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HIV and Hepatitis Health Disparities Update

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This newsletter is developed by AIDS Action Committee of Massachusetts in collaboration with the New England AIDS Education and Training Center.

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NEWS ROUNDUP

Issue Focus: The American Health Care Act and the 2018 Budget Blueprint

Health care policy under President Donald Trump and the Republican-majority Congress dominated health news during March. The Republican House leadership kept the provisions of the American Health Care Act (AHCA) secret before introducing the legislation on March 6. For the following 18 days, the proposed legislation was the subject of heated debate, was significantly amended, but was nevertheless withdrawn from consideration on March 24, when it became clear the bill was widely opposed and lacked the 215 votes needed to pass in the U.S. House of Representatives. Meanwhile, on March 16, the Trump administration released its budget blueprint for fiscal year (FY) 2018 – a document that included a large budget increase for U.S. defense spending, but major cuts to health, environmental, and many other domestic programs. Like the AHCA, the budget proposal has been met with strong opposition on many fronts and seems unlikely to be adopted in its current form.

Despite their uncertain futures, the FY18 budget blueprint and the effort to repeal and replace Obamacare nevertheless provide insights into the current health care priorities and the policies that might be expected to evolve during the 115th U.S. Congress and the Trump administration. For this reason, we are devoting much of this issue to the AHCA and the health-related sections of budget blueprint, with a series of articles focusing on their key provisions and the responses of the HIV, viral hepatitis, health care, and scientific communities.

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The American Health Care Act: Main Features and Congressional Debate

On March 24, U.S. House speaker Paul Ryan and President Donald Trump withdrew the proposed American Health Care Act (AHCA) from consideration shortly before the bill was to have come to a vote in the U.S. House of Representatives. AHCA was pulled because the legislation lacked the votes needed for passage, despite a series of amendments added to make the bill more attractive primarily to conservative House Republicans.

The AHCA was the House Republicans' plan to repeal and replace the Patient Protection and Affordable Care Act (ACA). The ACA – commonly known as Obamacare – was enacted in 2010 and has been targeted for repeal by Congressional Republicans ever since. [Please note: Since the acronyms "ACA" and "AHCA" are very similar and might easily be confused, in this newsletter issue we will generally refer to the Affordable Care Act by its unofficial name, "Obamacare," to help distinguish the proposed AHCA from the current law.]

During the 2016 election, Trump and many Congressional Republicans had vowed to end Obamacare quickly if they came to power. The U.S. House Republican leadership introduced their initial draft of the AHCA on March 6 and later amended the bill extensively in response to criticisms from conservative and moderate Republican legislators, both in Congress and at the state level. House speaker Paul Ryan and President Donald Trump lobbied hard for the bill's passage, but ultimately pulled the AHCA on the afternoon of March 24 when it became clear that the number of votes in favor of the bill would fall well short of the 215 needed for passage.

Key Provisions in the Original Bill

Soon after the bill was introduced, the Kaiser Family Foundation (KFF) produced a side-by-side comparison of key provisions in Obamacare and the AHCA, as well as more detailed information about 18 different aspects of the legislation, including insurance mandates, premium and cost-sharing subsidies, and provisions related to health financing, Medicaid, Medicare, and women's health.

The bulleted summary below of selected key provisions in the original bill draws heavily on the KFF comparison document, as well as a summary produced by the American Medical Association. As introduced on March 6, the AHCA would:

- repeal (retroactive to 2016) Obamacare insurance mandates requiring most U.S. citizens and legal residents to have health insurance;
- impose a 30% late-enrollment penalty that would temporarily increase the cost of insurance for people who have a lapse in continuous healthcare coverage and later re-enroll;
- repeal Obamacare tax credits (effective 2020) and replace them with refundable flat tax credits based on age;
- repeal cost-sharing subsidies (effective 2020) that help low-income individuals pay for out-of-pocket health costs;
- retain some of Obamacare's private health insurance market rules, including maintaining coverage for dependents up to age 26 and prohibiting discriminatory premiums and exclusions for pre-existing conditions;
- allow insurers to set premiums up to 5 times higher for older persons than for younger persons, compared to a maximum of only 3 times higher under Obamacare;
- retain health insurance marketplaces, annual open enrollment periods, and special enrollment periods;
- repeal funding for the Prevention and Public Health Fund at the end of FY18 and rescind any unobligated funds remaining at the end of that year;
- increase the annual tax-free contribution allowed for Health Savings Accounts to encourage their use;
- eliminate enhanced Federal Medical Assistance Percentages for Medicaid expansion as of January 1, 2020, except for people who are enrolled in Medicaid as of December 31, 2019 and do not have a break in eligibility of more than one month;
- convert federal Medicaid funding to a per capita allotment and limit growth beginning in 2020 using 2016 as a base year;
- no change to Medicare benefit enhancements or provider/Medicare Advantage plan payment savings;
- repeal Medicare Hospital Insurance payroll tax increase for high-income persons, as well as other Obamacare revenue provisions; and
- prohibit federal Medicaid funding to Planned Parenthood clinics.

Congressional Budget Office (CBO) Analysis of the AHCA as Introduced

One week after the public release of the original AHCA, the Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) published an analysis of the original bill's projected effects on levels of health insurance coverage, insurance premiums, stability of insurance markets, and the U.S. federal deficit. We have summarized below some of the key findings in CBO/JCT analysis. Further implications of AHCA's impact on the U.S. health care system are discussed in a separate article, "Perspectives on the

AHCA from HIV, Hepatitis, Health Care, and Elder Groups."

By 2026, 24 million more people would be uninsured under AHCA than Obamacare: In the first year, 14 million more people would be uninsured under the AHCA compared to Obamacare. This initial difference in coverage would largely be the result of an AHCA provision repealing the penalties associated with Obamacare's insurance mandate. The difference in the number of uninsured persons under AHCA versus Obamacare would increase to 21 million in 2020 and to 24 million in 2026, according to the analysis. "The reductions in insurance coverage between 2018 and 2026 would stem in large part from changes in Medicaid enrollment – because some states would discontinue their expansion of eligibility, some states that would have expanded eligibility in the future would choose not to do so, and per-enrollee spending in the program would be capped. In 2026, an estimated 52 million people would be uninsured, compared with 28 million who would lack insurance that year under current law [Obamacare]."

Average nongroup premiums would initially rise 15% to 20% compared to Obamacare: "The legislation would tend to increase average premiums in the nongroup market prior to 2020 and lower average premiums thereafter, relative to projections under current law," according to CBO/JCT. In 2018 and 2019, "average premiums for single policyholders in the nongroup market would be 15% to 20% higher than under current law, mainly because the individual mandate penalties would be eliminated, inducing fewer comparatively healthy people to sign up." These initial average increases in premiums would be later offset by other factors, so that by 2026, they would average about 10% lower under the AHCA than Obamacare.

Lower premiums for some younger persons, higher premiums for most older persons: Changes in insurance premiums in the nongroup health insurance market would differ significantly by age under AHCA, according to CBO/JCT. Since AHCA would allow insurers to charge up to five times higher premiums for older persons than younger ones, insurance premiums in the nongroup market could be lower for some younger persons under AHCA than under Obamacare. But the reverse would also be true, with substantially higher premiums projected for most older persons.

Projected $337 billion reduction in the U.S. federal deficit: According to the CBO/JCT analysis, the AHCA would reduce the U.S. federal deficit by a net of $337 billion during the period from 2017 through 2026. However, there would be large reductions in federal outlays for Medicaid ($880 billion) and for Obamacare premium assistance and cost-sharing ($673 billion). These potential savings for the AHCA versus Obamacare would be largely offset by loss of revenue related to tax reductions (primarily benefitting persons with very high incomes), and the elimination of penalties paid by uninsured persons and their employers.

March 20 Manager's Amendment to AHCA

Immediately after its introduction, the AHCA was sharply criticized by Democratic members of Congress. And despite its backing by House leadership and the Trump administration, the bill was also deemed unacceptable by the conservative House Freedom Caucus, as well as some moderate Republicans in the House and Senate and some Republican governors. Some members of the Freedom Caucus, as well as Senator Rand Paul, dubbed the bill "Obamacare 2.0" or "Obamacare Lite," because they felt it retained many objectionable provisions of Obamacare. These contested provisions included Medicaid expansion, extensive insurance regulations, and price controls. Some conservative Republicans also felt that

AHCA's refundable tax credits would essentially create a new entitlement program, which they strongly opposed. In contrast, some moderate Republicans were concerned about the curtailment of Medicaid expansion and the repeal of Obamacare's generous premium and cost-sharing subsidies, which had brought insurance coverage and affordable health care to millions. Some Republicans also opposed the AHCA provisions prohibiting Medicaid funding to Planned Parenthood clinics, which together are the largest providers of women's health care in the country.

Many medical, public health, and patient and elder advocacy organizations – including groups representing persons living with HIV and viral hepatitis – also opposed the bill for a variety of reasons, including: the projected loss of coverage for 24 million people; expected higher premiums, deductibles, and out-of-pocket expenses, particularly for low-income and older persons; large tax breaks for high-income individuals; and loss of Obama tax revenue that helps support the Medicare program.

In response to the House Freedom Caucus's harsh criticism of the AHCA, House leaders issued a "manager's amendment" to the original bill on March 20, which placed further restrictions on Medicaid. In particular, the amendment contained new provisions that would allow states: 1) to impose work requirements on able-bodied, childless adults who receive Medicaid; and 2) to receive Medicaid funding in the form of a block grant that would not rise if enrollment in the program increases. In addition, the amendment would eliminate federal funding for Medicaid beneficiaries who earn more than 133% of the Federal Poverty Level. Effective immediately, states that had not yet adopted Medicaid expansion would be prevented from doing so. Obamacare tax provisions that help fund tax credits for enrollees would be repealed in 2017, rather than in 2018 as in the original bill.

The original AHCA bill included a provision lowering the threshold for taking a medical expense tax deduction from 10% of adjusted gross income to 7.5%. The amendment would reduce this threshold further to 5.8% of adjusted gross income. According to a press release from the House Energy and Commerce Committee, the tax relief provided by lowering the medical expense deduction threshold – which some estimated might total $85 billion – could have been redirected by the U.S. Senate to provide additional tax credits for older persons who purchase insurance in the nongroup market. This provision was designed to address concerns about the large premium increases projected for older persons who don't qualify for Medicaid and who are not yet old enough to be eligible for Medicare.

The March 20 manager's amendment also included a measure specifically to win the support of some rural and suburban Congressional Republicans from New York state. This measure, which affects New York state only, would shift Medicaid costs from counties to the state government – a move opposed by New York governor Andrew Cuomo.

CBO Analysis of the AHCA as Amended

On March 23, the CBO issued a brief report recalculating the effects of the AHCA plus the March 20 Manager's Amendment. Like the original bill, the AHCA as amended on March 20 would increase the number of uninsured by 14 million in 2018, 21 million by 2020, and 24 million by 2026, according to CBO. Premiums for single policyholders in the nongroup market would also rise an average of 15% to 20% during the first 2 years. However, unlike the original bill, which was projected to reduce the federal deficit a total of $337 billion by 2026 compared to Obamacare, the bill as amended on March 20 would reduce the deficit by only $150 billion, according to CBO.

Final Changes to AHCA and Withdrawal of the Bill

In the final day before the vote, the House Freedom Caucus – which had more than enough votes to defeat the AHCA – negotiated additional changes to the bill, in particular, the repeal of an Obamacare requirement that all marketplace health insurance plans provide the following 10 essential health benefits (EHBs):

- ambulatory patient services;
- emergency services;
- hospitalization, such as surgery and overnight stays;
- pregnancy, maternity, and newborn care (both before and after birth);
- mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy);
- prescription drugs;
- rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills);
- laboratory services;
- preventive and wellness services and chronic disease management; and
- pediatric services, including oral and vision care

EHBs are of great concern for people living with HIV, viral hepatitis, other chronic illnesses, or a history of substance use, because plans lacking such benefits would have little value to them. Health analysts project that, if EHBs were no longer required, insurance plans lacking EHBs could be significantly cheaper than those with them, and could be attractive to young, healthy persons. However, policies that continued to offer EHBs could become much more expensive, especially since they would be most attractive to people who needed the benefits and less so for others. In addition, if people who purchased cheap policies without EHBs later needed these services, they would have to pay for their costs out of pocket or rely on free or subsidized care – placing a burden on the hospitals and other facilities that would provide such care.

Since final form of the AHCA was crafted just hours before the legislation came up for a vote, no CBO analysis was available regarding its impacts, including the repeal of Obamacare's EHBs on the federal budget, the number of uninsured persons, insurance premiums, and the stability of the U.S. health insurance market.

The repeal of the EHBs may have won support from some conservative House members. But that turned out not to be enough for the legislation to pass. Some conservative legislators still opposed the AHCA because, even after the final negotiated changes, the bill retained features of Obamacare that they would not support. In addition, some comparatively moderate House Republicans opposed the bill for opposite reasons. They felt that the AHCA rolled back too many features of Obamacare that their constituents valued – including EHBs, Medicaid expansion, and premium support.

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Perspectives on the AHCA from HIV, Hepatitis, Health Care, and Elder Groups

When U.S. House speaker Paul Ryan introduced the AHCA on March 6, he issued a brief statement contrasting what he considered to be the bill's strengths and Obamacare's shortcomings: "Obamacare is rapidly collapsing. Skyrocketing premiums, soaring deductibles, and dwindling choices are not what the

people were promised seven years ago . . . The American Health Care Act is a plan to drive down costs, encourage competition, and give every American access to quality, affordable health insurance. It protects young adults, patients with pre-existing conditions, and provides a stable transition so that no one has the rug pulled out from under them." President Donald Trump praised AHCA as "our wonderful new healthcare bill" and said that he was 100% behind it. Tom Price, the secretary of the Department of Health and Human Services also claimed that nobody would be worse off financially under AHCA compared to Obamacare and that people would be able to "select the kind of coverage that they want for themselves and for their family, not that the government forces them to buy."

However, as noted in the previous article, many organizations and patient advocacy groups viewed the legislation far differently and issued statements opposing it. The concerns of some of these groups are covered in detail below.

Joint Statement by Five HIV/AIDS and STD Organizations: Soon after the AHCA was introduced, five organizations – AIDS United, the National Alliance of State and Territorial AIDS Directors (NASTAD), the National Coalition of STD Directors, NMAC, and The AIDS Institute – issued a joint statement strongly opposing the legislation. The organizations argued that the AHCA "would significantly limit access to private insurance and Medicaid for those who need it most . . . substantially decrease coverage options and increase insurance costs for people living with HIV, and decrease STD screening and treatment through reduced insurance access." In addition, "The plan also reduces federal Medicaid contributions through a per capita cap, which could cause states to make cuts to eligibility, benefits, and important consumer protections and would mean going back to cruel pre-ACA rules where a person must wait to be disabled by HIV in order to be eligible for Medicaid," according to the statement. The five organizations also opposed AHCA's funding cuts for women's health and its elimination of the Prevention and Public Health Fund, which provides 12% of the CDC's budget.

"We believe that the proposed legislation would make it much harder, if not impossible, for people living with HIV and other chronic conditions to get the coverage needed to meet their care and treatment needs," noted NASTAD executive director Murray Penner. "We need a system of health coverage that works for everyone, including people with chronic conditions and disabilities, and the proposed legislation achieves the exact opposite."

The organizations argued that any new comprehensive health care legislation must include the following features:

- "Maintain the current Medicaid funding structure, including expansion of the program, to allow states to respond to current need and increased demand for Medicaid coverage during tough economic times, unanticipated outbreaks or disasters, and when there are health innovations, such as the recent curative breakthrough treatments for hepatitis C."
- "Ensure access to an affordable minimum essential benefits package that includes the range of services and treatments that people at risk for and those living with HIV and STDs need to stay healthy, including prescription drug benefits, substance use and mental health treatment, and preventive services without cost-sharing."
- "Keep health care affordable and accessible by maintaining non-discrimination protections and ensuring adequate, up front premium and cost sharing assistance for low income individuals.

This includes maintaining the bans on annual and lifetime benefits caps to ensure access to care and coverage when it is needed most."

- "Maintain funding for the Prevention and Public Health Fund and CDC to ensure that the end of HIV remains a winnable battle within our lifetime."

National Viral Hepatitis Roundtable (NVHR) Letter: The NVHR – a coalition of 500 organizations working to fight viral hepatitis – wrote a letter to Congress, urging representatives to oppose the bill. "The AHCA would burden states and families with new health care costs by capping what the federal government pays states for each person covered by their Medicaid program. Medicaid funding has proven critical to testing and treating low-income people with hepatitis B and/or C," according to the letter. "The AHCA's radical restructuring of Medicaid would strip states of their freedom to design their own Medicaid programs and would force them to cut coverage and benefits. The effects would be devastating for people with hepatitis B and/or C, who rely upon the ability of states to cover lifesaving treatment and care. Patients will be forced to go without treatment or go into debt to get the care they need." The NVHR letter also states that many lower-income families could see their deductibles increase by as much as $5,500 under AHCA. "These cost increases would make treatment for chronic hepatitis B and/or C and other chronic illnesses simply unaffordable. People with hepatitis B and/or C depend on consistent access to care and medications and cannot risk losing access to their health coverage or a cut in services."

The Fenway Institute AHCA Policy Brief: The AHCA would harm LGBT people, persons living with HIV, and Black and Latino Americans, according to a policy brief produced by The Fenway Institute (TFI). The TFI brief argued that AHCA's changes in Medicaid eligibility requirements, insurance premium penalties for persons who don't maintain continuous coverage, and prohibition of the use of Medicaid funding for services from Planned Parenthood would all threaten health care access and affordability for low-income LGBT persons and persons living with HIV.

"This bill holds potentially devastating consequences for low-income LGBT people, people living with HIV, and Black and Latino people," according to Sean Cahill, director of policy research for TFI. "The rates of uninsurance among LGBT people and people living with HIV have dropped dramatically since 2013, when the Affordable Care Act's Medicaid expansion was implemented. While people of all races benefitted from the expansion of insurance access, on a per capita basis Black and Latino people benefitted disproportionately. Those gains could be completely erased if this bill becomes law."

American Medical Association (AMA) Letter: An AMA letter to Congress raised similar concerns about expected adverse impacts of the AHCA. The AMA opposed the AHCA's changes in tax credits for people obtaining insurance; the rollback of Medicaid expansion; other changes to Medicaid that could limit states' ability to respond to changes in the demand for services, such as mental health, substance use, and addiction treatment; provisions that would prevent patients from receiving care from qualified providers of their choice, such as Planned Parenthood; and the repeal of the Prevention and Public Health Fund.

"As drafted, the AHCA would result in millions of Americans losing coverage and benefits," commented AMA president Andrew Gurman. "By replacing income-based premium subsidies with age-based tax credits, the AHCA will also make coverage more expensive – if not out of reach – for poor and sick Americans. For these reasons, the AMA cannot support the AHCA as it is currently written."

The AMA letter to Congress concluded: "As you consider this legislation over the coming days and weeks, we hope that you will keep upmost in your mind the potentially life-altering impact your decisions will have on millions of Americans who may see their public, individual, or even employer-provided health care coverage changed or eliminated. We encourage you to ensure that low and moderate income Americans will be able to secure affordable and adequate coverage and that Medicaid, CHIP [Children's Health Insurance Program], and other safety net programs are maintained and adequately funded. And critically, we urge you to do all that is possible to ensure that those who are currently covered do not become uninsured."

American Nurses Association (ANA) Letter: Like the American Medical Association, the ANA voiced concerns over the AHCA in a letter to ranking members of the U.S. House Ways and Means Committee and Energy and Commerce Committee. "In its current form, the bill changes Medicaid to a per capita cap funding model, eliminates the Prevention and Public Health Fund, restricts millions of women from access to critical health services, and repeals income-based subsidies that millions of people rely on. These changes in no way will improve care for the American people," the ANA stated.

The letter further urged Congressional leaders to seek input from nonpartisan experts and stakeholders on the long-term economic and health consequences of health reform legislation. "Any legislation that would fundamentally alter health-care delivery and deeply impact patients and providers deserves thoughtful, deliberate, and transparent consideration. ANA strongly urges Congress to allow opportunity for considered public and stakeholder feedback in the face of reforms that would have a far-reaching and personal impact on the lives of millions of people."

American Association of Retired Persons (AARP) Letter: The AARP – an organization with approximately 38 million members aged 50 and above – also sent a letter to Congress opposing the AHCA as introduced in early March and detailing its specific concerns. In a separate statement, AARP executive vice president Nancy LeaMond summarized some of the organization's main concerns, including that the legislation could weaken Medicare and leave the door open for a voucher program that would shift health care costs and risks to seniors.

"Before people even reach retirement age, big insurance companies could be allowed to charge them an age tax that adds up to thousands of dollars more per year," according to LeaMond. "Older Americans need affordable health care services and prescriptions. This plan goes in the opposite direction, increasing insurance premiums for older Americans and not doing anything to lower drug costs. On top of the hefty premium increase for consumers, big drug companies and other special interests get a sweetheart deal. Finally, Medicaid cuts could impact people of all ages and put at risk the health and safety of 17.4 million children and adults with disabilities and seniors by eliminating much-needed services that allow individuals to live independently in their homes and communities." LeaMond concluded that, "Although no one believes the current health care system is perfect, this harmful legislation would make health care less secure and less affordable."

Public Opposition to the Bill: In town hall meetings and demonstrations at various sites across the U.S., many Obamacare supporters voiced their opposition to the AHCA. During March, national opinion polls indicated that public support for Obamacare had risen to the highest level in years. In contrast, support for the AHCA was generally lacking. A Quinnipiac poll released on March 23 – the day before the AHCA was pulled – found that American voters disapproved of the bill by more than a three-to-one margin:

56% disapproved, 17% approved, and 26% were undecided. When asked about specific aspects of the bill, the voters indicated that they opposed provisions to cut federal funding for Planned Parenthood and to cut federal funding for Medicaid.

Nearly half (46%) of those surveyed said they would be less likely to vote for their U.S. senator or representative if they voted for the AHCA, compared to 19% who said they'd be more likely to vote for them, and 29% who said it wouldn't matter. Although it's not clear to what extent, if any, these and other polling numbers influenced the House Republicans – the opposition of many groups, combined with the lack of strong support even among Republican voters, probably made it easier for some legislators to resist pressure to vote for the AHCA.

Postscript: As this newsletter went to press, none of the organizations and advocacy groups above had issued official comments about the withdrawal of AHCA from consideration. However, the statements above indicate that these groups and their constituents are very likely to oppose any future legislation that could reduce insurance access, substantially increase premiums and out-of-pocket expenses, or limit services for women, older or chronically ill persons, and those at risk for disease.

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Uncertain Future of Obamacare and Health Reform

Now that Congress is no longer considering the AHCA, the future of efforts to repeal and replace Obamacare are unclear. During a news conference on March 24, House speaker Paul Ryan acknowledged that "Obamacare remains the law of the land," and that "we'll be living with Obamacare for the foreseeable future." In public statements and in a tweet following the withdrawal of the AHCA, President Trump claimed that "ObamaCare will explode and we will all get together and piece together a great healthcare plan for THE PEOPLE. Do not worry!" However, the CBO and health analysts generally agree that, despite some challenges, Obamacare is continuing to function and is not likely to "explode" any time soon.

Nevertheless, even though Obamacare remains in place, the President, Congress, and federal agencies can choose whether to take action to stabilize and strengthen the program or to undermine it either through direct action or inaction. In an article on March 27, Vox.com's health policy reporter Sarah Kliff highlighted several decisions the Trump administration will make that affect the future of Obamacare and the U.S. health care system. These include:

- Should it run a very active outreach campaign to encourage uninsured persons to buy coverage? If it doesn't, fewer healthy people might enroll, which could drive up insurance premiums.
- How should the administration handle counties where no companies want to sell coverage on the Obamacare insurance marketplace? Will it negotiate with insurers, as the Obama administration did, to convince them to provide coverage in such areas?
- Will the federal government continue to pay cost-sharing subsidies that make health coverage affordable for low-income enrollees?

Some Congressional Democrats have indicated they are willing to work with the Republican majority and President Trump to safeguard Obamacare's gains and fix its problems. Speaking on ABC's This Week, U.S. Senate minority leader Chuck Schumer said, "We Democrats, provided our Republican colleagues drop [repeal and replace] and stop undermining the ACA, are willing to work with our

Republican friends — as long as they say no more repeal." Schumer also noted that, "We have ideas, they have ideas to try to improve Obamacare. We never said it was perfect. We always said we'd work with them to improve it – we just said repeal was off the table."

The progressive wing of the Democratic party is also planning to introduce legislation of its own. Vermont senator Bernie Sanders and representative Peter Welch said they plan to introduce single-payer "Medicare for All" bills in the U.S. Senate and House within a few weeks. During a town hall meeting, Welch acknowledged that such legislation won't pass in the current Congress. "But I think we have to keep the goal out there, because we need in this country, like any industrialized country, a health care system that's affordable, accessible, and universal," Welch said, as quoted in The Hill.

Selected Articles Examining the Future of Obamacare and Health Reform
For your convenience, we have compiled a selection of articles published shortly after the withdrawal of the AHCA that discuss the future of Obamacare and health reform in the Trump administration and 115th Congress. We also suggest that readers who wish to follow this evolving story periodically visit the Kaiser Health News Morning Briefings page, which aggregates health policy coverage from many sources.

Fact Check: Trump Says Obamacare Is 'Exploding.' It's Not (National Public Radio)

Is Obamacare Exploding? Nope. But There Are Some Rough Spots (Bloomberg)

Now What? Options for Consumers as Health Law Drama Fades (Associated Press)

States Mulling Medicaid Options in Wake of Health Bill Failure (MedPage Today)

The Search for Intelligent Bipartisanship on Health Care (Roll Call)

Trump Is Now in Charge of Making Obamacare Work. What Could Go Wrong? (Vox)

2018 Dilemma for Republicans: Which Way Now on Obamacare? (New York Times)

Paul Ryan: House Republicans Will Continue Their Push for Health-Care Reform This Year (Washington Post)

Price Faces Unwanted Task of Administering ObamaCare (The Hill)

After GOP Bill's Failure, Health-Law Lawsuit Takes Center Stage (Wall Street Journal)

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Trump's 2018 Budget Blueprint Would Reduce HHS Funding 18%

The Trump administration's "America First" budget blueprint for fiscal year 2018 (FY18), released on March 16, would increase defense spending $54 billion, but would impose deep budget cuts to many federal agencies and programs, including the Department of Health and Human Services (HHS), the Environmental Protection Agency (EPA), and the State Department. Funding for HHS would be reduced

approximately 18%, from $84.1 billion in FY17 to $69.0 billion in FY18. The budget blueprint says these changes would be achieved by eliminating "programs that are duplicative or have limited impact on public health and well-being. The Budget allows HHS to continue to support priority activities that reflect a new and sustainable approach to long-term fiscal stability across the Federal Government."

Included in the HHS budget cuts are:

- A $5.8 billion cut in funding for the National Institutes of Health (NIH) to $25.9 billion in FY18. This would be achieved largely through "a major reorganization of NIH's Institutes and Centers to help focus resources on the highest priority research and training activities . . . and other consolidations and structural changes across NIH organizations and activities," according to the blueprint.
- The elimination of discretionary programs within HHS's Office of Community Services, including the Low Income Home Energy Assistance Program (LIHEAP) and the Community Services Block Grant (CSBG) – reducing the HHS FY18 budget by $4.2 billion compared to the previous year. The blueprint contends that, compared to other income support programs serving similar populations, "LIHEAP is a lower-impact program and is unable to demonstrate strong performance outcomes. CSBG funds services that are duplicative of other Federal programs, such as emergency food assistance and employment services, and is also a limited-impact program."
- The elimination of health professions and nursing training programs totaling $403 million, "which lack evidence that they significantly improve the Nation's health workforce," the blueprint contends. The proposed budget would, however, continue funding activities that provide scholarships and loan repayments in exchange for service in areas of the U.S. where there is a shortage of health professionals.

In contrast to the overall deep cuts and program eliminations within the HHS, the blueprint lists several HHS programs as its "highest priorities," including: health services through Ryan White HIV/AIDS providers, community health centers, and the Indian Health Service; early care and education; and medical products review and innovation. However, the blueprint does not include budget figures for these programs. As a response to the U.S. opioid epidemic, the proposed budget would include a "$500 million increase above 2016 enacted levels to expand opioid misuse prevention efforts and to increase access to treatment and recovery services to help Americans who are misusing opioids get the help they need."

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Responses to the FY18 Budget Blueprint

Shortly after the budget blueprint was released, five HIV/AIDS and STD organizations issued a joint statement that was largely critical of the proposal. Noting that the blueprint "severely cuts funding to agencies responsible for protecting the public health and responding to infectious diseases, including HIV," the statement called on the U.S. Congress to reject the budget and ensure that funding for non-defense discretionary programs is maintained. The five groups issuing the joint statement are: AIDS United, the National Alliance of State and Territorial AIDS Directors, the National Coalition of STD Directors, NMAC, and The AIDS Institute.

"We appreciate that the administration recognizes the importance of the Ryan White providers, other safety-net providers, and global health, including PEPFAR [President's Emergency Plan for AIDS Relief]," commented Michael Ruppal, Executive Director of The AIDS Institute. "However the cuts to the National Institutes of Health, Department of Housing and Urban Development, and other parts of HHS, including public health infrastructure, will reverse our progress on ending the HIV epidemic. If enacted, the budget would be devastating to our nation's public health infrastructure and would harm people living with and/or at risk for HIV and STDs. HIV and STD programs are critical to the public health of our nation and must not be cut."

The American Public Health Association (APHA) was also sharply critical of the proposal. "This budget proposal presents a fiscal agenda that would undermine the health and well-being of Americans," commented APHA executive director Georges Benjamin. "Cuts to these agencies [HHS and EPA] would threaten programs that protect the public from the next infectious disease outbreak, polluted air and water, health threats due to climate change, and our growing chronic disease epidemic. It would also weaken our nation's health workforce, which works to assure and improve the health of all of our communities, especially underserved and vulnerable populations."

"Public health and environmental health programs are vital to helping Americans lead healthy, productive lives – which saves money, makes our communities stronger, and helps our nation grow and prosper," Benjamin continued. "We urge this administration and Congress to pass sensible and balanced FY18 spending bills that protect the public's health."

The American Association for the Advancement of Science (AAAS) response to the budget blueprint highlighted its deep cuts and program eliminations to scientific and health research programs. In particular, several environmental, energy, and atmospheric research programs would be cut 44% to 100% in the FY18 budget proposal, and the National Institutes of Health (NIH) budget would be cut 20%.

The $5.8 billion cut to the NIH would reduce its funding to the lowest level in 15 years after adjusting for inflation. Because much of NIH's budget is used to make annual payments for ongoing research grants, the 20% cut could leave virtually no money for new research grants in FY18, according to Kathy Hudson, a former NIH deputy director. In its summary of the budget proposal, AAAS noted, however, that NIH has a long history of bipartisan support and that the U.S. Congress is therefore highly unlikely to go along with the Trump administration's proposed cuts to the NIH budget.

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OTHER NEWS REPORTS AND MATERIALS

Background Materials About the American Health Care Act

For people who would like to learn more about the AHCA, its provisions, and projected impacts, we have compiled an annotated list of resources below:

The Legislation

Full text of the original version of the American Health Care Act (H.R. 1628) as introduced on March 6
Full text of the 21-page Manager's Amendment dated March 20

Full text of a 4-page Section-by-Section Summary of the March 20 Manager's Amendment

Congressional Budget Office (CBO) Reports
Congressional Budget Office Cost Estimate: American Health Care Act – This 37-page report summarizes the major provisions of the AHCA as introduced in early March and details the legislation's projected impacts, compared to Obamacare, on: the U.S. federal budget deficit; health insurance coverage, including the number of uninsured persons; the stability of the U.S. health insurance market; and health insurance premiums.
CBO Analysis of the AHCA as Amended (March 20) – This 10-page CBO report has a revised analysis of the health coverage and budgetary impacts of the AHCA as amended on March 20. Please note that it does not include an analysis of the final changes made to the bill shortly before passage, including the removal of Obamacare's requirements that insurance plans cover 10 essential health benefits.

Issue Briefs, Interactive Maps, and Other Resources from the Kaiser Family Foundation
Summary of the American Health Care Act (issue brief) – This 9-page summary discusses the AHCA's provisions in extensive detail, including changes incorporated in subsequent amendments.
Compare Proposals to Replace the Affordable Care Act (interactive tool) – This tool allows users to compare key features of Obamacare, the AHCA, and several other health reform proposals.
What Is at Stake for Health and Health Care Disparities Under ACA Repeal? (issue brief)
How Affordable Care Act Repeal and Replace Plans Might Shift Health Insurance Tax Credits (issue brief)
Premiums and Tax Credits Under the Affordable Care Act vs. the American Health Care Act (interactive maps); also available in Spanish. These maps allow users to input information about a person's income, age, and state and county of residence to determine how much their health insurance premiums and tax credits would change under the AHCA compared to Obamacare.
Kaiser Health Tracking Poll: ACA, Replacement Plans, Women's Health (public opinion poll) and topline & methodology

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New Resources on HIV/AIDS in Rural Areas

The Health Resources and Services Administration's Rural Health Information Hub has developed a new Rural HIV/AIDS Prevention and Treatment Toolkit. The Toolkit has seven parts: 1) an introductory module that presents an overview of HIV/AIDS treatment and prevention in the U.S. and unique challenges that rural communities face; 2) a module that describes 14 different evidence-based and promising models for HIV/AIDS prevention and treatment programs; 3) a program clearinghouse module that provides examples of HIV/AIDS programs that have already been implemented in rural areas; 4) an implementation module that outlines important considerations for those planning to implement HIV/AIDS programs serving rural communities; 5) an evaluation module describing data collection and evaluation tools for measuring program outcomes; 6) a sustainability module with resources to help planners develop strategies for sustaining rural HIV/AIDS programs; and 7) a dissemination module with guidance on disseminating the findings from an HIV/AIDS program.

The National Center for Innovation in HIV Care has also posted a video recording and slide set for its recent webinar, "Living with HIV in Rural America – Stigma and Other Barriers to Care." People living in U.S. rural areas are less likely to be tested for HIV and diagnosed early, be retained in HIV care, and to achieve viral suppression than persons living in urban areas. The three webinar presenters focused on

the ways in which stigma by rural healthcare providers and rural healthcare teams affect the health outcomes of persons living with HIV in the U.S. and its territories.

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WHO Changes Guidance on Hormonal Contraception and HIV & Related Resources

The World Health Organization (WHO) has issued updated guidance on the use of hormonal contraception among women at high risk for HIV infection. The guidance statement changes the WHO classification of some long-acting contraceptives based on "evidence of a possible increased risk of HIV among progestogen-only injectable users." Specifically, WHO has changed the classification for long-acting injectable contraceptives from "use without restriction" to "benefits outweigh theoretical or proven risks." Earlier this month, the HIV prevention organization AVAC hosted a webinar, Hormonal Contraception and HIV: Putting New Developments in Context, in which an expert panel described the WHO grading system for family planning methods and the effects that WHO's updated classification of long-acting injectable contraceptives are expected to have on women, HIV programs, and research. An AVAC blog item, WHO Updates Guidance on Hormonal Contraception and HIV, also provides a quick overview with links to a plain-language fact sheet on the grading system, WHO FAQs, and additional resources.

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AIDSinfo and CDC Fact Sheets on HIV Prevention, Treatment, and Affected Populations

During the past several weeks, AIDSinfo and the CDC have released the following new and updated fact sheets related to HIV prevention, treatment, and affected or at-risk populations:

What is a Preventive HIV Vaccine? (Spanish)

What is a Therapeutic HIV Vaccine? (Spanish)

HIV and Injecting Drugs 101 (easy-to-read fact sheet)

PEP [post-exposure prophylaxis] 101 (easy-to-read fact sheet)

HIV and Tuberculosis

HIV Among American Indians and Alaska Natives in the United States

HIV Among Pregnant Women, Infants, and Children

HIV Among Women (easy-to-read fact sheet)

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New and Updated Fact Sheets on Harm Reduction and Viral Hepatitis

The HCV Advocate/Hepatitis C Support Project have produced a several new and updated fact sheets on hepatitis B, C, and harm reduction. These materials include:

HCV and Harm Reduction: Definitions

HCV and Harm Reduction: Alcohol

HCV and Harm Reduction: Indirect Sharing

Overview of HCV Diagnostic Tests

Nutrition and Hepatitis C

La Transmisión y Prevención de la Hepatitis C

Easy B Facts: What Are Antivirals?

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FEATURED HEALTH RESOURCES

Materials for National Youth HIV and AIDS Awareness Day (April 10)

The fifth annual National Youth HIV and AIDS Awareness Day (NYHAAD) is being observed this year on Monday, April 10. Many national, state, and private organizations are partners or supporters of NYHAAD. The day's founding partners include: Advocates for Youth; AIDS Alliance for Children, Youth, and Families; AIDS United; National Alliance of State and Territorial AIDS Directors; National Coalition of STD Directors; NMAC; and Sexuality Information and Education Council of the United States.

According to Advocates for Youth, the establishment of NYHAAD is a step toward acknowledging and addressing the needs of young people in the HIV and AIDS response. Each year, young activists in high schools and at colleges and universities across the country use the day to organize and educate about HIV and AIDS. They promote HIV testing, fight stigma, and start the necessary conversations to deal honestly and effectively with the challenges of fighting HIV/AIDS among youth.

To support activities commemorating NYHAAD, we have compiled an annotated list of online resources focusing on HIV/AIDS among children, adolescents, and young adults.

General Information

National Youth HIV and AIDS Awareness Day: This is the web page for NYHAAD. It provides background information about the day, together with links to information resources focusing on HIV/AIDS among young persons.

Children and HIV. Fact sheet from AIDS InfoNet. Also available in Spanish and Russian.

HIV Among Youth. Fact sheet from CDC.

Vital Signs: HIV Infection, Testing, and Risk Behaviors Among Youths – United States. Article from the *Morbidity and Mortality Weekly Report* (*MMWR*).

Vital Signs: HIV Among Youth in the U.S. Infographic from CDC.

Youth Risk Behavior Surveillance – United States, 2015. Article from *Morbidity and Mortality Weekly Report*.

HIV Surveillance – Adolescents and Young Adults. Slide set from CDC.

Young People, HIV, and AIDS (from Avert) – This page provides general information about HIV among youth and has links to many reports and articles focusing on youth.

Being Young and Positive (from Avert) – Information about HIV/AIDS for young persons. Topics include: taking responsibility for your health, telling your friends, having relationships, and having sex.

HIV Prevention Resources for Youth-Serving Professionals (from Advocates for Youth) – This page includes approximately 20 lesson plans, tools, strategy documents, and other resources for professionals.

HIV Information for Parents (from Advocates for Youth) – This page includes a variety of resources focusing on sexuality, alcohol and sexual risk taking, and parent-child communication skills.

Fact Sheets from Advocates for Youth:

- Young People and HIV in the United States
- Young People Living with HIV Around the World
- Understanding Disparities in the HIV Epidemic
- Young Women of Color and the HIV Epidemic
- Young Women of Color and Their Risk for HIV and Other STIs
- Young African American Women and HIV
- HIV and Young American Indian/Alaska Native Women
- HIV/STD Prevention and Young Men Who Have Sex with Men. Also available in Spanish.
- Young Men Who Have Sex with Men: At Risk for HIV and STDs. Also available in Spanish.

Materials for National Transgender HIV Testing Day (April 18)

The second annual National Transgender HIV Testing Day (NTHTD) will be observed on Tuesday, April 18. The event is being organized by the University of California-San Francisco's Center of Excellence for Transgender Health (CoE). According to the CoE, "NTHTD is a day to recognize the importance of routine HIV testing, status awareness, and continued focus on HIV prevention and treatment efforts among transgender people. This initiative encourages community-based organizations, health jurisdictions, and HIV prevention programs to participate by hosting local trans HIV testing community events (HIV testing, visibility campaign, community forums) and/or develop trans-specific HIV testing campaign materials and resources."

As part of the NTHTD initiative, the CoE has developed a Transgender HIV Testing Toolkit, which includes five modules "designed to reflect the most current HIV prevention research and best practices for serving trans and gender non-binary people." The modules are: 1) Get the Facts about Trans People and HIV; 2) Testing and Enhanced Communication Approaches with Trans People; 3) Building Capacity to Increase HIV Testing Efforts for Trans People; 4) Community Engagement and National HIV Transgender

HIV Testing Day; and 5) NTHTD and Toolkit Resources. The CoE has also produced a number of other resources for the testing day, including a condensed toolkit for health departments, testing placards in English and Spanish, and a series of flyers to promote testing.

To support activities commemorating NTHTD, we have compiled an annotated list of online resources focusing on HIV/AIDS among transgender people.

General Information

Center of Excellence for Transgender Health – Website that includes many resources on transgender health

Transgender Persons – CDC's compilation of resources and fact sheets related to transgender health

Transgender Health – Resource page from Fenway Health

National LGBT Health Education Center – Program of The Fenway Institute

Services and Advocacy for Gay, Lesbian, Bisexual, and Transgender Elders (SAGE) – Organization that provides services and advocacy for LGBT elders

LGBT Education and Training – Resource with a list of articles, training, and educational materials from the LGBT Resource Center at UCSF

All Children-All Families: Benchmarks of LGBTQ Cultural Competency – from the Human Rights Campaign

Selected Reports and Articles

The State of Transgender Health Care: Policy, Law, and Medical Frameworks (*American Journal of Public Health - AJPH*)

Affirmative Care for Transgender and Gender Non-Conforming Persons (National LGBT Health Education Center)

Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper from the American College of Physicians (*Annals of Internal Medicine*)

Important Considerations for Addressing LGBT Health Care Competency (*AJPH*)

Improving the Health Care of Lesbian, Gay, Bisexual, and Transgender People: Understanding and Eliminating Health Disparities (National LGBT Health Education Center)

Barriers and Facilitators to Engagement and Retention in Care Among Transgender Women Living with Human Immunodeficiency Virus (*Annals of Behavioral Medicine*)

Barriers to Healthcare for Transgender Individuals (*Current Opinion in Endocrinology, Diabetes, Obesity*)

Barriers to Quality Health Care for the Transgender Population (*Clinical Biochemistry*)

Satisfaction and Healthcare Utilization of Transgender and Gender Non-Conforming Individuals in NYC: A Community-Based Participatory Study (*LGBT Health*)

Improving Transgender Health by Building Safe Clinical Environments That Promote Existing Resilience: Results from a Qualitative Analysis of Providers (*BMC Pediatrics*)

Creating Welcoming Spaces for Lesbian, Gay, Bisexual, and Transgender (LGBT) Patients: An Evaluation of the Health Care Environment (*Journal of Homosexuality*)

Comprehensive Transgender Healthcare: The Gender Affirming Clinical and Public Health Model of Fenway Health (*Journal of Urban Health*)

Transgender Care Moves into the Mainstream (*JAMA*)

Trans Health Care in the USA: A Long Way to Go (*The Lancet*)

Access to Care for Transgender Veterans in the Veterans Health Administration: 2006-2013 (*AJPH*)

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RECENT RESEARCH ON THE CONTINUUM OF CARE/TREATMENT CASCADE FOR HIV AND VIRAL HEPATITIS

This newsletter section includes the titles, authors, and links to abstracts of recent research related to the continuum of care for HIV and viral hepatitis. This includes research on interventions to increase awareness of HIV and/or viral hepatitis status through expanded testing; to increase linkage to and retention in care and treatment; and to attain and maintain desired health outcomes. Papers are listed alphabetically according to the lead author's last name.

Disparity in Retention in Care and Viral Suppression for Black Caribbean-Born Immigrants Living with HIV in Florida. By E. Cyrus, C. Dawson, K.P. Fennie, and others, in *International Journal of Environmental Research and Public Health*. Free full text also available.

Jail Booking as an Occasion for HIV Care Reengagement: A Surveillance-Based Study. By M.C. Eastment, K.G. Toren, L. Strick, and others, in *American Journal of Public Health*.

Designing an Intervention to Improve Timely HIV Diagnosis Among Latino Immigrant Men. By S.D. Grieb, A. Flores-Miller, N. Gulledge, and others, in *Progress in Community Health Partnerships*.

The Continuum of HIV Care in Rural Communities in the United States and Canada: What Is Known and Future Research Directions. By A. Helmut, R. Dillingham, R.S. Hogg, and others, in *Journal of Acquired Immune Deficiency Syndromes*.

Retention in Buprenorphine Treatment Is Associated with Improved HCV Care Outcomes. By B.L.

Norton, A. Beitin, M. Glenn, and others, in *Journal of Substance Abuse Treatment*.

HIV Pre-Exposure Prophylaxis Programs Incorporating Social Applications Can Reach At-Risk Men Who Have Sex with Men for Successful Linkage to Care in Missouri, USA. By R.R. Patel, L.C. Harrison, V.V. Patel, and others, in *Journal of Association of Nurses in AIDS Care*.

Addressing Structural Barriers to HIV Care Among Triply Diagnosed Adults: Project Bridge Oakland. By C. Powers, M. Comfort, A.M. Lopez, and others, in *Health and Social Work*.

Sex, Race, and HIV Risk Disparities in Discontinuity of HIV Care After Antiretroviral Therapy Initiation in the United States and Canada. By P.F. Rebeiro, A.G. Abraham, M.A. Horberg, and others, in *AIDS Patient Care and STDs*. Free full text also available.

Developing a Patient Navigation Program to Improve Engagement in HIV Medical Care and Viral Suppression: A Demonstration Project Protocol. By C.L. Schumann, R.P. Westergaard, A.E. Meier, and others, in *AIDS and Behavior*.

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RECENT RESEARCH ON HIV AND HEPATITIS HEALTH DISPARITIES AND AFFECTED POPULATIONS

This section includes the titles, authors, and links to abstracts of recent research. Papers are listed alphabetically according to the lead author's last name.

Human Papillomavirus Co-Testing Results Effectively Triage Normal Cervical Cytology in HIV-Positive Women Aged 30 Years and Older. By R.O. Alade, O. Vragovic, C. Duffy, and others, in *Journal of Lower Genital Tract Disease*.

What About Us? Economic and Policy Changes Affecting Rural HIV/AIDS Services and Care. By T. Albritton, I. Martinez, C. Gibson, and others, in *Social Work in Public Health*.

Estimated HIV Inter-Test Interval Among People at High Risk for HIV Infection in the U.S. By Q. An, R. Song, T.J. Finlayson, and others, in *American Journal of Preventive Medicine*.

Examining the Effects of Transphobic Discrimination and Race on HIV Risk Among Transwomen in San Francisco. By S. Arayasirikul, E.C. Wilson, and H.F. Raymond, in *AIDS and Behavior*.

Social, Structural, Behavioral, and Clinical Factors Influencing Retention in Pre-Exposure Prophylaxis (PrEP) Care in Mississippi. By T. Arnold, L. Brinkley-Rubinstein, P.A. Chan, and others, in *PLoS One*. Free full text also available.

A Mixed-Method Study on Correlates of HIV-Related Stigma Among Gay and Bisexual Men in the Southern United States. By R.C. Berg, D. Carter, and M.W. Ross, in *Journal of the Association of Nurses in AIDS Care*.

Predictors of CD4 Health and Viral Suppression Outcomes for Formerly Homeless People Living with HIV/AIDS in Scattered Site Supportive Housing. By E.A. Bowen, J. Canfield, S. Moore, and others, in *AIDS Care*.

Stigma, Medical Mistrust, and Perceived Racism May Affect PrEP Awareness and Uptake in Black Compared to White Gay and Bisexual Men in Jackson, Mississippi, and Boston, Massachusetts. By S. Cahill, S.W. Taylor, S.A. Elsesser, and others, in *AIDS Care*.

Capturing the Social Location of African American Mothers Living with HIV: An Inquiry Into How Social Determinants of Health Are Framed. By C. Caiola, J. Barroso, and S.L. Docherty, in *Nursing Research*.

Spirituality/Religiosity, Substance Use, and HIV Testing Among Young Black Men Who Have Sex with Men. By A.W. Carrico, E.D. Storholm, A. Flentje, and others, in *Drug and Alcohol Dependence*.

Emerging Regional and Racial Disparities in the Lifetime Risk of Human Immunodeficiency Virus Infection Among Men Who Have Sex with Men: A Comparative Life Table Analysis in King County, WA, and Mississippi. By G.A. Chan, K.L. Johnson, N.G. Mosca, and others, in *Sexually Transmitted Diseases*.

Mobile Technology Intervention to Improve Care Coordination Between HIV and Substance Use Treatment Providers: Development, Training, and Evaluation Protocol. By K. Claborn, S. Becker, S. Ramsey, and others, in *Addiction Science and Clinical Practice*. Free full text also available.

Raising Awareness of Pre-Exposure Prophylaxis (PrEP) Among Women in New York City: Community and Provider Perspectives. By K.L. Collier, L.G. Colarossi, and K. Sanders, in *Journal of Health Communication*.

Evaluation of an Evidence-Based Intervention Implemented with African-American Women to Prevent Substance Abuse, Strengthen Relationship Skills, and Reduce Risk for HIV/AIDS. By D.A. Collins, S.R. Shamblen, T.N. Strader, and B.B. Arnold, in *AIDS Care*.

Mortality Disparities Among HIV+ Men and Women in Puerto Rico: Data from the HIV/AIDS Surveillance System 2003-2014. By V. Colón-López, S. Miranda-De León, M. Machin-Rivera, and others, in *Puerto Rico Health Sciences Journal*.

The Need for Treatment Scale-Up to Impact HCV Transmission in People Who Inject Drugs in Montréal, Canada: A Modelling Study. By A. Cousien, P. Leclerc, C. Morissette, and others, in *BMC Infectious Diseases*. Free full text also available.

Prevalence and Factors Associated with Hazardous Alcohol Use Among Persons Living with HIV Across the U.S. in the Current Era of Antiretroviral Treatment. By H.M. Crane, M.E. McCaul, G. Chander, and others, in *AIDS and Behavior*.

Preventing HIV and Hepatitis Infections Among People Who Inject Drugs: Leveraging an Indiana Outbreak Response to Break the Impasse. By J.S. Crowley and G.A. Millett, in *AIDS and Behavior*.

Ongoing Incident Hepatitis C Virus Infection Among People with a History of Injecting Drug Use in an

Australian Prison Setting, 2005-2014: The HITS-p Study. By E.B. Cunningham, B. Harjarizadeh, N.A. Bretana, and others, in *Journal of Viral Hepatitis*.

Acceptability of HIV Prevention Information Delivered Through Established Geosocial Networking Mobile Applications to Men Who Have Sex with Men. By H.N. Czarny and M.R. Broaddus, in *AIDS and Behavior*.

Body Image and Risk Behaviors in Youth with HIV. By R.H. Dallas, M.M. Loew, M.L. Wilkins, and others, in *AIDS Patient Care and STDs*.

The Effects of Housing Status, Stability, and the Social Contexts of Housing on Drug and Sexual Risk Behaviors. By J. Dickson-Gomez, T. McAuliffe, and K. Quinn, in *AIDS and Behavior*.

Antiretroviral Therapy in HIV-Infected Adolescents: Clinical and Pharmacologic Challenges. By J. Dobroszycki, P. Lee, D.L. Romo, and others, in *Expert Review of Clinical Pharmacology*.

In Australia, Most HIV Infections Among Gay and Bisexual Men are Attributable to Sex with "New" Partners. By I. Down, J. Ellard, B.R. Bavinton, and others, in *AIDS and Behavior*.

Willingness to Participate and Take Risks in HIV Cure Research: Survey Results from 400 People Living with HIV in the U.S. By K. Dubé, D. Evans, L. Sylla, and others, in *Journal of Virus Eradication*.

Hearing Loss and Quality of Life (QOL) Among Human Immunodeficiency Virus (HIV)-Infected and Uninfected Adults. By N. Duong, P. Torre 3rd, G. Springer, and others, in *Journal of AIDS in Clinical Research*. Free full text also available.

Drug Use and Sexual HIV Transmission Risk Among Men Who have Sex with Men and Women (MSMW), Men Who have Sex with Men Only (MSMO), and Men Who have Sex with Women Only (MSWO), and the Female Partners of MSMW and MSWO: A Network Perspective. By T.V. Dyer, M.R. Khan, M. Sandoval, and others, in *AIDS and Behavior*.

eHealth Familias Unidas: Pilot Study of an Internet Adaptation of an Evidence-Based Family Intervention to Reduce Drug Use and Sexual Risk Behaviors Among Hispanic Adolescents. By Y. Estrada, L. Molleda, A. Murray, and others, in *International Journal of Environmental Research and Public Health*. Free full text also available.

The Adolescent HIV Disclosure Cognition and Affect Scale: Preliminary Reliability and Validity. By M. Evangeli, in *Journal of Pediatric Psychology*.

An Electronic Health Record-based Intervention to Promote Hepatitis C Virus Testing Among Adults Born Between 1945 and 1965: A Cluster-Randomized Trial. By A.D. Federman, N. Kil, J. Kannry, and others, in *Medical Care*.

Stigma and Suicide Among Gay and Bisexual Men Living with HIV. By O. Ferlatte, T. Salway, J.L. Oliffe, and T. Trussler, in *AIDS Care*.

Network Centrality and Geographical Concentration of Social and Service Venues that Serve Young Men Who Have Sex with Men. By K. Fujimoto, R. Turner, L.M. Kuhns, and others, in *AIDS and Behavior*.

Medical Mistrust as a Key Mediator in the Association Between Perceived Discrimination and Adherence to Antiretroviral Therapy Among HIV-Positive Latino Men. By F.H. Galvan, L.M. Bogart, D.J. Klein, and others, in *Journal of Behavioral Medicine*.

Drug Resistant HIV: Behaviors and Characteristics Among Los Angeles Men Who Have Sex with Men with New HIV Diagnosis. By P.M. Gorbach, M. Javanbakht, L. Bornfleth, and others, in *PLoS One*. Free full text also available.

Caring for Youth Living with HIV Across the Continuum: Turning Gaps into Opportunities. By D.C. Griffith and A.L. Agwu, in *AIDS Care*.

Public Health Benefit of Peer-Referral Strategies for Detecting Undiagnosed HIV Infection Among High-Risk Heterosexuals in New York City. By M. Gwadz, C.M. Cleland, D.C. Perlman, and others, in *Journal of Acquired Immune Deficiency Syndromes*.

Use of Videos Improves Informed Consent Comprehension in Web-Based Surveys Among Internet-Using Men Who Have Sex with Men: A Randomized Controlled Trial. By E.W. Hall, T.H. Sanchez, A.D. Stein, and others, in *Journal of Medical Internet Research*. Free full text also available.

Lifetime Risk of a Diagnosis of HIV Infection in the United States. By K.L. Hess, X. Hu, A. Lansky, and others, in *Annals of Epidemiology*.

Health-Adjusted Life Expectancy in HIV-Positive and HIV-Negative Men and Women in British Columbia, Canada: A Population-Based Observational Cohort Study. By R.S. Hogg, O. Eyawo, A.B. Collins, and others, in *Lancet HIV*.

A Novel Modeling Approach for Estimating Patterns of Migration into and out of San Francisco by HIV Status and Race Among Men Who Have Sex with Men. By A.J. Hughes, Y.H. Chen, S. Scheer, and H.F. Raymond, in *Journal of Urban Health*.

Effect of Availability of HIV Self-Testing on HIV Testing Frequency in Gay and Bisexual Men at High Risk of Infection (FORTH): A Waiting-List Randomised Controlled Trial. By M.S. Jamil, G. Prestage, C.K. Fairley, and others, in *Lancet HIV*.

Drug-Drug Interactions and Diagnostics for Drug Users with HIV and HIV/HCV Coinfections: Introduction. By J.H. Khalsa, A.H. Talal, and G. Morse, in *Clinical Pharmacology in Drug Development*.

The Committed Intimate Partnerships of Incarcerated African-American Men: Implications for Sexual HIV Transmission Risk and Prevention Opportunities. By M.R. Khan, N. El-Bassel, C.E. Golin, and others, in *Archives of Sexual Behavior*.

Use of Pre-Exposure Prophylaxis (PrEP) in Young Men Who Have Sex with Men Is Associated with Race, Sexual Risk Behavior, and Peer Network Size. By L.M. Kuhns, A.L. Hotton, J. Schneider, and others, in

AIDS and Behavior.

Antiretroviral Therapy: Racial Disparities Among Publicly Insured Californians with HIV. By R.J. Landovitz, K.A. Desmond, and A.A. Leibowitz, in *Journal of Health Care for the Poor and Underserved*.

The Structural and Health Policy Environment for Delivering Integrated HIV and Substance Use Disorder Treatments in Puerto Rico. By J.A. Leff, D. Hernández, P.A. Teixeira, and others, in *BMC Health Services Research*.

HIV Risk Behaviours Among Immigrant and Ethnic Minority Gay and Bisexual Men in North America and Europe: A Systematic Review. By N.M. Lewis and K. Wilson, in *Social Science and Medicine*.

The Changing Face of Treatment: Mental Health Concerns and Integrated Care in an HIV Clinic. By E.J. Lopez, T. Toomey, K. Lewis, and others, in *Journal of Health Care for the Poor and Underserved*.

Sexual and Behavioral Health Disparities Among Sexual Minority Hispanics/Latinos: Findings from the National Health and Nutrition Examination Survey, 2001-2014. By O. Martinez, J.H. Lee, F. Bandiera, and others, in *American Journal of Preventive Medicine*.

HIV Prevalence, Sexual Partners, Sexual Behavior, and HIV Acquisition Risk Among Trans Men, San Francisco, 2014. By W. McFarland, E.C. Wilson, and H.F. Raymond, in *AIDS and Behavior*.

Predictors and Incidence of Sexually Transmitted Hepatitis C Virus Infection in HIV Positive Men Who Have Sex with Men. By N.A. Medland, E.P. Chow, C.S. Bradshaw, and others, in *BMC Infectious Diseases*.

Two Regimes of HIV/AIDS: The MMWR and the Socio-Political Construction of HIV/AIDS as a "Black Disease." By K.M. Moseby, in *Sociology of Health and Illness*.

"We as Black Men Have to Encourage Each Other:" Facilitators and Barriers Associated with HIV Testing Among Black/African American Men in Rural Florida. By A. Murray, L. Toledo, E.E. Brown, and M.Y. Sutton, in *Journal of Health Care for the Poor and Underserved*.

Older and Younger African Americans' Story Schemas and Experiences of Living with HIV/AIDS. By A. Nevedal, S. Neufeld, M. Luborsky, and A. Sankar, in *Journal of Cross-Cultural Gerontology*.

Black Women Make Progress in Reducing HIV Disparity. No authors listed, in *JAMA*.

Blacks Still Trail in HIV Care. No authors listed, in *JAMA*.

HIV-Associated Anal Dysplasia and Anal Carcinoma. By M. Oette, F.A. Mosthaf, M.L. Sautter-Bihl, and S. Esser, in *Oncology Research and Treatment*.

Acceptability of Microbicidal Vaginal Rings and Oral Pre-Exposure Prophylaxis for HIV Prevention Among Female Sex Workers in a High-Prevalence U.S. City. By S.M. Peitzmeier, C. Tomko, E. Wingo, and others, in *AIDS Care*.

The Adherence Gap: A Longitudinal Examination of Men's and Women's Antiretroviral Therapy Adherence in British Columbia, 2000-2014. By C.M. Puskas, A. Kaida, C.L. Miller, and others, in *AIDS*.

African-American Fathers' Perspectives on Facilitators and Barriers to Father-Son Sexual Health Communication. By S.D. Randolph, T. Coakley, J. Shears, and others, in Research in *Nursing and Health*.

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