STATE HEALTH REFORM IMPACT MODELING PROJECT

California

January 2013

Prepared by the Center for Health Law and Policy Innovation of Harvard Law School
and the Treatment Access Expansion Project

BACKGROUND

The Patient Protection and Affordable Care Act (ACA) will dramatically change how people living with HIV access healthcare.[1] In states that fully implement the law (including expanding Medicaid), thousands of uninsured people living with HIV—many of whom currently receive care and treatment through Ryan White programs—will have access to healthcare through Medicaid or subsidized private health insurance.

The State Health Reform Impact Modeling Project (the Modeling Project) assesses the impact that healthcare reform will have on people living with HIV by compiling and analyzing Ryan White program and AIDS Drug Assistance Program (ADAP) data to predict the shift of uninsured people living with HIV from these discretionary programs to Medicaid or private insurance in all 50 states pursuant to the ACA. In addition, for 21 states and the District of Columbia (DC), the Modeling Project compiles and analyzes detailed budgets and benefits guidelines to assess the services provided by the Ryan White program, ADAP, Medicaid, and plans sold on an exchange, in order to estimate the impact that a transition onto Medicaid will have on low-income people living with HIV.[2]

Information on the methodology used to model transitions in each state, as well as the numerical results for each state and DC, are available in Appendix A. See Appendix B for notes on data collection and a summary of the limitations of the modeling process.

In California, the Modeling Project focuses on four state-specific inquiries:

1. What demographic information is available about Ryan White program and ADAP clients?
2. How many ADAP clients will be newly eligible for Medicaid or private insurance subsidies in 2014?
3. What services are currently available to people living with HIV under the Ryan White program versus Medicaid or plans to be sold on an exchange, and what gaps in services currently exist?
4. Given the current Ryan White, Medicaid, and private insurance coverage, what are the likely outcomes of a transition from one program to another in 2014?

CALIFORNIA

CALIFORNIANS LIVING WITH HIV/AIDS

UNMET NEED

As of 2008, over 95,000 Californians were living and diagnosed with HIV/AIDS (HIV + aware).[3] In 2009, approximately 49% of individuals living with HIV, and 52% of those living with AIDS, did not receive any HIV primary care.[4] Nationally, an additional 21% are estimated to be HIV + but undiagnosed.[5] This proportion of the state's epidemic (the undiagnosed and those not in care) are not accounted for in the following modeling of the number of individuals who will transition over to Medicaid or subsidized private insurance under the Patient Protection and Affordable Care Act (ACA) because they are not currently receiving pharmaceutical treatment through the Ryan White program. Nonetheless, it is likely that nearly all will be newly eligible for either private or public insurance in 2014.

THE RYAN WHITE PROGRAM IN CALIFORNIA

The Ryan White program is a discretionary, federally funded program providing HIV-related services across the United States to those who do not have other means of accessing HIV/AIDS treatment and care. In 2010, California received $280,512,611 of Ryan White funding and served 97,626 duplicated clients in the state.[6,7,8] About 50% of the state's Ryan White funds were Part B grants, assigned based on HIV prevalence.[9] Of these, 72% covered the AIDS Drug Assistance Program (ADAP).[10]

ADAP IN CALIFORNIA

ADAP is a component of Ryan White (within Part B) that is also funded with matching state appropriations and covers the cost of antiretroviral therapy (ART) for enrollees. To be eligible for ADAP in California, one must be:

1. A California resident aged 18 years or older and diagnosed with HIV;
2. Earning a federal adjusted gross income of $50,000 or less; and
3. In possession of a prescription for an ADAP-covered drug and not have another source of coverage.[11]

In fiscal year 2010, California's ADAP served 39,481 individuals.[12] The state's ADAP budget for fiscal year 2011 was $452,181,453 (82% of which was federal funds).[13] In 2010, California's ADAP spent $386,856,487 million on prescription drugs (excluding dispensing costs).[14]

THE ACA AND ITS IMPACT ON HIV+ CALIFORNIANS

THE MEDICAID EXPANSION

Beginning in January 2014, the ACA expands Medicaid eligibility to most individuals under 65 years of age living below 133% of the federal poverty level (FPL).[15,*] Although the Department of Health & Human Services (HHS) cannot force states to comply with the expansion (by withdrawing existing federal medical funding), the federal government will cover 100% of the cost of newly eligible beneficiaries until 2016, and at least 90% thereafter.[16] Newly eligible enrollees will receive a benchmark benefits package that will include ten categories of essential health benefits (EHB), described in the "Essential Health Benefits" section.[17]

THE BASIC HEALTH PLAN

The ACA provides an option for states to create a Basic Health Plan (BHP) that would be largely federally funded (the state would receive up to 95% of the premium credits an individual would have been entitled to for purchase of a plan on the exchange).[18] A BHP would cover most individuals under 65 years of age living between 133-200% FPL as well as legal residents who do not qualify for Medicaid because of the 5-year residency requirement.[19] BHPs must cover at least the EHB and have the same actuarial value

*All undocumented immigrants as well as lawfully residing immigrant adults who have been in the country 5 years or less will not be eligible for Medicaid coverage. US Department of Health and Human Services, Office of The Assistant Secretary for Planning and Evaluation, the Affordable Care Act: Coverage Implications and Issues for Immigrant Families 7 (Apr. 2012), *available at* http://aspe.hhs.gov/hsp/11/ImmigrantAccess/Coverage/ib.pdf.

of coverage as a bronze plan the individual might otherwise purchase on an exchange.[20] Cost sharing on BHPs can be subsidized, either for all beneficiaries or for those with specific chronic conditions (eg, HIV/AIDS).[21] In addition to improved affordability, BHPs can minimize "churning" on and off Medicaid as individuals fluctuate around 133% FPL. Because state Medicaid offices can design and manage BHPs, these individuals would more easily transition into a plan with similar provider networks and administrative procedures.

SUBSIDIES FOR PRIVATE INSURANCE PREMIUMS AND STATE-BASED INSURANCE EXCHANGES

The ACA requires states to establish state-run insurance exchanges, to partner with the federal government to set up a hybrid state-federal exchange, or to default into a federally facilitated exchange.[22] Insurance exchanges will provide individuals and families with a choice of plans, tiered by actuarial value of coverage (bronze, silver, gold, and platinum). Each plan available on an exchange must, at a minimum, adhere to a state-defined and federally approved list of EHB; these benefits are discussed in the following section. All exchanges will be operational January 1, 2014.[23] As a benchmark plan for purposes of defining EHB on the private market, California submitted the Kaiser Small Group PPO plan.[24]

For those purchasing coverage on an exchange, the ACA extends insurance premium credits to individuals and families living below 400% FPL, to ensure that premiums do not exceed 2.0-9.8% of household income, and imposes out-of-pocket spending caps to protect healthcare consumers from medical bankruptcy.[25] Eligible individuals and families can employ these credits to purchase a private health insurance plan on a state- or federally operated insurance exchange.

ESSENTIAL HEALTH BENEFITS

The ACA requires both Medicaid and private health insurance plans sold on state-based insurance exchanges to provide certain EHB, to be defined by the Secretary of HHS.[26] EHB must include items and services within the following ten benefit categories[27]:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

HHS released a proposed rule that will define the scope of EHB on the private market, and will accept public comments before drafting final guidance.[28] The Centers for Medicare & Medicaid Services has indicated that the HHS rule on EHB will also apply to newly eligible Medicaid beneficiaries, in addition to the protections provided for under the Social Security Act.[29] This means that benefits provided by Medicaid will likely be more robust than on the private market. For example, the Social Security Act requires that a Medicaid benchmark plan cover any FDA-approved drugs with significant clinically meaningful therapeutic advantage over another.[30]

AN ESTIMATE OF CURRENT RYAN WHITE AND ADAP CLIENTS WHO WILL BE ELIGIBLE FOR MEDICAID OR INSURANCE CREDITS IN 2014

Given the ACA-instituted reforms, a large number of HIV+ individuals in California are expected to become eligible for public or private insurance in 2014. An estimated 55% of the state's Ryan White program clients in 2010 were living at or below the FPL and an additional 23% were between 100-200% FPL, making them potentially eligible for either Medicaid or a BHP in 2014.[31] We estimate that 31% of California's ADAP clients will be eligible for Medicaid following its expansion, and 22% will be eligible for insurance subsidies (see Appendix A). Finally, many of the tens of thousands of HIV+ Californians who are not receiving any medical care will also likely be eligible for Medicaid, a BHP, or subsidized private insurance in 2014.

The percentage of California's ADAP clients who will be newly eligible for Medicaid based on income levels (31%) is higher than the national average, which stands at 29% (see Appendix A). This is in part because a large proportion of ADAP clients (53% of the clients served in June 2011) live at or below 133% FPL, and 67% are completely uninsured.[32]

COMPARING SERVICES PROVIDED BY RYAN WHITE, ADAP, MEDICAID, AND THE EXCHANGE TO HIV+ CALIFORNIANS

Since a significant number of HIV+ individuals in California who are currently served by the Ryan White program or the AIDS Drug Assistance Program (ADAP) are likely to be eligible for public or private insurance in 2014, it is important to assess the outcome of transitioning from the former programs to the latter. This assessment compares and contrasts the services and treatments that the Ryan White program, ADAP, Medicaid, and California benchmark plan currently provide to HIV+ Californians.

COMPARING RYAN WHITE, MEDICAID, AND THE BENCHMARK PLAN FOR THE EXCHANGE IN CALIFORNIA

The Ryan White program funds both core medical and support services for patients living with HIV/AIDS (see Appendix C for a breakdown of core medical services versus support services). Both medical and ancillary services are critical to maintaining the health of low-income individuals who may not have access to many necessities that facilitate effective HIV/AIDS treatment and care (eg, transportation, child care, nutrition). However, Medicaid and California's benchmark plan do not cover ancillary services (although they cover a broader range of medical services). Accounting for the gaps between the Ryan White program and Medicaid or private insurance sold on the exchange will be critical in transitioning Ryan White beneficiaries while ensuring that their health status does not deteriorate (eg, due to lack of proper nutrition, access to transportation to a health clinic, or stable housing). Table 1 provides a comparison of covered services between California's Ryan White and Medicaid programs as well as the Kaiser Small Group PPO.

Table 1. Ryan White Versus Medicaid and the Benchmark Plan: Covered Services

Benefits applying only to beneficiaries under 21 years of age are not assessed in this report.

Covered Service	Ryan White[33]	Medicaid[34,35]	Kaiser Small Group PPO[36]
Ambulatory/Outpatient Care	X	X	X ($40 copay beyond preventive annual care; 30% coinsurance for ambulatory surgery)
Oral Healthcare	X	X (limited)	
Early-intervention Clinics	X		
Home Healthcare	X	X (limited)	X (100 days/year; 20% coinsurance after deductible)
Community-based Services	X	X (limited)	
Mental Health: Outpatient	X	X (limited)	X ($40 copay)
Mental Health: Inpatient		X (limited)	X (30% coinsurance)
Substance Abuse: Outpatient	X	X	X ($40 copay)
Substance Abuse: Inpatient	X		X (30% coinsurance)
Medical Case Management	X	X (limited)	
Nonmedical Case Management	X	X (limited)	
Child Care Services	X		
Emergency Financial Assistance	X		
Food Bank/Home-delivered Meals	X		
Health Education/Risk Reduction	X		X
Housing Services	X		
Legal Services	X		
Linguistics Services	X		
Nonemergency Medical Transportation	X	X	X (50% coinsurance for medically necessary nonemergency ambulance)
Outreach Services	X		
Permanency Planning	X		
Psychosocial Support Services	X		
Referral for Healthcare/Support Services	X		
Rehabilitation Services	X		
PT, OT, Speech Therapy		X (speech therapy limited)	X (60 visits/year combined; 30% coinsurance)
Respite Care	X		
Treatment Adherence Counseling	X		
Hospital Inpatient		X	X ($100 copay unless admitted; 30% coinsurance)
Prescription Drugs		X	X
Mental Retardation/Developmental Disability Services			
Family Planning			X
Obstetric and Prenatal Services		X	X (30% coinsurance after deductible)

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Table 1. (continued)

Nursing Home Care	X	
Skilled Nursing Care	X	X (60 days/year; 30% coinsurance after deductible)
Chiropractor Services		
Durable Medical Equipment	X (limited)	X (30% coinsurance)
Hospice Care		X (180 days; 30% coinsurance after deductible)
Laboratory and Radiology Services	X	X (30% coinsurance)
Renal Dialysis		
Vision Care	X	

OT = occupational therapy; PT = physical therapy.

As Table 1 illustrates, the Ryan White program provides a number of services that are not covered by Medicaid or the benchmark plan that will be used to determine EHB for the state's exchange (eg, emergency financial assistance, food-bank and meal delivery, and a variety of wrap-around services from housing and legal assistance to child care). These services are unlikely to be required EHB on either the public or private market, given existing federal guidance and proposed regulation.[37,38]

California's Medicaid program (Medi-Cal) contracts with three models of managed care organizations (MCOs) and offers varying coverage of services across counties.[39] Table 1 indicates services covered anywhere within the state, but not necessarily statewide coverage. Because the Medicaid benchmark plan (for newly eligible beneficiaries) is unlikely to be required to cover ancillary services as a part of EHB, and will be able to use cost-containment strategies common among MCOs, Ryan White will continue to be essential to ensure that low-income HIV+ Californians can access comprehensive antiretroviral therapy (ART).[40]

Table 1 also demonstrates that the state's benchmark plan, Kaiser's Small Group PPO, imposes significant cost-sharing responsibilities on patients (including 30% of the cost of many services, a $1,000 deductible for an individual, and $40 copays for all specialist visits). Physician visit and brand-name drug copays do not count toward the annual deductible. This can be prohibitive for low-income individuals living with HIV/AIDS, who require frequent provider visits. Ryan White will continue to be a critical payer of last resort if these individuals cannot access comprehensive ART on the private market.

COMPARING ADAP, MEDICAID, AND THE BENCHMARK PLAN FOR THE EXCHANGE IN CALIFORNIA

ADAP provides funding for a robust drug formulary that is necessary to afford low-income individuals access to a combination of drugs to treat HIV/AIDS. All states participating in ADAP must cover at least one drug in every class of ART; most cover almost all drugs in each class. Ensuring that Medicaid and plans sold on the exchange provide coverage for a sufficient number of antiretroviral medications and other drugs that are essential to ART will also be critical to maintaining the health of Californians living with HIV/AIDS. Table 2 provides a comparison of the antiretroviral and opportunistic infection drug formularies under the state's ADAP and current Medicaid programs, as well as Kaiser's Small Group PPO 2013 plan.

Table 2. ADAP Versus Medicaid: Covered Drugs[41]

Benefits applying only to beneficiaries under 21 years of age are not assessed in this report.

Drugs (ART class indicated in bold; brand name in normal type; generic in italics)	**ADAP[42]**	**Medicaid[43]**	**Kaiser Small Group PPO[44]**
Multiclass Combination Drugs	**2 Drugs Covered**	**3 Drugs Covered**	**3 Drugs Covered**
Atripla; *efavirenz + emtricitabine + tenofovir DF*	X	X	X
Complera; *emtricitabine + rilpivirine + tenofovir disoproxil fumarate*	X	X	X
Stribild; *elvitegravir + cobicistat + emtricitabine + tenofovir disoproxil fumarate*		X	X
NRTIs	**12 Drugs Covered**	**12 Drugs Covered**	**12 Drugs Covered**
Combivir; *lamivudine, zidovudine*	X	X	X
Emtriva; *emtricitabine*	X	X	X
Epivir; *lamivudine*	X	X	X
Epzicom; *abacavir, lamivudine*	X	X	X
Retrovir; *zidovudine*	X	X	X
Trizivir; *abacavir + zidovudine + lamivudine*	X	X	X
Truvada; *tenofovir DF + emtricitabine*	X	X	X
Videx; *didanosine (buffered versions)*	X	X	X
Videx EC; *didanosine (delayed-release capsules)*	X	X	X
Viread; *tenofovir disoproxil fumarate DF*	X	X	X
Zerit; *stavudine*	X	X	X
Ziagen; *abacavir*	X	X	X
NNRTIs	**5 Drugs Covered**	**5 Drugs Covered**	**5 Drugs Covered**
Edurant; *rilpivirine*	X	X	
Intelence; *etravirine*	X	X	X
Rescriptor; *delavirdine mesylate*	X	X	X
Sustiva; *efavirenz*	X	X	X
Viramune; *nevirapine*	X	X	X
Protease Inhibitors	**10 Drugs Covered**	**9 Drugs Covered**	**10 Drugs Covered**
Agenerase; *amprenavir*	X		X
Aptivus; *tipranavir*	X	X	X
Crixivan; *indinavir sulfate*	X	X	X
Invirase; *saquinavir mesylate*	X	X	X
Kaletra; *lopinavir + ritonavir*	X	X	X
Lexiva; *fosamprenavir*	X	X	X
Norvir; *ritonavir*	X	X	X
Prezista; *darunavir*	X	X	X
Reyataz; *atazanavir sulfate*	X	X	X
Viracept; *nelfinavir sulfate*	X	X	X
Fusion Inhibitors	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Fuzeon; enfuvirtide	X	X	X

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Table 2. (continued)

Entry Inhibitors – CCR-5 Coreceptor Antagonist	1 Drug Covered	1 Drug Covered	1 Drug Covered
Selzentry; maraviroc	X	X	X
HIV Integrase Strand Transfer Inhibitors	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Isentress; raltegravir	X	X	X
A1 Opportunistic Infection Medications	**31 Drugs Covered**	**29 Drugs Covered**	**34 Drugs Covered**
Ancobon; *flucytosine*	X		X
Bactrim DS; *sulfamethoxazole/trimethoprim DS*	X	X	X
Biaxin; *clarithromycin*	X	X	X
Cleocin; *clindamycin*	X	X	X
Copegus; *ribavirin, oral*	X (generic only)	X	X
Dapsone	X	X	X
Daraprim; *pyrimethamine*	X	X	X
Deltasone; *prednisone*	X (generic only)	X	X
Diflucan; *fluconazole*	X	X	X
Famvir; *famciclovir*	X		X
Foscavir; *foscarnet*	X	X	X
Fungizone; *amphotericin B*	X	X	X
INH; *isoniazid*	X (generic only)	X	X
Megace; *megestrol*	X	X	X
Mepron; *atovaquone*	X	X	X
Myambutol; *ethambutol*	X	X	X
Mycobutin; *rifabutin*	X	X	X
NebuPent; *pentamidine*	X	X	X
Nydrazid; *isoniazid, INH*			X
Pegasys; *peginterferon-alfa 2a*		X	X
PEG-Intron; *peginterferon-alfa 2b*		X	X
Probenecid	X	X	X
Procrit; *erythropoietin*	X	X	X
Pyrazinamide (PZA)	X (generic only)	X	X
Rifadin; *rifampin*	X (generic only)	X	X
Sporanox; *itraconazole*	X	X	X
Sulfadiazine – Oral	X	X	X
Valcyte; *valganciclovir*	X	X	X
Valtrex; *valacyclovir*	X	X	X
VFEND; *voriconazole*	X		X
Vistide; *cidofovir*	X	X	X
Wellcovorin; *leucovorin*	X		X

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Table 2. (continued)

Zithromax; *azithromycin*	X	X	X
Zovirax; *acyclovir*	X	X	

NNRTI = non-nucleoside reverse transcriptase inhibitors; NRTI = nucleoside reverse transcriptase inhibitors.

As Table 2 shows, most drugs used to treat HIV/AIDS available through ADAP are also available through Medicaid. The Medicaid plan available to newly eligible beneficiaries will likely be required to cover an equally, if not more, comprehensive list of drugs (including any FDA–approved drugs with significant, clinically meaningful therapeutic advantage over another).[45] However, cost-containment strategies will continue to be permissible, creating a potential barrier to comprehensive ART.[46] ADAP will continue to be a critical payer of last resort in such scenarios.

California's benchmark plan, Kaiser's Small Group PPO, has a comprehensive formulary (open) that covers all medically necessary drugs.[47] Brand-name drugs are more expensive for a patient; the plan imposes a $200 annual deductible on brand-name drugs, along with a $35 copay for each refill.[48] Generic drugs include a $15 copay.[49] The prescription drug EHB will likely require plans on the exchange to cover the same number of drugs per class as are covered by the benchmark plan, meaning that Kaiser's open formulary will create a comprehensive floor of mandatory coverage.[50] Nonetheless, just like cost-containment strategies, cost sharing can create a barrier to care for low-income individuals who require multiple brand-name prescriptions per month. ADAP will likely continue to serve a critical purpose in filling gaps in access to comprehensive ART for low-income Californians transitioning onto the exchange.

CONCLUSIONS AND NEXT STEPS

This report provides analyses of the Ryan White program, the AIDS Drug Assistance Program (ADAP), and Medicaid, enumerating the benefits covered under each, and the implications of transitioning individuals living with HIV/AIDS onto Medicaid or private insurance. This report is intended to assist lawmakers in implementing the Patient Protection and Affordable Care Act (ACA) in a manner that serves the needs of Californians.

While much of the ACA has yet to be implemented, it is certain that large numbers of people living with HIV/AIDS will be newly eligible for Medicaid. Given that a significant proportion of uninsured ADAP clients would transition onto Medicaid in California, implementing the ACA's expansion option is crucial to ensuring access to care and reducing transmission of HIV/AIDS across the state. In other words, expanding Medicaid is the state's only currently available option to provide access to treatment for the thousands of HIV+ individuals in the state who currently lack access to care.

In that vein, the Medicaid system must be ready and able to handle the needs of low-income people who have HIV/AIDS. Should California elect to expand its Medicaid program, this report provides an initial analysis of the capacity of the program to handle the needs of this influx of individuals living with HIV/AIDS. Comparing current Ryan White and ADAP services with existing Medicaid formularies allows for a baseline analysis of the needs of individuals living with HIV/AIDS moving into the Medicaid system. This report identified two challenges:

1. First, a number of services that are currently provided by the Ryan White program are not available under the state's current Medicaid program and are unlikely to be required as essential health benefits (EHB) for newly eligible beneficiaries.[51] Ryan White will remain a critical payer of last resort to support access to comprehensive antiretroviral therapy; and
2. Second, if the expanded Medicaid plan utilizes cost-containment strategies such as prior authorization, step therapy, or quantity limits (which federal guidance indicates it will be able to do), individuals requiring access to second- or third-line treatment may face barriers to care, making ADAP a continued necessary service.[52]

It is essential that private insurance plans on the California exchange provide a comprehensive scope of services that is sufficient to meet the needs of Ryan White clients who transition onto these plans. This report identified two challenges with respect to the state's benchmark plan, which will be used to define EHB for private insurance plans:

1. First, many of the services provided by the Ryan White program are not available under Kaiser's Small Group PPO, the state's benchmark plan (eg, transportation assistance to routine appointments, and nutrition, housing, and childcare support). Furthermore, the benchmark plan imposes significant cost-sharing requirements and deductibles that will be difficult for low-income Californians requiring frequent provider visits to afford. Those newly eligible for subsidized

insurance purchased on the exchange in 2014 are likely to still require the wrap-around services provided by Ryan White to maintain their health and quality of life; and

2. Second, low-income HIV+ Californians are likely to struggle to meet high cost-sharing requirements and deductibles with respect to prescription drugs. ADAP will be necessary to fill gaps in the plan formulary and as a payer of last resort to people living with HIV/AIDS.

There will remain an ongoing demand for Ryan White and ADAP services, to fill the gaps left by Medicaid coverage for low-income people living with HIV/AIDS. Identifying these gaps and structuring these programs to efficiently work together from the start is not only fiscally prudent, but also necessary to secure the health of low-income Californians living with HIV/AIDS.

In conclusion, this report makes clear that two factors will be essential to successfully implementing the ACA in a way that reduces the burden of HIV/AIDS on the state:

1. California must adopt the Medicaid expansion pursuant to the ACA, extending Medicaid eligibility to all individuals living under 133% of the federal poverty level (FPL) in order to slow the transmission of HIV/AIDS and make treatment accessible to tens of thousands of individuals who currently lack care; and
2. California must ensure that Ryan White and ADAP services are available where Medicaid or private insurance coverage or affordability gaps exist (eg, nonmedical case management, food and nutrition, coinsurance, deductibles).

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APPENDIX A

2014 STATE-SPECIFIC ESTIMATES

Medicaid Estimates

The Patient Protection and Affordable Care Act (ACA) directs states to extend Medicaid eligibility to all individuals living below 133% of the federal poverty level (FPL), and offers a 100% federal matching rate for these newly eligible individuals (those who were not otherwise eligible for Medicaid but for the new law).

To estimate the number of individuals currently using the AIDS Drug Assistance Program (ADAP) who will be eligible for Medicaid in 2014, the following formula was used:

	Total #	ADAP clients being served in fiscal year 2010[53]
–	**est. #**	ADAP clients with income above 133% FPL[54,†]
–	**est. #**	insured ADAP clients with incomes below 133% FPL[‡]
–	**est. #**	ADAP clients who are uninsured undocumented immigrants with incomes below 133% FPL[55]
=	**Total #**	ADAP clients served who will be newly eligible for Medicaid in 2014

California's ADAP served 39,481 individuals in fiscal year 2010. Of those, we estimate that 47% (18,556) ADAP clients currently have incomes above 133% FPL. An estimated 7,219 of individuals living below 133% FPL are currently insured, and approximately 7% of the state population were undocumented immigrants in 2008 (ADAP individuals with incomes below 133% FPL). Thus, the calculation for California is:

	39,481	ADAP clients in fiscal year 2010
–	**18,556.07**	ADAP clients with incomes above 133% FPL
–	**7,219.27**	insured ADAP clients living below 133% FPL
–	**1,431.88**	estimated uninsured undocumented immigrants living below 133% FPL on ADAP
=	**12,274**	individuals currently enrolled in ADAP who will be newly eligible for Medicaid in 2014, or 31% of those enrolled in California's ADAP in fiscal year 2010

This calculation was done similarly for all 21 states and the District of Columbia (DC). The results of the calculations are:

State	# ADAP Clients Newly Eligible for Medicaid	% ADAP Clients Newly Eligible for Medicaid
Alabama	1,345	76%
Arkansas	299	53%
California	12,274	31%
DC	1,124	41%
Florida	7,321	51%
Georgia	3,075	52%
Illinois	4,374	68%
Kentucky	619	42%
Louisiana	No data available	No data available
Maryland	1,394	22%
Massachusetts	1,400	21%
Mississippi	1,008	68%
New Jersey	2,101	29%
New York	4,233	20%
North Carolina	3,476	62%
Ohio	1,287	37%
Pennsylvania	1,334	22%
South Carolina	1,428	39%
Tennessee	2,505	60%
Texas	8,797	53%
Virginia	2,690	66%
Wisconsin	696	40%
United States	**62,780**	**29%**

Note: Data on the insurance status of ADAP clients in Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.[56] (The 2010 NASTAD report is missing data for North Carolina and Kentucky, and the percentages of insured clients exceeded 100% for Maryland and Ohio.)

† In order to estimate the number of ADAP clients in any income group, we apply the percentage of clients served in each income group (acquired from Table 13 of the 2012 NASTAD Report) to the number of clients served in fiscal year 2010 (acquired from Table 8 of the same report).
‡ *See* Methodology for Distribution of Insured ADAP Clients by Income.

The percentages of ADAP clients who will be newly eligible for Medicaid in 2014 vary considerably from state to state. These differences can be explained by the different eligibility standards currently in place for ADAP within each state, as well as by the differences in estimated percentages of undocumented immigrants in each state. For instance, states with higher-than-average newly eligible Medicaid beneficiaries may currently require that ADAP recipients have no other sources of insurance (eg, Virginia). On the other hand, states with lower-than-average newly eligibles have higher insurance rates all around (eg, Massachusetts) or other public assistance programs that supplement ADAP. In sum, this report does not capture all groups of people living with HIV/AIDS who may be eligible for Medicaid in 2014.

Private Insurance Subsidy Estimates

To estimate the number of people currently using ADAP who will be eligible for private insurance subsidies through health insurance exchanges, the following formula was used:

	Total #	ADAP clients served in fiscal year 2010[57]
–	**est. #**	ADAP clients living below 133% FPL[58]
–	**est. #**	ADAP clients living above 400% FPL[59, §]
–	**est. #**	insured ADAP clients living between 133-400% FPL[60,**]
–	**est. #**	uninsured undocumented ADAP clients living between 133-400% FPL[61]
=	**Total #**	clients who will be eligible for subsidized private insurance in 2014

California's ADAP served 39,481 individuals in fiscal year 2010. Of those, we estimate that 54% (21,320) of ADAP clients have incomes below 133% or above 400% FPL. We further estimate that 21% (8,338) of individuals living between 133-400% FPL are currently insured. An estimated 7% of the state's population were undocumented immigrants in 2008. Applying this percentage to the individuals enrolled in California's ADAP computes to approximately 1,243 ADAP clients in California who are uninsured undocumented immigrants living between 133-400% FPL. Thus, completing the calculation for California's ADAP yields:

	39,481	ADAP clients in fiscal year 2010
–	**21,319.74**	ADAP clients with incomes below 133% FPL or above 400% FPL
–	**8,338.35**	ADAP clients living between 133-400% FPL
–	**1,242.77**	estimated undocumented immigrants on ADAP with incomes between 133-400% FPL
=	**8,580**	individuals currently enrolled in ADAP who will be eligible for private insurance subsidies in 2014 or 22% of those enrolled in California's ADAP in fiscal year 2010

This calculation was done similarly for all 21 states and DC. The results of the calculations are:

State	# ADAP Clients Newly Eligible for Subsidies	% ADAP Clients Newly Eligible for Subsidies
Alabama	305	17%
Arkansas	147	26%
California	8,580	22%
DC	829	30%
Florida	4,134	29%
Georgia	1,404	24%
Illinois	1,127	17%
Kentucky	269	18%
Louisiana	No data available	No data available
Maryland	1,726	28%
Massachusetts	932	14%
Mississippi	384	26%
New Jersey	1,879	26%
New York	4,502	21%
North Carolina	621	11%
Ohio	901	26%
Pennsylvania	1,567	26%
South Carolina	1,091	30%
Tennessee	1,531	37%
Texas	4,301	26%
Virginia	896	22%
Wisconsin	401	23%
US National Average	**32,758**	**15%**

Note: Data on the insurance status of ADAP clients in Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.[62] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages of insured clients exceed 100% for Maryland and Ohio.)

§ In order to estimate the number of ADAP clients in any income group, we apply the percentage of clients served in each income group (acquired from Table 13 of the 2012 NASTAD Report) to the number of clients served in fiscal year 2010 (acquired from Table 8 of the same report).

** *See* Methodology for Distribution of Insured ADAP Clients by Income.

METHODOLOGY FOR DISTRIBUTION OF INSURED ADAP CLIENTS BY INCOME

Distributing insured ADAP clients by income in each state required several steps:

1. The percentage of adults living below 133% FPL, between 133-400% FPL, and above 400% FPL in each state who are insured was determined using data available at the Kaiser Family Foundation's STATEHEALTHFACTS.ORG website. The website lists insurance status for people beginning at 139% FPL instead of 133% FPL, but because of the ACA's 5% income disregard, the Medicaid expansion applies to all individuals living below 138% FPL, making this distinction irrelevant. The website also divides the 133-400% FPL income group into two groups: 133-250% FPL and 250-399% FPL. The number of insured adults, and the total number of adults in these two groups were pooled in order to determine the percentage of adults living between 133-400% FPL who are insured.

   In California, for example, 54% of adults living below 133% FPL are insured, 72% of adults living between 133-400% FPL are insured, and 93% living above 400% FPL are insured;

2. Next, we determined the likelihood of an adult in each of the three income groups being insured relative to the likelihood of being insured in the other income groups. To do this, we gave the figure for the insurance rate for adults living below 133% FPL the baseline number 1, and the insurance rates for the other income groups were calculated to be multiples of this baseline.

   For example, in California, the figure 54% was given the baseline number 1; 72% is 1.33 times 54%, and 93% is 1.72 times 54%. In other words, an adult in California living between 133-400% FPL is 1.33 times more likely to be insured than an adult with income below 133% FPL, while an adult living above 400% FPL is 1.72 times more likely to be insured;

3. We then calculated the number of insured ADAP clients in each state, by referring to Tables 8 and 14 of the 2012 NASTAD National ADAP Monitoring Project Report.[63] Table 8 lists the total number of ADAP clients served in each state in 2010. Using this number, and applying to it the percentage of ADAP clients who are insured in each state (Table 14), we attempted to estimate the number of insured ADAP clients in each state.[††]

   In California, we estimated that about 15,792 of the state's 39,481 ADAP clients served in 2010 were insured;

4. In order to proportionately divide the number of insured ADAP clients among the three income groups listed, the percentage of a state's ADAP clients who fall in each income group was required. Table 13 of the 2012 NASTAD Report shows the percentage of ADAP clients in most states who have incomes below 133% FPL, incomes between 133-400% FPL, and incomes above 400% FPL.

   In California, 53% of ADAP clients have income below 133% FPL, 46% have incomes between 133-400% FPL, and 1% have incomes above 400% FPL; and finally

5. We then treated the number of insured ADAP clients in each income group as a product of the relative likelihood of being insured (determined previously), and compared it with the proportion of clients in that income group among the total clients (based on the percentage of ADAP clients in each income group), along with a weighing factor called *a*.

We relied on two formulas:

Formula 1:

Number of insured clients in each group
= (relative likelihood of being insured)
x (proportion of income group)
x *a*

Formula 2:

Total number of insured ADAP clients
= (number of insured clients living below 133% FPL)
+ (number of insured clients living between 133-400% FPL)
+ (number of insured clients living above 400% FPL)

†† The NASTAD Report lists the percentage of ADAP clients in each state who were covered by various kinds of insurance (Medicaid, Medicare, private insurance) in 2011. We added the different insurance percentages to estimate the number of ADAP clients in each state who were insured. This leads to an overestimation of the number of insured people in each state since a single ADAP client may be enrolled in multiple insurance plans (eg, Medicare and private insurance). Adding up the insurance percentages may result in double-counting a number of ADAP clients.

Thus, for California:

15,792
= (1 x 0.53 x a)
+ (1.33 x 0.46 x a)
+ (1.6 x 0.01 x a)

Solving for a,

$a = 13{,}621.26$

Applying the determined value of a to Formula 1:

The estimated number of insured ADAP clients in California with,

Incomes below 133% FPL = 7,219
Incomes between 133-400% FPL = 8,338
Incomes above 400% FPL = 234

These figures were applied to the general calculations estimating the number of ADAP clients who will be eligible for Medicaid or private insurance subsidies.

APPENDIX B

DATA COLLECTION METHODOLOGY

In the interest of consistency among state profiles, and to ensure that data among states are comparable, data sources that provide information for all 21 states and the District of Columbia (DC) were prioritized. More recent or more detailed data available for a particular state have also been included.

Ryan White Program Data

Demographic information about Ryan White program clients was culled from a number of sources. For the sake of continuity, the Federal Health Resources and Services Administration (HRSA) 2010 State Profiles were used for data about the Ryan White program. Where available, information from state departments of health has also been included. Demographic information for AIDS Drug Assistance Program (ADAP) clients is most thoroughly documented by the National Alliance of State & Territorial AIDS Directors (NASTAD), and information from that organization has been provided for income and insurance status of ADAP clients. NASTAD's data for fiscal years 2010 and 2011 and June 2011 were used (fiscal year 2010 was necessary for states that did not report data in 2011). Because ADAP data compiled by NASTAD are unduplicated (ie, patients are not double-counted by multiple providers), it is one of the most reliable sources of information about demographic information for people living with HIV/AIDS. Data from June 2011 provide information on how many people living with HIV/AIDS currently enrolled in ADAP live between 100-133% of the federal poverty level (FPL). Since the expansion of Medicaid eligibility to those living under 133% FPL is a new development, there is a dearth of data regarding the number of HIV+ individuals currently living between 100-133% FPL. NASTAD provides the only reliable source of these data to date. NASTAD's ADAP information was used for estimates regarding people living with HIV/AIDS who are newly eligible for Medicaid in 2014 at the end of this report. Information available from state departments of health or HRSA has also been provided.

Estimates of unmet needs for people living with HIV/AIDS in each state are available in each state's Statewide Coordinated Statement of Need (SCSN). SCSNs must be provided by all states receiving Ryan White program funding, but different states provide SCSNs in different years, so comparability among states is limited. Information about unmet need available from other sources has also been included.

Information on current services covered by the Ryan White program is available from HRSA and the SCSNs, and these data have been included in each state profile. More detailed information was included in the profiles if it was available.

Income thresholds for ADAP eligibility, cost-containment measures in each state, and ADAP formularies are available from a variety of sources. The most common sources for this information are MEDICARE.GOV, Kaiser Family Foundation, and NASTAD's *ADAP Watch* publication. This information has been included for every state and standardized to the extent possible among states.

Ryan White program budget allocations are also available from a number of sources, and information from the Kaiser Family Foundation has been included in every profile for the sake of consistency among states. ADAP budget information is available from NASTAD, including the fiscal year 2011 total budget, and a breakdown of expenditures. This information is provided in each state profile. Kaiser Family Foundation's information on ADAP expenditures has also been included for information on the amount spent by ADAP services on insurance assistance and full prescription coverage.

Medicaid Coverage Data

Services currently covered by Medicaid and their limitations are detailed by state departments of health and state Medicaid manuals. Amounts of information available and levels of detail differ among states, and detailed information is provided in the profiles where available. The focus in each profile is on services most relevant to people living with HIV/AIDS, as well as limitations that may impede access to needed services.

Benchmark Plan Coverage Data

California's benchmark plan is Kaiser's Small Group PPO. Information about this plan was collected from Kaiser's 2013 promotional materials and summary of benefits, as well as from information submitted to the Center for Consumer Information and Insurance Oversight.

NOTES

Data for certain states were incomplete in the 2012 National ADAP Monitoring Project Annual Report, so missing data were obtained from alternative sources:

- Data on the insurance status of ADAP clients in Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.[64] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages of insured clients exceed 100% for Maryland and Ohio.)
- Data on the number of clients served by Mississippi's ADAP appear to be incorrect in NASTAD's Monitoring Report, as the number of clients served is listed as larger than the number of eligible ADAP clients in the state. The number listed was used in these calculations, and while the specific number of ADAP clients eligible for Medicaid and private insurance subsidies in Mississippi may not be reliable, the proportion of clients eligible for both programs was obtained in the same way as that for other states.

CAVEATS AND ASSUMPTIONS

The estimates provided require a number of caveats and assumptions:

1. ADAP data (as opposed to Ryan White data) were used to account for insurance status and to avoid double-counting individuals who may be enrolled in multiple Ryan White programs (ie, seeing multiple providers). The estimates presented here, therefore, are only for the proportion of ADAP clients who will be eligible for Medicaid and private insurance subsidies;
2. Data for ADAP clients served were used rather than data for clients enrolled because the number of individuals enrolled may exceed the actual number of clients accessing ADAP services. Potential clients who are currently on ADAP waiting lists in several states are also not included in these calculations. Thus, the numbers provide a conservative estimate of ADAP beneficiaries who will transition onto Medicaid or into subsidized private insurance;
3. National data (NASTAD and HRSA) were used in calculations instead of state-specific data to ensure that these estimates could be compared across the states surveyed; and
4. The number of undocumented immigrants on ADAP is a rough estimate extrapolated from estimates of the overall number of undocumented immigrants in the state as a whole as of 2008. It is possible that this estimate either overestimates or underestimates the actual number of undocumented immigrants currently served by ADAP.

With these caveats and assumptions in mind, the figures discussed are our best estimates of the number and percentage of ADAP clients who will be newly eligible for Medicaid in 2014 (assuming full implementation of the ACA) and the number and percentage of ADAP clients who will be eligible for private insurance subsidies.

These estimates are for ADAP recipients only, and are of limited analytical assistance in determining percentages of all people living with HIV/AIDS who will be newly eligible for Medicaid and insurance subsidies in 2014. While the percentages provided could be extrapolated to apply to the broader HIV/AIDS population in states, given the number of caveats and assumptions needed to arrive at this rough estimate, it would be better to obtain additional information about the unmet need within states before attempting to make such calculations.

APPENDIX C

Part A of the Ryan White program funds both medical and support services, allowing states to provide HIV+ individuals with a continuum of care. States are required to spend 75% of Part A awards on core medical services, which include:

- Outpatient and ambulatory care;
- ADAP (full coverage of drugs or insurance assistance);
- Oral health;
- Early-intervention services;
- Health insurance premiums and cost-sharing assistance;
- Medical nutrition therapy;
- Hospice services;
- Home- and community-based health services;
- Mental health services;
- Substance abuse outpatient care;
- Home healthcare; and
- Medical case management (including treatment adherence services).

States may spend up to 25% on support (ancillary) services that are linked to medical outcomes (eg, patient outreach, medical transportation, linguistic services, respite care for caregivers of people living with HIV/AIDS, healthcare or other support service referrals, case management, and substance abuse residential services).

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This report discusses research that is conducted by the Center for Health Law and Policy Innovation of Harvard Law School, which is funded by Bristol-Myers Squibb with no editorial review or discretion. The content of the report does not necessarily reflect the views or opinions of Bristol-Myers Squibb.

Prepared by the Center for Health Law and Policy Innovation of Harvard Law School
and the Treatment Access Expansion Project

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A collaboration between the HIV community and Bristol-Myers Squibb