Commentary

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

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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). 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

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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