HHS Public Access

Author manuscript

J Assoc Nurses AIDS Care. Author manuscript; available in PMC 2015 June 18.

Published in final edited form as:

J Assoc Nurses AIDS Care. 2014 ; 25(6): 476–482. doi:10.1016/j.jana.2014.05.002.

The Affordable Care Act and Low-Income People Living With HIV: Looking Forward in 2014 and Beyond

Winston Abara, MD, PhD [Health Policy Fellow] and
Satcher Health Leadership Institute, and Department of Community Health and Preventive Medicine, Morehouse School of Medicine, Atlanta, Georgia.

Harry J. Heiman, MD, MPH [Director]
Division of Health Policy, Satcher Health Leadership Institute, and an Assistant Professor, Department of Family Medicine, Morehouse School of Medicine, Atlanta, Georgia, USA.

Keywords

Affordable care act; health disparities; HIV; HIV health policy; low-income people living with HIV; Medicaid expansion

There are approximately 1 million people living with HIV (PLWH) in the United States, with an estimated 50,000 new HIV infections occurring annually (Centers for Disease Control and Prevention [CDC], 2012a). Racial and ethnic minorities, sexual minorities, and low-income populations bear a disproportionate burden of HIV (CDC, 2012a; 2012b). In the United States, African Americans and Hispanics/Latinos accounted for 44% and 21% of all new HIV infections in 2010 respectively, while men who have sex with men comprised an estimated 63% of all new HIV infections in the same year (CDC, 2012a). In an effort to address the HIV epidemic in the United States, the Obama administration put forward the National HIV/AIDS Strategy (NHAS) in 2010 with a vision for the "United States to become a place where new HIV infections are rare, and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socioeconomic circumstance will have unfettered access to high-quality, life-extending care, free from stigma and discrimination" (CDC, 2012c, p. vii).

This vision drives the goals of the NHAS to reduce new HIV infections, increase access to care, optimize health outcomes, and reduce HIV-related health disparities.

Unfortunately, not all PLWH have access to high-quality care and treatment (Hall et al., 2013) despite extant data and clinical guidelines that show that HIV treatment is also HIV prevention (Granich, Gilks, Dye, De Cock, & Williams, 2009). Current research findings estimate that of all PLWH, approximately 66% are linked to care, 37% are retained in care, 33% are prescribed antiretroviral therapy (ART), and only 25% achieve viral suppression necessary to maintain long-term health and reduce HIV transmissibility (Hall et al., 2013).

Disclosures

The authors report no real or perceived vested interests that relate to this article that could be construed as a conflict of interest.

These numbers reflect critical gaps and barriers in the current HIV health care system that prevent optimal treatment outcomes, especially among the subpopulations that have been most impacted (Hall et al., 2013; Joy et al., 2008; Krawczyk, Funkhouser, Kilby, & Vermund, 2006). Low-income populations, in particular, are less likely to receive care and life-saving HIV medications even though they have significantly higher HIV-related mortality (Joy et al., 2008; Krawczyk et al., 2006). Implementation of the Patient Protection and Affordable Care Act (ACA) provides many opportunities for advancing the goals of the NHAS and addressing many of the shortcomings of HIV health care, especially for low-income PLWH. However, the complexity and variability of ACA implementation across the United States, combined with the continued politicization of health reform and uncertainty related to funding of current programs, especially the Ryan White Program, create continued challenges for patients, providers, policymakers, and advocates. This article reviews HIV health care policy and programs for low-income PLWH in the United States and assesses challenges and opportunities for realizing the goals of the NHAS and improving HIV care and outcomes for low-income PLWH with ACA implementation in 2014.

Pre-ACA Health Care Coverage for Low-Income PLWH

Prior to the passage of the ACA, nearly one in three PLWH had no insurance coverage and fewer than one in five PLWH had private insurance (Fleishman et al., 2005). For low-income PLWH, Medicaid is the single largest source of health care coverage and services (inpatient and outpatient medical treatment, laboratory services, long-term care, and HIV prescription drugs; Kaiser Family Foundation [KFF], 2013a; 2013b; 2013c). Funding for Medicaid is shared jointly by federal and state governments with pre-ACA federal contributions ranging from 50% to 75% (Centers for Medicaid and Medicare Services [CMS], 2013). To be eligible for Medicaid prior to 2014, PLWH had to meet both income and categorical requirements, which restricted eligibility to poor children, pregnant women, and elderly and disabled adults (CMS, 2010). These criteria excluded most low-income parents and childless adults with HIV. They also prevented low-income HIV-infected persons from accessing life-saving HIV medications until they became very sick and disabled (CMS, 2010). For people over the age of 65 years or who are permanently disabled, Medicare represents a source of health care coverage.

The Ryan White Program is also another important source of funding for HIV care. It is a federal program designed for HIV-infected persons who are low-income, uninsured, or underinsured. The program started in 1990 and is dependent on periodic reauthorizations by Congress. Reauthorization of the program was due in 2013, but was deferred due to uncertainty related to ACA implementation and variable state-level expansion of Medicaid, leaving most of the current funding in place. The Ryan White Program supports the AIDS Drug Assistance Program and pays for premiums, deductibles, and co-payments to engage and retain low-income PLWH in care (National Alliance of State and Territorial AIDS Directors [NASTAD], 2012). The program also funds HIV-related services, including primary medical care, training programs for health care providers, and wrap-around services (Ashman, Conviser, & Pounds, 2002; Health Resources and Services Administration [HRSA], 2014). Wrap-around services include non-clinical services such as case management, treatment adherence supports, transportation to medical appointments, mental

and substance abuse care, and legal and housing services, all of which are critical to comprehensive HIV care (Ashman et al., 2002; HRSA, 2014).

ACA and Opportunities for Low-Income PLWH

The ACA was signed into law in March 2010 and was designed to help improve health care access and quality, and to control costs. Prior to January 2014, there were approximately 48 million uninsured non-elderly Americans, the majority of whom were low to moderate income (NASTAD, 2013). Implementation of the ACA has significant implications for access to affordable health care services for low-income PLWH. The ACA prohibits insurance companies from denying coverage to HIV-infected persons due to preexisting conditions and eliminates annual or lifetime dollar limits on health care coverage. For the first time, the ACA supports expansion of Medicaid coverage to low-income Americans with incomes up to 138% of the federal poverty level ($15,856 for an individual and $32,499 for a family of four; KFF, 2013c) without categorical requirements. It also provides tax credits and subsidies for private plans in the health insurance marketplace for persons with incomes between 100% and 400% of the federal poverty level. This means that low-income PLWH, especially parents and childless adults who did not previously meet the income eligibility requirements for Medicaid, will no longer need to progress to AIDS and become disabled to gain coverage in states that expand Medicaid.

The ACA also establishes coverage standards for insurance policies through essential health benefits requirements. While benchmarked differently in each state, these must include coverage for ambulatory care, emergency care, hospitalization, pre- and post-natal care, mental health and substance abuse disorders, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive services, and pediatric services for all health plans, including the Medicaid expansion population (NASTAD, 2013). Health plans are also required to provide preventive services with a rating of A or B from the U.S. Preventive Services Task Force without cost sharing. This removes financial barriers to HIV screening and testing as well as other preventive services that are vital to the overall care and quality of life for PLWH given their increased risk and prevalence of comorbidities. In their study on Medicaid-expansion states in 2013, Wagner, Wu, and Sood (2014) demonstrated that Medicaid expansion and the impact of the ACA will result in an additional half a million people getting tested for HIV and the identification of 2,598 new cases of HIV by 2017, accompanied by a 22% decrease in the population that is unaware that they are HIV infected (Wagner et al., 2014).

Additionally, implementation of the ACA has significant implications for access to antiretroviral medications by closing the coverage gap (donut hole) in Medicare Part D Prescription Drug Plans (CMS, 2014a). Because HIV medications are expensive, PLWH are likely to reach the coverage gap quickly, creating significant challenges to continued access to ART, especially for those with low incomes. Similarly, all health plans must now cover at least one drug from every U.S. Pharmacopeia category or the same number of prescription drugs from each category; whichever is greater (NASTAD, 2013). This provision is important for low-income patients on combination ART because it ensures early HIV treatment as well as continued access to and coverage for medications. Overall, this is

pivotal because early HIV treatment increases life expectancy, and prevents new HIV infections and productivity losses (Goldman, Juday, Seekins, Linthicum, & Romley, 2014). Modeling studies conducted by Goldman and colleagues (2014) on data between 1996 and 2009 found that early HIV treatment prevented approximately 13,500 new HIV infections annually, averting the equivalent of $128 billion in life expectancy losses during this time period.

Health system improvements in the ACA will benefit low-income HIV-infected persons. Patient-centered medical home models and Accountable Care Organizations support more coordinated and integrated care through improved systems for communication and health care provision across providers and improved alignment between payment and health outcomes. Research has shown that patient-centered medical home models lead to improved health outcomes, medication adherence, retention in care, and reduced health care costs (Reid et al., 2010; Rosenthal, 2008). This model supports integrated care for PLWH aimed at improving overall health across a continuum of health care providers and services. The ACA also increases funding for community health centers, which represent an important source of health care for low-income persons (Andersen et al., 2002). Overall, these provisions of the ACA present important opportunities to expand access to quality health care coverage, improve quality of life, and reduce medical costs and job productivity losses for some of the most vulnerable PLWH.

Policy Challenges of the ACA and Consequences for Low-Income PLWH

As a result of the June 2012 U.S. Supreme Court ruling, Medicaid expansion, intended as a core provision of the ACA, was left to the discretion of state-level decisions. As of March 2014, 19 states had elected not to move forward with Medicaid expansion (KFF, 2014). State decisions not to expand Medicaid have significant implications for HIV care in those states (KFF, 2013b). Most low-income adults living with HIV in nonexpansion states will remain ineligible for Medicaid, and will continue to lack opportunities for comprehensive care and remain more likely to seek episodic medical treatment in emergency departments or free clinics. In these states, the vast majority of low-income adults living with HIV will be eligible for Medicaid only when their disease progresses and they become disabled, at which point treatment will be more costly and the quality of life markedly reduced (Chen et al., 2006). Continued lack of eligibility for Medicaid for low-income HIV-infected patients in nonexpansion states will perpetuate current challenges in engaging and retaining PLWH in care and predictably lead to continued disparate health care access and poor health outcomes in these states.

Churning may pose additional challenges to low-income PLWH. Churning refers to the involuntary movement of consumers from one health plan or system of coverage to another (Sommers & Rosenbaum, 2011). The different income eligibility requirements for Medicaid and subsidies in the health insurance marketplace mean that HIV-infected patients may cycle in and out of Medicaid and marketplace plans as their incomes change. While states have the opportunity to create coordinated systems allowing for movement between systems, integration of these systems is variable across the states. Thus, churning and the potential for interruptions in HIV care are likely. It is estimated that close to 30% of people

receiving Medicaid or subsidies in the health insurance marketplace will change their health care coverage annually (Buettgens, Nichols, & Dorn, 2012). Given this number, it is imperative that proactive measures are put in place to ensure seamless and timely migration between health plans, especially between state Medicaid enrollment systems and enrollment systems for health plans in the health insurance marketplace.

Medicaid expansion and increased access to health insurance create both challenges and opportunities related to the health care workforce and delivery system. Increased demand and health care utilization by newly covered beneficiaries may stress health care provider networks, especially safety net providers. There are already significant challenges for states to ensure an adequate health professions workforce, particularly in low-income urban and rural settings. In addition, while Medicaid recipients overall experience access levels similar to privately insured patients (Long, Coughlin, & King, 2005), challenges remain for both primary care and specialty care access, with significant variation both within and between states (Backus et al., 2001; Decker, 2012). Although the ACA provides increased Medicaid reimbursement for primary care services through the end of 2014, it is unclear whether this funding will be continued beyond 2014. However, the Medicaid program allows for considerable state flexibility through waivers and state plans to develop targeted programs to meet the needs of their low-income populations. New initiatives, including the State Innovation Models Initiative, provide opportunities for states to develop and test new models for payment and health care delivery (CMS, 2014b). In the absence of states (a) proactively addressing reimbursement levels, (b) developing targeted workforce strategies, and (c) leveraging and aligning health care delivery and payment system improvements in Medicaid to support broader health system transformation, access to health insurance by low-income PLWH will not necessarily ensure access to optimal care.

Uncertainty with regard to reauthorization and funding for the Ryan White Program and other discretionary HIV programs creates additional challenges for low-income PLWH. Because of the expected increase in health insurance coverage for HIV-infected patients, policymakers may not understand the need to continue funding these programs. The Ryan White Program funds critical wrap-around services that are not covered by insurance plans but are vital to treatment adherence, and engagement and retention in care for low-income PLWH (Ashman et al., 2002; HRSA, 2014). Wrap-around services mitigate the life circumstances of low-income PLWH, including unstable housing conditions, higher incidence of mental health and substance use disorders, low literacy levels, and lack of transportation, all of which have been shown to hinder consistent HIV care (Ashman et al., 2002; Lo, MacGovern, & Bradford, 2002; Sherer et al., 2002). A number of studies have demonstrated the success of wrap-around services in assisting low-income PLWH to engage and remain in care and to navigate the health care system (Ashman et al., 2002; Lo et al., 2002; Sherer et al., 2002). This includes a national multisite study showing that HIV-infected clients receiving housing, food, and transportation assistance, as well as mental health and substance abuse counseling, were more likely to see a health care provider and remain in regular care (Ashman et al., 2002). Additional studies conducted in HIV primary care settings demonstrated that HIV-infected patients receiving wrap-around services were significantly more likely to receive, use, and remain in regular HIV care (Lo et al., 2002; Sherer et al., 2002).

In addition to its support for wrap-around services, the Ryan White Program also funds co-pays, deductibles, and premiums to help engage and retain PLWH in care. This will continue to support HIV treatment services for those who remain uninsured in states that do not expand Medicaid. These HIV treatment services will also be crucial to the care of recent legal immigrants who are HIV infected but are subject to a 5-year waiting period before they are eligible for Medicaid, as well as undocumented immigrants who are not eligible for Medicaid or subsidies in the health insurance marketplace. Against this backdrop, it is critical that policymakers remain aware of the important role Ryan White funding will continue to play in providing access to HIV care and supportive services in both expansion and nonexpansion states.

Finally, the planned reduction in Disproportionate Share Hospital (DSH) payments beginning in 2015 (CMS, 2014c) may adversely impact safety net hospitals that provide HIV care to uninsured and low-income populations. While put in place in anticipation of affordable health coverage options for low- and moderate-income populations, including Medicaid expansion in all 50 states, the loss of DSH payments will create significant challenges, especially in nonexpansion states. Reductions in DSH payments may lead to a decrease in the type and number of services provided to low-income PLWH in both urban and rural settings, paradoxically threatening the availability of critical services to the very vulnerable populations the ACA was designed to help.

Policy Implications and Conclusion

More than 30 years after the advent of the HIV epidemic, the United States is at a historic crossroads with regard to meeting this challenge. In conjunction with the NHAS and the availability of combination ART, the ACA provides new opportunities for insurance coverage and consistent access to treatment and comprehensive care for low-income PLWH. State-level ACA implementation decisions and federal policy decisions regarding reauthorization and funding of current programs, including Ryan White, will have significant implications with regard to our success in meeting the needs of PLWH and achieving NHAS goals.

It is imperative that health care and public health leaders, health care providers, community-based organizations, and advocates share a consistent message to political leaders about the health implications and consequences of the policy decisions we are currently facing. In order to achieve the NHAS goals of reducing new infections, increasing access to care, optimizing health outcomes, and reducing health disparities, it is essential that states expand Medicaid. Furthermore, it requires that states integrate Medicaid enrollment with enrollment in the health insurance marketplace and take advantage of opportunities to leverage innovative health delivery systems in Medicaid, all of which are critical to transforming the current HIV health care system. Systems to reduce churning and ensure seamless migration between health insurance plans must be in place to avoid undermining the continuity and consistency of care. Similarly, workforce policies and strategies to ensure that health care providers are available to meet the needs of newly covered low-income PLWH, and states' abilities to advance innovative payment and delivery system models across payers will prove critical to successfully implementing the ACA and realizing NHAS goals. It is also

essential that federal policy-makers recognize that health insurance coverage is necessary but not sufficient to ensure access to care and improved health outcomes, especially for low-income PLWH. Continued support and funding for wrap-around services, funded through Ryan White and other HIV discretionary programs, are crucial to HIV care and achieving both treatment and prevention goals. Budgetary decisions regarding these programs must be informed by best evidence regarding both the health and economic returns on investments for these critical services. Failure to take advantage of these historic opportunities will cause significant harm to the health of low-income PLWH and, subsequently, to the health of our nation.

References

Andersen RM, Yu H, Wyn R, Davidson PL, Brown ER, Teleki S. Access to medical care for low-income persons: How do communities make a difference? Medical Care Research and Review. 2002; 59(4):384–411. [PubMed: 12508702]

Ashman JJ, Conviser R, Pounds MB. Associations between HIV-positive individuals' receipt of ancillary services and medical care receipt and retention. AIDS Care. 2002; 14(S1):109–118.

Backus L, Osmond D, Grumbach K, Vranizan K, Phuong L, Bindman AB. Specialists' and primary care physicians' participation in Medicaid managed care. Journal of General Internal Medicine. 2001; 16(12):815–821. [PubMed: 11903760]

Buettgens, M.; Nichols, A.; Dorn, S. Churning under the ACA and state policy options for mitigation. 2012. Retrieved from http://www.urban.org/UploadedPDF/412587-Churning-Under-the-ACA-and-State-Policy-Options-for-Mitigation.pdf

Centers for Disease Control and Prevention (CDC). HIV in the United States: At a glance. 2012. 2012a. Retrieved from http://www.cdc.gov/hiv/statistics/basics/ataglance.html

Centers for Disease Control and Prevention (CDC). Communities in crisis: Is there a generalized HIV epidemic in impoverished urban areas of the United States?. 2012b. Retrieved from http://www.cdc.gov/hiv/risk/other/poverty.html

Centers for Disease Control and Prevention. National HIV/AIDS Strategy. 2012c. Retrieved from http://www.cdc.gov/hiv/policies/nhas.html

Centers for Medicaid and Medicare Services. Brief summaries of Medicare and Medicaid. 2010. Retrieved from http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/downloads/MedicareMedicaidSummaries2010.pdf

Centers for Medicaid and Medicare Services. Medicaid financing and reimbursement: Financing and reimbursement. 2013. Retrieved from http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Financing-and-Reimbursement.html

Centers for Medicaid and Medicare Services. Closing the coverage gap - Medicare prescriptions drugs are becoming more affordable. 2014a. Retrieved from http://www.medicare.gov/pubs/pdf/11493.pdf

Centers for Medicaid and Medicare Services. State innovation models initiative: General information. 2014b. Retrieved from http://innovation.cms.gov/initiatives/State-Innovations/

Centers for Medicaid and Medicare Services. Provider payments. 2014c. Retrieved from http://www.medicaid.gov/AffordableCareAct/Provisions/Provider-Payments.html

Chen RY, Accortt NA, Westfall AO, Mugavero MJ, Raper JL, Cloud J, Saag MS. Distribution of health care expenditures for HIV-infected patients. Clinical Infectious Diseases. 2006; 42(7):1003–1010. [PubMed: 16511767]

Decker SL. In 2011 nearly one-third of physicians said they would not accept new Medicaid patients, but rising fees may help. Health Affairs (Millwood). 2012; 31(8):1673–1679.

Fleishman JA, Gebo KA, Reilly ED, Conviser R, Mathews WC, Korthuis PT, Moore RD. Hospital and outpatient health services utilization among HIV-infected adults in care 2000-2002. Medical Care. 2005; 43(9):40–52.

Goldman DP, Juday T, Seekins D, Linthicum MT, Romley JA. Early HIV treatment in the United States prevented nearly 13,500 infections per year during 1996-2009. Health Affairs (Millwood). 2014; 33(3):362–369.

Granich RM, Gilks CF, Dye C, De Cock KM, Williams BG. Universal voluntary HIV testing with immediate antiretroviral therapy as a strategy for elimination of HIV transmission: A mathematical model. Lancet. 2009; 373(9657):48–57. [PubMed: 19038438]

Hall HI, Frazier EL, Rhodes P, Holtgrave DR, Furlow-Parmley C, Tang T, Gray KM, Skarbinski J. Differences in human immunodeficiency virus care and treatment among subpopulations in the United States. Journal of the American Medical Association. 2013; 173(14):1337–1344.

Health Resources and Services Administration. About the Ryan White HIV/AIDS program. 2014. Retrieved from http://hab.hrsa.gov/abouthab/aboutprogram.html

Joy R, Druyts EF, Brandson EK, Lima VD, Rustad CA, Zhang W, Hogg RS. Impact of neighborhood-level socioeconomic status on HIV disease progression in a universal health care setting. JAIDS. 2008; 47(4):500–505. [PubMed: 18197117]

Kaiser Family Foundation. Medicaid: A primer – key information on the nation's health coverage program for low-income people. 2013a. Retrieved from http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf

Kaiser Family Foundation. Medicaid and HIV/AIDS. 2013b. Retrieved from http://kff.org/hivaids/fact-sheet/medicaid-and-hivaids/

Kaiser Family Foundation. Commission on Medicaid and the uninsured: The role of Medicaid in state economies and the ACA. 2013c. Retrieved from http://kaiserfamilyfoundation.files.wordpress.com/2013/11/8522-the-role-of-medicaid-in-state-economies-looking-forward-to-the-aca.pdf

Kaiser Family Foundation. Status of state action on the Medicaid expansion decision, 2014. 2014. Retrieved from http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

Krawczyk CS, Funkhouser E, Kilby JM, Vermund SH. Delayed access to HIV diagnosis and care: Special concerns for the Southern United States. AIDS Care. 2006; 18(S1):35–44. [PubMed: 16282074]

Lo W, MacGovern T, Bradford J. Association of ancillary services with primary care utilization and retention for patients with HIV/AIDS. AIDS Care. 2002; 14(S1):45–57.

Long SK, Coughlin T, King J. How well does Medicaid work in improving access to care? Health Services Research. 2005; 40(1):39–58. [PubMed: 15663701]

National Alliance of State and Territorial AIDS Directors. Insurance purchasing and continuation. 2012. Retrieved from http://www.nastad.org/docs/NASTAD%20ADAP%20TA%20Brief%20-%20Insurance%20Purchasing%20-%20July%202013.pdf

National Alliance of State and Territorial AIDS Directors. Essential health benefits. 2013. Retrieved from http://www.nastad.org/docs/HCA-Brief-ACA-EHB-May-2013.pdf

Reid RJ, Coleman K, Johnson EA, Fishman PA, Hsu C, Soman MP, Larson EB. The group health medical home at year two: Cost savings, higher patient satisfaction, and less burnout for providers. Health Affairs (Millwood). 2010; 29(5):835–843.

Rosenthal TC. The medical home: Growing evidence to support a new approach to primary care. Journal of the American Board of Family Medicine. 2008; 21(5):427–440. [PubMed: 18772297]

Sherer R, Stieglitz K, Narra J, Jasek J, Green L, Moore B, Cohen M. HIV multidisciplinary teams work: Support services improve access to and retention in HIV primary care. AIDS Care. 2002; 14(S1):31–44.

Sommers BD, Rosenbaum S. Issues in health reform: How changes in eligibility may move millions back and forth between Medicaid and insurance exchanges. Health Affairs (Millwood). 2011; 30(2):228–236.

Wagner Z, Wu Y, Sood N. The Affordable Care Act may increase the number of people getting tested for HIV by nearly 500,000 by 2017. Health Affairs (Millwood). 2014; 33(3):378–385.