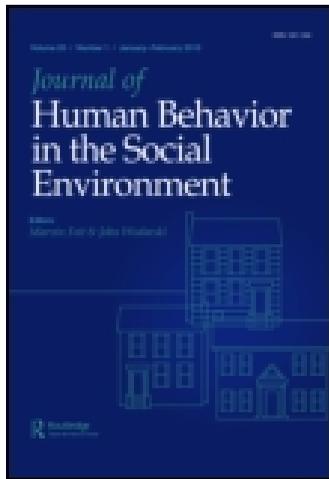


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# **The Affordable Care Act: Implications for African Americans Living with HIV**

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*This article reviews the Patient Protection and Affordable Care Act (ACA), 2010. It highlights the implications of the ACA for African Americans living with HIV/AIDS. This law is a practical step toward decreasing disproportionate chronic disease in vulnerable communities. Proper implementation of provisions will help the United States catch up to other industrialized nations with well-established public health care programs. Included is a concise table referencing notable provisions that support increased access to treatment, health education, and quality of care for clients. Social workers can use this information to ensure that clients benefit from this legislation.*

**KEYWORDS** *Affordable Care Act, HIV, African Americans, health care access, social workers*

## INTRODUCTION

Health inequities within the United States of America (U.S.) have a long and well-documented history (Bent-Goodley, 2007; Braithwaite, Taylor, & Treadwell, 2009; Keefe, 2010; Smedley, Stith, & Nelson, 2003; U.S. Department of Health and Human Services, 2010b; Washington, 2006). These inequities are exacerbated by a health care system in need of substantial reform to address high-cost, mediocre treatment, and unequal access (Weitz, 2010; White, 2005).

The United States of America is the last industrialized nation to develop a comprehensive health coverage system with the enactment of the Patient Protection and Affordable Care Act (ACA), 2010. While not everyone will

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be covered, a significant percentage of Americans will have access to care following the full implementation of the ACA. Because creation of a comprehensive health care system lags behind, our nation struggles with excessive health care spending. In 2007, the U.S. spent \$2.2 trillion on health care expenses. Nearly half of that spending was used to treat only 5% of the U.S. population, leaving the vast majority, 95% of the population, to share the remainder (Kaiser Family Foundation, 2009). Policy experts believe that new and existing treatment technologies, which are not always necessary, account for a large portion of medical spending (Kaiser Family Foundation, 2009). Furthermore, cost of care continues to grow; today, more than \$2.5 trillion is spent annually (Rosich & Hankin, 2010). Although cost of care is high, the quality of care is debatable. In fact, medical errors, such as prescribing or administering incorrect medications, result in nearly 1.5 million injuries each year. Medical errors are responsible for more than 50,000 deaths annually in the U.S. (Weitz, 2010; Institute of Medicine, 2001).

The current U.S. health system is fragmented. It traditionally places emphasis on illness maintenance rather than preventative care, despite knowledge that early detection and treatment can reduce incidents and prevalence of disease. Not only is the U.S. health system riddled with excessive spending and questionable care but there is also limited access to health care for low-income persons and those in most need (Agency for Healthcare Research and Quality, 2008; Beeuwkes-Buntin, 2010; Kaiser Family Foundation, 2005). Poor access to health care is proven to contribute to health disparities and the uneven distribution of disease and illness, which are rooted in social injustice and discrimination (Keefe, 2010; Morbidity and Mortality Weekly Report, 2005; Smedley et al., 2003).

To illustrate this point, consider health care access for low-income African Americans. Within this community, limited access is tantamount to inadequate insurance coverage, few culturally competent health care providers, and inconvenient clinic locations (Rhee et al., 2005; Smedley et al., 2003). Although health disparities within the African American community are well known, efforts to eliminate disparities have lacked political and financial power. This changed with the passing of the ACA. The ACA was signed into law by President Obama on March 23, 2010 (Public Law. 111-148) and quickly amended on March 30, 2010 by the Health Care and Education Reconciliation Act (Public Law. 111-152) (United States Congress, Senate, 2010). The act is a meaningful effort to reduce disparities given its political, economic, and social significance (Gorin, 2011; U.S. Department of Health and Human Services, 2010a). The ACA, like the Social Security Act of 1935 and its 1965 amendments (known as the Medicare/Medicaid Act) provide vital resources needed to address health inequality for many citizens (Marmor & Mashaw, 2006).

This article provides a concise overview of notable ACA provisions that are especially salient for individuals living with HIV or AIDS in the African

American community. It informs social work practitioners on provisions of the law that address their client's needs. Furthermore, what follows is an information source for policy makers as they create regulations that can decrease health disparities.

## OVERVIEW OF THE AFFORDABLE CARE ACT

The Affordable Care Act is a significant policy effort to decrease health disparities throughout the nation. The law represents an opportunity for the nation to expand health benefits to those who would most benefit and provides unparalleled health benefits to low-income individuals and families. The structure created by the ACA ensures that federal policy prevents unnecessary financial burden for chronically ill persons. In addition, the new health reform legislation addresses the systematic injustice and devastating impact of health disparities on Americans by creating educational initiatives, increasing access to care, improving treatment quality, and building up the currently strained health care workforce.

Like most legislation, the ACA is a broad blueprint that requires regulatory review and legislative amendments to correct unintended problems (Stephen McConnell, personal communication, April 12, 2011). Social workers must be aware of the ACA provisions and advocate for continued strides to eliminate health care inequality. This is particularly true for social workers assisting African Americans living with HIV/AIDS. The law tackles basic measures of health care system quality, particularly efficient spending, affordability, and accessibility (U.S. Department of Health and Human Services, 2010a). In addition, multiple provisions within the law specifically address community-level educational initiatives, workforce training programs, and consumer protection. Implementation of the ACA will lessen the disproportionate burden of HIV/AIDS in the African American community.

### HIV in the African American Community

The disproportionate burden of chronic diseases such as diabetes, cardiovascular disease, and HIV/AIDS, adds to the long-standing and continuous social obstacles faced by the African American community. The Centers for Disease Control and Prevention (CDC) report that a range of social issues contribute to high prevalence of HIV/AIDS within the African American community that include high rates of poverty, intravenous drug use, power imbalances within intimate relationships, and stigma related to alternative lifestyle choices (CDC, 2010; Satcher, 2010). In addition, the CDC describes the burden of HIV on African Americans noting that blacks make up 49% of new HIV infections despite making up a small percentage, 12.6%, of the overall U.S. population (CDC, 2010; Office of Minority Health [OMH],

2011b; Martin, Younge, & Smith, 2003; U.S. Census Bureau, 2011). In 2008, the estimated number of African Americans with HIV infection was 21,289 persons compared to 11,778 Whites (CDC, 2010). Although these facts are shocking alone, they are particularly salient when compared to HIV/AIDS prevalence in the 1990s. In 1994, 29% of the total AIDS cases were African American; today the incidence rate is 20% higher (Randolph, Billingsley, & Caldwell, 1994). The continued increase of HIV infections in the African American community indicates a need for deliberate action to slow the pace of this epidemic.

Further, the CDC found that black women are far more affected by HIV than women from other racial and ethnic groups. Black women HIV infection rates are more than 14 times higher than White women and nearly four times higher than Hispanic/Latinas (CDC, 2010). Likewise, African American women are 22 times more likely than White women to have AIDS (OMH, 2011b). Consequently, AIDS mortality rate for Black women in America is 20 times higher than White women. In fact, HIV/AIDS is the leading cause of death among African American women ages 25 to 34 (CDC, 2010).

The HIV incidence rates within Black women are surpassed only by the extremely high incidence rate in Black men. There are 115 per 100,000 Black men living with HIV compared to 19 per 100,000 White men living with the virus. Furthermore, African Americans are more likely to die from AIDS than White men (OMH, 2011b). Among 13- to 29-year-old men, African Americans hold the greatest percentage of HIV incidence: 48% (CDC, 2008; Hightow-Weidman et al., 2011). The epidemic in Washington, DC illustrates the impact of HIV within the African American community.

Washington, DC, the nation's capital, has one of the highest concentrations of people living with HIV/AIDS in the United States. A recent report revealed that nearly 3% of the Washington, DC residents are HIV-positive (AIDSVu, 2011; Public Radio International, 2010). The majority of Washington, DC's newly diagnosed residents are African Americans with low annual incomes. The HIV/AIDS epidemic in Washington, DC exemplifies the magnitude and urgent need for strategic action. Provisions in the ACA attempt to curtail this reality and stop the devastation of high mortality rates due to HIV/AIDS.

### HIV/AIDS, African American and Affordable Care Act, 2010

African Americans are vulnerable to various chronic illnesses, but HIV/AIDS poses a special challenge because diagnosis and treatment occur within America's complex sociocultural and political environment. The ACA attempts to resolve some of the systematic injustice that created a reality where African Americans have the lowest high school graduation rates and consequently rank highest among the uninsured, underinsured, and unemployed citizens (U.S. Department of Education, 2010).

The ACA is an innovative social policy that addresses health-related injustice through educational initiatives, increased emphasis on primary care, easier access to community-based care, additional support with prescription drug costs, and increased cultural and linguistic competence training for the health and allied health workforce. The ACA has the potential to shift the trend of HIV/AIDS infection within the African American community. Table 1 offers an overview of ACA provisions that directly benefit persons living with HIV/AIDS.

### Access to Treatment

America lags behind in health care access compared to other developed nations (Reid, 2009; Quadagno, 2010). The ACA addresses this insufficiency by expanding Medicaid coverage to include persons with annual incomes up to 133% of the federal poverty level, approximately \$30,000 annually (Beuwkes-Buntin, 2010; Kaiser Family Foundation, 2011a; U.S. Department of Health and Human Services, 2010a). This is particularly relevant to African Americans given the median household income is less than \$35,000 a year (\$34,218; U.S. Census Bureau, 2011). Braveman, Cubbin, Egerter, Williams, and Pamuk (2010) found that overall health is in direct relationship with socioeconomic status. More specifically, wealthy persons tend to have better overall health than those in the middle class. Likewise, middle-class individuals are generally healthier than poor persons. These findings confirm the unfair American trend that allows income advantage to shape health. This legislation encourages the nation to recognize proper health care as a human right in which everyone deserves regardless of socioeconomic status.

Historically, persons living with HIV would not have access to Medicaid support until they were disabled and impoverished by the disease. Due to the ACA, persons may qualify for Medicaid treatment benefits before their health and financial resources are drained. HIV/AIDS medical treatment is a major expense not only for the individual but for the federal government; in that, Medicaid is the largest single funder of HIV/AIDS medications. The ACA is a practical step toward health care cost control (The Committee for a Responsible Federal Budget, 2010). Further, multiple ACA provisions require the development and deployment of educational strategies that promote prevention and wellness programs. These provisions are sure to decrease in HIV transmission rates, thereby decreasing Medicaid spending over time.

Moreover, the ACA mandates the creation of affordable and adequate health insurance programs for state residents. Affordable health insurance exchanges are state- or regionally based health care plans available for individuals not eligible for Medicare, Medicaid, or employer-based plans. As of July 2011, 10 states, including California, Maryland, and Oregon, have established exchanges, well before the January 1, 2015 mandated start date (Kaiser Family Foundation, 2011b). Furthermore, the National Academy of

**TABLE 1** HIV/AIDS Issues Addressed by the Affordable Care Act

Area	Method	Provision of the law
Access to treatment	Increases number of individuals eligible for state based medical assistance with a focus on family planning services and supplies	Section §2303
	Creates grants to support the renovation and operation of school-based health centers [SBHC]; many grants “pay the costs associated with expanding and modernizing existing buildings”	Section §4101
Health education	Increases disease prevention and wellness education among youth populations particularly youths living with an HIV/AIDS diagnosis	Section §2953
	Educates adolescents on contraception use to slow HIV transmission rates	Section §5313
	Promotes prevention of chronic diseases through screening and testing	Section §4004
	Mandates the use of the “Patient Decision Aid,” a tool designed to assist patients in making treatment decisions that align with their cultural beliefs and preferences	Section §936
Quality of treatment	Expands maternal and infant home visiting programs for those at risk and living with HIV	Section §2951
	Identifies and provides comprehensive services designed to improve health outcomes for underserved populations	
	Improves cultural and linguistic competence of health and allied health professionals	Section §1311 Section §5313
Workforce	Creation of Accountable Care Organization and community health team treatment models focused on improving communication among providers	Section §3022 Section §3501 Section §3502
	Increases training in team based health service delivery and the care of vulnerable populations—social workers specifically mentioned	Section §2703 Section §2951 Section §3501
	Training grants to medical residents in preventative medicine, designed to increase the number of primary care physicians willing to work in underserved communities	Section §5102 Section §5306 Section §768

Sources: Dawes, D. E. (2010); Patient Protection and Affordable Care Act (Public Law. 111-148); Health Care and Education Reconciliation Act (Public Law. 111-152).

Social Insurance created a toolkit that assists state legislators construct viable insurance programs and exchanges.

For many residents, insurance coverage does not directly correlate to access to care; therefore, the new law appropriates \$11 billion to fund construction and operation of health clinics in impoverished communities

across the nation. Funding is also earmarked for school-based health centers. These provisions ensure that African Americans with insurance coverage can truly access routine care and chronic-disease treatment.

## Health Education

The ACA not only provides health care coverage for millions of Americans, it creates opportunities for health educators to share facts about HIV/AIDS. The new law mandates the strengthening and development of programs to educate at-risk youths about disease transmission. In addition, the health promotion and outreach requirements of the law will raise awareness about healthy lifestyle choices, which is likely to spur action by community members. Culturally tailored health education will help dispel myths and decrease the stigma. Health education is recognized as a meaningful prevention strategy that addresses social determinants of health (OMH, 2011a). Further, the ACA provides funding to duplicate effective faith-based community participatory research projects similar to the Your Blessed Health project.

Griffith, Pichon, Campbell, and Allen (2010) designed an intervention to increase awareness of HIV/AIDS and lower the stigma attached to the disease in order to decrease the incidences of HIV in Flint, Michigan. Many neighborhoods in Flint are improvised with high concentrations of African American residents. Like Washington, DC, Flint exemplifies the interplay between poverty, race, and high prevalence of HIV among residents. The researchers used community engagement strategies, training sessions, sermons from the pulpit, and in-church presentation on HIV/AIDS along with a free health fair targeted toward non-church-affiliated community members to share information on HIV/AIDS treatment and testing. Researchers found that the Your Blessed Health intervention raised church members' awareness and helped church leaders feel "comfortable and competent" in their ability to counsel regarding HIV/AIDS issues. This project plans to expand to include other faith-based institutions and additional community engagement strategies such as free HIV testing.

Historically, persons with HIV/AIDS faced prejudice and discrimination due to negative social attitudes toward a homosexual lifestyle and myths regarding disease transmission (Poindexter & Linsk, 1999; Galvan, Davis, Banks & Bing, 2008). Conrad and Barker (2010) suggest that the biological effects of illness are at times less frightening than the negative social reactions to certain diagnoses. Further, social stigma can stand in the way of treatment and hinder others from being tested. Valdiserri (2002) assert that individuals at risk for HIV refuse testing due to fear of rejection from family members and co-workers, previous experience with judgmental health care providers, lack of insurance for follow-up care, and expensive medications. An estimated 232,700 people in the United States are infected with HIV but are unaware of their status (CDC, 2010).

In addition, Martin et al. (2003) discuss social barriers to HIV/AIDS prevention efforts that include the black churches' "justified" prejudicial responses to persons living with HIV/AIDS. Traditionally the black church, the single most influential social force in the African American community, conveyed the message that HIV disease was the natural repercussion of sinful behaviors such as intravenous drug use or a homosexual lifestyle. The "cure" was sexual abstinence outside of marriage. Some authors suggest that these messages contributed to lack of treatment and testing, which perpetuated the spread of the disease. Although the stigma of HIV/AIDS remain a reality, it has moderately subsided as is evident in the creation and success of multiple faith-based community participatory research projects (Griffith et al., 2010; Berkley-Patton et al., 2010). Today, black church leaders are adjusting the messages about HIV by educating congregations on safer sexual behaviors. Because the black church remains a sociopolitical force, this shift in message is critically important in decreasing incidents and ultimately eradicating HIV/AIDS (Martin et al., 2003; Thomas, Quinn, Billingsley, & Caldwell, 1994).

Recently, Berkley-Patton and colleagues conducted community participatory research entitled, "Taking it to the Pews," designed to address the raising incidences of HIV in the African American community. Social science researchers with support from church leaders incorporated HIV education in to churches' "responsive readings," an interactive part of many church services. Authors found this strategy effective in raising awareness and decreasing stigma among participants. In addition, the intervention increased church members' willingness to be tested for HIV (Berkley-Patton et al., 2010).

### Quality of Treatment

A fundamental goal of the ACA is to improve the efficiency and quality of the fragmented U.S. health care system (U.S. Department of Health and Human Services, 2010). The law contains several quality reform provisions that meet the needs of African Americans living with HIV including the strengthening of maternal and infant home-visiting programs and the creation of health teams. By improving home-visiting programs, the law addresses the rising rate of infant mortality. Similarly, establishing home health teams will provide coordinated treatment to chronically ill patients in their community rather than nursing homes. This measure intends to mend the current fragmented care model, which ultimately decreases the chances of medical errors. The creation of home health teams begins the regulation of the present day financial incentive structures so that higher reimbursement is given for better patient care instead of patient volume.

Historically, African Americans were either ignored by the U.S. health care system or used as "guinea pigs" in medical experiments (Washington, 2006; Weitz, 2010). Washington suggests that African Americans rarely seek

traditional medical assistance due to the legacy of maltreatment. For many African Americans, avoiding health treatment until symptoms are unbearable is a self-preservation strategy passed down from community elders (Djokic et al., 2009). However, the quality-of-care standards delineated by the ACA can help transcend this tradition to promote preventative and safe treatments.

The ACA calls for systematic quality measure development. To this end, the new Office of Medicare and Medicaid Innovation will ensure new models of health care delivery are developed and implemented quickly to improve treatment quality and reduce cost (Dawes, 2010). Likewise, the ACA calls for the development of a clinical and community prevention taskforce to review effective systems. Funding is also available for intervention research to assess the efficacy of programs.

Furthermore, the ACA requires the establishment of Offices of Minority Health (OMH) within the agency for health care research and quality (AHRQ) and five other U.S. Department of Health and Human Services agencies. The OMH is “dedicated to improving the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate health disparities” (OMH, 2011a). Similarly, the AHRQ’s mission is to “improve the quality, safety, efficiency, and effectiveness of health care for all Americans” (AHRQ, 2011). By physically placing complementary programs such as the OMH and the AHRQ in close proximity, the law intends to improve communication and strategic planning between the agencies (OMH, 2011a).

## Workforce

Quality health care cannot occur without competent professionals. The current health system struggles with a shortage of qualified primary care physicians, high worker turnover among allied health professionals, and limited professional training for direct-care workers. The health care system is in great need of skilled health care providers to serve the needs of the chronically ill, particularly individuals and families managing HIV/AIDS.

With this knowledge, the OMH assembled African American leaders from a variety of disciplines to develop recommendations for improving health across the life span. The leaders produced a set of consensus statements that offer recommendations that address workforce competence issues. The leaders recommended the immediate implementation of a systematic strategy to improve cultural and linguistic training of health and allied health care providers (OMH, 2011a). This will be a vital step in the elimination of health disparity and align with provisions in the ACA. In fact, the ACA allocates resources to historically black colleges and universities to train more minority students majoring in science, technology, engineering, and math. This is a practical step toward increasing the number of qualified health professionals. Training more providers from minority backgrounds

will fill various workforce gaps. Research indicates that providers from diverse backgrounds account for the majority of health providers in minority communities (Institute of Medicine, 2008, p. 126). Furthermore, the ACA provides educational grants to medical residents with a preventative medicine specialty. Similar grants are available to allied health professionals, such as social workers, to increase the number of professionals assisting vulnerable populations. These efforts are sure to increase the number and diversity of health professionals available to care for African Americans living with HIV/AIDS.

A central social work premise is that everyone deserves to live in a just community, which is why many social workers support health care reform legislation (Gorin, 2011; Quadagno, 2010). The health care reform legislation makes clear the interconnection between the U.S. health care system and the social welfare system. Since social work practitioners are the primary deliverers of social welfare benefits, we will execute health reform legislation (Fellin, 2001; Hasenfeld, 2010). Therefore, it is important that social workers not only know about policy provisions but have input on the implementation of the law. This is especially true because the ACA will dictate resources available to Medicaid and Medicare beneficiaries, reimbursement schedules for private practice therapists, and employment opportunities for new graduates. The law will be only as effective as its regulations and the funding allocated to programs. Social workers must continue to be vocal in our support and refinement of the law (National Association of Social Workers, 2009).

## DISCUSSION

This article describes elements of the ACA that directly influence the care of African Americans living with HIV. From this overview, it is evident that the ACA brings the full influence of the federal government, through mandated actions, to address fully health disparities. Federal-level intervention was required due to the “extraordinary fragmentation” of the U.S. health system, not to mention powerful groups’ stake in keeping the system disjointed (Wright & Perry, 2010). This law moves health care from its current private domain onto the public platform, which can equalize health care access.

The ACA is a step toward improving the overall health care system, thereby decreasing disproportionate chronic disease burden and lowering the number of preventable deaths. The law not only makes health care readily available to millions but it can reestablish the nation’s confidence in health professionals and social welfare safety net programs (Mechanic & McAlpine, 2010). Although the law is in place, social workers must continue to advocate for the law to ensure its effective implementation. Proper im-

plementation of the ACA will help the U.S. catch up to other nations that include Canada, England, and Japan with well-established public health care programs. Further, the high demand of health care support for persons living with chronic illness such as HIV/AIDS, paired with troubling socioeconomic issues, makes the full enactment of the ACA in 2014 critical for the African American community.

Opponents of the law contend that the federal government cannot afford the cost associated with this legislation. However, the nation cannot afford to wait to ensure the health of its citizens. With proper oversight, the initial monetary costs will be balanced by lowering long-term health care costs through early detection and disease prevention. In addition, fees and taxes are written in the law to offset costs associated with this effort. Over the last year, legislators passed amendments to secure the financial base of the legislation.

Opponents of the law further contend that the individual health insurance mandate is unconstitutional. Conservative lawmakers in Virginia, Florida, Idaho, Montana, New Hampshire, and Texas argue that the individual insurance provision violates citizens' and states' rights. To date, most courts have upheld the constitutionality of the ACA, but opposition to the reform remains (National Conference of State Legislatures, 2011). The United States Supreme Court is scheduled to examine and rule on the ACA's constitutionality in 2012. If the ACA is deemed unconstitutional, states can choose not to establish health insurance exchanges, which would crush efforts to expand health coverage to all citizens. Further, removing the individual mandate would undermine provisions that prevent health-related discrimination by insurance companies and perpetuate the vicious cycle of under treatment, which the law is designed to resolve (Millhiser, 2011). Now is the time for social workers to speak out against attempts to disembowel the ACA. Social workers must give voice to those without a political platform and demand justice for Americans disproportionately impacted by disease.

Last, when discussing the need for equality in health care, it is easy to become desensitized to statistics; however, it is important to remember the real people who needlessly suffer due to insufficient health care coverage. In line with fundamental social work values, I believe all people in the United States are entitled to sufficient health care; the ACA moves the nation closer to this goal.

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