Perspective

Implications of the Affordable Care Act for People With HIV Infection and the Ryan White HIV/AIDS Program: What Does the Future Hold?

There are numerous aspects of the Patient Protection and Affordable Care Act that will be important for people in the United States with HIV infection, including consumer protections and private insurance reforms, establishment of health care marketplaces in every state, new benefit standards, Medicare fixes, prevention enhancements, expansion of Medicaid, and health system improvements. However, it is unlikely that these changes will address all the needs of people with HIV infection in the United States. The Ryan White HIV/AIDS Program will thus remain crucial for the provision of adequate health care to HIV-infected individuals, but it will need to change. Changes in the role of the Ryan White HIV/AIDS Program will depend largely on state decisions on Medicaid expansion and health care marketplaces. This article summarizes a presentation by Jennifer Kates, PhD, at the IAS–USA continuing education program held in New York, New York, in April 2013.

Keywords: HIV, Patient Protection and Affordable Care Act, PPACA, ACA, Ryan White Program, health insurance, exchanges, marketplaces, state health care, Medicaid

More than 30 years into the HIV epidemic, there are now more than 1 million people in the United States living with HIV. The number of new HIV infections has remained relatively stable for more than a decade at approximately 50,000 new infections per year, although new infections are rising among men who have sex with men. People with HIV infection are more likely than the overall US population to be low-income and uninsured and to rely heavily on Medicaid for insurance coverage.1–5

However, the Centers for Disease Control and Prevention (CDC) estimates that close to two-thirds (63%) of people with HIV infection are not retained in care, only 33% are taking antiretroviral therapy, and only 25% are virally suppressed, despite new data indicating that early initiation of antiretroviral therapy not only has tremendous clinical benefit but also substantially reduces the risk of HIV transmission. These findings have pointed to the real possibility of achieving an AIDS-free generation, if more people with HIV infection can be engaged and retained in care (Figure 1).4,5

Implications of the Affordable Care Act for People with HIV Infection

There are numerous aspects of the Patient Protection and Affordable Care Act, commonly referred to as the Affordable Care Act (ACA), that will be important for people with HIV infection, including consumer protections and private insurance reforms, health care marketplaces in every state, new benefit standards, Medicare fixes, prevention enhancements, expansion of Medicaid, and health system improvements.

The consumer protection and private insurance reforms provisions put an end to lifetime and annual coverage limits, eliminate exclusions for preexisting conditions, prohibit insurers from rescinding coverage, and extend eligibility for dependent coverage to up to 26 years of age. Under the ACA, health plans can no longer charge higher premiums to individuals with preexisting conditions and cannot discriminate against individuals on the basis of sexual orientation or gender identity.

The ACA will require most individuals to have health insurance by 2014. To help achieve this goal, health care marketplaces, also called exchanges, where individuals and small businesses may purchase coverage, will be created in every state. These state-based marketplaces are intended to create a more organized and competitive

Figure 1. The proportion of individuals at each stage of the cascade of HIV care in the United States. Adapted from Centers for Disease Control and Prevention and Kaiser Family Foundation.4,5 aIncludes individuals who are unaware of their HIV infection.

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insurance market. They must offer a choice of qualified health plans (those certified by each marketplace and that meet any other specified requirements) and provide information to consumers about the offerings of each plan. To make coverage in the marketplaces more affordable, the ACA includes provisions that lower insurance premiums and cost-sharing obligations for those individuals or families with lower incomes. Tax credits will be available to those with incomes between 100% and 400% of the federal poverty level; in 2013, the federal poverty level is defined at $11,490 for individuals and $19,530 for a family of 3. In addition, those with incomes between 100% and 250% of the federal poverty level will also be eligible for cost-sharing subsidies through lower deductibles and copayments. States can choose to run their own marketplace, do so in partnership with the federal government, or choose to default to a fully federally run marketplace.

Many more states than anticipated reportedly intend to default to federal health insurance marketplaces (27 states), thus the federal government will be responsible for the operation of health care marketplaces in the majority of states (Figure 2). Seven states have indicated that they intend to partner with the federal government to run their marketplace, and 16 states, plus the District of Columbia, will run their own marketplaces.

Qualified health plans that will participate in state health care marketplaces are in the process of setting up their provider networks now. As required by the health reform law, qualified health plans must include what are termed essential community providers, those providers who primarily serve low-income and underserved communities; Ryan White HIV/AIDS Program providers have been included in this definition. However, although states must ensure that networks include a certain share of essential community providers, they do not have to seek out community providers from all sectors. Thus, it will be important for Ryan White HIV/AIDS Program providers and other HIV-focused essential community providers to proactively engage with the new marketplaces in their states and work to become part of qualified health plan networks, efforts that should be undertaken now.

With regard to benefit standards, the ACA mandates that all new individual and group health plans sold inside and outside state marketplaces include Essential Health Benefits (EHB), a comprehensive set of services across 10 categories. Individuals newly eligible for Medicaid in states that choose to expand Medicaid must also be provided EHB coverage. The 10 EHB categories consist of ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. The final rule for coverage of prescription drugs is that plans must cover “at least the greater of” 1 drug from every US Pharmacopeia category and class or the same number of prescription drugs in each category and class as the EHB benchmark, which is crucial in combination antiretroviral therapy because more than 1 drug is used in category and class. Plans must also have procedures in place “that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan.”

Beyond this and other requirements, states have been given the flexibility to choose a benchmark plan to use as a standard for determining the scope of EHB coverage. Therefore, it will be important for practitioners and other patient advocates to assess whether health plans include all the HIV-related medications and other benefits needed to enable HIV-infected patients to receive appropriate care. Preliminary analysis indicates that most benchmark plans chosen by states go beyond the minimum required by law and include most antiretroviral drugs.

The ACA also made important changes to Medicare. First, by 2020, the ACA will close the Medicare prescription drug gap (or “donut hole”) currently impacting all Medicare Part

Figure 2. State-by-state decisions to date on the implementation of Patient Protection and Affordable Care Act health insurance marketplaces. Adapted from Kaiser Family Foundation and Centers for Disease Control and Prevention. 

Table 1. State marketplaces (16 states and DC) – 42%*  
State-federal marketplace (7 states) – 7%*  
Federal marketplace (27 states) – 51%*
D beneficiaries. This donut hole is the gap in Medicare Part D coverage during which beneficiaries must pay out of pocket (true out-of-pocket [TrOOP] costs) for medications until they reach the catastrophic level when Medicare drug coverage begins again. Second, and more specific to HIV-infected individuals, prior to the ACA, spending by the AIDS Drug Assistance Program (ADAP) for Part D beneficiaries in the donut hole did not count toward their TrOOP costs; the ACA changed this, as of 2011, permitting ADAP spending to count toward TrOOP, thus allowing ADAP dollars to extend further.

There is considerably more emphasis on prevention under the ACA than there has been in the health care system in the past. The ACA requires that all new health plans provide certain preventive services at no cost, including those services rated A or B by the US Preventive Services Task Force (USPSTF). Medicare must also provide such services at no cost, and newly eligible Medicaid beneficiaries, in states that expand Medicaid, must also receive these services at no cost. Traditional state Medicaid programs, for those already eligible, are not required to cover these services, but the federal government will pay a 1% increase in the Federal Medical Assistance Percentages (FMAPs) for these services to states that provide them at no cost. Routine HIV screening received an A rating by the USPSTF in April 2013, and annual HIV counseling and testing for sexually active women are now offered free of charge.

One of the most important health reforms for people with HIV infection is the expansion of Medicaid. As of January 2014, the law expands Medicaid eligibility to nearly all low-income individuals and establishes an eligibility floor of 138% of the federal poverty level (approximately $16,000 annual income for an individual and $27,000 for a family of 3, in 2013). Previously, individuals had to be both low-income and categorically eligible (eg, disabled, a pregnant woman, a senior) to qualify for Medicaid in their state. For many low-income people with HIV infection, this change eliminates a catch-22 situation in which they could not qualify for Medicaid and receive antiretroviral treatment through the program until they were categorized as disabled, despite the fact that antiretroviral therapy may help prevent this kind of disability. The law also provides enhanced FMAPs to states and will cover the full cost of the expansion from 2014 to 2016, before scaling down to cover 90% of the cost in 2020 and thereafter.

A ruling by the US Supreme Court in June 2012, however, while upholding the Medicaid expansion (and the rest of the ACA), limited the authority of the Department of Health and Human Services (DHHS) Secretary to enforce the expansion, effectively making expansion of coverage a state option. There are currently 25 states, plus the District of Columbia, that have indicated they will move forward with expansion and 25 states that have indicated they will not move forward (Figure 3).7,9 Approximately 57% of people with HIV infection live in states that have indicated they are expanding Medicaid and approximately 43% live in states that indicate they are not expanding. Many southern states oppose expansion, and it is in southern states that HIV care infrastructure and access are often weakest. States can choose to expand Medicaid at some point in the future (the Supreme Court decision effectively removed the requirement that they must do so as of 2014), allowing states to continue to debate into the coming years whether they support or oppose Medicaid expansion.

Notably, there were several health system improvements under the ACA that may help people with HIV infection, including the creation of Medicaid Health Homes for people with chronic conditions; increased Medicaid payments for primary care physicians and subspecialists in 2013 and 2014, with ongoing discussion about extending the duration of these provisions; and new investments in community health centers, which serve many HIV-infected people.

**Implications for the Ryan White HIV/AIDS Program**

Insurance coverage alone does not ensure access to or receipt of care. The Ryan White HIV/AIDS Program acts as a national safety net for people with HIV infection, filling gaps in care not provided by other sources.
covered by other resources and serving as a payer of last resort. In fact, most clients in the Ryan White HIV/AIDS Program today are insured and use the Program to supplement or complete their coverage. Although the ACA is expected to expand coverage to many people with HIV infection, it is also expected that the Ryan White HIV/AIDS Program will still be needed to provide comprehensive, quality HIV care and to help engage and retain HIV-infected patients in that care. There are many crucial HIV-related services provided by the Program that are not typically covered by insurance plans, such as assistance with treatment adherence and case management (Figure 4).

An example of how the role of the Ryan White HIV/AIDS Program may change can be seen in the evolution of health coverage in Massachusetts, which began major coverage expansions more than a decade ago and now has near universal health coverage. Even with this expanded coverage in Massachusetts, the Ryan White HIV/AIDS Program has remained crucial. An increasing share of Program funding has paid for premiums and copayments to engage and retain HIV-infected patients in care in the state. Massachusetts has reported a reduction in new HIV diagnoses, very high care-retention rates, and high rates of viral suppression, results that it attributes to coverage expansions and the Ryan White HIV/AIDS Program, among other factors.

Ultimately, the impact of the ACA on the Ryan White HIV/AIDS Program will depend largely on state decisions, particularly concerning Medicaid expansion but also the scope of benefits in their marketplace plans. As seen in the state of Massachusetts, a greater share of Program funding may be used to assist clients in paying for new coverage in state marketplaces and in completing that coverage where there are limits. Ryan White funding will still be needed to assist people with HIV infection in traditional Medicaid programs who may continue to face benefit limits as they do today. Moreover, the Ryan White HIV/AIDS Program will be crucial for people with HIV infection who live in states that do not choose to expand Medicaid (Figure 3). Lastly, the Program will continue to be an important source of care and services for HIV-infected immigrants, because undocumented persons are not eligible for Medicaid or health insurance marketplaces and newly legal residents have a 5-year waiting period before Medicaid eligibility.

Program practitioners have an important role to play in helping clients, through education and guidance, maximize opportunities to obtain new coverage. In some cases, Program practitioners may receive funding to become Patient Navigators who will play a key role in helping individuals to access coverage. Practitioners may also join Medicaid and marketplace provider networks. However, as mentioned above, Program practitioners must seek out such opportunities proactively. It is also important to note that the payer-of-last-resort requirement will still be in place for the Ryan White HIV/AIDS Program and that Program funds may not be used “for any item or service to the extent that payment has been made or can reasonably be expected to be made.”

The Ryan White HIV/AIDS Program, first authorized in 1990, has been reauthorized by the US Congress 4 times, most recently in 2009. Although its current authorization ended on September 30, 2013, reauthorization is not required for the Program to continue, as long as funding is provided by Congress through annual appropriations. Discussions about the future role of and potential changes to the Program have already begun, but there are still many uncertainties about how the ACA will affect it, particularly given state decisions on Medicaid expansion. These uncertainties have led some to question what the most appropriate timing for reauthorization of the Ryan White HIV/AIDS Program might be.

Presented by Dr Kates in May 2013. First draft prepared from transcripts by Matthew Stenger. Reviewed and edited by Dr Kates in July 2013.

Financial Affiliations: Dr Kates has no relevant financial affiliations to disclose.

References


