STATE HEALTH REFORM IMPACT MODELING PROJECT

Florida

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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 or private insurance will have on low-income people living with HIV.[2]

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

In Florida, 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?

FLORIDA

FLORIDIANS LIVING WITH HIV OR AIDS

UNMET NEED

As of 2010, 95,188 Floridians were diagnosed and living with HIV/AIDS (HIV+ aware).[3] An estimated 38,377 of these individuals did not access medical care in the past 12 months,[4] and approximately 40,000 additional Floridians are 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 FLORIDA

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, Florida received $225,842,849 in Ryan White funding,[6] serving 102,974 duplicated clients in the state.[7,8] About 54,242 (59%) had household incomes equal to or below the federal poverty level (FPL); 21,543 (23%) were living between 101-200% FPL.[9] About 56.5% of the state's Ryan White funds were Part B grants, distributed based on the prevalence of HIV/AIDS in the state.[10] Of these, 25.2% covered core medical services, 1.8% covered supplemental services (nonmedical), 66.7% went toward the AIDS Drug Assistance Program (ADAP), and 5.5% provided ADAP Emergency funding.[11]

ADAP IN FLORIDA

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 Florida, one must be:

1. A Florida resident diagnosed with HIV;
2. Living at or below 400% FPL; and
3. Not receiving the same services from Medicaid, Project AIDS Care, or other means of insurance.[12]

In fiscal year 2010, ADAP served 14,305 Floridians.[13] The state's 2011 ADAP budget was $114,427,754 (91% in federal funds).[14] In the previous fiscal year, Florida spent $101,943,759 on ADAP, of which 93% went toward full payment for drugs, and another 2% went toward insurance assistance.[15] As of August 1, 2010, Florida restricted its formulary to only antiretroviral and opportunistic infection medications, a total of 49 drugs.[16]

THE ACA AND ITS IMPACT ON HIV+ FLORIDIANS

THE MEDICAID EXPANSION

Beginning in January 2014, the Patient Protection and Affordable Care Act (ACA) expands Medicaid eligibility to most individuals under 65 years of age living below 133% FPL.[17,*] Although the US Department of Health and 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.[18] 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.[19]

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

[*] 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.

entitled to for purchase of a plan on the exchange).[20] A BHP would cover most individuals under 65 years of age living between 133-200% of the federal poverty level (FPL), as well as legal residents who do not qualify for Medicaid because of the 5-year residency requirement.[21] BHPs must cover at least the EHB and have the same actuarial value of coverage as a bronze plan the individual might otherwise purchase on an exchange.[22] Cost sharing on BHPs can be subsidized, either for all beneficiaries or for those with specific chronic conditions (eg, HIV/AIDS).[23] 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 onto 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.[24] 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.[25]

Florida has requested more guidance from HHS with regard to defining EHB in the state, and has not submitted a benchmark plan.[26,27] Thus, the EHB for purposes of its exchange will be defined using BlueCross BlueShield BlueOptions Plan (the largest small-group plan in the state).[28]

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.[29] 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 a minimum of EHB, to be defined by the Secretary of HHS.[30] EHB must include items and services within the following ten benefit categories[31]:

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.[32] CMS has indicated that the HHS rule on EHB will also apply to newly eligible Medicaid beneficiaries, in addition to the protections provided under the Social Security Act.[33] 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 US Food and Drug Administration–approved drugs with significant clinically meaningful therapeutic advantage over another.[34]

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 number of HIV+ Floridians are expected to become eligible for Medicaid, a BHP, or private insurance subsidies in 2014, provided that Florida fully implements the law. An estimated 23% of the state's Ryan White program clients in 2010 were living between 101-200% FPL,

making them potentially eligible for either Medicaid or a BHP in 2014.[35] An estimated 51% of Florida's AIDS Drug Assistance Program (ADAP) clients will be eligible for Medicaid following its expansion and 28% are estimated to be eligible for private insurance subsidies (see Appendix A).[36] Finally, many HIV+ Floridians who do not have access to care are likely to be eligible for Medicaid, a BHP, or subsidized private insurance in 2014.

The percentage of Florida's ADAP clients who will be newly eligible for Medicaid (51%) is considerably higher than the national proportion of newly eligible (29%) (Appendix A). This is primarily because Florida's ADAP mostly serves individuals with income below 133% FPL (approximately 62% of the state's ADAP clients were below 133% FPL in 2011), 100% of whom were uninsured in 2011.

The percentage of Florida's ADAP clients who are expected to qualify for private insurance subsidies (29%) is higher than the national proportion (15%) (Appendix A), likely because Florida's ADAP serves a substantial number of individuals with income above 133% FPL (approximately 38% in 2011).[37]

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

Since a significant number of HIV+ individuals in Florida who are currently served by the Ryan White program or the AIDS Drug Assistance Program (ADAP) are likely to be eligible for Medicaid or subsidized private insurance in 2014, it is important to assess the outcome of transitioning from the former programs to Medicaid or onto the exchange. This assessment compares and contrasts the services and treatments that the Ryan White program, ADAP, Medicaid, and Florida's health insurance exchange currently or will provide to HIV+ Floridians.

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

The Ryan White program funds both core medical and support services for patients living with HIV (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 affect access to HIV treatment and care (eg, transportation, child care, nutrition). However, Medicaid and Florida's benchmark plan, which will determine essential health benefits (EHB) for private insurance sold on the state's exchange, 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 onto Medicaid and private insurance, 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 that supports treatment adherence).

Table 1 provides a comparison of covered services between Florida's Ryan White and Medicaid programs (as of 2010), as well as the largest small-group market plan in the state (the benchmark plan used for purposes of defining EHB on the exchange).

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[38]	Medicaid[39]	BlueCross BlueShield BlueOptions[40,41]
Home Health Care	X	X (PA)	X (PA; excludes cooking, housekeeping, meal preparation)
Outpatient Mental Health	X	X (PA)	X
Inpatient Mental Health			X

Outpatient Substance Abuse Treatment	X	X	X
Inpatient Substance Abuse Treatment			X
Medical Case Management	X	X	
Community-based Care	X	X	
Ambulatory/Outpatient Care	X	X	X
Oral Health Care	X		
Early Intervention Clinic	X	X	
Intermediate Care Facilities for the Mentally Retarded		X (15 days per hospital stay; 45 days per year)	
Ambulance		X	X
Family Planning		X (PA; familial dyautonomia diagnosis required)	
Durable Medical Equipment		X	X
Hospital Services		X	X
Lab and X-ray Services		X	X
Eyeglasses Related to Accident, Surgery, or Medical Condition		X	
Nursing Facility		X	X
Midwife/NP services		X	
Private Duty Nursing		X	
Physician Services		X	X
Nonmedical Case Management Services	X		
Child Care	X		
Emergency Financial Assistance	X		
Food Bank/Home Delivered Meals	X		
Housing Services	X		
Health Education/Risk Reduction	X		
Legal Services	X		
Linguistic Services	X		
Nonemergency Medical Transportation	X	X	
Outreach Services	X	X	
Psychosocial Support	X		
Referral Agencies	X		
Treatment Adherence Counseling	X		
Chiropractor		X	X
Podiatry		X	
Hospice		X	X
Respiratory Therapy		X	
PT, OT, and Speech Therapy		X	
Orthotics and Prosthetics		X	

OT = occupational therapy; PA = prior authorization; PT = physical therapy.

As Table 1 indicates, the Ryan White program offers HIV+ individuals a number of ancillary services that Medicaid and Florida's benchmark plan do not cover, and that will not be required components of EHB, given existing federal guidance and proposed regulation.[42,43] Additionally, Florida's benchmark plan is subdivided into plans with varying cost-sharing schedules. For example, primary care copays may be as high as $75 per visit, with specialists costing up to $100. Given the frequency with which HIV+ individuals must see physicians, including specialists, this cost sharing may be prohibitive. Ryan White will remain a critical payer of last resort in this scenario.

The transition from the Ryan White program will affect more than just HIV+ individuals. Some HIV providers may also be adversely affected as their patients leave the Ryan White program for Medicaid, since Medicaid reimbursement rates for providers not working at federally qualified health centers may be lower than reimbursement rates under the Ryan White program. Although the US Department of Health and Human Services (HHS) has decided, pursuant to the Patient Protection and Affordable Care Act (ACA), that Medicaid will reimburse certain healthcare providers at Medicare levels in 2013-2014—a move that might ensure that Medicaid reimbursement rates match Ryan White rates in the coming years—Congress must reauthorize this increase in Medicaid reimbursements in 2017.[44,45] Thus, there is uncertainty regarding the reimbursement that HIV healthcare providers can expect in the coming years as their patients transition from the Ryan White program to Medicaid.

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

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. All states participating in ADAP must cover at least one drug in every class of ART; most cover almost all drugs in each class.[46-48] Medicaid's drug formulary is defined differently (and its formulary for newly eligible individuals has yet to be defined). Ensuring that Medicaid provides coverage for a sufficient number of antiretroviral medications will also be critical to maintaining the health of Floridians living with HIV.

Table 2. ADAP Versus Medicaid and the Benchmark Plan Used to Define Essential Health Benefits: Covered Drugs†

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[49]**	**Medicaid[50]**	**BlueCross BlueShield FL: BlueOptions[51]**
Multiclass Combination Drugs	**2 Drugs Covered**	**2 Drugs Covered**	**3 Drugs Covered**
Atripla; *efavirenz + emtricitabine + tenofovir DF*	X	X	X (tier 2)
Complera; *emtricitabine + rilpivirine + tenofovir disoproxil fumarate*	X	X	X (tier 2)
Stribild; *elvitegravir + cobicistat + emtricitabine + tenofovir disoproxil fumarate*			X (tier 3)
CCR-5 Coreceptor Inhibitor	**1 Drug Covered**	**0 Drugs Covered**	**1 Drug Covered**
Selzentry; *maraviroc*	X		X (tier 2)
Fusion Inhibitors	**1 Drug Covered**	**0 Drugs Covered**	**1 Drug Covered**
Fuzeon; *enfuvirtide*	X		X (tier 2)
Integrase Inhibitors	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Isentress; *raltegravir*	X	X	X (tier 2)
NNRTIs	**5 Drugs Covered**	**5 Drugs Covered**	**5 Drugs Covered**
Intelence; *etravirine*	X	X	X (tier 2)

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Table 2. (continued)

Rescriptor; *delavirdine mesylate*	X	X	X (tier 2)
Sustiva; *efavirenz*	X	X	X (tier 2)
Viramune; *nevirapine*	X	X	X (tier 2)
Edurant; *rilpivirine*	X	X	X (tier 2)
NRTIs	**12 Drugs Covered**	**10 Drugs Covered**	**12 Drugs Covered**
Combivir; *zidovudine + lamivudine*	X	X	X (tier 1)
Emtriva; *emtricitabine*	X	X	X (tier 2)
Epivir; *lamivudine*	X	X	X (tier 2)
Epzicom; *abacavir sulfate + lamivudine*	X	X	X (tier 2)
Retrovir; *zidovudine*	X		X (tier 1)
Trizivir; *abacavir + zidovudine + lamivudine*	X	X	X (tier 2)
Truvada; *tenofovir DF + emtricitabine*	X	X	X (tier 2)
Videx; *didanosine (buffered versions)*	X	X	X (tier 2)
Videx ER; *didanosine (delayed-release capsules)*	X		X (tier 1)
Viread; *tenofovir disoproxil fumarate DF*	X	X	X (tier 2)
Zerit; *stavudine*	X	X	X (tier 1)
Ziagen; *abacavir*	X	X	X (tier 2)
Protease Inhibitors	**9 Drugs Covered**	**9 Drugs Covered**	**10 Drugs Covered**
Agenerase; *amprenavir*			X (tier 3)
Aptivus; *tipranavir*	X	X	X (tier 2)
Crixivan; *indinavir sulfate*	X	X	X (tier 2)
Invirase; *saquinavir mesylate*	X	X	X (tier 2)
Kaletra; *lopinavir + ritonavir*	X	X	X (tier 2)
Lexiva; *fosamprenavir*	X	X	X (tier 2)
Norvir; *ritonavir*	X	X	X (tier 2)
Prezista; *darunavir*	X	X	X (tier 2)
Reyataz; *atazanavir sulfate*	X	X	X (tier 2)
Viracept; *nelfinavir sulfate*	X	X	X (tier 2)

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Table 2. (continued)

"A1" OI‡ Medications	15 Drugs Covered	21 Drugs Covered	30 Drugs Covered
Ancobon; *flucytosine*			X (tier 1)
Bactrim DS; *sulfamethoxazole/trimethoprim DS*	X	X	X (tier 1)
Biaxin; *clarithromycin*	X	X	X (tier 1)
Cleocin; *clindamycin*		X	X (tier 1)
Dapsone	X	X	X (tier 2)
Daraprim; *pyrimethamine*	X	X	X (tier 2)
Deltasone; *prednisone*		X	X (tier 2)
Diflucan; *fluconazole*	X	X	X (tier 1)
Famvir; *famciclovir*			X (tier 1)
Foscavir; *foscarnet*		X	X (tier 3)
Fungizone; *amphotericin B*		X	X (tier 3)
INH; *isoniazid*		X	X (tabs tier 1; syrup tier 2)
Megace; *megestrol*		X	X (tier 1)
Mepron; *atovaquone*	X	X	X (tier 2)
Myambutol; *ethambutol*	X	X	X (tier 2)
Mycobutin; *rifabutin*	X	X	X (tier 2)
NebuPent; *pentamidine*		X	X (tier 2)
Probenecid		X	X (tier 1)
Procrit; *epoetin alfa*		X	X (tier 2)
Pyrazinamide (PZA)		X	X (tier 1)
Rifadin; Rimactane; *rifampin*			X (tier 1)
Sporanox; *itraconazole*	X		X (tier 1)
Sulfadiazine – Oral	X	X	X (tier 1)
Valcyte; *valganciclovir*	X		X (tier 2)
Valtrex; *valacyclovir*	X		X (tier 1)
VFEND; voriconazole			X (oral susp tier 2; tabs tier 3)
Vistide; *cidofovir*			X (tier 3)

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† Chart adapted from National Alliance of State & Territorial AIDS Directors (NASTAD). National ADAP Monitoring Project Annual Report, August 2012, Table 28, *available at* http://www.nastad.org/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.
‡ Opportunistic treatments.

Table 2. (continued)

Wellcovorin; *leucovorin*	X		X (tier 3)
Zithromax; *azithromycin*	X	X	X (tier 1; packets tier 2)
Zovirax; *acyclovir*	X	X	X (tier 1)

NNRTI = non-nucleoside reverse transcriptase inhibitor; NRTI = nucleoside reverse transcriptase inhibitor; PA = prior authorization.

As Table 2 indicates, Medicaid's formulary is limited, posing a potential problem for people living with HIV. Because management of HIV/AIDS diagnoses may require many and varied prescription drugs, Medicaid's deficient prescription drug coverage could pose challenges for people living with HIV.

On the other hand, prescription drug benefits under Florida's benchmark plan are comprehensive but can be costly for beneficiaries. The proposed federal rule that will define EHB provides that plans sold on exchanges must cover at least the same number of drugs in each category and class as the benchmark plan (or one drug per class if the benchmark plan does not cover any).[52] Thus, assuming the proposed rule is adopted, plans in Florida must cover only the number of drugs in each class listed (or one per class in the case where none are covered on the benchmark plan). Yet on the benchmark plan, many drugs necessary for antiretroviral therapy (ART) are tier 2 or 3, and can cost up to $100 per refill. Given the number of drugs comprehensive ART requires and the cost-sharing requirements of the benchmark plan, ADAP will remain critical as a payer of last resort for HIV+ individuals for whom cost sharing becomes prohibitive.

COMMUNITY HEALTH CENTERS

The ACA has provided Florida with $111.7 million to fund new and existing community health centers.[53] The Health Resources and Services Administration (HRSA) of HHS has also awarded health center planning grants of between $79,190 and $80,000 to each of 11 health clinics and universities in Florida.[54]

In 2009, Florida had 44 community health centers providing services at 290 delivery sites for a total of 997,110 patients. Of these patients, 31% were Medicaid beneficiaries. All of the community health centers provided general primary medical care, and 93% offered HIV testing and counseling. In 2010, 58,459 Florida residents were tested for HIV.[55] There is also one designated AETC National Center for HIV Care in Minority Communities (NCHCMC) site in Florida, located in Miami.[56]

MEDICAID MANAGED CARE PROFILE

Over 1.9 million Florida Medicaid enrollees (64%) are enrolled in managed care. Because federal guidance indicates that Medicaid plans for newly eligible beneficiaries will be subject to cost-sharing strategies common in managed care, these plans are important to consider as Florida plans for the transition into 2014 and the needs of individuals living with HIV/AIDS.[57]

Florida contracts with varying types of managed care organizations, including Health Maintenance Organizations (HMOs), Primary Care Case Management Systems (PCCMS), and Provider Service Networks (PSNs).[58] State law mandates that most Medicaid recipients (about 76%) must enroll in a managed care plan within 30 days of becoming Medicaid eligible.[59] Other beneficiaries may voluntarily choose managed care, although some groups are not eligible, including dual eligibles, individuals enrolled in the Project AIDS Care Waiver (AIDS patients at risk of hospitalization or institutionalization in a skilled nursing facility), or those receiving assertive community treatment (for mental illness).[60]

Unlike traditional Medicaid, managed care plans do not use fee-for-service reimbursement systems for many providers (eg, PCPs). Moreover, utilization review is common. For example, only a few services are exempt from HMO or PSN prior authorization, including diagnosis and treatment of HIV/AIDS.[61]

In 2010, 29.6% of Florida's Medicaid beneficiaries were enrolled in a Prepaid Inpatient Health Plan (PIHP), which provides a narrower range of services than the comprehensive coverage provided by the previously mentioned managed care programs, and has responsibility for the provision of inpatient hospital and institutional services.[62] Meanwhile, 11.6% of beneficiaries were enrolled in a Prepaid Ambulatory Health Plan, which provides similar services as a Prepaid Inpatient Health Plan, but does not cover hospital or inpatient institutional services.[63]

CONCLUSIONS AND NEXT STEPS

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

While much of the ACA has yet to be implemented, it is certain that a large number of people living with HIV will be newly eligible for Medicaid under the law's income eligibility standard (extending eligibility to individuals living under 133% of the federal poverty level [FPL]). Given that a significant proportion of uninsured ADAP clients would transition onto Medicaid in Florida, implementing the ACA's expansion option is crucial to ensuring access to care and reducing transmission of HIV 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.

Nonetheless, the Medicaid system must be ready and able to handle the needs of low-income people who have HIV. Should Florida 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. Comparing current Ryan White and ADAP programs with existing Medicaid formularies allows for a baseline analysis of the needs of individuals living with HIV moving onto 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 may reduce the ability of those living with HIV to access services. For instance, the Ryan White program, unlike Medicaid, covers early-intervention clinics and treatment-adherence counseling; and
2. Second, limitations on Medicaid recipients' pharmacy benefits may pose challenges for individuals in need of multiple branded prescriptions. Those living with HIV are likely to exceed the maximum allowable number of monthly branded prescriptions covered by Medicaid. Although federal guidance indicates that newly eligible beneficiaries must have access to any drug with a therapeutic advantage over another, utilization-review tactics such as prior authorization may impede access to comprehensive care.[64]

It is also essential that private insurance plans sold on Florida's exchange provide a level and scope of services that are sufficient to meet the needs of HIV+ individuals who may transition to these plans. This report identified two challenges with respect to the state's default benchmark plan, which will be used to define EHB for private insurance plans sold on the exchange:

1. First, a number of services that are currently provided by the Ryan White program are not available under the benchmark plan. Moreover, cost-sharing requirements may prohibit low-income HIV+ individuals from accessing certain services available under private insurance plans on the exchange. HIV+ individuals in Florida transitioning from Ryan White to subsidized private insurance are therefore likely to have trouble accessing a number of services currently available to them; and
2. Second, while the benchmark's formulary is comprehensive, cost-sharing requirements are likely to restrict low-income HIV+ individuals' access to the multitude of prescription drugs they require for comprehensive antiretroviral therapy (ART). ADAP will continue to be essential to fill both coverage and affordability gaps.

It is essential that private insurance plans in Florida provide a level and scope of services that are sufficient to meet the needs of ADAP clients who may transition to these plans. As EHB is defined and plans are set in place, for both newly eligible Medicaid beneficiaries and the private market, it is essential to keep these challenges to healthcare access in mind.

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. 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 Floridians.

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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 on the state:

1. Adopting the Medicaid expansion, pursuant to the ACA, Florida must extend Medicaid eligibility to all individuals living under 133% FPL in order to slow the transmission of HIV and make treatment accessible to thousands of individuals who currently lack care; and
2. Florida must ensure that Ryan White and ADAP services are available where Medicaid or private insurance coverage or affordability gaps exist (eg, transportation, nonmedical case management, food and nutrition, and copays).

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% 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[65]
−	**est. #**	ADAP clients with incomes above 133% FPL[66,§]
−	**est. #**	ADAP clients with incomes below 133% FPL[**]
−	**est. #**	ADAP clients who are undocumented immigrants with incomes below 133% FPL in June 2011[67]
=	**Total #**	ADAP clients who will be newly eligible for Medicaid in 2014[††,‡‡]

Florida's ADAP served 14,305 individuals in 2010. Of those, we estimate that 5,435.90 (38%) ADAP clients have incomes above 133% FPL. We also estimate that there were 1,067.34 insured ADAP clients with incomes below 133% FPL. Approximately 5.42% of the state population was composed of undocumented immigrants in 2008 (amounting to approximately 480.57 ADAP clients with incomes below 133% FPL).

Thus, the calculation for Florida is:

	14,305	ADAP clients being served in fiscal year 2010
−	**5,435.90**	ADAP clients with incomes above 133% FPL
−	**1,067.34**	insured ADAP clients with incomes below 133% FPL
−	**480.57**	undocumented immigrants with incomes below 133% FPL in June 2011
=	**7,321**	ADAP clients who will be newly eligible for Medicaid in 2014; or 51.2% of ADAP clients served in fiscal year 2010

Results of similar calculations for all 21 states and the District of Columbia (DC) are:

State	# of ADAP Clients Newly Eligible for Medicaid	% of 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	1,336	22%
South Carolina	1,428	39%
Tennessee	2,505	60%
Texas	8,797	53%
Virginia	2,690	66%
Wisconsin	696	40%
United States	**62,971**	**29%**

Note: Data regarding the percentage of insured ADAP clients in Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report. The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages are greater than 100% for Maryland and Ohio and hence are not workable for the calculations.

§ 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 Appendix A for a description of the method used to estimate the distribution of insured ADAP clients in Florida by income group.

†† The final estimate provided is likely be somewhat higher than the actual number of ADAP clients who will be newly eligible for Medicaid, since the formula does not account for insured ADAP clients whose incomes fall below 139% FPL—these clients will not be newly eligible for Medicaid in 2014. The number of insured clients with incomes below 133% FPL is likely to vary by state.

‡‡ The final number is an estimate based on figures largely taken from 2010-2011.

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 being served in fiscal year 2010[68]
–	**est. #**	ADAP clients living below 133% FPL[69,§§]
–	**est. #**	ADAP clients living above 400% FPL[70]
–	**est. #**	insured ADAP clients living between 133-400% FPL [71,***]
–	**est. #**	ADAP clients who are undocumented immigrants living between 133-400% FPL[72]
=	**Total #**	ADAP clients who will be newly eligible for subsidized private insurance

Florida's ADAP served 14,305 individuals in fiscal year 2010. Of those, we estimate that 8,869.10 (62%) of ADAP clients have incomes below 133% FPL or above 400% FPL. This leaves 38% (5,436) of ADAP clients with incomes between 133-400% FPL. We also estimate that there were 1,106.88 insured ADAP clients with incomes between 133-400% FPL. Approximately 5% of Florida's population was undocumented as of 2008 (294.54 ADAP clients living between 133-400% FPL).

Thus, the calculation for Florida is:

	14,305	ADAP clients being served in June 2011
–	**8,869.10**	ADAP clients with incomes below 133% FPL or above 400% FPL
–	**1,106.88**	insured ADAP clients with incomes between 133-400% FPL
–	**294.54**	uninsured undocumented immigrants with incomes between 133-400% FPL in June 2011
=	**4,034**	ADAP clients who will be eligible for insurance subsidies in 2014 or 28.2% of ADAP clients being served in fiscal year 2010

Results of similar calculations for all 21 states and the District of Columbia (DC) are:

State	#ADAP Clients Newly Eligible for Medicaid	% of ADAP Clients Newly Eligible for Medicaid
Alabama	305	17%
Arkansas	152	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%
United States	**32,758**	**15%**

§§ 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 Appendix A for a description of the method used to estimate the distribution of insured ADAP clients in Florida by income group.

METHODOLOGY FOR DISTRIBUTION OF INSURED ADAP CLIENTS BY INCOME

Estimating the proportion of insured ADAP clients falling into each income bracket 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.[73] 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 251-399% 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 Florida, 47% of adults living below 133% FPL are insured, 73% of adults living between 133-400% FPL are insured, and 90% 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.

   In Florida, the figure 47% was given the baseline number 1; 73% is 1.55 times 47%, and 90% is 1.91 times 47%. Thus, in other words, an adult in Florida with income between 133-400% FPL is 1.55 times more likely to be insured than an adult with income below 133% FPL, while an adult with income above 400% FPL is 1.91 times more likely to be insured;

3. Next, we 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.[74] 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 Florida, we estimated that none of the state's 14,305 ADAP clients served in 2010 were insured. The insurance rate for ADAP clients in that state stood at 0% in 2011;

4. In order to proportionately divide the number of insured ADAP clients among the three income groups in these steps, 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 Florida, 62% of ADAP clients have incomes below 133% FPL, and 38% have incomes between 133-400% FPL. None have income 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 relative 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 ADAP 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 2011 and 2012 NASTAD National ADAP Monitoring Project Reports list the percentage of ADAP clients in each state that was covered by various kinds of insurance. 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 often result in double-counting a number of ADAP clients.

Thus, for Florida:

0
= (1 x 0.62 x *a*)
+ (1.55 x 0.38 x *a*)
+ (1.91 x 0 x *a*)

Solving for a,

$a = 0$

Applying the determined value of a to Formula 1:

The estimated number of insured ADAP clients in Florida with,

Income below 133% FPL = 0
Income between 133-400% FPL = 0
Income above 400% FPL = 0

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 between 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. Income, race/ethnicity, gender, and insurance status for 2008 are available from HRSA and have been provided for each state. 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 and Territorial AIDS Directors (NASTAD), and information from that organization has been provided for income, race/ethnicity, gender, and insurance status of ADAP clients. NASTAD's data are for fiscal year 2010 and June 2011. Because ADAP data compiled by NASTAD are unduplicated, it is one of the most reliable sources of information about demographic information for people living with HIV. Data from June 2011 provide information on how many people living with HIV currently enrolled in ADAP live between 100-133% FPL. Since the expansion of Medicaid eligibility to those under 133% FPL is a new development, there is a relative dearth of data regarding the number of individuals whose incomes are 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 who will be newly eligible for Medicaid in 2014 at the end of this report. Information from state departments of health or HRSA has been provided if it was available.

Estimates of unmet need for people living with HIV 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 all data are not from the same year. 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. These data are relatively general, enumerating the services offered by the Ryan White program in each state, as well as the most utilized services and the services each state has identified as priorities for funding in the future. 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. Fiscal year 2010 total budget is available, and NASTAD has broken down its expenditures. This information is provided in each state profile. The Kaiser Family Foundation's information on ADAP expenditures has also been included for information on the amount spent by ADAP programs 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, as well as limitations that may impede access to needed services.

Benchmark Plan Coverage Data

The governor of Florida has requested more guidance from the US Department of Health and Human Services (HHS) with regard to defining essential health benefits (EHBs) in the state, and as such has not submitted a benchmark plan.[75,76] Therefore, Florida's largest small-group plan will be the current default benchmark plan: BlueCross BlueShield of Florida's BlueOptions Plan, which is Florida's largest small-group market plan.[77]

Community Health Center Data

Community health center (CHC) information is standardized across the states studied, and has been acquired from HEALTHCARE.GOV, published information about Health Resources and Services Administration (HRSA) Health Center Planning grant awards, state health center fact sheets, and the National Center for HIV Care in Minority Communities. In providing information about CHCs, the focus in each profile is on the amount of money invested in these centers and the services most relevant to people living with HIV within them.

Medicaid Managed Care Data

Information on Medicaid managed care programs in each state varies widely. While some state departments of health minutely detail the various aspects of their Medicaid managed care programs, including eligibility, services provided, and number or percentage of clients enrolled, information for other states is limited to data compiled by the Kaiser Family Foundation from July and October 2010. Kaiser Family Foundation data have been provided in each state profile, and more detailed information has also been included.

NOTES

Data for certain states were incomplete in the 2012 National ADAP Monitoring Project Annual Report, so missing data were obtained from alternate 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.[78] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages of the insured clients exceed 100% for Maryland and Ohio.); and
- Data on the number of clients served by Mississippi's ADAP program 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 for other states for interstate comparability reasons.

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 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 finally
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 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 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;
- AIDS Drug Assistance Program (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).

REFERENCES

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) [hereinafter Affordable Care Act], 26 U.S.C. 36(B) and 42 U.S.C. §§ 1396, 18001-18121.
2. The states assessed include: Alabama, Arkansas, California, District of Columbia, Florida, Georgia, Illinois, Kentucky, Louisiana, Maryland, Massachusetts, Mississippi, New Jersey, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, and Wisconsin.
3. FLORIDA DEPARTMENT OF HEALTH, DIVISION OF DISEASE CONTROL AND HEALTH PROTECTION, HIV/AIDS IN FLORIDA: A SNAPSHOT THROUGH 2010, 15, *available at* http://www.doh.state.fl.us/disease_ctrl/aids/updates/facts/10Facts/2010_Florida_Snapshot.pdf.
4. FLORIDA DEPARTMENT OF HEALTH, DIVISION OF DISEASE CONTROL AND HEALTH PROTECTION, FLORIDA'S 2012–2015 STATEWIDE COORDINATED STATEMENT OF NEED AND COMPREHENSIVE PLAN (2012), 10 *available at* http://www.doh.state.fl.us/disease_ctrl/aids/SCSN_Comprehensive_Plan.pdf.
5. See FLORIDA DEPARTMENT OF HEALTH, DIVISION OF DISEASE CONTROL AND HEALTH PROTECTION, HIV INCIDENCE, PREVALENCE, AND MORTALITY: EPIDEMIC SNAPSHOT, FLORIDA (2011), *available at* http://www.doh.state.fl.us/disease_ctrl/aids/Docs/HIV_Epidemic_Snapshot_FL_2010.pdf.
6. STATEHEALTHFACTS.ORG, *Florida: Ryan White Program*, http://statehealthfacts.org/profileind.jsp?cat=11&sub=126&rgn=11&cmprgn=1 (*last visited* December 2, 2012).
7. The number of duplicated clients reflects the cumulative number of clients served by each provider (clients are counted more than once if they receive services from two or more providers).
8. U.S. Department of Health & Human Services, Health Resources and Services Administration, Ryan White HIV/AIDS Program 2010 State Profiles: Florida, Client Characteristics, *available at*: http://hab.hrsa.gov/stateprofiles/2010/states/fl/print.htm (*last visited* September 27, 2012).
9. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVS., HEALTH RES. AND SERVS. ADMIN., Florida, 2010 STATE PROFILES: RYAN WHITE HIV/AIDS PROGRAM (2010), http://hab.hrsa.gov/stateprofiles/2010/states/fl/print.htm [hereinafter HRSA, *Florida 2010 State Profile*].
10. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVS., HEALTH RES. AND SERVS. ADMIN., Florida, 2010 STATE PROFILES: RYAN WHITE HIV/AIDS PROGRAM (2010), http://hab.hrsa.gov/stateprofiles/2010/states/fl/print.htm [hereinafter HRSA, *Florida 2010 State Profile*].
11. STATEHEALTHFACTS.ORG, *Florida: Ryan White Program*, http://statehealthfacts.org/profileind.jsp?cat=11&sub=126&rgn=11&cmprgn=1 (*last visited* December 2, 2012).
12. FLORIDA DEPARTMENT OF HEALTH, DIVISION OF DISEASE CONTROL AND HEALTH PROTECTION, ADAP ELIGIBILITY ENROLLMENT GUIDELINES (2012), 2. *available at* http://www.doh.state.fl.us/Disease_ctrl/aids/care/Eligibility_Brochure_2012.pdf.
13. NASTAD, National ADAP Monitoring Project Annual Report, 2012, Table 8, http://prod.nastad.dotnet-web1.advansiv.com/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf
14. STATEHEALTHFACTS.ORG, Florida: *Distribution of AIDS Drug Assistance Program (ADAP) Budget by Source, FY2011*, http://www.statehealthfacts.org/profileind.jsp?rgn=11&cat=11&ind=545 (*last visited* December 2, 2012).
15. STATEHEALTHFACTS.ORG, *Florida: AIDS Drug Assistance Program (ADAP) Expenditures, FY 2010*, http://www.statehealthfacts.org/profileind.jsp?rgn=11&cat=11&ind=668 (*last visited* December 2, 2012).
16. FLORIDA DEPARTMENT OF HEALTH, DIVISION OF DISEASE CONTROL AND HEALTH PROTECTION, AIDS DRUG ASSISTANCE PROGRAM: FORMULARY, *available at* http://www.doh.state.fl.us/Disease_ctrl/aids/care/formulary.html (*last visited* September 27, 2012).
17. Affordable Care Act, tit. II, § 2001(a)(1), 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2010).
18. Affordable Care Act, tit. II, § 2001(a)(3)(B), 42 U.S.C. § 1396d(y)(1) (2010).
19. Affordable Care Act, tit. II, § 2001(a)(2)(A), 42 U.S.C. § 1396a(k)(1) (2010).
20. Affordable Care Act, tit. I, § 1331(d)(3), 42 U.S.C. § 18051(d)(3) (2010).
21. Affordable Care Act, tit. I § 1331(e), 42 U.S.C. § 18051(e) (2010).
22. Affordable Care Act, tit. I, § 1331(a)(1)-(2), 42 U.S.C. § 18051(a)(1)-(2) (2010).
23. Affordable Care Act, tit. I, § 1331(a)(2)(A)(ii), 42 U.S.C. § 18051(a)(2)(A)(ii) (2010).
24. Affordable Care Act, tit. I, § 1321(b)-(c), 42 U.S.C. § 18041(b)-(c) (2010).
25. Affordable Care Act, tit. I, § 1311(b)(1), 42 U.S.C. § 18031(b)(1) (2010).
26. STATEREFORUM.ORG, State Progress on Essential Health Benefits (Nov. 28, 2012), http://www.statereforum.org/state-progress-on-essential-health-benefits (*last visited* December 14, 2012).
27. Letter from Rick Scott, Governor, Florida, to Kathleen Sebelius, Secretary, Department of Health & Human Services (September 28, 2012).
28. Centers for Medicare & Medicaid Services – Center for Consumer Information and Insurance Oversight (CCIIO), Essential Health Benefits: List of the Largest Three Small Group, July 3, 2012. *Available at*: http://cciio.cms.gov/resources/files/largest-smgroup-products-7-2-2012.pdf.PDF
29. Affordable Care Act, tit. I, § 1401(a), 26 U.S.C. § 36(B) (2010).
30. Affordable Care Act, tit. I, § 1302(a), 42 U.S.C. § 18022(a) (2010).
31. Affordable Care Act, tit. I, § 1302(b), 42 U.S.C. § 18022(b) (2010).
32. 45 C.F.R. pts. 144, 147, 150, et al (proposed Nov. 26, 2012).
33. Letter from Cindy Mann, Director, Centers for Medicare & Medicaid Services, to State Medicaid Director (November 26, 2012).
34. Social Security Act, 42 U.S.C. § 1927 (2010).
35. U.S. Department of Health & Human Services, Health Resources and Services Administration, Ryan White HIV/AIDS Program 2010 State Profiles: Florida, Client Characteristics, *available at:* http://hab.hrsa.gov/stateprofiles/2010/states/fl/Client-Characteristics.htm (*last visited* October 11, 2012).
36. U.S. Department of Health & Human Services, Health Resources and Services Administration, Ryan White HIV/AIDS Program 2010 State Profiles: Florida, Client Characteristics, *available at:* http://hab.hrsa.gov/stateprofiles/2010/states/fl/Client-Characteristics.htm (*last visited* October 11, 2012).
37. NASTAD, National ADAP Monitoring Project Annual Report, 2012, Table 13, *available at* http://www.nastad.org/Docs/023054_Module%20One%20-%20National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20January%202012.pdf
38. U.S. Department of Health & Human Services, Health Resources and Services Administration, Ryan White HIV/AIDS Program 2010 State Profiles: North Carolina, Services Utilization, *available at:* http://hab.hrsa.gov/stateprofiles/2010/states/fl/Services-Utilization.htm
39. Florida Agency For Health Care Administration, Florida Medicaid Summary of Services: Fiscal Year 11/12, *available at:* http://www.fdhc.state.fl.us/medicaid/flmedicaid.shtml.
40. Center for Consumer Information and Insurance Oversight: Essential Health Benefits: List of the Largest Three Small Group Products by State, July 3, 2012, *available at:* http://cciio.cms.gov/resources/files/largest-smgroup-products-7-2-2012.pdf.PDF.
41. HEALTHCARE.GOV, BlueOptions Summary of Cost & Coverage for Small Group, *available at:* http://finder.healthcare.gov/sbiz/get_benefits?audience=sbiz&effective_day=01&effective_month=12&effective_year=2012&employeeNum=30&issuer_ids=16842&nojs=n&plan_id=16842FL001&situation=need&sliders=false&state=FL&utf8=%E2%9C%93&x=36&y=26&zip=33034.
42. 45 C.F.R. pts. 144, 147, 150, et al (proposed November 26, 2012).
43. Letter from Cindy Mann, Director, Centers for Medicare & Medicaid Services, to State Medicaid Director (November 26, 2012).
44. *See* Department of Health & Human Services, CMS-1589-FC (proposed May 9, 2012), (to be codified at 42 C.F.R. pts. 416, 419, 476, 478, 480, and 495).
45. Press Release, Healthcare law increases payments to doctors for primary care, Department of Health & Human Services (May 19, 2012).
46. Ryan White CARE Act Amendments of 2000, 42 U.S.C. §§ 300ff-26(c)(1), (e) (2000).
47. HEALTH RESOURCES AND SERVICES ADMINISTRATION, PART B – AIDS DRUG ASSISTANCE PROGRAM, IMPLEMENTATION, HIV/AIDS PROGRAMS, http://hab.hrsa.gov/abouthab/partbdrug.html (*last visited* October 11, 2012).

48. NASTAD, National ADAP Monitoring Project Annual Report, 2012, 124, http://prod.nastad.dotnet-web1.advansiv.com/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.

49. FLORIDA DEPARTMENT OF HEALTH, DIVISION OF DISEASE CONTROL AND HEALTH PROTECTION ADAP FORMULARY (2012), *available at* http://www.doh.state.fl.us/disease_ctrl/aids/care/formulary.html.

50. http://www.fdhc.state.fl.us/medicaid/prescribed_drug/pharm_thera/pdf/pdl.pdf

51. Florida Blue, Medication Guide, July 2012, *available at:* http://www.bcbsfl.com/DocumentLibrary/Providers/Content/MedGuide.pdf

52. 45 C.F.R. pts. 144, 147, 150, et al (proposed November 26, 2012).

53. HEALTHCARE.GOV, *How the Health Care Law is Making a Difference for the People of Florida*, http://www.healthcare.gov/law/resources/fl.html (*last visited* December 14, 2012).

54. *Health Center Planning Grant Awards*, HEALTH RES. AND SERVS. ADMIN. http://www.hrsa.gov/about/news/2011tables/1108healthcenterplanning.html (*last visited* June 18, 2012).

55. *Florida Health Center Fact Sheet*. NATIONAL ASSOCIATION OF COMMUNITY. HEALTH CENTERS, http://www.nachc.com/client/documents/FL11.pdf (*last visited* June 18, 2012).

56. *AETC National Center for HIV Care in Minority Communities,* HealthHIV (June 2011), www.healthhiv.org/modules/info/files/files_4de679ecea200.pdf.

57. Letter from Cindy Mann, Director, Centers for Medicare & Medicaid Services, to State Medicaid Director (November 26, 2012).

58. STATEHEALTHFACTS.ORG, *Florida: Medicaid Managed Care* (2011), http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=56&rgn=11 (*last visited* December 14, 2012).

59. *Overview of Medicaid Managed Care Programs in Florida,* FLA. S. (Nov. 2010), http://www.flsenate.gov/Committees/InterimReports/2011/2011-221hr.pdf.

60. Florida Agency For Health Care Administration, Florida Medicaid Summary of Services: Fiscal Year 11/12, *available at:* http://www.fdhc.state.fl.us/medicaid/flmedicaid.shtml.

61. Florida Agency For Health Care Administration, Florida Medicaid Summary of Services: Fiscal Year 11/12, *available at:* http://www.fdhc.state.fl.us/medicaid/flmedicaid.shtml.

62. STATEHEALTHFACTS.ORG, *Florida: Medicaid Enrollment in Managed Care By Plan Type, as of July 1, 2010*, http://www.statehealthfacts.org/profileind.jsp?ind=218&cat=4&rgn=11 (*last visited* December 2, 2012).

63. STATEHEALTHFACTS.ORG, *Florida: Medicaid Enrollment in Managed Care By Plan Type, as of July 1, 2010*, http://www.statehealthfacts.org/profileind.jsp?ind=218&cat=4&rgn=11 (*last visited* December 2, 2012).

64. Letter from Cindy Mann, Director, Centers for Medicare & Medicaid Services, to State Medicaid Director (November 26, 2012).

65. NASTAD, National ADAP Monitoring Project Annual Report, 2012, Table 8, http://prod.nastad.dotnet-web1.advansiv.com/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf

66. NASTAD, National ADAP Monitoring Project Annual Report, 2012, Table 13, http://prod.nastad.dotnet-web1.advansiv.com/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf

67. The number of undocumented immigrants on ADAP in each state in FY2009 will be extrapolated from the Pew Research Center's report, "A Portrait of Unauthorized Immigrants in the United States," available at http://pewhispanic.org/files/reports/107.pdf. This report provides the estimated number of undocumented immigrants in each state for 2008. This number, divided by the overall population of each state in 2008 (estimated at http://www.census.gov/popest/data/state/totals/2011/index.html), provides the percentage that undocumented immigrants make up of the total population in the state. This percentage is then applied to the number of individuals enrolled in ADAP who have incomes below 133% FPL to estimate how many ADAP beneficiaries will not be newly eligible for Medicaid in 2014 as a result of their immigration status.

68. NASTAD, National ADAP Monitoring Project Annual Report, 2012, Table 8, http://prod.nastad.dotnet-web1.advansiv.com/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf

69. NASTAD, National ADAP Monitoring Project Annual Report, 2012, Table 13, http://prod.nastad.dotnet-web1.advansiv.com/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf

70. NASTAD, National ADAP Monitoring Project Annual Report, 2012, Table 13, http://prod.nastad.dotnet-web1.advansiv.com/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf

71. NASTAD, National ADAP Monitoring Project Annual Report, 2012, Table 14, http://prod.nastad.dotnet-web1.advansiv.com/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf

72. The number of undocumented immigrants on ADAP in each state in FY2009 will be extrapolated from the Pew Research Center's report, "A Portrait of Unauthorized Immigrants in the United States," *available at* http://pewhispanic.org/files/reports/107.pdf. This report provides the estimated number of undocumented immigrants in each state for 2008. This number, divided by the overall population of the state in 2008 (estimated at http://www.census.gov/popest/data/state/totals/2011/index.html),), provides the percentage that undocumented immigrants make up of the total population in the state. This percentage is then applied to the number of individuals enrolled in ADAP to estimate how many ADAP beneficiaries will not be newly eligible for private insurance subsidies as a result of their immigration status.

73. http://www.statehealthfacts.org

74. NASTAD, National ADAP Monitoring Project Annual Report, 2012, http://prod.nastad.dotnet-web1.advansiv.com/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.

75. STATEREFORUM.ORG, State Progress on Essential Health Benefits (Nov. 28, 2012), http://www.statereforum.org/state-progress-on-essential-health-benefits (*last visited* December 14, 2012).

76. Letter from Rick Scott, Governor, Florida, to Kathleen Sebelius, Secretary, Department of Health & Human Services (September 28, 2012).

77. Centers for Medicare & Medicaid Services – Center for Consumer Information and Insurance Oversight (CCIIO), Essential Health Benefits: List of the Largest Three Small Group, July 3, 2012. *Available at:* http://cciio.cms.gov/resources/files/largest-smgroup-products-7-2-2012.pdf

78. NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS (NASTAD), NATIONAL ADAP MONITORING PROJECT ANNUAL REPORT, MAY 2011, *available at* http://www.nastad.org/Docs/highlight/2011429_Module%20One%20-%20National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20March%202011.pdf.

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