Improving Health Outcomes & Reducing Medicaid Expenditures Among People Living With HIV/AIDS (PLWHA) By Promoting Stable Housing

A proposal to impose a 30% rent cap on total household income towards rent for PLWHA who qualify for public rental assistance

Issue

About 10,000 New Yorkers permanently disabled by HIV/AIDS and their families are at risk for homelessness, which results in disruption of HIV care, poor health outcomes, and sharp increases in medical expense due to avoidable crisis care and ongoing HIV transmissions. It also results in increased expenses due to emergency housing placements.

The current rent budgeting policy of the HIV/AIDS Service Administration (HASA), a division of NYC Human Resources Administration (HRA), undermines the effectiveness of the State and City funded rental assistance program for low-income people living with HIV/AIDS by leaving participants with disability income extremely rent burdened and at risk of housing loss. This policy should be corrected to align with other state low-income housing programs and the federal Department of Housing and Urban Development (HUD) policy requiring residents of subsidized housing to contribute no more than 30% of income towards rent.

Solution

Pass the "30 percent rent cap" bill (A.6275/S.4098) to prevent homelessness for New Yorkers permanently disabled by HIV/AIDS and their families.

This legislation proposes to enact a 30% rent cap affordable housing protection for clients of the HIV/AIDS Services Administration (HASA) who already receive a rental subsidy. The bill does not create a new program or expand eligibility for existing supports. It is a simple fix to make a successful program work better. This legislation would correct HASA's rental assistance program by aligning it with all other low-income housing programs available in New York and the federal HUD standard for affordable housing.

It is important to note that the bill is cost-neutral without even taking into account expected savings in health costs attributable to avoidable emergency and acute care among unstably housed PLWHA, and prevented HIV infections. By averting just a third of emergency housing placements by keeping disabled PLWHA in their own affordable housing, the bill will pay for itself.[1] Savings multiply as additional HIV-related health costs and new infections are prevented.

[1] Ibid.

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Background

The primary housing program for poor New Yorkers living with HIV/AIDS is tenant-based rental assistance. As with other state housing programs for disabled people, residents with income from disability benefits are expected to contribute a portion of those benefits toward their rent. Unlike the other similar programs, however, the HIV/AIDS rental assistance program put in place in the 1980s did not include an affordable housing protection. All other state disability housing programs – and all federally funded housing assistance – cap the tenant's rent contribution at 30% of income. In contrast, disabled HIV-ill New Yorkers who receive rental assistance through HASA are required to pay upwards of 70% or more of their federal disability income (SSI, SSDI or Veterans' benefits) towards their rent. HUD defines payment of more than half of income towards rent as "severe rent burden."

Each HASA client in the program is budgeted to retain less than $12 per day to cover utilities, transportation, food and clothing and all other expenses – regardless of the amount of disability income received. This policy forces tenants to literally choose between paying their rent and other essential needs like travelling to visit a doctor, buying toiletries and covering co-payments and other unreimbursed medical care. Those are difficult choices for any New Yorker to make, but a matter of life and death for PLWHA who are managing a complex and expensive chronic illness. Not surprisingly, at least one in four rent-burdened HASA clients fall into arrears every year and one in nine become homeless.[2] On average, 1,800 HASA clients are homeless in expensive and often inappropriate emergency shelters, including for-profit single room occupancy (SRO) hotels on any given day.[3] Many are in the emergency shelter system because they were severely rent-burdened, fell into rent arrears and lost their apartment, while others cannot afford to move out.

Indeed, approximately one in four formerly homeless New Yorkers living with HIV/AIDS who receive housing assistance lose their housing within 6-12 months, according to the Columbia University "CHAIN" study funded by the NYC Department of Health & Mental Hygiene (DOHMH). The study also found that among PLWHA receiving rental assistance, 43% report not enough money for food, utilities, unreimbursed medical care or other health needs at least some time during the past 6 months. [4]

Saving Money By Improving Housing Stability

Housing assistance should be an essential component of the State's Medicaid cost containment strategy. According to a recent study, in 2007 9.4% of NY's Medicaid recipient with HIV/AIDS accounted for 45% of the total of HIV/AIDS related Medicaid costs[5]. (Chestnut, 2011) The Institute of Medicine recommends that housing assistance be a part of the successful management of HIV disease.

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[2] Based on FOIL data and Quarterly Performance Reports from HRA/HASA.

[3] HRA/HASA monthly Fact Sheets.

4 Dr. Angela Aidala, Columbia University Mailman School of Public Health. Presentation to NY Assembly Hearings on Proposed Rent Increases for PLWHA in Supportive Housing, Dec 21, 2006.

[5] Chestnue, T.J., Laufer, F.N., Carrascal, A.F. & MD, Feldman, I.S. (2011). An Expenditure Analysis of High-Cost Medicaid Recipients with HIV Disease in New York State. *Journal of Health Care for the Poor and Underserved*, 22: 329-344.

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A large-scale study commissioned by the Los Angeles Homeless Services Authority and conducted by the Economic Roundtable examined a wide range of public costs among 10,193 homeless persons in Los Angeles County, including 1,007 who were able to exit homelessness via supportive housing. Public costs were found to go down for all homeless persons once they were housed. Savings were greater for more vulnerable persons with greater needs. The average public cost for impaired homeless adults decreased 79% when they were placed in supportive housing, from a monthly average $2,897 in the group experiencing homelessness, to a monthly average of $605 for the group in supportive housing. Most savings in public costs came from reductions in outlays for avoidable crisis health services, with the greatest average cost savings realized among persons with HIV/AIDS who moved from homelessness into housing.

Extremely low-income people living with HIV/AIDS who are homeless or unstably housed are 2-6 times more likely to engage in risky behavior such as sharing needles or trading sex for housing, increasing community risk. (Aidala, et.al., 2005)

- *Reduced Medicaid expenditures*: Research has repeatedly demonstrated that increased housing stability is strongly associated with sharp reductions in the medical costs of managing HIV disease.[6] For example, the landmark CDC and HUD Housing and Health (H&H) study, an unprecedented randomized control trial looking at the impact of housing on healthcare utilization among PLWHA, found that stable housing for PLWHA reduced emergency room use by 35% and hospitalizations by 57%. However, those who remained homeless were 2.5 times more likely to use an emergency room, 2.8 times more likely to have a detectible viral load, and more likely to report perceived stress.[7] Preliminary calculations from the H&H study indicate that housing is a cost effective health care intervention for PLWHA, with a cost per QALY in the same range as HAART and other widely accepted health care interventions such as renal dialysis.[8] Indeed, housing assistance generates savings in avoidable crisis health services that more than offset the cost of housing interventions.[9] Furthermore, stable housing reduces HIV risk behaviors that can lead to new infections.

- *Improved HIV health outcomes*: Stable and affordable housing is the foundation for effective HIV/AIDS treatment and care. Receipt of housing assistance is independently associated with entry into appropriate HIV care, access and adherence to antiretroviral therapy, improved HIV

[6] Wolitski, R., Kidder, D. & Fenton, F. (2007). *HIV, homelessness, and public health: Critical Issues and a call for increased action.* AIDS & Behavior. 11(6)/Supp 2: S167-S171; Holtgrave, D., Briddell, K., Little, E., et al. (2007). *Cost and threshold analysis of housing as an HIV prevention intervention*. AIDS & Behavior, 11(6)/Supp2: S162-S166.

[7] Wolitski, R.J., Kidder, D.P., Pals, S.L., Royal, S., Aidala, A., et al. (2010). *Randomized trial of the effects of housing assistance on the health and risk behaviors of homeless and unstably housed people living with HIV*. AIDS & Behavior, 14(3): 493–503.

[8] "An Update on the H&H Economic Evaluation," Presented at the 2009 National HIV Prevention Conference by David Holtgrave, Johns Hopkins Bloomberg School of Public Health.

[9] Bauer, J., Battist, A, & Bamberger, J.D. (2010). *Housing the Homeless with HIV in San Francisco*. Presented at the North American Housing and HIV/AIDS Research Summit V, Toronto, Ontario, June 2010; Flaming, D., Matsunaga, M., & Burns, P., for the Economic Roundtable (2009). *Where we sleep: The costs of housing and homelessness in Los Angeles*. Prepared for the Los Angeles Homeless Services Authority. http://www.lahsa.org/CostAvoidance-Study.asp

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health outcomes and reduced HIV risk behaviors – after controlling for other factors that can impact HIV care and outcomes.[10]

- *Fewer HIV infections*: PLWHA who have stable housing are also less likely to transmit HIV to others compared with those who are homeless or unstably housed, regardless of other determinants of risk.[11] Each HIV infection prevented through more stable housing saves over $300,000 in lifetime medical costs (a conservative estimate).[12] Compared with stably housed people living with HIV/AIDS, homeless and unstably housed PLWHA are up to six times as likely to engage in behaviors that can transmit HIV to others.[13] One analysis of the potential impact of a 30% rent cap estimated that it would prevent at least 54 new HIV infections annually, saving at least $16,215,000 attributable to averted infections alone.[14]

- *Reduced emergency housing placements*: Improved housing stability will generate savings in City and State spending on rent arrears payments and costly evictions that will more than offset the additional rental assistance costs of capping rent contributions at 30% of disability income.[15] It is a far more efficient use of limited housing resources to keep people with HIV/AIDS in independent housing instead of expensive, substandard emergency housing.

- *Fairness*: HASA is the only low-income or disability housing assistance program in New York State that does not cap the tenant's rent contribution at 30% of income, HUD's standard definition for affordable housing and the requirement for all federally funded programs. The rent share burden of tenants in other subsidized programs, such as supportive housing, NYCHA and Section 8, is calculated at 30% of their income.

[10] Aidala, A., Leae, G., Abramson, D., Messeri, P. & Siegler, A. (2007). *Housing need, housing assistance, and connection to medical care*. AIDS & Behavior, 11(6)/Supp 2: S101-S115.

[11] Lima, V.D. (2008). *Expanded access to highly active antiretroviral therapy: a potentially powerful strategy to curb the growth of the HIV epidemic*. Journal of Infectious Diseases, 198(1): 59-67; Wolitski, R., Kidder, D. & Fenton, F. (2007). *HIV, homelessness, and public health: Critical Issues and a call for increased action*. AIDS & Behavior, 11(6)/Supp 2: S167-S171; Holtgrave, D. and Curran, J. (2006). *What works, and what remains to be done, in HIV prevention in the United States*. Annual Review of Public Health, 27: 261-275.

[12] Schackman, B.R., Gebo, K.A., Walensky, R.P., et al. (2006). *The lifetime cost of current human immunodeficiency virus care in the United States*. Medical Care, 44(11): 990-997.

[13] Kidder, D., Wolitski, R., Pals, S., et al. (2008). *Housing status and HIV risk behaviors among homeless and housed persons with HIV*. JAIDS, 49(4): 451-455; Aidala, A., Cross, J., Stall, R., et al. (2005). *Housing status and HIV risk behaviors: Implications for prevention and policy*. AIDS and Behavior, 9(3): 251-265.; Purcell, D.W. and McCree, D.H. (2009). *Recommendations from a research consultation to address intervention strategies for HIV/AIDS prevention focused on African Americans*. American Journal of Public Health, 99(11): 1937-1940; Auerbach, J. (2009). *Transforming social structures and environments to help in HIV prevention*. Health Affairs, 28(6): 1655-1665; Gupta, G. R., Parkhurst, J. O., Ogden, J. A., et al. (2008). *Structural approaches to HIV prevention*. Lancet, 372(9640): 764-775.

[14] Shubert Botein Policy Associates (2010). *Memo on S2664/A2565 (HIV Affordable Housing Protection)*. Submitted to Governor David Paterson on August 12, 2010.

[15] Ibid.

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