Published in final edited form as:
J Acquir Immune Defic Syndr. 2012 May 1; 60(1): 72–76. doi:10.1097/QAI.0b013e31824c0dd4.

What Does U.S. Health Reform Mean for HIV Clinical Care?

Erika G. Martin, PhD, MPH[1] and **Bruce R. Schackman, PhD**[2]

[1]Department of Public Administration & Policy and Nelson A. Rockefeller Institute of Government, University at Albany—State University of New York, Albany, NY

[2]Division of Health Policy, Department of Public Health, Weill Cornell Medical College, New York, NY

Abstract

The Patient Protection and Affordable Care Act (ACA), more commonly known as health reform, is designed to expand health coverage to 32 million uninsured Americans by 2019 and makes significant changes to public and private health insurance systems that will affect providers of HIV care. We review the major features of the legislation and when they will be implemented, discuss the ways in which it will affect HIV care for different patient populations, and outline implementation challenges that are relevant for HIV care. We conclude with ways in which HIV providers can get involved to learn more about the law and help their patients take advantage of the new opportunities for health coverage.

Keywords

Affordable Care Act; health insurance coverage; Medicaid; Medicare; Ryan White HIV/AIDS Program

The Patient Protection and Affordable Care Act (ACA), more commonly referred to as simply “health reform,” was signed into law in March 2010 (P.L. 111–148). It is the most significant attempt to increase health coverage in the United States since Medicare and Medicaid were created in 1965. If implemented according to the current law, it is projected to reduce the number of uninsured Americans by 32 million by 2019.[1] Recent analyses suggest that in addition to a decline in the number of Americans without any health insurance, the number of “underinsured” Americans will drop by 70%.[2] Although the law primarily addresses access to care, it was also motivated by other important concerns. These include the rising cost of healthcare, which now accounts for one-sixth of US gross domestic product,[3, 4] in the face of evidence of poor quality performance including inappropriate use of medical services and practices,[5] volatile revenues for state and local governments,[6] and poor coordination of care.[7]

The legislation is complex, there is a lengthy timeline until the law is fully implemented in 2019 (although many key provisions relevant for HIV care will occur in 2014), and there will be significant differences across states in how it will be implemented. We review the most important features of the ACA and their implications for HIV clinical practice, and provide guidance for obtaining more information about local implementation.

Corresponding author: Erika G. Martin, Rockefeller College of Public Affairs & Policy, Milne 300E, University at Albany—State University of New York, 1400 Washington Avenue, Albany, NY 12222, Tel: (518) 442-5243, Fax: (518) 442-5298, emartin@albany.edu.

Conflicts of Interest: The authors report no conflicts of interest.

Key Provisions of ACA

ACA will expand health insurance coverage through a combination of Medicaid expansions, the establishment of state-run health insurance exchanges, and tax credits to subsidize health insurance premiums. Tax penalties will be imposed for not purchasing health insurance. It also contains patient protections for health insurance policies, changes in Medicare and Medicaid provider payments, and a variety of other changes in incentives such as those promoting improved preventive care. These provisions will occur over nearly a decade in three successive waves: a variety of specific changes prior to 2014, major changes in insurance coverage during 2014, and changes after 2014 that will primarily affect payments and financing.

Several provisions have already taken effect, including:

- A requirement that health insurance companies allow dependent young adults to stay on their parents' health insurance until age 26.
- The establishment of high-risk health insurance pools to cover adults with pre-existing conditions known as PCIPs (pre-existing condition insurance pools); 27 states administer their own PCIP, and the remainder use a federally-run plan.[8] (See details at http://www.pcip.gov.)
- Incentives for small businesses to provide health insurance to employees.
- A ban on lifetime health insurance coverage limits.
- A minimum "medical loss ratio" (the percentage of medical insurance premiums spent on clinical services and quality).
- Improvements in preventive care, such as grants for small businesses to establish wellness programs, the elimination of cost-sharing for Medicare-covered preventive services, and new nutrition labeling.
- Changes in the Medicare Part D prescription drug coverage "donut hole" to reduce out-of-pocket drug costs.[9]
- A 10% bonus to Medicare primary care physicians and primary care physicians and general surgeons who practice in "health professional shortage areas."
- Other incentives to encourage primary care training, such as redistributing unused resident training slots to primary care, general surgery, and areas with few physicians per capita, establishing teaching health centers, and increased payments for primary care residency programs.

In 2012, provisions will link payment and quality (such as plans to reduce Medicare payments to hospitals for patients who must be readmitted after their initial treatment fails, and Medicare payments to hospitals that will be based on value replacing volume). To encourage integrated health care, Medicare providers and hospitals will be allowed to organize accountable care organizations (ACOs) that coordinate patient care across settings. ACOs that demonstrate quality improvement (improved patient outcomes and patient satisfaction) will be allowed to share any cost savings.[10] In 2013, provisions will increase Medicaid payments to primary care providers (to 100% of Medicare payment rates), limit insurance company executive compensation, require physicians to disclose financial relationships with pharmaceutical companies and medical suppliers, and improve preventive health Medicaid coverage.

The most visible provisions affecting access to health insurance will be implemented in 2014. Medicaid eligibility will be expanded to include all individuals within 133% of the

federal poverty level. This is equivalent to approximately $14,500 for a family of one and $29,700 for a family of four in 2011 (authors' calculation based on published HHS threshold for 100% FPL). Currently the income eligibility ceiling varies across states, with the ceiling for parents ranging from 24% of the federal poverty level in Arkansas, to 215% in Minnesota.[11] Individuals also need to meet additional requirements such as having a disability, being pregnant, or in some situations being a member of a "limited income" family with children (although with different income requirements).[12] The Medicaid expansion will remove these requirements, thereby expanding eligibility to low income non-disabled adults without children, and will make the income eligibility ceiling consistent across states (and in some cases, considerably higher).

State health insurance exchanges (one of the most widely discussed features of the ACA) will become available to individuals at higher income levels. These exchanges are healthcare marketplaces designed to make purchasing individual insurance easier and more affordable. To reduce the number of underinsured individuals, plans available through the exchange will be regulated with respect to their benefits and pricing. This includes sliding-scale caps on out-of-pocket costs for services covered in essential benefits packages.[2, 13] Information will be displayed in a standard user-friendly format to help patients select a plan. Enrollment processes will be simplified, thereby reducing the administrative hassle of purchasing insurance. Health plans on the exchange must also establish electronic systems to perform various tasks including enrolling individuals and scheduling electronic payments. In conjunction with establishing an exchange, citizens and legal residents without coverage will face a tax penalty.

Recognizing that not everyone with incomes above 133% of the federal poverty level will be able to afford private insurance, individuals at 133% to 400% of the federal poverty level who do not have employer-sponsored coverage will be able to purchase individual insurance through the exchange on a sliding scale. These subsidies will be in the form of tax credits, which will be paid monthly directly to the insurance plan.[14] States also have the option to offer a Basic Health Plan for individuals whose incomes fall between 133% and 200% of the federal poverty level, rather than requiring them to purchase subsidized insurance through the insurance exchange. To encourage employers to continue to offer health insurance and reduce the potential burden on the insurance exchanges, medium and large businesses that do not provide employer-sponsored coverage will be taxed and small businesses (which may have less capacity to provide employer-sponsored coverage) will be incentivized to offer this benefit through enhanced small business tax credits. Subsequent provisions to be implemented include reduced Medicare payments for hospitals with poor safety performance (such as hospital-acquired infections) (2015), and a "Cadillac tax" on high-cost insurance plans (2018).

Readers interested in a detailed explanation of the provisions and their timing are encouraged to visit the Kaiser Family Foundation health reform resource center at http://healthreform.kff.org and the federal website at http://www.healthcare.gov.

What Will ACA Mean for HIV Clinical Care?

Even before the full implementation of insurance expansion in 2014, there are some new opportunities for HIV patients who do not meet current eligibility criteria for Medicare, Medicaid, or other public insurance to gain access to private health insurance. PCIPs are available to uninsured HIV patients who are unable to secure private insurance due to pre-existing conditions. However, there is substantial interstate variation in whether PCIPs are run by the state or federal government, whether ADAP covers premiums or other cost sharing, and the extent to which the state imposes enrollment restrictions for ADAP clients

(personal communication, Lanny Cross, June 23, 2011). Overall, only 27,489 people have enrolled in PCIPs nationally,[8] and few HIV patients have transitioned to PCIPs. In addition, young adults have the opportunity to remain on their parents' private insurance through age 26. Preliminary findings show that 900,000 young adults have already gained coverage through this provision.[15] Given that the highest rates of new HIV diagnoses are among young adults in the 20–24 and 25–29 age groups,[16] this is potentially an important new source of coverage for this group.

For HIV patients who are covered by Medicare or who are Medicare/Medicaid "dual eligible" (other than those enrolled in Medicare managed care plans), changes in "donut hole" provisions of Medicare Part D prescription drug coverage may be particularly beneficial. Currently Medicare pays 75% of coverage until beneficiaries reach $2,840 of drug costs.[17] Recipients are then required to cover all costs until they have incurred enough costs to reach catastrophic coverage. These "true out-of-pocket costs" (trOOP) are also known as the donut hole; in 2010 most Medicare Part D plans had a coverage gap of $3,610.[18] Because antiretroviral medications alone often cost over $2,000 per month,[19] HIV patients often reach the donut hole quickly. The ACA gradually eliminates the donut hole. Starting this year, individuals in the coverage gap are eligible for a 50% manufacturer's discount on brand-name drugs, with additional subsidies for brand-name and generic drugs forthcoming. By 2020, the donut hole will be phased out so that enrollees are responsible for 25% of drug costs in the coverage gap.[17] Importantly, payments by state AIDS Drug Assistance Programs (ADAPs) can now count towards trOOP, which means that once the donut hole is filled, patients can revert from ADAP back to Medicare Part D for their drug coverage. While this requires additional administrative effort from ADAPs and sometimes from providers and patients, the result should be that more ADAP funds are available to cover non-Medicare patients, potentially reducing ADAP waiting lists. Furthermore, ADAP funds may become available to help Medicare Part D patients afford their copayments.

Greater incentives for preventive care will also have benefits both for HIV patients and persons at risk for HIV infection. Eventually, Medicare, Medicaid, and private insurance plans (except private plans that are "grandfathered"[20]) must cover preventive services and immunizations with an A or B recommendation by the U.S. Preventive Services Task Force, without out-of-pocket costs to patients such as copays and deductibles. Examples of relevant preventive services for HIV patients include screening for cervical cancer, depression screening, screening for sexually transmitted infections, and alcohol misuse counseling.[21] It is likely that the Institute of Medicine's recommendation that preventive services for women include annual HIV screening and counseling and contraception[22] will also be incorporated into the final coverage rules. Other evidence-based prevention and treatment practices may be encouraged by ACA provisions related to better integration of care (e.g. Accountable Care Organizations) or investments in patient-centered outcomes research, but none have been specified at this time.[10, 23]

The greatest impact of the coverage expansion beginning in 2014 for HIV patients is likely to be the Medicaid expansion. Low-income populations are disproportionately burdened by the HIV epidemic.[24] Currently, 70% of HIV patients qualify for Medicaid through the Social Security Income (SSI) pathway (low income and permanent disability).[25] Although a handful of states have already secured Medicaid expansion waivers to broaden coverage to low-income HIV patients, these criteria generally exclude HIV patients who are childless adults and are relatively healthy. The planned Medicaid expansion to all persons with incomes below 133% of the federal poverty level without any additional eligibility requirements is likely to improve access to care for a sizeable portion of HIV patients, particularly those who have not yet reached late stage disease. For example, 75% of AIDS

Drug Assistance Program clients had income at or below 200% of the federal poverty level;[26] many of these individuals will become eligible for Medicaid.

For uninsured HIV patients with higher incomes, coverage expansion will occur through state health insurance exchanges, which are scheduled to become functional in 2014. Insurance plans on the exchanges will have to conform to specific regulations, including covering an essential benefits package, not being able to discriminate against people with pre-existing conditions, and not imposing lifetime or annual caps on coverage. These provisions will be important to HIV patients who need continuing access to expensive antiretrovirals and treatment of comorbid conditions.

At the clinical practice level, there will be a shift of resources to community health centers (CHCs). HHS recently made available $700 million to develop and improve CHCs. Over five years, there will be $11 billion available for the development and operation of CHCs.[27] On the other hand, the ACA phases out Disproportionate Share Hospital (DSH) payments to safety net hospitals. Reductions in federal funding to safety net hospitals may present a challenge to HIV clinicians working at academic health centers affiliated with DSH-eligible hospitals that serve low-income patients. Pulling in the other direction, the planned funding increases to CHCs may benefit academic medical centers associated with CHCs. Many academic medical centers have existing symbiotic relationships with CHCs, and there exist opportunities to further develop these ties.[28] At the same time, CHCs will need to develop expertise in managing HIV care since they may become a source of care for HIV patients newly eligible for Medicaid coverage.

Finally, HIV care providers will need to move to electronic health records. This change is not exclusively due to the ACA; the ACA expands past legislative efforts such as the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act to encourage providers and clinics to adopt health information technology in order to improve patient health and healthcare system performance.[29] The capacity to securely share medical records that are “interoperable” across clinics is particularly important for HIV patients who may see multiple specialists to manage comorbid conditions and also want to assure confidentiality. However, there will be a difficult adjustment period and a high start-up cost for HIV clinics that have not yet implemented electronic record-keeping.[30]

Policy Challenges Remain

Although the ACA addresses several important issues related to coverage, reimbursement, and the minimum set of benefits to be offered through insurance plans, several challenges lie ahead. First, it is likely that some HIV patients will continue to fall through the insurance coverage cracks. Undocumented immigrants are excluded from the key provisions of the legislation, including the Medicaid expansion, PCIPs, and purchasing subsidized insurance through the exchanges. Paperwork requirements to apply for PCIPs and tax credits for subsidized insurance may lower enrollment rates, particularly among HIV patients with complex social service needs. Although PCIPs provide new coverage opportunities for patients with preexisting conditions, uptake has been less than expected because of high premium costs. HIV patients who enroll in PCIPs will likely need assistance from ADAP to help pay for premiums and out-of-pocket costs such as deductibles and copayments. many clients will need assistance from ADAP to help finance out-of-pocket costs such as deductibles and copayments.[31] Further complicating this issue is the problem of churning, which is when individuals go on and off healthcare coverage.[32, 33] Medicaid recipients who cross the 133% threshold may subsequently lose eligibility for Medicaid and need to purchase exchange on the market. However, it may be difficult for them to change their enrollment and pay for premiums up-front. Similarly, low-income individuals may have

their premium subsidies reduced or eliminated as their income changes due to loss of employment. This may make it challenging for low-income individuals to retain a consistent source of insurance coverage. These enrollment and transfer issues have been recognized by the Department Health and Human Services, which has proposed Exchange Eligibility and Employer Standards for eligibility processes, and ACA provisions for state-administered Consumer Assistance Programs to help residents locate and enroll in plans.[34] Even those with insurance coverage may not receive all medically appropriate services relevant to HIV care. For example, although dental services are clinically important (as evidenced by Ryan White funding to improve oral health care for HIV patients),[35] the ACA is unlikely to significantly improve adults' access to oral health care.[36]

Third, the future of the Ryan White HIV/AIDS Program is uncertain. Ryan White is the largest federal program exclusively devoted to HIV care, and is designed to be a payer of last resort for individuals who have coverage gaps or are unable to afford treatment.[37] The next reauthorization is scheduled for 2013, the year before the Medicaid expansion and the insurance exchanges will be implemented. In the absence of re-authorization, the program can continue to be funded through annual appropriations but may be more vulnerable to budget cuts or elimination. Issues tend to fade from the policy agenda when policymakers believe that the problem has been solved.[38] If policymakers perceive that access to care among HIV patients is being addressed through ACA, there may be less future political support for continuing funding Ryan White services. In addition to filling insurance coverage gaps that will continue to occur, Ryan White funds help support provision of care by HIV specialists which has been shown to result in better quality care for HIV patients.[39] If Ryan White funding is continued, the program will need to adapt to the new healthcare environment. New roles may include a shift from directly funding clinical care to funding wrap-around insurance (such as assistance with out-of-pocket health insurance copayment and deductible costs), directing more funding to services (such as dental) with inadequate coverage by patients' insurance plans, funding healthcare navigators to help HIV patients find insurance plans that suit their needs, and expanding its training role for primary care providers on how to manage HIV disease.

Although many of the initial costs of expanded access to health insurance under the ACA will be financed by the Federal government, states and local governments will eventually experience financial pressures. One financial burden that is especially relevant to HIV patients is the cost to states to expand Medicaid. The initial expansion effort will be financed by the Federal government, but states will have to pay an increasing portion (up to 10%) of these costs by 2020. The Congressional Budget Office has estimated that health reform will increase costs to states by 1.25%, compared to what states would have spent on Medicaid from 2014 to 2019 in the absence of health reform.[40] The Congressional Research Service reports that states estimate a range of costs to their jurisdictions that is substantially higher: $1.1 billion for North Dakota, $27 billion for Texas, $3.6 billion for Indiana, $1.5 billion for Virginia, $7.1 billion for Louisiana, $766 million for Nebraska, and $441 million for Oklahoma. (These estimates are provided by states, which may not use consistent methodologies.)[41] HIV patients in states with budget shortfalls may have reduced opportunities to gain coverage.

Divided political support may also hinder full implementation of the law. Some states have filed a joint lawsuit against the Federal government to overturn the individual mandate. (Updated details on state legislation and actions to challenge the ACA are available at http://www.ncsl.org.) Jurisdictions with lukewarm or hostile local political support may not implement all provisions on time or take advantage of optional provisions such as Medicaid waivers that allow states to cover low-income patients before 2014.

Providers Are Crucial to Helping HIV Patients Benefit from the ACA

Although the ACA will not solve all of the problems with the fragmented US healthcare system, it presents an important opportunity to expand access to care among HIV patients. Implementation will occur at the state and local level, and there is likely to be wide variation across jurisdictions. HIV providers have an important role in helping their patients navigate the evolving healthcare system and ensuring that local implementation enhances opportunities to provide high quality care.

Providers can get involved first by learning more about how the law will unfold in their locality, such as special state efforts to ensure that HIV patients are eligible for Medicaid medical homes. Good places to start include identifying resources from state-based health policy centers that describes how various features of the law will be implemented locally (as examples, see http://scphi.org/affordable-care-act-implementation-initiative/ and http://hcfany.org/policy-center/new-york-state-health-reform/) and contacting officials from the state Ryan White and Medicaid programs for further information. Next, they can identify local opportunities to improve implementation. For example, they could determine how their state will enforce new requirements for coverage of preventive services relevant to HIV care without out-of-pocket charges to patients, and then meet with those responsible for implementation to provide input into these plans. Finally, it will be particularly important to maintain ongoing relationships with key state legislators and health program administrators as ACA unfolds, either directly or through professional organizations. These individuals will be facing many different economic and political pressures as they interpret and implement the legislation. HIV care professionals will be an important resource for them in ensuring that the potential benefits of the ACA are extended to HIV care.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgments

Financial support: This work was supported through Nelson A. Rockefeller Institute of Government and National Institute of Mental Health (R01 MH065869).

We thank Terence Meehan for providing research assistance on this project. The information in this article represents the authors' opinions, and not those of the funders.

References

1. Congressional Budget Office. [Accessed September 5, 2011] Letter to the Honorable Nancy Pelosi providing an analysis of the amended reconciliation proposal. 2010. http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf
2. Schoen C, Doty MM, Robertson RH, Collins SR. Affordable Care Act reforms could reduce the number of underinsured US adults by 70 percent. Health Affairs. 2011; 30(9):1762–1771. [PubMed: 21900668]
3. Chernew ME, Hirth RA, Cutler DM. Increased spending on health care: long-term implications for the nation. Health Affairs. 2009; 28(5):1253–1255. [PubMed: 19738238]
4. Aaron HJ, Ginsburg PB. Is health spending excessive? If so, what can we do about it? Health Affairs. 2009; 28(5):1260–1275. [PubMed: 19738241]
5. Institute of Medicine. Crossing the quality chasm: a new health system for the twenty-first century. Washington, DC: National Academies Press; 2001.
6. Dadayan, L.; Ward, RB. PIT, overall tax revenues show strong growth in second quarter; local property taxes declined for the third consecutive quarter. 2011. http://www.rockinst.org/pdf/government_finance/state_revenue_report/2011-10-26-SRR_85.pdf

7. Shoen C, Osborn R, Squires D, Doty M, Pierson R, Applebaum S. New 2011 survey of patients with complex care needs in eleven countries finds that care is often poorly coordinated. Health Affairs. 2011; 30(12):2437–2448. [PubMed: 22072063]
8. Department of Health and Human Services. [Accessed September 5, 2011] State by state enrollment in pre-existing insurance plan, as of June 30, 2011. 2011. http://www.healthcare.gov/news/factsheets/pcip08122011a.html
9. Department of Health and Human Services. [Accessed December 17, 2011] The Affordable Care Act reduces out-of-pocket drug costs for millions of peole with Medicare. 2011. http://www.healthcare.gov/law/resources/reports/donuthole03222011a.html
10. Centers for Medicare and Medicaid Services. [Accessed September 5, 2011] What providers need to know: accountable care organizations. 2011. http://www.cms.gov/MLNProducts/downloads/ACO_Providers_Factsheet_ICN903693.pdf
11. Henry J. Kaiser Family Foundation. [Accessed September 5, 2011] State Health Facts. 2011. http://www.statehealthfacts.org
12. Centers for Medicare and Medicaid Services. [Accessed December 17, 2011] Medicaid eligibility overview [website]. 2011. http://www.cms.gov/MedicaidEligibility/
13. Families USA Foundation. [Accessed December 17, 2011] Worry less, spend less: out-of-pocket spending caps protect America's families. 2011. http://www.familiesusa.org/resources/publications/reports/health-reform/out-of-pocket-spending-caps.html
14. U.S. Treasury. [Accessed September 5, 2011] Treasury lays the foundation to deliver tax credits to help make health insurance affordable for middle-class Americans. 2011. http://www.treasury.gov/press-center/Documents/36BFactSheet.pdf
15. Cohen, RA.; Martinez, ME. [Accessed September 23, 2011] Health insurance coverage: early release of estimates from the National Health Interview Survey, January-March 2011. 2011. http://www.cdc.gov/nchs/nhis/releases.htm
16. Centers for Disease Control and Prevention. HIV surveillance report, 2009. 2011; 21 http://www.cdc.gov/hiv/topics/surveillance/resources/reports.
17. Henry J. Kaiser Family Foundation. [Accessed September 5, 2011] Medicare: the Medicare prescription drug benefit. 2010. http://www.kff.org/medicare/upload/7044-11.pdf
18. Hoadley, J.; Summer, L.; Hargrave, E.; Cubanski, J.; Neuman, T. [Accessed September 5, 2011] Medicare part D 2010 data spotlight: the coverage gap. 2009. http://www.kff.org/medicare/8008.cfm
19. Schackman BR, Gebo KA, Walensky RP, et al. The lifetime cost of current human immunodeficiency virus care in the United States. Medical Care. 2006; 44:990–997. [PubMed: 17063130]
20. Henry J. Kaiser Family Foundation. [Accessed September 23, 2011] Grandfathering explained. 2011. http://healthreform.kff.org/
21. U.S. Preventive Services Task Force. [Accessed September 23, 2011] USPSTF A and B recommendations. 2011. http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm
22. Committee on Preventive Services for Women, Board on Population Health and Public Health Practice. Clinical preventive services for women: closing the gap. Washington, DC: National Academies Press; 2011.
23. Dentzer S. The researcher-in-chief at the Patient-Centered Outcomes Research Institute. Health Affairs. 2011; 30(12):2252–2258. [PubMed: 22147852]
24. Measuring what matters: allocation, planning, and quality assessment for the Ryan White CARE Act. Washington, DC: National Academies Press; 2004. Committee on the Ryan White CARE Act: Data for Resource Allocation Planning and Evaluation, Board on Health Promotion and Disease Prevention.
25. Henry J. Kaiser Family Foundation. [Accessed September 5, 2011] Medicaid and HIV/AIDS factsheet. 2009. http://www.kff.org/hivaids/upload/7172_04.pdf
26. National Alliance of State and Territorial AIDS Directors. National ADAP monitoring project annual report module. 2011; 1 http://www.nastad.org/Docs/020035_2011%20NASTAD%20National%20ADAP%20Monitoring%20Project%20Annual%20Report.pdf.

27. Department of Health and Human Services. [Accessed September 23, 2011] HHS announces Affordable Care Act funding opportunity to create jobs by building, renovating and repairing community health centers. 2011. http://www.hhs.gov/news/press/2011pres/09/20110909a.html
28. Brutger, RD. [Accessed December 17, 2011] Academic health centers and community health centers: the landscape of current partnerships. 2011. http://www.aahcdc.org/policy/reddot/AAHC_Community_Health_Centers_The_Landscape.pdf
29. Blumenthal D. Launching HITECH. New England Journal of Medicine. 2010; 362(5):382–385. [PubMed: 20042745]
30. Health Resources and Services Administration. [Accessed September 15, 2011] Information technology: improving HIV/AIDS care. 2007. http://www.careacttarget.org/library/SPNSBulletin/spnsbulletin.jul07.pdf
31. Cross, J. [Accessed December 17, 2011] Pre-existing insurance plans (PCIPs) webinar. 2011. http://www.nastad.org
32. Short PF, Graefe DR. Battery-powered health insurance? Stability in coverage of the uninsured. Health Affairs. 2003; 22(6):244–255. [PubMed: 14649453]
33. Short, PF.; Graefe, DR.; Schoen, C. [Accessed September 5, 2011] Churn, churn, churn: how instability of health insurance shapes America's uninsured problem. 2003. http://www.commonwealthfund.org/usr_doc/Short_churn_688.pdf
34. Department of Health and Human Services. [Accessed December 17, 2011] Affordable insurance exchanges: seamless access to affordable coverage - overview. 2011. http://www.healthcare.gov/news/factsheets/2011/08/exchanges08122011a.html
35. Rajabium S, Backman SS, Fox JE, Tobias C, Bednarsh H. A typology of models for expanding access to oral health care. Journal of Public Health Dentistry. 2011; 71:212–219. [PubMed: 21972461]
36. Sparer M. US health reform and the future of dentistry. American Journal of Public Health. 2011; 101(10):1841–1844. [PubMed: 21852628]
37. Health Resources and Services Administration. [Accessed September 5, 2011] Ryan White HIV/AIDS Program website. 2011. http://hab.hrsa.gov
38. Kingon, JW. Agendas, alternatives, and public policies. 2. New York: Longman; 2003.
39. Landon BE, Wilson IB, McInnes K, et al. Physician specialization and the quality of care for human immunodeficiency virus infection. Archives of Internal Medicine. 2005; 165(10):1133–1139. [PubMed: 15911726]
40. Angeles, J.; Broaddus, M. [Accessed September 5, 2011] Federal government will pick up nearly all costs of health reform's Medicaid expansion. 2010. http://www.thcc2.org/PDFs/cbppgooddeal.pdf
41. Congressional Research Service. [Accessed September 26, 2011] Variation in analyses of PPACA's fiscal impact on states. 2010. http://www.ncsl.org/documents/health/StateImpact.pdf