# Health Reform and People Living with HIV in North Carolina

**Duke AIDS Policy Project**
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## *The Patient Protection and Affordable Care Act:*

### *Overview:*

The Patient Protection and Affordable Care Act was signed into law on March 23, 2010. Parts of health reform have already gone into effect. The law is scheduled to be fully implemented in 2014, assuming it is left undisturbed by the Supreme Court. For people living with HIV/AIDS, the most important aspects of Health Reform are --

- **Expanded coverage options:**
  - **Expanded Medicaid:** Open to persons with incomes at or below 138 percent of poverty, regardless of disability.
  - **New state-based insurance marketplace -- Health Benefit Exchange.** This marketplace will serve people seeking individual insurance policies, as well as small employers seeking group insurance.
- **Elimination of pre-existing condition limitations –** Starting 2014, insurance can no longer be denied for pre-existing conditions.
- **Health status can no longer considered in insurance rate setting –** Starting 2014, only age, geography and tobacco use can be considered
- **Elimination of annual and lifetime limits on coverage -- L**ifetime limits already eliminated; starting 2014, annual caps eliminated.
- **Affordability mechanisms** – Free public coverage (expanded Medicaid) and subsidies for private insurance sold on the exchange.
- **Prevention** – Medicaid, Medicare, and private insurance will be required to offer all preventive services recommended by the U.S. Preventive Services Task Force. Medicare and private insurance will be required to offer these preventative services for free.
- **Workforce improvements:** Additional funding for the National Health Service Corp, for medical education, and for medically underserved areas.
- **Additional funding for Federally Qualified Community Health Centers**

### *Coverage Requirement:*

The aspect of health reform that has received the most attention in the media and public discourse is the so-called **"individual mandate."** The Affordable Care Act ("ACA") refers to this as the obligation to have **"minimum essential coverage."** This controversial provision is the key target of the legal challenges to the ACA that were heard in the U.S. Supreme Court. A decision on whether the "individual mandate" is constitutional is expected in June 2012.

***Exemptions/Penalties:*** Many people will be exempt from the coverage requirement:

- Those for whom insurance is too expensive, even with subsidies;
- Immigrants who are undocumented or have been in the U.S. for less than five years;
- Members of certain religious groups, members of American Indian tribes, and
- Those who opt to pay the small **tax penalty** for failing to obtain coverage. In 2014, that penalty is only $95. It will increase to $695 by 2016.

***This means that many people, including PLWHA, will still be uninsured in 2014.*** This group will include immigrants and people with incomes too high for Medicaid, but who still can't afford insurance on the Exchange, even with subsidies. Some may prefer to continue accessing free services, such as ADAP, Ryan White, and free/sliding scale coverage at community health centers.

***Coverage That Will Satisfy the Coverage Requirement:*** Most people who currently have insurance will satisfy the requirement with the insurance they have now. Coverage will meet the requirement as long as it meets minimal standards of benefit quality. This will include

- **Government Insurance programs:** Medicare, Medicaid, Expanded Medicaid, TRICARE, and Veteran's Administration health care.
- **Employer sponsored plans:** Most existing plans, as well as new small group plans sold on the Exchange
- **Individual insurance policies:** Both those currently in existence and those sold on the Exchange.

## *Essential Health Benefits:*

The law requires that insurance provided through Medicaid and the Exchange cover "essential health benefits." The law lists 10 categories of benefits that are considered "essential" and must be included in all plans, whether private or Medicaid:

- 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
- pediatric services, including oral and vision care.

The law provides no detail on what these categories should include. **Fleshing out what satisfies the "essential health benefit" requirement is an important task that is still underway.** Federal rules are expected soon that will provide additional guidance, but guidance issued from the U.S. Department of Health and Human Services so far indicates that states will be given a great deal of latitude in determining the parameters of "essential health benefits"

It is likely that what counts as "essential health benefits" for Medicaid will not be exactly the same as what is determined for insurance sold on the Exchange. There will probably be two separate determinations of essential health benefits, one made by the N.C. Department of Insurance (for private plans) and another by the N.C. Department of Health and Human Services/Division of Medical Assistance (for Medicaid). **These determinations will be made in 2012.**

## A Closer Look at New Coverage Options for PLWHA

### *Medicaid Expansion:*

The ACA creates a new Medicaid program that will be open to people with incomes **under 138% of the federal poverty level** ($15,415 for a single person in 2012). This "Expanded Medicaid" program will supplement, but not replace, existing Medicaid programs that cover children, their caregivers, the aged, blind, and disabled, and SSI recipients. The two programs will co-exist and have different eligibility requirements, benefits and ways of counting income. Those who qualify for traditional Medicaid will still be able to enroll in that program.

The most important distinctions between the two Medicaid programs are that they will have different income/asset eligibility requirements and different benefits. Most important for PLWHA is that Expanded Medicaid does not have a disability requirement. So, for the first time, childless adults will be able to access Medicaid. Because there is no resource test, low income people will not be excluded because they have some assets, such as an interest in a plot of family land, or some savings.

Under Expanded Medicaid, income will be computed in a different way than for Traditional Medicaid: "Modified Adjusted Gross Income" – "MAGI." MAGI is the amount of income a household reports on their federal tax return. There will be no income "disregards" other than an across the board 5% disregard (the 138% level above is actually 133% plus the 5% disregard). MAGI will also be used to determine eligibility for insurance subsidies and Health Choice. This will make it possible to coordinate eligibility between Medicaid, CHIP and insurance subsidies.

MAGI also simplifies the verification process and eliminates the need for paper documentation. For most people, MAGI can be verified electronically based on IRS records. Because less paperwork will be required and verification can be done by using existing federal data on income and citizenship/immigration status, enrollment can be done quickly and electronically.

# Traditional Medicaid vs. Expanded Medicaid

| | Traditional Medicaid | Expanded Medicaid |
|---|---|---|
| **People eligible** | Children, caretakers, aged, blind, disabled, SSI recipients | Everyone |
| **Income limit** | Varies by program, but generally 100% of FPL.<br>• Income counted according to Medicaid formula | 138% FPL (133% plus 5% income disregard)<br>• Income determined based on taxable income (Modified Adjustable Gross Income – "MAGI") |
| **Asset/Resource limits** | $2000 individual, $3000 couple | None |
| **Benefits package** | **Highlights:**<br>• Adult dental (limited)<br>• Ambulance<br>• CAP programs<br>• Case Management<br>• Chiropractor<br>• Clinics<br>• Durable Medical Equipment<br>• Eye Exams - routine<br>• Family Planning<br>• Home Health<br>• Home infusion therapy<br>• Hospice<br>• Hospital Services<br>• Mental Health<br>• Midwife & Nurse Practitioner<br>• Nursing Facility<br>• Orthotics and Prosthetics<br>• Personal Care; Private Nursing<br>• Physician<br>• Podiatry<br>• Prescription Drugs<br>• Psychiatric Residential<br>• PT, OT & ST<br>• Respiratory Therapy<br>• Transportation | **"Essential Health Benefits"**<br>• Ambulatory Services<br>• Hospitalization<br>• Maternity & Newborn Care<br>• Mental Health/Substance Abuse<br>• Prescription Drugs<br>• Emergency Services<br>• Rehabilitative/Habilitative<br>• Lab Services<br>• Preventative & Wellness Services & Chronic Disease Management<br>• Pediatric services<br><br>Specific services in these categories to be determined by the State of N.C. (DMA), with federal rules expected soon. |
| **Administration** | Division of Medical Assistance/DSS | Division of Medical Assistance/DSS |
| **Federal Contribution** | Approximately 65%. Unchanged by ACA | 2014-16: 100%<br>2017-2020: gradually reduced to 90% |

**What will happen to "old" Medicaid?** Traditional Medicaid will continue to operate beside the "new" expanded Medicaid. Current financial eligibility rules will be retained for existing Medicaid programs. People who are currently enrolled in Medicaid will continue to be covered for the same services as before. They can expect few if any changes in their coverage and services. Even after expanded Medicaid is offered in 2014, applicants will be assessed not only for the new programs, but also for traditional Medicaid. Low income children will continue to be covered under Medicaid and Health Choice.

**Benefits: An important unanswered question is what will be covered under Expanded Medicaid**. We know that Expanded Medicaid benefits will be different from traditional Medicaid. As discussed above, the specifics of "essential health benefits," under Expanded Medicaid remains to be determined.

**Implementation: Benefits in Expanded Medicaid**

**The state needs to hear from the HIV/AIDS community about what benefits should be included in Expanded Medicaid. Areas of particular concern are transportation, case management, nutrition services and oral health. These services are not usually included in private insurance policies, and the state is supposed to look to the insurance market in determining benefits for Expanded Medicaid.**

### *Improved Medicaid reimbursement for primary care providers in 2013-14:*

In anticipation of increased enrollment in Medicaid in 2014, the ACA establishes increased provider reimbursement rates in 2013 and 2014, both in fee-for-service and managed care. Primary care physicians will be paid at the Medicare rate for those two years. This increase is fully funded by the federal government. The intention is to encourage more providers to participate in Medicaid. It is not clear whether states will continue this enhanced rate in 2015 when federal support ends.

## Insurance Changes

PLWHA who have insurance before health reform takes effect will be able to keep that insurance if they like it. In 2014, PLWHA whose employer-sponsored coverage is inadequate or unaffordable can decline that coverage and seek insurance on the Exchange. Coverage is deemed unaffordable if the employee's contribution is more than 9.5% of household income that month.

The elimination of discriminatory insurance practices and creation of a market for individual insurance plans will increase access to insurance for PLWHA.

### *Elimination of Discriminatory Insurance Practices:*

A primary goal of health reform is to eliminate the kinds of discriminatory practices that have been obstacles to PLWHA and others with expensive, chronic disease. The law requires all plans to eliminate annual limits (effective 2014) and lifetime caps (effective now). Plans are prohibited from dropping people when they get sick. Enrollees can be terminated only based on fraud. Most importantly,

**effective 2014, plans will no longer be able to impose pre-existing condition limitations.** Removal of these three barriers will greatly increase access to insurance in the private market and will give PLWHA the freedom to change jobs without worries about losing insurance coverage.

A second change that will reduce discrimination is that people will be able to buy insurance **that is not rated based on health factors.** That is, the health status of people insured will not affect the price. The only factors considered will be age, geographic area, family composition, and tobacco use. So individuals and small employers will be able to purchase insurance at rates that do not factor in the health of the enrollees. This will enable PLWHA to participate in plans offered by small employers. Without protections, PLWHA have feared health questionnaires required for enrollment in small employer plans, where there is less buffer between the boss and the insurance plan, and where one employee's costs can cause everyone's rates to skyrocket. Many have declined employer-sponsored coverage because of legitimate concerns about confidentiality and discrimination. With health factors irrelevant to insurance rating, there should be no need for health questionnaires and no worry that a PLWHA's high costs will raise the employer's rate.

Plans that existed when the law was enacted on March 23, 2010 will be exempt from many of the requirements of new plans. These plans are referred to as "grandfathered" plans. Over time, as these plans make changes, they will be required to comply with the new requirements.

## *Health Benefit Exchange—A new marketplace for insurance*

Beginning in 2014, those who are uninsured and have incomes over 138% of the poverty level will have access to a "qualified health plan." Plans will be sold through a new state-based insurance marketplace known as the "Health Benefits Exchange." Coverage purchased through the Exchange will be made affordable through premium and cost-sharing subsidies, as well as lower out-of-pocket maximums. The Exchange will also have a marketplace for small group employers to purchase insurance.

The number of people with HIV/AIDS who currently buy insurance in the individual market is small. Pre-existing limitations preclude enrollment in most plans. For plans that are available, the rates for people with HIV/AIDS are prohibitive for most. The premiums alone can exceed $1000/month. Health Reform will make it feasible for PLWHA to purchase individual insurance on the Exchange. Most likely the number of PLWHA taking advantage of this option will be relatively small because most will qualify for Medicaid.

States are encouraged to create their own exchanges, but if they do not have plans in place by January 1, 2013, the federal government will step in and create one for the state. North Carolina has not yet created an exchange, but has made some progress. A North Carolina Institute of Medicine Task Force recommended that the legislature create a quasi-state agency to operate the Exchange, rather than placing it within an existing agency. It recommended an Exchange board with substantial consumer representation. The legislature instead considered House Bill 115, which would have created an exchange dominated by insurance industry representatives, with minimal consumer representation. House Bill 115 passed the House in the 2011 legislative session, and is eligible for consideration in the 2012 session. Although the legislature did not pass legislation creating an exchange, it did pass a bill stating its intent to create one, and directing the N.C. Department of Insurance and Department of Health and Human Services to continue work on it.. The Exchange still remains to be created. This is an issue that is in the hands of the North Carolina General Assembly for the coming session.

## *Essential Health Benefits*

The Secretary of Health and Human Services has left it to the states to determine the specifics of the essential health benefits for plans sold in the Exchange. Federal guidance instructs states to choose a "benchmark" plan from existing small group or federal employee health plans. The selected benchmark plan will be expanded as necessary to include any of the 10 categories of essential health benefits that is absent. Importantly, plans offered through the Exchange will be required to offer mental health and substance abuse services in parity with other services.

Insurance plans will also be required to offer free coverage of preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) and vaccines recommended by the Advisory Committee on Immunizations Practices (ACIP) with no cost-sharing. (This coverage of recommended clinical preventive services and vaccines went into effect for any new plan purchased on or after September 23, 2010.)

In North Carolina, the task of determining the state's "essential health benefits" has fallen to the NC Department of Insurance. The North Carolina Department of Insurance is currently studying potential benchmark plans. Once the required essential health benefits are determined, insurers offering products on the North Carolina Health Benefits Exchange must include those benefits. Thus, the particular benefits (that is, services covered) offered by plans on the Exchange can be expected to be quite similar. What will differentiate the plans will be cost sharing and utilization limits, e.g., limits on numbers of prescriptions, doctor visits, etc.

**Implementation: Essential Health Benefits in the Exchange**

**The North Carolina Department of Insurance is working on determining what the Essential Health Benefits will be. It is important that the needs of PLWHA are taken into account, including access to multiple medications and case management. Also, because many PLWHA will move between Medicaid and the Exchange, it will be important that the benefits and utilization limits in each program are similar.**

## *Making coverage affordable -- Subsidies for Premiums and Cost Sharing*

Lower income people purchasing insurance on the Exchange will be able to access subsidies to make insurance more affordable. Assistance comes in several forms:

***Premium subsidies***: People with incomes up to 400% of the federal poverty level will be eligible for reduced premiums. In 2012, 400% of the federal poverty level is $92,200/year for a family of four.

***Cost sharing subsidies:*** People with incomes under 250% will be eligible for reduced cost sharing. They will have lower deductibles, copays, and/or co-insurance.

***Maximum Out-of-Pocket Spending Limits:*** People with incomes at or below 250% of the Federal Poverty Level will also be eligible for a lower maximum out-of-pocket spending limit. So while normally the out-of-pocket maximum might be $5950, a low income person will have that

amount reduced. For example, a person under 150% of the FPL would have a 2/3 reduction in the out of pocket maximum. The maximum would be reduced from $5950 to $1983.

***Mechanism for Subsidy Payment:*** The subsidies take the form of a tax credit that is paid in advance to the insurer so the employee does not have to wait until tax filing. This is referred to as an "Advance Payment of Tax Credit ("APTC"). The subsidy will be recognized at the point of service.

***Subsidies are limited to the Exchange:*** These subsidies are not available for employer sponsored insurance. Someone who has access to employer sponsored insurance that meets affordability definitions (premiums no more than 9.5% of income) is not eligible to purchase insurance on the Exchange. So there will likely be some working people who will only have access to costly insurance through their employer and will not be eligible for subsidies. These people may remain uninsured or require assistance with premiums and cost sharing – a service that could be provided by Ryan White.

***Provider Networks for Exchange Policies:***
Plans offered in the Exchange must provide access to **"essential community providers."** These include federally qualified health centers, rural health clinics, health departments, and certain hospitals. Proposed regulations from the U.S. Department of Health & Human Services provide that health plans under the exchange must contract with a sufficient number of essential community providers that serve low-income, medically underserved people. However, insurers are not required to contract with all ECPs. Specifically, plans are not required to contract with providers that will not accept the generally applicable payment rates.

**Implementation: Provider Networks in the Exchange**

**Community providers are an important source of care for PLWHA. An important issue for implementation is to ensure that Ryan White clinics and other providers of care for PLWHA are included as "essential community providers."**

## Enrollment in New Coverage Options

### *Streamlined Enrollment:*

The ACA calls for single, streamlined application for coverage under Medicaid, Health Choice and the Exchange. The vision is that a person can make one application, provide income and other required information, and get a quick determination of what he or she is eligible for. So, while Medicaid and the Exchange will be separate entities, each can assess an applicant for all insurance affordability options. Application can be made online, by phone, by mail, or in person. Ideally, determinations could be made "in real time" because verification can be done electronically through access to government electronic databases such as IRS, Employment Security Division, and Immigration. This will reduce the administrative burden of verification for the state.

Regulations released by the U.S. Department of Health and Human Services provide that this single portal would enable assessment not only for Medicaid and subsidies, but also gather information necessary to determine whether an applicant was eligible for other Medicaid categories that require more detailed analysis, such as disabled.

For this eligibility and enrollment system to work as envisioned, it will require advanced enrollment IT systems. North Carolina is currently planning for roll-out of its new public benefits eligibility system, NC FAST. It is expected that this system will also serve as the eligibility system for the new coverage options, but it will be a challenge to have the IT system up and running by late 2013 when enrollment is scheduled to begin.

## *Outreach and Education*

Additionally, both Medicaid and the Exchange are required to engage in **outreach and education** efforts to ensure that potentially eligible citizens are enrolled in coverage. The Exchange is required to create a system of trained "**navigators**" to help people learn about and enroll in coverage. Health Care providers and facilities, case managers and AIDS Services Organizations, will need training about the new options and how they will impact PLWHA.

## *Exchange:*

Outreach on the Exchange will include both general information and outreach to community groups, individuals or government entities, as well as personal assistance in gathering information, reviewing options, and enrolling in a plan. Information must also be available through a toll free call center and website with detailed information about qualified health plans available on the Exchange so that consumers can compare the various plans in a meaningful way.

## *Navigators*

Navigators are individuals who will be trained and credentialed to educate consumers about plans in the Exchange and facilitate enrollment. The state can also permit the navigators to address Medicaid and Health Choice outreach and enrollment. The navigators will need to have expertise in eligibility, enrollment, and program specifications. The law provides that navigators must provide information in a culturally and linguistically appropriate manner for the population being served. North Carolina has an excellent model for navigators in the form of the Senior's Health Insurance Information Program (SHIIP), operated by the North Carolina Department of Insurance.

Entities can receive grant funding for acting as a navigator entity. To qualify, the entity must have an existing relation with people likely to enroll in a plan under the Exchange, or be able to readily establish one. It will be up to the Exchange to decide which entities will receive navigator grants.

**Implementation: Navigators**

**Organizations working with PLWHA may be well positioned to become navigator entities or have staff trained as navigators. Some grant funding will be available from the Exchange for navigator entities.**

### *Medicaid*

The Medicaid Agency is also required to conduct outreach. It is charged with seeking out "vulnerable populations," including PLWHA. DMA will be required to help people who are applying for or renewing coverage. The state will be permitted to facilitate Medicaid enrollment by allowing certain provider facilities to determine presumptive eligibility for Medicaid. These facilities include hospitals, FQHCs, Rural Health Clinics, and local health departments.

## Insurance Bridge to 2014:

### *Temporary Pre-Existing Condition Insurance Program (PCIP)*

Even before 2014, PLWHA have access to insurance through **a temporary Pre-existing Condition Insurance Program (PCIP)** created under health reform. This high risk pool has been implemented in North Carolina by **Inclusive Health**, which also **administers** the state high risk pool. The PCIP provides relatively affordable coverage for NC residents with pre-existing conditions (such as HIV) who have been **uninsured for 6 months** prior to applying for coverage. The benefits and provider network offered under the plan are generous and a small number of PLWHA have enrolled. Unfortunately, even this coverage is not affordable for many.

## Other Health Reform Provisions of Importance to PLWHA

### *Medicaid Health Home*

Another initiative in the ACA is the encouragement of patient centered medical homes. This model is already employed by Community Care of North Carolina (CCNC). Under this option, the state can apply for a State Plan Amendment to support medical homes. This will permit the state to receive a higher federal match of 80% of up to 8 fiscal quarters. The State of North Carolina is seeking this additional funding for medical homes.

It will be important to ensure that HIV/AIDS is included as an eligible condition for a medical home. Also, providers who care for PLWHA could benefit from qualifying as a medical home. There is a HRSA initiative to assist Ryan White providers in obtaining this status.

### *Medicare Changes*

Under health reform, Medicare will improve in a few ways beneficial to PLWHA. First, coverage of medications under Part D will improve, through the gradual closure of the coverage gap (the "donut hole"). In 2011, beneficiaries began receiving a 50% discount on brand-name prescription drugs in the coverage gap. Over time, changes will be introduced so that cost sharing in the "donut hole" will be reduced to 25% by 2020. The amount of out of pocket cost that the beneficiary pays will also be reduced by 2020, so the coverage gap will be smaller.

Also important to PLWHA, on January 1, 2011, ADAP payments made in the Part D coverage gap began to qualify as TrOOP ("true out of pocket payments"). This will enable recipients to pass through the donut hole and reach the catastrophic coverage level, where cost sharing is reduced to 5%.

### *Prevention*

Beginning January 1, 2011, Medicare has covered annual wellness visits as well as all preventive services recommended by the U.S. Preventive Services Task Force, and vaccines recommended by the Advisory Committee on Immunizations Practices. There is no cost sharing for these preventive services. HIV testing is included as a preventive service for those who are pregnant, at risk of HIV, or who request a test.

### *Dual Eligibles*

The ACA provides for improved care coordination for dual eligible. The law creates the Federal Coordinated Health Care Office within the Centers for Medicare and Medicaid Services. This office is charged with improving coordination between the federal government and the states in order to improve health care access and quality for dual eligibles.

## *Prevention and Public Health Fund*

The ACA included $15 billion in funding over 10 years for a Prevention and Public Health fund. This fund was intended to provide needed support for the nation's public health infrastructure. In early 2012, the allocation was reduced to $10 billion.

## *Community Health Center Expansion*

The ACA provides $11 in funding to, among other things, support centers in applying for FQHC status.

# Issues for AIDS Service Providers and the Ryan White Program

If the ACA is implemented as planned, in 2014 many of the patients who have been receiving medical care through Ryan White will have access to insurance. Those providing services to PLWHA will need to be prepared for the changes that will come with increased access to health coverage.

A major concern is that policy makers will conclude that health reform will eliminate the need for the Ryan White program, at least at current funding levels. Since everyone theoretically will be able to access insurance, Ryan White funding would seem duplicative. With Ryan White up for reauthorization in 2013, and the current deficit pressure, there is a real risk of funding reductions. Advocacy in support of the Ryan White program will be an important priority in 2013.

**How can Ryan White funding be justified in the context of health reform?** One important point is that even with the ACA's coverage expansion, there will still be PLWHA who are uninsured and there will still be gaps to fill.

**Gaps created by "Churning":** In addition to those who remain uninsured, there will also be a sizeable population of low income people whose incomes will fluctuate so that they will "churn" back and forth between eligibility for Medicaid and insurance subsidies. A recent study showed that about half of adults with incomes below 200 percent of the FPL would be expected to shift between Medicaid and insurance subsidies over the course of a single year. This raises concerns about maintaining continuity of care, especially for PLWHA. Thus it is important for advocates to work to ensure that Medicaid and the Exchange both have broad provider networks that include most or all HIV care providers. Also, Ryan White programs need to be ready to fill gaps that result from transitioning back and forth between programs.

**Services not covered by Insurance or Medicaid:** Even though both Medicaid and Exchange plans will be required to cover "essential health benefits," there may be utilization limits (e.g. maximum numbers of prescriptions) or missing services for which people will need assistance. Many clients will need services that are not traditionally covered by insurance, such as transportation to medical appointments, dental services, nutrition services, or case management. Clients will need to turn to Ryan White programs for these support services.

Most of the patients now receiving care funded by Ryan White will be covered by – or at least eligible for – Medicaid. This may be a boon for some providers which have provided uncompensated care. Some large medical centers have provided free care through charity programs or drug studies. As patients enroll in Medicaid or insurance, the burden of uncompensated care may be relieved.

**Funding changes for Ryan White Providers:** For providers who have previously been Ryan White funded, there may be some complications. If Ryan White funding for medical services is reduced, providers may find that Medicaid and insurance billings are not sufficient to make up for the loss of Ryan White funds.

**Tracking PLWHA for retention in care:** Another challenge after health reform will be tracking clients for retention in care, adherence, prevention for positives, etc. Clients who are no longer receiving medical services through Ryan White will still need to be followed. New mechanisms for ensuring retention in care will need to be developed.

## Conclusion:

2014 will bring welcome access to insurance for many PLWHA. But it will also require that state agencies, HIV/AIDS medical and service providers, and HIV advocates work together to make the new system work for PLWHA. Some changes will be painful for clients – they may now have to pay for services they once got for free through ADAP, Ryan White, charity care and pharmaceutical patient assistance programs. Clients will need to be educated about the benefits of the new system. Ryan White programs may find that changing funding streams will require them to rethink their financial model and adapt to a new funding environment. Government agencies will need to increase collaboration with other agencies and with new entities such as the Exchange. Many decisions remain to be made throughout the health care system, and the interests of PLWHA must be heard.