP
State Health Insurance Assistance Program

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How do I close gaps in Medicare coverage?

Medicare does not cover 100% of your health expenses. It does not pay for dental care or custodial care at home or in a nursing home. Medicare also requires you to pay Medicare Part A and Part B copayments and deductibles. If you only have Medicare, consider the following insurance options:

Medicare Coverage Choices At-A-Glance

Step 1: Decide how you want to get your health care

OR

I want Original Medicare so that I can choose my Medicare doctors

Original Medicare
Part A Hospital Insurance
Part B Medical Insurance

Step 2: Enroll in a Part D plan if you want drug coverage

Part D Prescription Drug Plans

- Only provide drug coverage
- Do not affect your Medicare A & B benefits

Step 3: Get insurance that will cover your Part A and B copayments

Medi-Cal Health insurance for low income Californians. Provides additional benefits: dental, vision, long-term nursing home services,

OR

Medicare Supplement Insurance
Medigap policies are sold by private companies. They help pay Part A and B copayments.

I want a Medicare Advantage plan to reduce my out-of-pocket costs and get added benefits like dental and vision services

Medicare Advantage Plans (HMO or PPO)

- Managed care plans provide Medicare Part A, B and D benefits.
- **Medicare Advantage HMOs** You assign your Medicare benefits to the plan and agree to use only Medicare Advantage plan providers.
- **Medicare Advantage PPOs** You can see out of network medical providers but your out-of-pocket costs will be higher.

Morbidity and Mortality Weekly Report (*MMWR*)

Progress Toward Achieving National HIV/AIDS Strategy Goals for Quality of Life Among Persons Aged ≥50 Years with Diagnosed HIV — Medical Monitoring Project, United States, 2017–2023

Weekly / September 12, 2024 / 73(36);781–787

Summary

What is already known about this topic?

The U.S. National HIV/AIDS Strategy set 2025 goals for improving quality of life among persons with diagnosed HIV (PWH), monitored through five indicators: self-rated health, unmet needs for mental health services, unemployment, hunger or food insecurity, and unstable housing or homelessness. Among the growing population of PWH aged ≥50 years, progress toward these goals has not been assessed.

What is added by this report?

By 2022, no 2025 goal was met for PWH aged ≥50 years. If recent trends continue, goals are unlikely to be met. Although no goal was met for PWH aged ≥50 years overall, the goal for reducing hunger or food insecurity was met for those aged ≥65 years.

What are the implications for public health practice?

Multisectoral strategies to improve access to housing, employment, food, and mental health could improve quality of life among PWH aged ≥50 years.

Related Materials

Article PDF

Full Issue PDF

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Abstract

Ensuring good quality of life (QoL) among persons with diagnosed HIV (PWH) is a priority of the National HIV/AIDS Strategy (NHAS), which established 2025 goals for improving QoL. Goals are monitored through five indicators: self-rated health, unmet needs for mental health services, unemployment, hunger or food insecurity, and unstable housing or homelessness. Among the growing population of PWH aged ≥50 years, progress toward these goals has not been assessed. Data collected during the 2017–2022 cycles of the Medical Monitoring Project, an annual complex sample survey of U.S. adults with diagnosed HIV, assessed progress toward NHAS 2025 QoL goals among PWH aged ≥50 years, overall and by age group. The recent estimated annual percentage change from baseline (2017 or 2018) to 2022 was calculated for each indicator. Among PWH aged ≥50 years, the 2025 goal of 95% PWH with good or better self-rated health is 46.2% higher than the 2022 estimate. The 2025 goals of a 50% reduction in the other indicators range from 26.3% to 56.3% lower than the 2022 estimates. Decreasing hunger or food insecurity by 50% among PWH aged ≥65 was the only goal met by 2022. If recent trends continue, other NHAS QoL 2025 goals are unlikely to be met. Multisectoral strategies to improve access to housing, employment, food, and mental health will be needed to meet NHAS 2025 goals for QoL among older PWH.

Top

Introduction

As advances in HIV treatment have resulted in improved health and longevity (*1*), a large and growing proportion of U.S. persons with diagnosed HIV (PWH) are now aged ≥50 years (*2*). PWH are disproportionately affected by adverse social determinants of health, which affect their HIV-related health (*3*,*4*). To ensure good quality of life (QoL) among PWH, in 2022 the National HIV/AIDS Strategy (NHAS) set 2025 goals for improving five QoL indicators (*5*). These include 1) good or better self-rated health,* 2) unmet need for mental health services,† 3) unemployment,§ 4) hunger or food insecurity,¶ and 5) unstable housing or homelessness.** Indicator goals are designed to increase good or better self-rated health to 95% and decrease all other indicators by 50% from their respective baselines by 2025. Baseline values and 2025 goals are presented in Figures 1 and 2 and in the Table. As persons age, their needs might change because of increasing age-related comorbidities and becoming eligible for Medicare. Thus, age-stratified estimates of QoL, and factors affecting QoL, among older age groups can help guide intervention strategies. QoL indicators are monitored using data from the Medical Monitoring Project (MMP) (*6*), a CDC-funded HIV surveillance system. This analysis examined recent trends in QoL indicators among PWH aged ≥50 years (overall and stratified by age 50–64 and ≥65 years), assessed whether recent trends are sufficient to meet NHAS 2025 QoL goals, and examined selected theoretically related factors potentially affecting the indicators (hereafter referred to as factors) to help guide intervention efforts to improve QoL among older PWH.

Top

Methods

Data Collection

MMP uses a two-stage sample design: 1) 16 states and Puerto Rico were sampled from among all U.S. states, the District of Columbia, and Puerto Rico and 2) simple random samples of adult PWH were selected annually within participating jurisdictions from the National HIV Surveillance System (NHSS) (*6*). Interview and medical record abstraction data were collected in annual cycles during June 2017–May 2023. Annual response rates were 100% at the state and territory level and ranged from 40% to 46% at the PWH level. MMP was reviewed by CDC, deemed not research, and was conducted consistent with applicable federal law and CDC policy.††

Statistical Methods

Data were weighted for unequal selection probabilities, adjusted for nonresponse, and poststratified to NHSS population totals. Among 13,475 PWH aged ≥50 years who participated in the 2017–2022 MMP cycles, weighted prevalence estimates and 95% CIs were calculated for each QoL indicator and theoretically related factors, overall and stratified by age (50–64 versus ≥65 years). For each indicator and theoretically related factor, Poisson regression models were used to calculate the recent estimated annual percentage change (EAPC) from baseline (2017 or 2018 cycle, depending on the indicator) to the 2022 cycle. EAPC measures the average percentage change per year over the period for which it is calculated. The percentage difference between the 2025 NHAS goal and the 2022 estimate, expressed as a percentage of the 2022 estimate, was also calculated (i.e., [2025 goal − 2022 estimate] / 2022 estimate).

Top

Results

Good or Better Self-Rated Health

The 2025 NHAS goal for PWH aged ≥50 years to self-report good or better health is 95%. During 2018, 65.6% (95% CI = 63.5%–67.6%) of these adults reported good or better health and 65.0% (95% CI = 62.7%–67.2%) reported this in 2022. (Figure 1) (Supplementary Table 1, https://stacks.cdc.gov/view/cdc/160729). The 2025 goal is 46.2% higher than the 2022 estimate. Change in factors influencing self-rated health was minimal (Table) (Supplementary Table 2, https://stacks.cdc.gov/view/cdc/160728). Age-stratified trends were similar across the goal and factors that might influence it.

Unmet Need for Mental Health Services

The 2025 NHAS goal for PWH aged ≥50 years with unmet need for mental health services among those with a need is 9.4%. The observed need in this population was 18.8% (95% CI = 15.4%–22.1%) in 2017 and 21.5% (95% CI = 16.5%–26.5%) in 2022 (Figure 1) (Supplementary Table 1, https://stacks.cdc.gov/view/cdc/160729). The 2025 goal is 56.3% lower than the 2022 estimate. Overall and stratified by age, minimal change in symptoms of major or other depression and symptoms of generalized anxiety disorder among those with a mental health need during 2017–2022 was observed (Table).

Unemployment

The 2025 NHAS goal for unemployed PWH aged ≥50 years is 5.9%. Unemployment declined from 11.7% (95% CI = 9.7%–13.6%) in 2017 to 8.0% (95% CI = 6.6%–9.5%) in 2022 (Figure 2) (Supplementary Table 1, https://stacks.cdc.gov/view/cdc/160729). The 2025 goal is 26.3% lower than the 2022 estimate. Over time, unemployment was lower among those aged ≥65 years than those aged 50–64 years. Minimal change overall or by age group among factors contributing to unemployment was observed (Table) (Supplementary Table 2, https://stacks.cdc.gov/view/cdc/160728).

Hunger or Food Insecurity

The 2025 NHAS goal for PWH aged ≥50 years experiencing hunger or food insecurity is 9.0%. Among this population, hunger or food insecurity was 17.9% (95% CI = 15.4%–20.4) in 2017 and 14.1% (95% CI = 12.5%–15.8%) in 2022; those aged ≥65 years experienced the largest reduction in hunger or food insecurity, and this was the only group that met the NHAS 2025 goal by 2022 (Figure 2), (Supplementary Table 1, https://stacks.cdc.gov/view/cdc/160729). The 2025 goal is 36.2% lower than the 2022 estimate for PWH aged ≥50 years. Change in unmet need for food assistance or food stamps was minimal, as was unmet need for food or meal delivery overall and by age group (Table), (Supplementary Table 2, https://stacks.cdc.gov/view/cdc/160728).

Unstable Housing or Homelessness

The 2025 NHAS goal for PWH aged ≥50 years experiencing unstable housing or homelessness is 7.4%. Unstable housing or homelessness was 14.7% (95% CI = 13.0%–16.4%) in 2018 and 12.5% (95% CI = 10.8%–14.2%) in 2022 (Figure 2) (Supplementary Table 1, https://stacks.cdc.gov/view/cdc/160729). The 2025 goal is 40.8% lower than the 2022 estimate. Over time, except during the 2022 cycle, unstable housing or homelessness was lower among those aged ≥65 years than those aged 50–64 years. Overall and stratified by age, there was little change in unmet need for shelter or housing services during 2017–2022 (Table).

Top

Discussion

Overall, the five QoL indicators among PWH aged ≥50 years changed little during 2017–2022. QoL estimates among PWH aged ≥65 years were more favorable for unemployment, hunger or food insecurity, and unstable housing or homelessness than among those aged 50–64 years. By 2022, the 2025 goal for decreasing hunger or food insecurity was exceeded among PWH aged ≥65 years. However, for all other indicators and age groups, the magnitude of improvement required to

meet 2025 goals suggests these QoL goals will not be met if recent trends continue. The NHAS QoL indicators were adopted in late 2022, leaving <2 years to implement changes to reach 2025 goals (*5*). A federal implementation plan for achieving QoL goals is still being developed (*5*).

Evidence-based interventions exist to improve adherence to antiretroviral therapy, and thus viral suppression[§§]; however, few are tailored to older PWH, who might have specific challenges (e.g., numerous prescribed medications and social isolation).[¶¶] PWH have poorer physical and mental health than does the overall U.S. population (*7*). Structuring HIV care delivery for older PWH to encompass comprehensive management of chronic diseases and disabilities, including programs that support living with health challenges,*** might improve self-rated health and decrease unmet need for mental health services (*8*). Increasing routine mental health screening and integrating HIV and mental health care could decrease unmet need for these services among PWH (*9*).

Improving QoL and addressing social determinants of health requires a multisectoral approach that moves beyond clinical care. Addressing unemployment can include delivery of skill-building and job-seeking services tailored to older PWH,[†††] who might face barriers to employment because of age-related disability and discrimination, as well as family caregiving responsibilities. COVID-19–related food and housing challenges resulting from increases in unemployment related to the COVID-19 pandemic, and assistance programs instituted to counteract these challenges, might have affected observed trends.[§§§] Reductions in unmet need for food assistance might have contributed to meeting the NHAS goal for hunger or food insecurity among PWH aged ≥65 years. Addressing housing insecurity among older PWH might require additional efforts, such as ensuring that federal housing resources are allocated according to need (*10*).

Limitations

These findings are subject to at least two limitations. First, measurement error might result from recall or social desirability biases, although any biases should not affect assessment of trends if they are constant over time. Second, EAPC is a measure of relative change, so its magnitude is affected by the prevalence of the variable assessed.

Implications for Public Health Practice

CDC will continue to monitor QoL among PWH to identify areas for intervention. This information can be used to direct multisectoral implementation of programmatic efforts and guide future goals for improving health and well-being among older PWH. CDC-funded HIV prevention and care partners provide linkage to behavioral health and subsistence service providers. The Capacity Building Assistance Program[¶¶¶] offers technical assistance for addressing social determinants of health, which are closely linked to the NHAS 2025 QoL goals.

Top

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Top

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Top

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Top

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Top

* Good or better self-rated health was defined as reporting one's general health at the time of interview to be good, very good, or excellent as opposed to poor or fair.

† Unmet need for mental health services among those with any need was defined as reporting needing but not receiving services from a mental health professional during the previous 12 months among all persons reporting receiving, or needing but not receiving, services from a mental health professional.

§ Unemployment was defined as reporting being out of work at the time of interview, as opposed to being employed for wages, a homemaker, a student, retired, or unable to work.

¶ Hunger or food insecurity was defined as reporting being hungry and not eating because of lack of money for food during the previous 12 months.

** Unstable housing or homelessness was defined as reporting moving in with others because of financial issues, moving more than two times, being evicted, or living on the street, in a shelter, in a single-room–occupancy hotel, or in a car during the previous 12 months.

†† 45 C.F.R. part 46.102(l)(2), 21 C.F.R. part 56; 42 U.S.C. Sect. 241(d); 5 U.S.C. Sect. 552a; 44 U.S.C. Sect. 3501 et seq.

§§ https://www.cdc.gov/hiv/effective-interventions/treat/index.html

¶¶ https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/aging-guide-new-elements.pdf (Accessed May 2024).

*** The Chronic Disease Self-Management Program (https://selfmanagementresource.com/programs/small-group/chronic-disease-self-management-small-group/), Positive Self-Management Program (https://selfmanagementresource.com/programs/small-group/hiv-positive-self-management-small-group/), or the Living Well with a Disability program (https://www.cdc.gov/mmwr/volumes/65/su/su6501a10.htm).

††† https://www.dol.gov/agencies/odep/program-areas/hiv-aids

§§§ For example, although hunger and housing instability might have increased because of pandemic-related job losses and economic impacts, measures like the increase in Supplemental Nutrition Assistance Program benefits, federal eviction moratorium, and authorization for Ryan White HIV/AIDS Program–funded recipients to use Coronavirus Aid, Relief, and Economic Security Act and Emergency Financial Assistance funds to mitigate pandemic-related problems among PWH might have alleviated these increased needs.

¶¶¶ https://www.cdc.gov/hiv/capacity-building-assistance/index.html

Top

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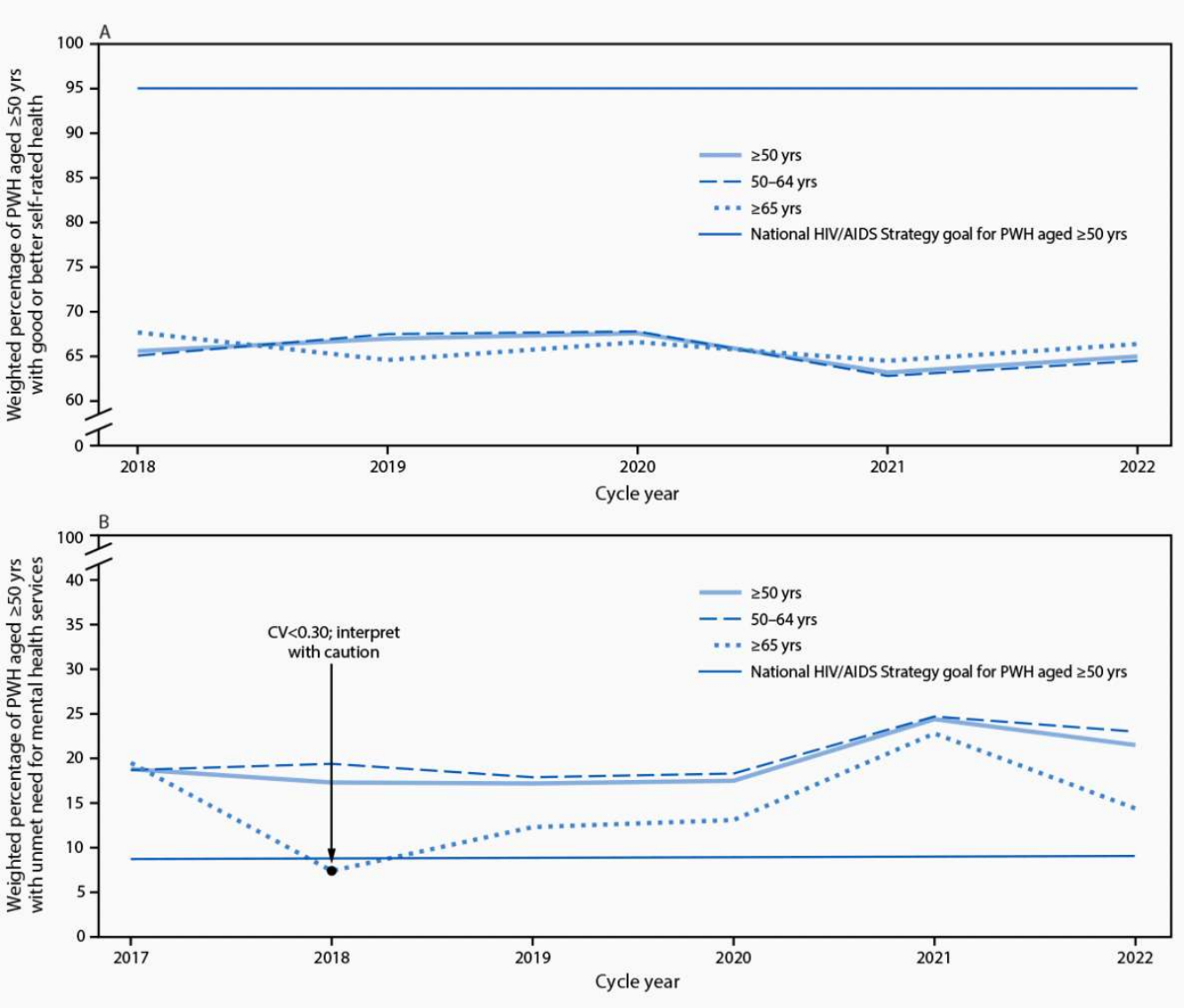
Top

FIGURE 1. Trends in the weighted percentage of adults aged ≥50 years with diagnosed HIV with good or better self-rated health* (A) and unmet need for mental health services among those with any need for services† (B), compared with National HIV/AIDS Strategy 2025 goals,§ overall and stratified by age group — Medical Monitoring Project, United States, 2017–2022¶

Return



Abbreviations: CV = coefficient of variation; PWH = persons with diagnosed HIV.

* PWH aged ≥50 years who reported their general health at the time of interview to be good, very good, or excellent as opposed to poor or fair.

† PWH aged ≥50 years who reported needing but not receiving services from a mental health professional during the previous 12 months among all PWH aged ≥50 years receiving, or needing but not receiving, services from a mental health professional.

§ National HIV/AIDS Strategy 2025 goals for PWH aged ≥50 years are available online. https://files.hiv.gov/s3fs-public/2022-09/NHAS_Federal_Implementation_Plan.pdf

¶ Annual data collection cycles began June 1 of the cycle year and ran through May 30 of the following year. Collection of data on good or better self-rated health began in the 2018 cycle.

Top

TABLE. Estimated annual percentage change in factors related to National HIV/AIDS Strategy quality of life indicators* among persons aged ≥50 years with diagnosed HIV, overall and stratified by age — Medical Monitoring Project, United States, 2017–2022†

Return

Characteristic§	Age group, yrs	2017 cycle		2022 cycle		EAPC 2017 to 2022 cycles
		No.	Weighted % (95% CI)	No.	Weighted % (95% CI)	
Factors related to good or better self-rated health¶						
Sustained viral suppression	≥50	1,593	68.9 (65.4 to 72.3)	1,614	67.3 (63.4 to 71.3)	−0.5 (−0.6 to −0.5)
	50–64	1,320	67.9 (64.5 to 71.3)	1,159	66.4 (62.0 to 70.9)	−0.8 (−0.9 to −0.7)
	≥65	273	74.2 (67.7 to 80.8)	455	69.8 (64.4 to 75.2)	−0.5 (−0.6 to −0.3)
Antiretroviral dose adherence, previous 30 days	≥50	1,396	66.5 (64.1 to 68.8)	1,515	71.8 (69.3 to 74.4)	1.9 (1.8 to 2.0)
	50–64	1,139	64.4 (61.7 to 67.2)	1,053	68.9 (66.0 to 71.7)	1.7 (1.6 to 1.8)
	≥65	257	77.4 (72.6 to 82.3)	462	79.7 (75.9 to 83.5)	1.2 (1.1 to 1.4)
Self-reported disability	≥50	1,155	52.8 (49.7 to 55.8)	1,037	48.0 (45.7 to 50.3)	−2.1 (−2.2 to −2.1)
	50–64	952	51.4 (48.3 to 54.4)	743	47.9 (45.3 to 50.4)	−1.9 (−2.0 to −1.8)
	≥65	203	60.4 (54.0 to 66.8)	294	48.4 (44.1 to 52.7)	−3.8 (−4.0 to −3.6)
Emergency department visit	≥50	849	38.7 (36.2 to 41.2)	802	36.5 (34.7 to 38.4)	−2.0 (−2.1 to −1.9)
	50–64	727	39.6 (36.9 to 42.2)	597	36.7 (34.5 to 38.9)	−2.2 (−2.4 to −2.1)
	≥65	122	33.8 (28.6 to 38.9)	205	36.0 (32.4 to 39.6)	−1.1 (−1.3 to −0.9)

Characteristic[§]	Age group, yrs	2017 cycle		2022 cycle		EAPC 2017 to 2022 cycles
		No.	Weighted % (95% CI)	No.	Weighted % (95% CI)	
Hospitalization	≥50	460	21.4 (19.5 to 23.2)	400	18.2 (16.3 to 20.1)	−3.7 (−3.9 to −3.6)
	50–64	378	20.8 (18.6 to 22.9)	284	16.8 (14.7 to 18.9)	−4.8 (−4.9 to −4.6)
	≥65	82	24.7 (19.8 to 29.5)	116	22.3 (17.5 to 27.1)	−1.9 (−2.2 to −1.6)
Factors related to unmet needs for mental health services**						
Symptoms of major or other depression among those with any mental health service need	≥50	263	33.9 (29.1 to 38.7)	211	27.0 (22.4 to 31.6)	−4.2 (−4.3 to −4.0)
	50–64	237	34.4 (29.3 to 39.5)	177	27.8 (23.1 to 32.4)	−4.0 (−4.3 to −3.8)
	≥65	26	29.9 (19.5 to 40.3)	34	23.3 (15.0 to 31.7)	−3.8 (−4.3 to −3.2)
Symptoms of generalized anxiety disorder among those with any mental health service need	≥50	218	27.0 (23.2 to 30.8)	200	25.3 (20.7 to 30.0)	−0.9 (−1.1 to −0.7)
	50–64	198	27.6 (23.7 to 31.5)	170	26.7 (22.0 to 31.4)	−0.2 (−0.5 to −0.0)
	≥65	20	22.3 (13.6 to 31.0)	30	19.1 (11.2 to 27.0)	−2.6 (−3.3 to −2.0)
Factors related to unemployment[††]						
Some college education or higher educational attainment	≥50	1,230	55.6 (51.3 to 59.9)	1,300	60.3 (57.7 to 63.0)	2.0 (1.9 to 2.1)
	50–64	1,016	54.5 (50.5 to 58.4)	921	59.4 (56.7 to 62.1)	2.2 (2.1 to 2.3)
	≥65	214	62.1 (54.0 to 70.1)	379	63.0 (57.7 to 68.2)	0.2 (0.0 to 0.4)
Household income at or below poverty threshold	≥50	879	41.6 (36.3 to 46.8)	707	35.2 (31.0 to 39.4)	−3.8 (−3.9 to −3.7)
	50–64	758	42.4 (37.0 to 47.8)	538	36.8 (32.4 to 41.1)	−3.8 (−3.9 to −3.6)
	≥65	121	37.1 (30.3 to 43.9)	169	31.0 (25.5 to 36.5)	−2.4 (−2.6 to −2.1)

Characteristic[§]	Age group, yrs	2017 cycle		2022 cycle		EAPC 2017 to 2022 cycles
		No.	Weighted % (95% CI)	No.	Weighted % (95% CI)	
Factors related to hunger or food insecurity[§§]						
Unmet need for food assistance or food stamps	≥50	243	11.8 (9.9 to 13.8)	211	10.4 (8.5 to 12.3)	−2.8 (−3.0 to −2.6)
	50–64	214	12.7 (10.7 to 14.8)	180	12.3 (10.0 to 14.7)	−1.1 (−1.3 to −0.9)
	≥65	29	6.9 (3.9 to 9.9)	31	5.0 (3.1 to 6.9)	−6.9 (−7.5 to −6.4)
Unmet need for food or meal delivery	≥50	161	7.6 (6.3 to 8.8)	160	8.3 (6.2 to 10.4)	−0.4 (−0.6 to −0.2)
	50–64	138	7.9 (6.5 to 9.3)	131	9.2 (6.7 to 11.7)	0.5 (0.2 to 0.8)
	≥65	23	5.7 (3.0 to 8.3)	29	5.9 (3.3 to 8.5)	−0.6 (−1.2 to 0.1)
Factors related to housing instability or homelessness[¶¶]						
Unmet need for shelter or housing services	≥50	194	9.6 (8.0 to 11.2)	210	10.4 (8.4 to 12.3)	1.6 (1.4 to 1.8)
	50–64	178	10.3 (8.6 to 12.0)	178	11.7 (9.7 to 13.7)	2.6 (2.4 to 2.9)
	≥65	16	6.0 (2.8 to 9.1)	32	6.7 (3.8 to 9.5)	4.6 (3.9 to 5.3)

Abbreviation: EAPC = estimated annual percentage change.

* Includes good or better self-rated health, unmet need for mental health services, unemployment, hunger or food security, and housing stability or homelessness.

† Factors were collected in annual data collection cycles that began June 1 of the cycle year and ran through May 30 of the following year.

§ All measures self-reported and measured over the previous 12 months except where otherwise noted.

¶ Includes 1) sustained viral suppression, defined as all viral load measurements documented undetectable or <200 copies/mL as measured by medical record review; 2) antiretroviral dose adherence, defined as having taken all prescribed antiretroviral doses during the previous 30 days among persons taking antiretroviral therapy; 3) self-reported disability, defined as serious difficulties with hearing, seeing, cognition, mobility, self-care, or independent living; 4) emergency department visit, defined as any visit to an emergency department; and 5) hospitalization, defined as any inpatient hospitalization.

** Includes 1) symptoms of major or other depression, defined as symptoms consistent with a diagnosis of major or other depressive disorder during the previous 2 weeks as measured by the Patient Health Questionnaire-8 among those with any mental health service need and 2) symptoms of generalized anxiety disorder, defined as symptoms consistent with a diagnosis of generalized anxiety disorder during the previous 2 weeks as measured by the Generalized Anxiety Disorder-7 among those with any mental health service need.

†† Includes 1) some college education or higher educational attainment, defined as having attended college or having

received a college degree and 2) household income at or below poverty threshold, defined as previous calendar year household income at or below poverty threshold according to U.S. Department of Health and Human Services poverty guidelines.

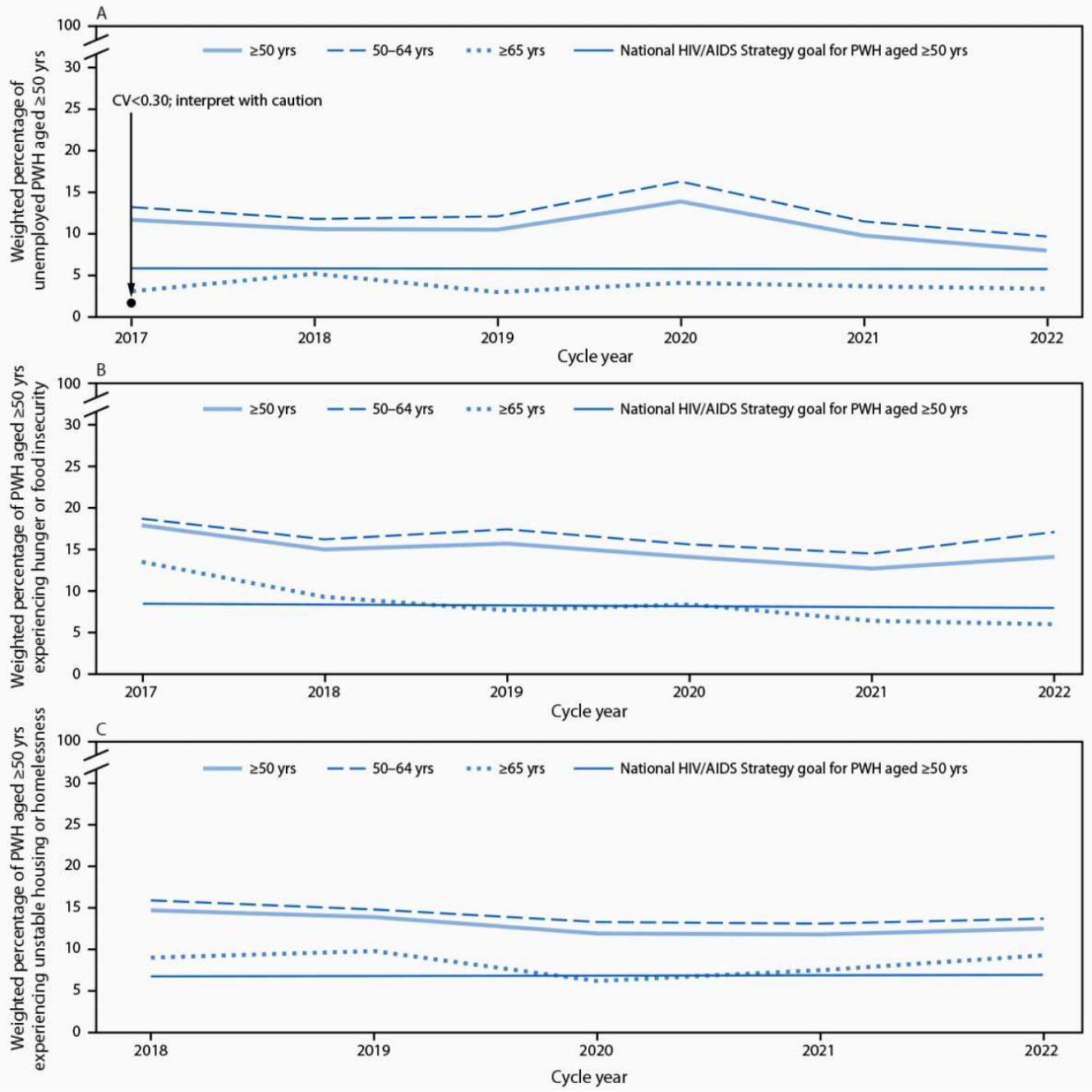
§§ Includes 1) unmet need for food assistance or food stamps, defined as needing but not receiving food assistance or food stamps and 2) unmet need for food or meal delivery, defined as needing but not receiving food or meal delivery.

¶¶ Includes unmet need for shelter or housing services, defined as needing but not receiving shelter or housing services.

Top

FIGURE 2. Trends in the weighted percentage of adults aged ≥50 years with diagnosed HIV who experienced unemployment* (A), hunger or food insecurity† (B), and unstable housing or homelessness§ (C), compared with National HIV/AIDS Strategy 2025 goals,¶ overall and stratified by age group — Medical Monitoring Project, United States, 2017–2022**

Return



Abbreviations: CV = coefficient of variation; PWH = persons with diagnosed HIV.

* PWH aged ≥50 years who reported being out of work at the time of interview as opposed to being employed for wages, a homemaker, a student, retired, or unable to work.

† PWH aged ≥50 years who reported being hungry and not eating because of lack of money for food during the previous 12 months.

§ PWH aged ≥50 years who reported moving in with others because of financial issues, moving more than two times, being evicted, or living on the street, in a shelter, in a single-room–occupancy hotel, or in a car during the previous 12 months.

¶ National HIV/AIDS Strategy 2025 goals for PWH aged ≥50 years are available online. https://files.hiv.gov/s3fs-public/2022-09/NHAS_Federal_Implementation_Plan.pdf

** Annual data collection cycles began June 1 of the cycle year and ran through May 30 of the following year. Collection of data on unstable housing or homelessness began in the 2018 cycle.

Top

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