

What the American Health Care Act means for LGBT people and people living with HIV

By Tim Wang and Sean Cahill

Introduction

On Friday, March 6, 2017, GOP House Speaker Paul Ryan released the American Health Care Act (AHCA), which is the first of a proposed three-step process by the Republican Party to replace the Affordable Care Act (ACA).¹ The first step would reduce federal spending on Medicaid. The second step would change many of the regulatory reforms implemented under the ACA through the US Department of Health and Human Services. The third step would introduce additional health insurance market reforms, such as the ability to purchase health insurance across state lines, through additional legislation. This policy brief will address the impact of the AHCA—the proposed first step in replacing the ACA—on lesbian, gay, bisexual, and transgender (LGBT) people and people living with HIV (PLWH).

The Congressional Budget Office (CBO), which provides nonpartisan budget analysis of proposed legislation to Congress, has estimated that the AHCA would reduce federal deficits by \$337 billion by 2026.² These savings would be derived from reductions in federal funding for Medicaid and eliminating the ACA's subsidies for individual, nongroup health insurance. The CBO estimated that 14 million Americans would lose their health insurance by 2018 due to the AHCA's elimination of the ACA's individual and employer mandates, which levies a fine on individuals or employers who opt out of health insurance coverage.³ By 2026, the freezing of Medicaid expansion and the prohibition on states from reimbursing "prohibited entities," which has been understood to apply almost exclusively to Planned Parenthood clinics, with Medicaid funding would result in 24 million Americans losing their health insurance. That figure is four million people more than the 20 million who have obtained health insurance under the ACA.⁴

The Congressional Budget Office has estimated that 24 million Americans will lose their health insurance by 2026 as a result of the American Health Care Act.

The AHCA's proposed changes to Medicaid would negatively affect many low-income LGBT people and PLWH, particularly LGBT people and PLWH of color. Below, each of these changes, and their implications for the health of LGBT people and PLWH, is described in detail. We will also describe how some popular and critically important elements of the ACA, such as the ban on insurance company discrimination against people with preexisting health conditions, would not be affected by the AHCA.

Important Affordable Care Act reforms impacting LGBT people and PLWH will remain

Political reality dictates that any attempts to replace the ACA must be done through the budget reconciliation process, which requires a simple majority vote in the United States Senate.⁵ That means that the AHCA can only contain provisions that impact the federal budget, and cannot impact insurance industry reforms that have benefited all Americans, but LGBT people and PLWH in particular. Those reforms include:

- A ban on insurance company discrimination (refusal of coverage) against people with preexisting health conditions.
- Permitting young people to stay on parents' insurance through age 26.
- A ban on annual and lifetime spending caps.

The ban on discrimination based on preexisting conditions, and the elimination of annual and lifetime spending caps, are two key provisions of the ACA that have resulted in expanded access to health insurance for PLWH. Prior to the ACA, PLWH were often denied coverage for having a preexisting condition, or they were met with high premiums and prohibitive spending caps. These reforms are critically important for gay and bisexual men, who represent two-thirds of new HIV infections in the United States, and transgender people, who are disproportionately burdened by high rates of HIV.⁶ In each of these populations the reforms impact people of the color the most: Black and Latino men who have sex with men experience the highest HIV burden among all sub-populations,⁷ and transgender women of color experience disproportionately high rates of HIV.⁸

Medicaid expansion

- Under the ACA, in states that expanded Medicaid, low-income people up to at least 138% of the Federal Poverty Level can qualify for coverage based on income alone. This has been extremely helpful for low-income LGBT people and PLWH who previously could not qualify for Medicaid, because they did not have dependent children or a disability, or because they were not poor enough.
- The Center for American Progress found that in states expanding Medicaid, 386,000 uninsured low-income LGBT people qualified for Medicaid.⁹
- The percentage of PLWH on Medicaid increased from 36% in 2012 to 42% in 2014,¹⁰ when the Medicaid expansion was implemented in 26 states.¹¹ Currently, 31 states and the District of Columbia have expanded their Medicaid programs.
- The AHCA would continue to allow Medicaid expansion through 2020, and fund recipients who became eligible through expansion rules at the federal 90% match. The 19 remaining states that haven't expanded yet could still expand up until that time. In 2020, new enrollment in Medicaid expansion would freeze. Under the AHCA, the federal government would continue paying its share of Medicaid costs for anyone who enrolls up until January 1, 2020. After that date, new

enrollees would have to meet previous standards of Medicaid eligibility (i.e. low-income people must also have children or be disabled, which would require low-income PLWH who do not have children to let their disease progress to an AIDS diagnosis in order to be eligible for coverage).

- If enacted, as of 2020 the AHCA would place individuals who accessed Medicaid through the ACA expansion at higher risk of losing health insurance coverage. For example, a low-income man with HIV who is not a parent, but who enrolled in Medicaid under the ACA expansion would need to weigh the risks to his health insurance coverage if he accepted a higher paying job with private insurance. If he accepted the job but was laid off a year later, he would not be able to re-enroll in Medicaid based on

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his low-income status alone. States could decide to continue the Medicaid expansion on their own, but they would be responsible for funding 100% of the costs of those covered under the expansion, without any federal funds.¹² According to an estimate by the Center on Budget and Policy Priorities (CBPP), it would cost the 31 states and Washington, DC which have expanded Medicaid an additional \$253 billion over the next decade to maintain the ACA Medicaid expansion on their own.¹³

Medicaid funding

- The AHCA would change the funding structure for Medicaid that existed even prior to implementation of the ACA. Currently, the federal government has an open-ended commitment to provide at least a 50% federal match to pay for state Medicaid costs, no matter how high the costs go. Under the AHCA, the federal government would pay for Medicaid in a “per capita cap” system where states would get a set amount of money from the federal government for each enrollee adjusted annually by the Cost of Medical Care Services (MCS) in the Consumer Price Index (CPI). This is different from a block grant, in which the federal government would provide states with a set amount of money, because the per capita system does somewhat account for changes in Medicaid enrollment.^{14,15} However, it does not take into account differences of cost or acuity in different patient populations.
- The set amount of money per enrollee would grow every year in response to inflation. However, according to estimates from the CBPP, while the projected growth of the per capita amount would account for inflation, it would still fall below the projected growth of Medicaid costs, resulting in an estimated \$116 billion cut to Medicaid over 10 years.¹⁶ Many states currently provide Medicaid coverage beyond what is required by the federal government. This includes coverage for services to many people with developmental or intellectual disabilities, who require extensive caregiving assistance. This optional coverage may have to be sacrificed in order to make up for the reduced federal spending on Medicaid.

- The per capita cap system also may not respond well to unexpected increases in cost. Under the current system, if a state experiences a natural disaster or epidemic and Medicaid costs rise unexpectedly as a result, the federal government’s spending should increase as well to match state spending. Under the AHCA, the states will get a set amount based on the number of enrollees. If an unexpected increase in costs occurs, states will have to find ways to make up the difference themselves.¹⁷ Examples of unexpected disasters and epidemics include Hurricane Katrina in Louisiana, the recent outbreak of HIV and Hepatitis C in southern Indiana, and the Zika virus outbreak in Puerto Rico and Texas.

Case Study: HIV Outbreak in Indiana

States need resources to respond to increased health care costs related to public health threats. In 2014 and 2015, 181 people from Scott County, Indiana were diagnosed with HIV. By contrast, between 2004 and 2013 only five people in Scott County had been diagnosed. On March 26, 2015, then-Gov. Mike Pence declared a public health emergency. A study of the outbreak published in the *New England Journal of Medicine* found that the outbreak was clustered among a large network of people who use intravenous drugs with no access to needle exchange or substance use treatment, and limited access to basic health services.¹⁸ Additionally, the only clinic in the county that had provided free HIV testing, a Planned Parenthood clinic, had closed in 2013 after Indiana lawmakers voted to defund it.¹⁹ Three months before the public health emergency was declared, the *NEJM* study authors write, the state of Indiana had “fortuitously” accepted the Medicaid expansion offered by the ACA. The expansion of health insurance “helped to ensure health care coverage in the largely uninsured and impoverished community that was affected by the outbreak and facilitated the immediate enrollment, coverage, and access to critical health care services, including HIV treatment. Even with access to health insurance, a local HIV treatment provider, and care coordination, there were substantial challenges to the rapid initiation of therapy with antiretroviral medications.” The *NEJM* study authors noted that there are numerous counties around the country with conditions similar to those that facilitated the outbreak of HIV in Scott County, Indiana and concluded that while outreach, prevention, and treatment efforts are difficult to mount in rural areas, they “are necessary to prevent a similar outbreak in the future.”

Individual mandate

- The AHCA would eliminate the individual mandate, and institute a continuous coverage policy which would penalize people who experience a lapse in health insurance coverage lasting longer than 63 days. When people who have gone without health insurance coverage for longer than 63 days re-enroll, they would be required to pay a 30% surcharge on their insurance. The

surcharge would last for one year, and it would be paid to the insurance company instead of the federal treasury as is the case with the individual mandate.

- The AHCA continuous coverage policy would penalize PLWH and others with chronic health conditions. Healthy people who lose insurance and are unable to replace it within 63 days may opt to stay out of the insurance market until they really need it in order to avoid paying the 30% surcharge. But PLWH and those with other chronic conditions require access to affordable health care and medicine to remain alive. PLWH and those with other chronic conditions who lose their health insurance through job loss, and are unable to replace it within the 63-day window, would be forced to pay the 30% surcharge once they do obtain insurance again.
- The AHCA might increase overall health costs. Elimination of the individual mandate would reward young, healthy people who lose health insurance and decide to leave the risk pool until they require insurance again. This act, repeated on a major scale by millions of young healthy people, would establish tiers of coverage, low cost insurance with minimal benefits, and more expensive insurance for high cost utilizers like PLWH and others with chronic diseases, who need to remain enrolled in health insurance in order to access life-saving medicine.²⁰

Tax credits

- The ACA currently provides insurance subsidies based on income, cost of insurance in the enrollee's home state, and age. The ACA subsidies also increase annually based on the cost of insurance premiums, and the ACA caps the costs of health insurance at 9.69% percent of income.²¹ The AHCA would provide tax credits based on age that do not take cost of health care into account or the percentage of income that is being paid toward health insurance. Everyone in the same age group who earns less than \$75,000 would get the same flat tax credit under the AHCA. Those in the youngest age group would receive a \$2000 credit which gradually increases with age up to a \$4,000 tax credit for those in the oldest age group.
- The AHCA would also tie increases in the tax credit to inflation, not increases in health insurance premiums, which generally increase faster than inflation.²² The AHCA would also permit health insurers to charge older Americans five times as much as younger Americans.²³ The Kaiser Family Foundation has created an interactive map of the country that shows the difference in subsidies under the ACA and the AHCA based on income, age, and state.²⁴ It shows that the AHCA would provide lower subsidies to low-income, older Americans, particularly those living in rural areas where the costs of health care are higher than those in urban areas. For example, a 60 year-old making \$30,000 annually in Scotts Bluff County, Nebraska receives \$16,950 in health insurance subsidies under the ACA, but would receive just \$4,000 under the AHCA. In Aroostook County, Maine, such a person receives \$13,210 from the ACA, but would receive just \$4,000 under the AHCA. The Kaiser Family Foundation estimates that

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on average, across all incomes and ages, the credits for the AHCA would be 36% less than the ones people currently receive under the ACA.²⁵

“Prohibited Entities”

- The AHCA prevents states from using federal Medicaid funds to pay “prohibited entities.” The AHCA defines a “prohibited entity” as one that meets all of the following requirements:
 - “The entity operates as a nonprofit corporation;
 - The entity qualifies as an essential community provider under federal regulations for qualified health plan contracting purposes;
 - The entity is primarily engaged in family planning services, reproductive health, and related medical care; the entity provides abortions other than those related to rape, incest, or life-endangerment situations; and,
 - The entity and its subsidiaries and affiliates received federal and state Medicaid payments during fiscal year (FY) 2014 exceeding \$350 million.”²⁶
- It is commonly understood that this funding bar was written to target Planned Parenthood clinics.^{27,28} Planned Parenthood provides a wide array of family planning and sexual health services to low-income women. Planned Parenthood is already barred from using federal funding to pay for abortion services, and 60% of Planned Parenthood’s federal funding comes from reimbursements from Medicaid for preventative and primary care. The Government Accountability Office estimated that 390,000 women could lose access to preventive care and 650,000 could face reduced preventive care within a year if Congress defunded Planned Parenthood.²⁹
- The LGBT population experiences disproportionate burden related to sexual health outcomes, and the defunding of Planned Parenthood could worsen these disparities. Gay and bisexual men, as well as transgender women, are disproportionately burdened by HIV and other STIs.^{30,31} Lesbian and bisexual adolescent women are at greater risk of unwanted pregnancies.³² The sexual health education, STI screenings, and family planning services that Planned Parenthood offers play a role in reducing these disparities.
- Planned Parenthood also provides thousands of women with mammograms, Pap tests, and other preventive cancer screenings. Lesbians and bisexual women are less likely to get mammograms³³ and Pap tests,³⁴ as are black and Latina women.³⁵ Black and Latina lesbian and bisexual women may experience the lowest rates of these preventive screenings. Nulliparity—never having given birth—is a risk factor for breast and ovarian cancer.³⁶ Obesity

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can also contribute to cancer risk. Both nulliparity and obesity are more common among lesbians. For all these reasons, the preventive cancer screenings provided by Planned Parenthood to millions of American women are disproportionately important to Black and Latina women and to low-income women, and may be disproportionately important to lesbian and bisexual women.

Conclusion: The American Health Care Act would reduce insurance coverage for LGBT people and PLWH, particularly those who are also members of racial and ethnic minority groups

The cuts to Medicaid funding, the per capita cap, the proposed phase-out of the Medicaid expansion, and the defunding of Planned Parenthood that would occur under the ACHA disproportionately threaten the health of LGBT people and PLWH, particularly those of color.

Since the ACA was passed in 2010, 20 million Americans have obtained health insurance coverage who were previously unable to obtain it due to preexisting conditions or because they could not afford it.³⁷ This increase in coverage has significantly benefited groups that experienced lower rates of health insurance coverage, such as LGBT people, PLWH, and Black and Latino people. Prior to implementation of the Affordable Care Act (ACA), studies showed that 22% of Black adults

On a per capita basis, Black and Latino people have disproportionately benefited from the increases in insurance coverage under the ACA.

and 33% of Latino adults were uninsured, compared with just 14% of White non-Hispanic adults.³⁸ The Kaiser Family Foundation estimates that uninsurance rates declined among Latino nonelderly individuals from 30% in 2013 to 21% in 2015. Among Black individuals the uninsurance rate declined from 19% in 2013 to 11% in 2015. Among Asian American individuals the uninsurance rate was cut in half, from 14% to 7%, and among White non-Hispanic individuals the uninsurance rate declined from 12% in 2013 to 7% in 2015.³⁹ Of the 20 million newly insured for whom we have racial ethnic data, 7.4 million were White non-Hispanic, 2.6 million were Black, and 4.0 million were Hispanic.⁴⁰ On a per capita basis, Black and Latino people have disproportionately benefited from the increases in insurance coverage under the ACA.

In 2013, when the ACA's Medicaid expansion was implemented, just 17% of the estimated 1.2 million Americans living with HIV had private health insurance.⁴¹ The U.S. Centers for Disease Control and Prevention and the Kaiser Family Foundation estimate that the percentage of people living with HIV who lacked any kind of health insurance coverage was 22% in 2012 and dropped to 15% in 2014, following implementation of key elements of health care reform. The percentage of PLWH on Medicaid increased from 36% in 2012 to 42% in 2014.⁴² The ACA, and Medicaid expansion in particular, have been very important to covering the health care costs and needs of PLWH. Between June/September 2013 and December 2014/March 2015, the percentage of LGB adults without health insurance decreased from 21.7% to 11.1%, which is a larger decrease than in the non-LGB adult population.⁴³

LGBT people and PLWH experience widespread discrimination in health care, which can act as a barrier to seeking routine and emergency medical care.⁴⁴ Compared to heterosexual individuals, LGB individuals report higher rates and earlier onset of disability;⁴⁵ lesbian and bisexual women are less likely to receive preventive cancer screenings;⁴⁶ and gay and bisexual men represent two-thirds of new HIV infections in the United States, with Black and Latino men who have sex with men (MSM) experiencing the highest HIV burden among all sub-populations.⁴⁷ Transgender people, especially transgender women of color, are disproportionately burdened by high rates of HIV and other STIs,⁴⁸ as well as high prevalence of victimization and mental health issues, including suicidality.⁴⁹ LGBT people are also disproportionately affected by risk factors that contribute to poorer health outcomes, such as poverty,⁵⁰ homelessness,⁵¹ and substance abuse.⁵² All of these access issues are exacerbated for LGBT and PLWH of color as members of racial and ethnic minority groups experience a myriad of health disparities at the patient, provider, and system level.⁵³

The ACA has implemented numerous, critical steps to reduce the health disparities experienced by these populations, and its impact on health outcomes and health care costs remains a work in progress. But the loss of health insurance that would take place under the ACHA would reverse these gains by severely limiting access to health insurance for an estimated 24 million Americans.

While it is estimated that the ACHA will reduce the federal deficit by \$337 billion over the next decade,⁵⁴ costs of health insurance under the ACA are lower than originally anticipated. In a March 7, 2017 letter to the House Committee on the Budget, Keith Hall, Director of the Congressional Budget Office, noted that the CBO and the staff of the Joint Committee on Taxation estimated in 2010 that the ACA would cost \$214 billion by 2019, but they now project that the ACA, if continued, would

cost just \$148 billion by 2019.⁵⁵ While the ACHA might reduce overall health insurance costs for the federal government, they will largely occur by reducing the scope of benefits in some insurance plans, and dramatically reducing the number of people who have access to Medicaid, including many heterosexual Americans of all racial/ethnic backgrounds, LGBT people and PLWH. Some of those costs will be strictly monetary in the form of higher out-of-pockets expenses. Other costs are more difficult to calculate, as they will consist of the costs of health care for individuals who delay routine or emergency health care due to a lack of health insurance. Additional systemic cost savings that would come from increasing health equity and reducing disparities in health and health outcomes under the ACA will also be lost. Under the ACHA the costs to America's health would be great, and the financial costs to the health care system would likely outweigh short-term budgetary savings.

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