

UNIVERSAL HEALTH CARE

Our Vision

All women living with HIV will have access to high-quality, culturally relevant, non-stigmatizing and affordable health care and services to achieve emotional, mental and physical wellness, regardless of sex at birth, race, immigration status or ability to pay.

Current State of Play:

Health care for WLHIV in the U.S. is currently delivered through a patchwork of systems. More than half a million PLHIV rely on the Ryan White program for medical and associated services. Over 40% of PLHIV nationally are on Medicaid and about a quarter of PLHIV are covered through Medicare. A PWN survey in 2015 found that 44% of our members were on Medicaid. 20 million people have gained coverage since the Affordable Care Act (ACA) was passed in 2010.

The ACA significantly expanded access to care for WLHIV by reducing discrimination, improving the quality and consistency of care, and by reducing financial barriers to health care for low-income people. Specifically, the ACA prevented insurers from discriminating against people with people with chronic and pre-existing medical conditions, women and those who are aging. Caps on out-of-pocket costs and subsidies provided through the creation of state insurance marketplaces or “exchanges” made the private insurance market affordable to millions for the first time. Importantly for PLHIV, the ACA permitted and incentivized states to expand Medicaid coverage to all individuals up to 138% of the Federal Poverty Line (FPL).

Yet, with all of its advances, the ACA has faced severe opposition and has come under repeated attack from corporate interests and conservative ideology. A 2012 Supreme Court case eliminated the federal mandate to expand Medicaid coverage. As a result, virtually all Southern states, where racial, economic and health inequities persist, and where nearly half of U.S. WLHIV reside, have refused to expand coverage under the program. The law provides no coverage for undocumented immigrants, with limited coverage for other immigrants. Further, the ACA maintained the



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federal ban on abortion coverage. The law also failed to offer a publicly funded coverage option as an alternative to the private insurance market -- maintaining a health care system largely driven by profit and private interests instead of public health.

Our vision reflects the critical need to defend, protect and build upon the progress of the ACA while advancing real universal health care. For these reasons:

At the Federal Level, We Support:

1. Creation of a Federal Single Payer Health Care System

To truly achieve health care for all, we cannot depend on companies driven by profit. Achieving universal health care will require divestment from and disruption of reliance on the private insurance market, which should be replaced by a system-wide transformative shift to a single government insurance program that covers all comprehensive medical services that uphold full sexual and reproductive autonomy for all people. We recommend the passage of federal legislation that builds on the successes of the Medicaid and Medicare programs in ensuring quality care for people who are low-income, people with disabilities and the elderly. Current proposals aligned with this vision include:

Expanded & Improved Medicare for All Act & Medicare for All (H.R. 676 and S. 1804)

Legislation proposing a single-payer, government-run system has been introduced in the Senate and the House. H.R.676 Ellison (D-MN) and S. 1804 Sanders (D-VT) both lay the groundwork to establish a national health insurance program that would extend Medicare benefits to all U.S. residents. Under both single-payer proposals, health care would be free. Senator Sanders has been advancing this solution since the 1990s, and the Medicare for All proposal has gained significant support in Congress, with 16 co-sponsors in the Senate and 121 co-sponsors in the House at the time of writing.

Medicare Extra for All

The Center for American Progress (CAP) has also introduced Medicare Extra for All legislation model, outlining a more gradual approach to achieving universal coverage that combines federal insurance programs including Medicare, Medicaid and the Children's Health Insurance Program into a single system that all U.S. residents would be eligible to join. Unlike the Medicare for All proposals, most families would have to pay at least some premiums. Families below 150% of the federal poverty level would be exempt from paying these premiums; others would pay on a sliding scale based on income. Newborns and people turning 65 would be automatically enrolled in Medicare Extra for All, expanding the program over time.

2. Maintaining and Fully Funding the Ryan White Care Program

The Ryan White program remains a critical source of high-quality, lifesaving health care for half a million PLHIV in the U.S. The program largely works well for WLHIV by providing quality medical care along with services that support wellness and help WLHIV gain access to care. Ryan White should be maintained and expanded, while the quality and availability of reproductive health and mental health care are improved. To achieve this, funding for Ryan White must be increased.

3. Expanding Access to Health Care for All Immigrants, Regardless of Immigration Status

Immigrants face tremendous barriers in accessing health care, including language barriers, cost, fear of being reported to authorities and policies that fully exclude or aim to deter access to government services. Brazen anti-immigrant rhetoric and the intensification of violent immigration enforcement tactics have forced

many immigrants underground in recent years, delaying and in some instances causing them to completely avoid seeking critical health services for fear of being deported and separated from their families and communities. These policies are couched in language that frames immigrants as burdensome or problematic, failing to recognize that this nation was founded on mass genocide of indigenous people by immigrants, and that borders are drawn by those in power to support their political and economic interests.

- We support removing legal and policy barriers that hinder immigrant access to health care including:
- Remove the 5-year ban on enrollment for Medicaid and the Children's Health Insurance Plan (CHIP).
- Allow all immigrants to fully participate in and receive subsidies for ACA marketplace insurance exchanges.

We oppose any use of "public charge" determinations, assessing how likely an immigrant is to use public services and government subsidized health care, to exclude and deter immigrants from lower-income countries or to adjust the immigration status of current immigrants. To that end, we strongly oppose the collection of immigration status data by any service delivery or health care entity.

At the Federal Level, We Oppose:

1. Efforts to Diminish Coverage Gains Made under the ACA

Following the ACA's passage, insurance plans had to provide necessary prevention services at no cost, including well-woman visits, counseling and screening for intimate partner violence, HIV screening and contraception counseling and dispensing. Section 1557 of the Affordable Care Act prohibited discrimination on the basis of sex and gender identity in health care settings. Attempts to undermine the ACA have included attacks on these protections as well as proposals to radically upend the funding structure of the Medicaid program by capping federal funding contributions to state programs at fixed rates that do not account for unpredictable medical costs and fluctuating state budgets. We will continue to actively oppose efforts to diminish or undermine the current health care law, coverage, access and ACA protections through legislation, regulation, appropriations or through the use of executive orders.

2. Cuts to Medicaid and Medicaid Work Requirements

Medicaid is the single largest source of coverage for people with HIV in the U.S. and should be fully maintained. Medicaid is a jointly funded state and federal health insurance program for low-income people and people with disabilities. Prior to the ACA, state Medicaid programs were only required to cover low-income children and some of their parents, low-income pregnant women, certain low-income seniors and some individuals with disabilities under the age of 65. Before the ACA, many adults living with HIV were forced to wait until their disease progressed to an AIDS diagnosis before being categorically eligible to receive Medicaid coverage. As a result of the program's expanded eligibility through the ACA, Medicaid covered 42% of PLHIV nationally by 2014, compared with 36% in 2012.

Accordingly:

We will continue to oppose any legislation that caps federal funding contributions to state Medicaid programs at fixed rates that do not account for unpredictable medical costs and fluctuating state budgets. Proposals such as per capita caps (limits on the amount of funding a state can receive per Medicaid enrollee) and block grants (fixed grants given directly to states) are likely to result in states being forced to cut services for low-income residents, including seniors and people with disabilities.

We oppose any program shifts that erect barriers to maintaining coverage through Medicaid such as work requirements, onerous eligibility reporting and lockout periods for beneficiaries who fail complete an annual eligibility redetermination process or report a change in income by a deadline. These practices will disproportionately impact low-income women and people of color.

At the State Level, We Support:

1. Statewide Single-Payer Health Plans

State-level single-payer legislation has been introduced in 26 states at one time or another and several states are currently building support for advancing campaigns for publicly funded universal health care programs. PWN supports the passage of state-level single payer legislation, along with requisite and sustainable funding structures.

2. Expanding Medicaid in Every State and U.S. Territory

One of the most successful components of the ACA was the expansion of Medicaid, allowing states to extend coverage solely based on income. To date, 33 states have expanded Medicaid, which covers over 40% of people living with HIV and has expanded access to care for millions of other low-income and vulnerable communities. Yet many states, notably in the South, where some of the deepest health and HIV disparities persist for low-income and people of color, have failed to expand the program. All states should expand access to comprehensive care, including sexual and reproductive care and gender transition-related care, inclusive of hormone therapy and gender affirming surgery, by expanding Medicaid.

At the State Level, We Oppose:

The Addition of Work Requirements for Participants in Medicaid

The purpose of the Medicaid program is to expand access to care for low-income people. Yet for the first time in the program's history, states have been given permission by the Centers for Medicaid and Medicare Services (CMS) to impose work requirements as a condition for Medicaid eligibility as part of a radical restructuring of the 50-year old program. At the time of writing, three states (AR, IN, KY) have already been approved to implement work requirements for Medicaid, and eight more have applications pending. Most people on Medicaid who can work are already working, often in low-wage jobs that do not provide health care coverage. The majority of those who are not working report facing barriers to employment, such as illness or caregiving responsibilities. In some states with low-income thresholds for Medicaid eligibility, working at minimum wage could actually disqualify people from Medicaid.

There is no data showing that imposing work requirements for people with HIV would be beneficial to our health. In fact, this change is likely to exacerbate barriers to health care and economic insecurity for low-income PLHIV. We ardently oppose the implementation of work requirements for Medicaid beneficiaries as well as policy proposals that condition Medicaid expansion on work requirements.