NHeLP
NATIONAL HEALTH LAW PROGRAM

Protect Medicaid Funding
Women Living with HIV
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A personal story from a family in Georgia:

For Shyronn, a woman living with HIV, having Medicaid allows her to be active in her community. With Medicaid, she doesn't worry about dying prematurely. Because of the services she receives through Medicaid, she can live a normal life expectancy, remain a productive citizen, and be there for her three children, including a 19-year-old son who is actively serving our country in the United States Marine Corps, a 14-year-old son who is engaged in school and community service projects, and her 4-year-old daughter (pictured) who is a ray of life who brightens every soul she encounters. Medicaid has allowed her entire family to stay healthy even when money is tight.

Shyronn is passionate about HIV prevention and empowering people living with HIV. She volunteers her time to educate her community, youth, and policymakers both in person and online about HIV risk, prevention and care. She is also a member of Positive Women's Network – USA, a national membership body of women that works to empower women living with HIV and develop their leadership skills. Shyronn relies on essential supportive services covered by Medicaid, such as mental health and case management, in order to contribute to her family and community. She says, "the mental health counseling and case management I receive through Medicaid work hand-in-hand to strengthen and support my ability to handle the ups and downs of life. Having Medicaid has motivated me to adhere to my medical appointments and treatment plans. When I did not have Medicaid, I rarely sought medical attention."

Women Living With HIV

Medicaid provides a long-term investment in health that helps people succeed. It increases the diagnosis and early treatment of chronic conditions, enhances educational achievement and future earnings for covered children, and reduces health care disparities.[1] Medicaid coverage is tailored to the unique needs of low-income individuals and families, but still costs less per enrollee than employer-based insurance.[2] Despite Medicaid's proven success and efficient use of funds, opponents repeatedly seek to cut or cap funding for the program. These proposals seriously jeopardize the health and financial security of the 97 million people who benefit from Medicaid each year.[3] Medicaid's core consumer protections make the program work for enrolled populations, including children, parents, pregnant women, low-income workers, older adults, and people with disabilities. This fact sheet explains why Medicaid is so critical for women living with HIV and examines how they would be harmed by Medicaid funding caps.

Why Medicaid is important for women living with HIV:

- **Medicaid covers nearly half of all people getting regular treatment for HIV**. Because women living with HIV are disproportionately women of color, their communities benefit most from the coverage, treatment, and care Medicaid provides.[4] Individuals with health insurance coverage are more likely to receive HIV testing and become aware of their HIV status.[5] Those who know they are HIV-positive are more likely to seek and retain care. This benefits the public's health by reducing the transmission rate between partners.

- **Medicaid expansion offers states the opportunity to cover more women living with HIV**. Under traditional Medicaid eligibility rules, many adults living with HIV must wait until their disease progresses to an AIDS diagnosis before they can be considered disabled and categorically eligible to receive Medicaid coverage, even if they are very low-income. The ACA's Medicaid expansion creates a new category of Medicaid eligibility that states can use to cover most low-income adults. Medicaid also allows states to use other optional categories or to seek approval for innovative pilot programs to provide coverage for individuals living with HIV.

- **Medicaid covers many services that women living with HIV need**. State Medicaid programs must cover an array of mandatory services. These include inpatient and outpatient hospital services, physician visits, laboratory and x-ray services, family planning services and supplies, and pregnancy-related services.[6] Further, Medicaid programs must also cover many specialized services, such as long-term care and non-emergency medical transportation, which are critical to populations living with HIV/AIDS who are at an increased risk of developing a permanent or episodic disability from their disease. States may also choose to cover many important optional services, such as prescription drugs (which all states provide) and personal care services.

- **Medicaid expansion helps support other safety-net programs**. The Ryan White AIDS Drug Assistance Programs (ADAPs) provide HIV-related drugs to individuals with limited

or no prescription drug coverage, and women make up nearly a quarter of ADAP enrollees. States that expand Medicaid are able to shift over half of the individuals currently enrolled in the ADAPs into the Medicaid expansion, thereby freeing up ADAP funding for improved HIV/AIDS care in the state. Medicaid expansion also helps support community health clinics and reduces their uncompensated care costs.[7]

How funding caps would harm women living with HIV:

- **Funding caps threaten Medicaid coverage for HIV care**. Funding caps reduce federal Medicaid funding and shift more of the costs onto states. States would likely respond to budget gaps by reducing Medicaid eligibility. For example, states that have already expanded Medicaid may consider reversing their expansions, and states that are considering expansion may halt their efforts.[8] This threatens the coverage of nearly 115,000 people living with HIV that would be Medicaid eligible if all states expanded their program.[9] It also would disproportionately affect certain communities: the HIV/AIDS rate is twenty times higher among African-American women and four times higher among Latinas, compared to white women.[10]

- **Funding caps would likely result in states covering fewer HIV-related services**. With less Medicaid funding under a spending cap, states would likely reduce coverage of Medicaid services. States could do this by cutting out optional services, particularly more expensive services such as home and community-based services, or by imposing strict limits on the amount, duration, and scope of services. For example, states could reduce the number of prescriptions an individual can obtain.

- **Funding caps threaten access to needed HIV-related treatment**. Under funding caps, states may also attempt to reduce costs by restricting the network of providers Medicaid enrollees are able to visit. Women living with HIV, who depend disproportionately on providers with specialized expertise in HIV care, would be greatly harmed by restrictive networks with limited access to specialists. States might also attempt to pass costs onto Medicaid enrollees – forcing low-income women with HIV to choose between health care and other necessities such as food and rent.

Funding caps would leave states at risk for HIV/AIDS or other epidemics. Funding caps limit states to a pre-set amount of federal funding, regardless of how future health care costs actually increase. This means states would not be prepared to finance health-related epidemics, including surges in the number of HIV patients or in the cost of their care due to new effective but expensive treatments.[11]

[1] Harvey W. Kaufman et al., *Surge in Newly Identified Diabetes among Medicaid Patients in 2015 within Medicaid Expansion States under the Affordable Care Act*, 38 DIABETES CARE 833 (2015) (Medicaid coverage improves diabetes screening and treatment initiation); DAVID W. BROWN ET AL., NAT'L BUREAU OF ECON. RESEARCH, MEDICAID AS AN INVESTMENT IN CHILDREN: WHAT IS THE LONG-TERM IMPACT ON TAX RECEIPTS? 20 (Jan. 2015), http://www.nber.org/papers/w20835 (Medicaid improves long-term outcomes for children); Thomas C. Buchmeuller et al., *Effect of the Affordable Care Act on Racial and Ethnic Disparities in Health Insurance Coverage* 106 AM. J. PUB. HEALTH 1416, 1420 (2016) (Medicaid expansion reduced health care disparities).

[2] Teresa Coughlin et al., KAISER COMM'N ON MEDICAID & THE UNINSURED, WHAT DIFFERENCE DOES MEDICAID MAKE? 4, 7 (2013), http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf (Employer-based coverage would cost 28% more than covering the same low-income individual with Medicaid).

[3] CONG. BUDGET OFFICE, DETAIL OF SPENDING AND ENROLLMENT FOR MEDICAID FOR CBO'S MARCH 2016 BASELINE (Mar. 2016), https://www.cbo.gov/sites/default/files/51301-2016-03-Medicaid.pdf. Though 97 million individuals enrolled in Medicaid over the course of 2015, the average monthly enrollment was 76 million. *Id*. This underscores the importance of Medicaid as a source of coverage for individuals who temporarily lose coverage, such as individuals between jobs.

[4] *See* KAISER. FAMILY FOUND., MEDICAID AND HIV: A NATIONAL ANALYSIS (2011), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8218.pdf.

[5] *See* AIDS.gov, *The Affordable Care Act and HIV*, https://www.aids.gov/federal-resources/policies/health-care-reform.

[6] 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a). *See also* LEONARDO CUELLO, NAT'L HEALTH LAW PROGRAM, WHAT MAKES MEDICAID, MEDICAID: FIVE REASONS WHY MEDICAID IS ESSENTIAL FOR LOW INCOME PEOPLE (2015), http://www.healthlaw.org/issues/medicaid/what-makes-medicaid-medicaid-five-reasons-why-medicaid-is-essential-to-low-income-people#.VRXOpfnF9rs.

[7] JESSAMY TAYLOR, NAT'L HEALTH POLICY FORUM, CHANGES IN LATITUDES, CHANGES IN ATTITUDES: FQHCS AND COMMUNITY CLINICS IN A REFORMED HEALTH CARE MARKET 6 (2012), http://www.nhpf.org/library/issue-briefs/IB848_FQHCsandReform_12-18-12.pdf.

[8] JAMILLE FIELDS & DEBBIE REID, NAT'L HEALTH LAW PROGRAM, EARLIER ACCESS TO CARE FOR UNINSURED WOMEN LIVING WITH HIV: THE AFFORDABLE CARE ACT'S MEDICAID EXPANSION AND 1115 DEMONSTRATION PROJECTS (2015), http://www.healthlaw.org/publications/browse-all-publications/Earlier-Access-to-Care-for-Uninsured-Women-Living-with-HIV-and-the-ACA#.WFFN5PkrKUk.

[9] Jennifer Kates & Rachel Garfield, *The ACA and People with HIV*, Health Affairs Blog (March 3, 2014), http://healthaffairs.org/blog/2014/03/03/the-aca-and-people-with-hiv-the-acas-impact-and-the-implications-of-state-choices/.

[10] HHS.gov, *Minority Populations Profiles*, http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=26.

[11] Sarah Kaplan, *Indiana is Battling the Worst HIV Outbreak in its History*, WASH. POST, Mar. 26, 2015, http://www.washingtonpost.com/news/morning-mix/wp/2015/03/26/indiana-is-battling-the-worst-hiv-epidemic-in-state-history.