STATE HEALTH REFORM IMPACT MODELING PROJECT

Georgia

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Prepared by the Center for Health Law and Policy Innovation of Harvard Law School
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BACKGROUND

The Patient Protection and Affordable Care Act (ACA), signed into law in March 2010, 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, in 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 private insurance, 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 data collection methodology, notes, and limitations on the modeling process.

In Georgia, 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?

GEORGIA

GEORGIANS LIVING WITH HIV/AIDS

UNMET NEED

As of December 31, 2010, there were an estimated 41,986 Georgians known to be living with HIV/AIDS (HIV+ aware).[3] More than 50% of those diagnosed with HIV are not receiving medical care, according to the latest data available, and an estimated 20% of Georgians living with HIV are undiagnosed.[4,5] This proportion of the state's epidemic is 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 eligible for either private or public insurance in 2014.

THE RYAN WHITE PROGRAM IN GEORGIA

The Ryan White program provides federal funding to states to help fulfill unmet medical needs of individuals living with HIV/AIDS. To be eligible for Ryan White–funded services in Georgia, an individual must:

- Be a Georgia resident diagnosed with HIV;
- Lack other healthcare payment sources; and
- Be living at or below 300% of the federal poverty level (FPL).[6]

In 2010, the Ryan White program served 27,817 duplicated clients in Georgia.[7,8] Among these individuals, approximately 20% were insured by Medicaid, 18% by Medicare, 1% by other public insurance programs, and 11% by private insurance companies. Approximately 50% of the Georgians served by the Ryan White program were uninsured.

In 2010, Georgia received $83,473,949 in Ryan White program funding. More than one-half (56.8%) of those funds were devoted to Ryan White Part B, of which 25.8% was spent on base and emerging communities and 72.6% was spent on the AIDS Drug Assistance Program (ADAP).[9]

ADAP IN GEORGIA

ADAP provides federal and state support to low-income HIV/AIDS patients otherwise unable to afford medications. To be eligible for Georgia's ADAP, one must:

- Be a Georgia resident, aged 18 years or older, diagnosed with HIV;
- Have a CD4 count ≤350 mm^3 or an AIDS-defining illness;
- Have a valid prescription from a physician licensed in Georgia;
- Be living at or below 300% FPL; and
- Not have Medicaid or third-party coverage.[10]

In fiscal year 2010, Georgia's ADAP program provided assistance to 5,919 individuals.[11] In June 2011, Georgia's ADAP program served 3,958 clients, of whom 72% would be eligible for Medicaid under the expansion (if not already) and 16% would be eligible for a Basic Health Plan (BHP).[12]

In fiscal year 2010, Georgia's total ADAP budget was $49,898,649; in fiscal year 2011, the budget decreased approximately 1% to $49,349,266.[13] Of that budget, $35,970,218 came from Ryan White Part B funding, $11,379,048 from state funds, and $3,000,000 from emergency funding.[14]

THE AFFORDABLE CARE ACT AND ITS IMPACT ON HIV+ GEORGIANS

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.[15,*] (To calculate eligibility, a 5% "disregard" is applied to income, meaning that, for practical purposes, those living up to 138% FPL are eligible.) 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 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

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]

Because Georgia has not submitted a benchmark plan to HHS for purposes of defining benefits offered on the exchange, the largest small-group plan in the state, BlueCross BlueShield Healthcare Plan of Georgia POS, has become the default benchmark plan for purposes of defining EHB.

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.[24] Eligible individuals and families can employ these credits to purchase a private health insurance plan on a state- or federally operated insurance exchange.

[*] 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 & 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.

ESSENTIAL HEALTH BENEFITS

The ACA requires both Medicaid plans and private health insurance plans sold on insurance exchanges to provide certain EHB, to be defined by the Secretary of HHS.[25] These EHB must include items and services within the following ten benefit categories[26]:

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.[27] 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 Social Security Act.[28] 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.[29]

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

Given the ACA-instituted reforms, a large number of HIV+ individuals in Georgia are expected to become eligible for Medicaid or a BHP in 2014 (provided that Georgia expands Medicaid and institutes a BHP). An estimated 22% of the state's Ryan White program clients in 2010 were between 100-200% FPL, making them potentially eligible for either Medicaid or a BHP in 2014.[30] Among Georgians served by the state's ADAP program, we estimate that 52% will be newly eligible for Medicaid following its expansion. An additional 24% of ADAP clients will be eligible for private insurance subsidies.†

The percentage of Georgia's ADAP clients who will be newly eligible for Medicaid (52%) is significantly higher than the national proportion of newly eligibles (29%), likely because of Georgia's strict Medicaid eligibility standards.‡ The percentage expected to qualify for private insurance subsidies (24%) is also higher than the national proportion (15%) (Appendix A).

COMPARISON OF COVERED SERVICES UNDER RYAN WHITE, ADAP, MEDICAID, AND THE INSURANCE EXCHANGE

Since a significant number of HIV+ individuals in Georgia who are currently served by the Ryan White program or the AIDS Drug Assistance Program (ADAP) are likely to be eligible for Medicaid or insurance subsidies 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 Georgia's health insurance exchange would provide to HIV+ Georgians.

† Georgia's Health Insurance Continuation Program provides premium assistance of up to $1,100 per month to individuals living with HIV/AIDS living at or below 300% FPL (with only limited assets) who have non-Medicaid insurance coverage. Georgia Department of Public Health, HIV Care Program – Healthcare Insurance Continuation Program, *available at* http://www.health.state.ga.us/programs/stdhiv/hicp.asp (*last visited* Dec. 6, 2012).

‡ Currently, Georgia's Medicaid program is restricted to low-income individuals who are pregnant, 18 years of age or younger, 65 years of age or older, legally blind, disabled, or who require nursing home care. Georgia Department of Community Health, Applying for Medicaid, *available at* http://dch.georgia.gov/applying-medicaid (*last visited* Nov. 14, 2012).

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

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 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 treatment and care (eg, transportation, child care, nutrition). However, Medicaid and the benchmark plan, which will largely determine essential health benefits (EHB) for private insurance sold on the exchange, do not cover ancillary services (although they do cover a broader range of medical services).

Accounting for gaps in coverage of ancillary services will be critical in transitioning beneficiaries onto Medicaid and the insurance exchanges in order to ensure that health status does not deteriorate (eg, due to lack of access to transportation to a health clinic, proper nutrition, or stable housing).

Table 1 provides a comparison of covered services between Georgia's Ryan White program, Medicaid, and the BlueCross BlueShield Healthcare Plan of Georgia POS (the default benchmark plan for the insurance exchange).

Table 1. Ryan White, Medicaid, and the Benchmark Plan Used to Define Essential Health Benefits: Covered Services

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

Covered Service	Ryan White[31]	Medicaid[32,33]	BlueCross BlueShield Healthcare Plan of Georgia POS[34-36]
Home health care		X	X (120 visits/year)
Mental health	X	X	X
Substance abuse (outpatient)	X		X
Substance abuse (inpatient)			X
Medical case management	X	X (for targeted groups only; includes adults with AIDS)	
Community-based care		X	
Ambulatory/outpatient care	X	X	X
Oral health care	X	X	
Early-intervention clinic	X		
Intermediate care facilities for the mentally retarded		X	
Ambulance		X	X
Family planning		X	
Durable medical equipment		X	X
Hospital services		X	X
Lab and x-ray services		X	X

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Table 1. (continued)

Nursing facility		X	X (30 days/year)
Midwife/NP services		X	X
Private duty nursing			
Physician services		X	X
Non-medical 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		X (for diabetes)
Legal services	X		
Linguistic services	X		
Medical transportation	X	X	
Outreach services	X		
Psychosocial support	X		
Referral agencies	X		
Treatment adherence counseling	X		
Chiropractor			X (20 visits/year)
Podiatry		X	
Hospice		X	X
Respiratory therapy			X (20 visits/year)
PT, OT, and speech therapy		X	X (20 visits/year for PT and OT combined; 20 visits/year for speech therapy)
Orthotics and prosthetics		X	X (orthotics covered for diabetic foot only; prosthetics covered)
Personal care			
Home infusion therapy			

NP = nurse practitioner; OT = occupational therapy; PT = physical therapy.

As Table 1 indicates, the Ryan White program offers HIV+ individuals a number of ancillary services that Georgia's Medicaid program and default benchmark plan do not cover. Since these ancillary services are important for the well-being of HIV+ individuals, those individuals who leave the Ryan White program for Medicaid or private insurance plans are likely to be at a disadvantage if Ryan White wrap-around services are unavailable.

Furthermore, Georgia's default benchmark plan—BlueCross BlueShield Healthcare Plan of Georgia POS—imposes certain copay requirements that might prove prohibitive for low-income HIV+ individuals. At present, individuals on the plan pay $20-$40 per prescription refill and physician visit, and up to 30% of the cost of total care (in addition to premiums).[37] These copay requirements, together with the lack of ancillary services, might limit access to medical care for HIV+ individuals who leave the Ryan White program for private insurance plans on the exchange.

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 Department of Health & 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 the years 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.[38,39] 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 COVERED MEDICATIONS UNDER ADAP, MEDICAID, AND THE BENCHMARK PLAN FOR THE EXCHANGE IN GEORGIA

ADAP provides funding for a robust drug formulary that is necessary to allow low-income individuals affordable access to a combination of drugs to treat HIV. All states participating in ADAP must cover at least one drug in every class of antiretroviral drugs; most cover all drugs in each class.[40-42] Georgia's ADAP program covers most of the US Food and Drug Administration (FDA)–approved antiretroviral medications, but only a limited number of Centers for Disease Control and Prevention (CDC)–recommended "A1" medications for opportunistic infections.[43,44] Georgia's Medicaid program offers most of the same antiretroviral medications as well as a slightly larger number of medications to treat opportunistic infections. Ensuring that Medicaid and plans sold on the exchange provide coverage for a sufficient number and variety of medications will be critical to maintaining the health of Georgians living with HIV.

Table 2 provides a comparison of the antiretroviral drug formularies included in Georgia's ADAP and Medicaid programs, as well as BlueCross BlueShield's small-group POS plan.

Table 2. ADAP, Medicaid, and the Benchmark Plan Used to Define Essential Health Benefits: Drug Formularies

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) **Multiclass Combination Drugs**	**ADAP[45]** **1 Drug Covered[§]**	**Medicaid[46]** **3 Drugs Covered**	**BCBS Healthcare Plan of Georgia POS[47]** **3 Drugs Covered**
Atripla; *efavirenz, emtricitabine, tenofovir disoproxil fumarate*	X	X	X (tier 2)
Complera; *rilpivirine, emtricitabine, tenofovir disoproxil fumarate*		X (PA; QL)	X (tier 2)
Stribild; *elvitegravir, cobicistat, emtricitabine, tenofovir disoproxil fumarate*		X (PA)	X (tier 2)

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[§] The most recent available ADAP formulary was created in 2009. The state likely covers more recent drugs not indicated as covered here. Telephone call between Alison Rosenblum, law student, Harvard Law School, and Libby Brown, Georgia ADAP/HICP coordinator, Georgia Department of Public Health (Dec. 6, 2012).

Table 2. (continued)

NRTIs	10 Drugs Covered**	12 Drugs Covered	12 Drugs Covered
Combivir; *zidovudine + lamivudine*	X (PA)	X (QL)	X (generic tier 1; brand name tier 3)
Emtriva; *emtricitabine*	X	X	X (tier 2)
Epivir; *lamivudine*	X	X (QL)	X (generic tier 1; brand name tier 2)
Epzicom; *abacavir sulfate + lamivudine*	X	X	X (tier 4)
Retrovir; *zidovudine*		X (NP)	X (generic tier 1; brand name tier 2)
Trizivir; *abacavir + zidovudine + lamivudine*	X	X	X (tier 2)
Truvada; *tenofovir DF + emtricitabine*	X	X	X (tier 2)
Videx		X	X (tier 4)
Videx EC; *didanosine – delayed-release capsules*	X	X (NP)	X (tier 3)
Viread; *tenofovir disoproxil fumarate DF*	X	X (QL)	X (tier 3)
Zerit; *stavudine*	X	X (NP)	X (generic tier 1; brand name tier 3)
Ziagen; *abacavir*	X	X (QL)	X (generic tier 1; brand name tier 3)
NNRTIs	**4 Drugs Covered††**	**4 Drugs Covered**	**5 Drugs Covered**
Intelence; *etravirine*	X	X (PA; QL)	X (tier 3)
Rescriptor; *delavirdine mesylate*	X	X	X (tier 2)
Sustiva; *efavirenz*	X	X	X (tier 2)
Viramune; *nevirapine*	X		X (generic tier 1; brand name tier 3)
Edurant; *rilpivirine*		X (PA; QL)	X (tier 2)
Protease Inhibitors	**9 Drugs Covered‡‡**	**9 Drugs Covered**	**9 Drugs Covered**
Aptivus; *tipranavir*	X	X (PA)	X (tier 4)
Crixivan; *indinavir sulfate*	X	X	X (tier 2)
Invirase; *saquinavir mesylate*	X	X	X (tier 2)
Kaletra; *lopinavir + ritonavir*	X	X (QL)	X (tier 2)

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** The most recent available ADAP formulary was created in 2009. The state likely covers more recent drugs not indicated as covered here. Telephone call between Alison Rosenblum, law student, Harvard Law School, and Libby Brown, Georgia ADAP/HICP coordinator, Georgia Department of Public Health (Dec. 6, 2012).

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Table 2. (continued)

Lexiva; *fosamprenavir*	X	X	X (tier 2)
Norvir; *ritonavir*	X	X (NP, PA for tabs)	X (tier 2)
Prezista; *darunavir*	X	X (PA)	X (tier 4)
Reyataz; *atazanavir sulfate*	X	X	X (tier 2)
Viracept; *nelfinavir sulfate*	X	X	X (tier 2)
Fusion Inhibitors	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Fuzeon; *enfuvirtide*	X (PA)	X (PA; QL)	X
Entry Inhibitors – CCR-5 Co-Receptor Antagonist	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Selzentry; *maraviroc*	X (PA)	X (PA)	X (tier 4)
HIV Integrase Strand Transfer Inhibitors	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Isentress; *raltegravir*	X (PA)	X (PA)	X (tier 4)
"A1" Opportunistic Infection Medications	**19 Drugs Covered**	**16 Drugs Covered**	**27 Drugs Covered**
Zovirax; *Acyclovir*	X	X (QL; brand name cream or ointment only)	X (generic tier 1; brand name tier 2)
Fungizone; *Amphotericin B*			
Zithromax; *Azithromycin*	X	X (QL; brand name NP and PA)	X (generic tier 1; brand name tier 3; QL)
Vistide; *Cidofovir*			X (brand name tier 4)
Biaxin; *Clarithromycin*	X	X (QL; brand name NP)	X (brand name tier 3)
Cleocin; *Clindamycin*	X		X (generic tier 1)
Myambutol; *Ethambutol*	X (generic only)		X (generic tier 1)
Famvir; *Famciclovir*		X (QL; brand name NP)	X (generic tier 1)
Diflucan; *Fluconazole*	X	X (brand name NP)	X (generic tier 1)
Ancobon; *Flucytosine*	X	X (brand name NP)	X (generic tier 1)
Foscavir; *Foscarnet*			
Cytovene; *Ganciclovir*	X	X (brand name PA)	X (generic tier 1; brand name tier 4)
INH; *Isoniazid*	X		X (tier 1)
Sporanox; *Itraconazole*	X (generic only)	X (generic only; PA; QL)	X (generic only; PA)
Wellcovorin; *Leucovorin*	X (generic only)		
PEG-Intron; *Peg-Interferon alfa-2b*		X (NP; PA; QL)	X (brand name tier 3; PA)
NebuPent; *Pentamidine*		X (QL)	X (brand name tier 2)

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Table 2. (continued)

Deltasone; *Prednisone*	X (generic only)		X (generic only)
Probenecid			X (tier 1)
Pyrazinamide (PZA)	X		X (tier 1)
Daraprim; *Pyrimethamine*	X	X	X (brand name tier 2)
Fansidar *(Pyrimethamine + Sulfadoxine)*			X (brand name tier 2)
Virazole; *Ribavirin*		X (generic only)	X (generic only)
Rebetol; *Ribavirin*		X (brand name NP)	X (brand name tier 4)
Copegus; *Ribarvirin*		X (brand name NP and PA)	X (brand name tier 3)
Mycobutin; *Rifabutin*	X	X	X (brand name tier 2)
Rifadin; *Rifampin (RIF)*	X (generic only)		X (generic only)
Microsulfon; *Sulfadiazine*	X		
Bactrim; *sulfamethoxazole/trimethoprim DS*	X (generic only)		X (generic only)
Valtrex; *Valacyclovir*		X (NP; PA; QL)	X (tier 1; brand name tier 3)
Valcyte; *Valganciclovir*	X	X (brand name PA and QL)	X (brand name tier 2)

NP = non-preferred medication; PA = prior authorization; QL = quantity limits.

As Table 2 indicates, although the HIV/AIDS-related pharmacy services covered by Georgia's Medical Assistance program are comparable to those covered by Georgia's ADAP program, more of the medications covered by Medicaid have quantity limits or require prior approval. Furthermore, the Medicaid formulary covers a number of recommended A1 medications not covered by Georgia's ADAP program. It is important to note, however, that this analysis uses Georgia's current Medicaid formulary, which will not apply to newly eligible beneficiaries under the ACA (newly eligible beneficiaries will be guaranteed access to any FDA-approved drugs with significant clinically meaningful therapeutic advantage over another).[48]

Georgia's benchmark plan, BlueCross BlueShield Healthcare Plan of Georgia's small group POS plan, includes most HIV/AIDS-related medications on its drug formulary and thus provides more comprehensive coverage than ADAP. 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).[49] Thus, assuming the proposed rule is adopted, plans in Georgia must cover at least the number of drugs in each class listed for the BlueCross BlueShield plan (although not necessarily the same drugs). Cost, however, may become prohibitive as most of these medications are tier 2 or 3 drugs, costing patients $30-$60 per refill.[50,§§]

Ultimately, if Georgians living with HIV/AIDS are unable to access appropriate and affordable antiretrovirals and other medications through Medicaid or the insurance exchange, Ryan White and ADAP will continue to be necessary as payers of last resort.

§§ Tier 4 drugs are priced as tier 3 drugs within a three-tier plan.

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 law makers in implementing the Patient Protection and Affordable Care Act (ACA) in a manner that serves the needs of Georgians.

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 into Medicaid in Georgia, 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/AIDS. Should Georgia 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. The Medicaid benefits that will be available to newly eligible beneficiaries, including those living with HIV/AIDS, have not yet been defined. As such, an analysis of the barriers to care that this population is likely to face (based upon the existing Medicaid program) is timely as states prepare for the transition to a possible Medicaid expansion. Comparing current Ryan White and ADAP programs with existing Medicaid formularies allows for a baseline analysis of the needs of individuals living with HIV/AIDS moving onto the Medicaid system. This report identified a key challenge:

1. A number of services that are currently provided by the Ryan White program are not available under Georgia's current Medicaid program. HIV+ individuals who shift from the Ryan White program to Medicaid are therefore likely to have difficulty accessing a number of services currently available to them. Final guidance on Medicaid EHB will be crucial in this respect, but is unlikely to require coverage of ancillary services given federal direction to states thus far.[51]

Many other HIV+ Georgians currently receiving services through Ryan White programs will be eligible for subsidies to purchase health insurance coverage through Georgia's insurance exchange. It is therefore also essential that these private insurance plans provide a comprehensive range of services sufficient to meet the needs of Ryan White clients who transition onto them. This report identified two challenges with respect to the state's benchmark plan, which will be used to define essential health benefits (EHB) for private insurance plans:

1. First, a number of services that are currently provided by the Ryan White program are not available under Georgia's default benchmark plan, and are not required as EHB pursuant to the proposed rule issued by the US Department of Health & Human Services (HHS).[52] HIV+ individuals who shift from the Ryan White program to private insurance plans on the exchange are therefore likely to have trouble accessing a number of services currently available to them; and

2. Second, the prescription drug coverage under Georgia's benchmark plan imposes significant costs for HIV/AIDS medications. HIV+ individuals shifting from ADAP to private insurance plans may therefore have trouble accessing certain drugs.

Medicaid expansion and private insurance subsidies under the ACA will significantly increase access to healthcare coverage in Georgia for individuals living with HIV/AIDS. Still, there will be ongoing, albeit reduced, demand for Ryan White and ADAP services to fill the gaps in coverage or due to cost-sharing for low-income people. Structuring these programs to efficiently work together from the start is not only fiscally prudent but also necessary to secure the health of Georgians.

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. Georgia should extend Medicaid eligibility to all individuals living under 133% of the federal poverty level, pursuant to the ACA, in order to slow the transmission of HIV/AIDS and make treatment accessible to thousands of individuals who currently lack care; and

2. Georgia 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).

Questions may be directed to Katherine Record, krecord@law.harvard.edu.

APPENDIX A

2014 STATE-SPECIFIC ESTIMATES

Medicaid Estimates

The Patient Protection and Affordable Care Act 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 the fiscal year 2010[53]
−	**est. #**	ADAP clients living above 133% FPL[54,***]
−	**est. #**	insured ADAP clients living below 133% FPL[†††]
−	**est. #**	ADAP clients who are undocumented immigrants living below 133% FPL in June 2011
=	**Total #**	ADAP clients who will be newly eligible for Medicaid in 2014[‡‡‡]

Using data from Georgia, 5,919 individuals were served by Georgia's ADAP during fiscal year 2010. Of those, an estimated 42% (2,485.98) of ADAP clients have incomes above 133% FPL. An estimated 159.00 ADAP clients are below 133% FPL and insured. Finally, we estimate that approximately 199.23 of the state's 475,000 undocumented immigrants in 2008 are uninsured, have incomes below 133% FPL, and are served by ADAP. Thus, the calculation for Georgia is:

	5,919	ADAP clients served in fiscal year 2010
−	**2,485.98**	ADAP clients with income above 133% FPL
−	**159.00**	insured ADAP clients with income below 133% FPL
−	**199.23**	estimated uninsured undocumented immigrants with incomes below 133% FPL
=	**3,075**	ADAP clients who will be newly eligible for Medicaid in 2014; this constitutes 52% of the ADAP clients served 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	% ADAP Clients Newly Eligible
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	**62,971**	**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.[55] The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages sum to greater than 100% for Maryland and Ohio and hence are not workable for the calculations.

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 eligibility within each state, as well as by the differences in estimated percentages of undocumented immigrants in each state.

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

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, NASTAD's data do 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 being served in fiscal year 2010[56]
–	**est. #**	ADAP clients living below 133% FPL or above 400% FPL[57,§§§]
–	**est. #**	insured ADAP clients living between 133% and 400% FPL[58,****]
–	**est. #**	ADAP clients who are undocumented immigrants living between 133% and 400% FPL[59]
=	**Total #**	ADAP clients who will be eligible for subsidized private insurance††††

In Georgia, 5,919 individuals were served by ADAP during fiscal year 2010. Of those, 72% (4,261.68) of ADAP clients have incomes below 133% or above 400% FPL. We estimate that 2% (136.95) of ADAP clients have incomes between 133-400% FPL and are currently insured. We further estimate that approximately 116.22 of the state's 475,000 undocumented immigrants in 2008 are uninsured, have incomes between 133-400% FPL, and are served by ADAP. Thus, completing the calculation for Georgia's ADAP program yields:

	5,919	ADAP clients served in fiscal year 2010
–	**4,261.68**	ADAP clients living below 133% FPL or above 400% FPL
–	**136.95**	insured ADAP clients living between 133-400% FPL
–	**116.22**	ADAP clients who are undocumented immigrants living between 133-400% FPL[60]
=	**1,404**	ADAP clients who will be eligible for subsidized private insurance, which constitutes 24% of ADAP clients served in fiscal year 2010

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

State	# ADAP Clients Eligible for Subsidies	% ADAP Clients 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%
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* Methodology for Distribution of Insured ADAP Clients by Income.

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

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.[61] 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 Georgia, 51% of adults living below 133% FPL are insured, 75% of adults living between 133-400% FPL are insured, and 91% 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 Georgia, we gave the figure 51% the baseline number 1. 75% is 1.48 times 51%, and 91% is 1.79 times 51%. In other words, an adult in Georgia with income between 133-400% FPL is 1.48 times more likely to be insured than an adult with income below 133% FPL, while an adult with income above 400% FPL is 1.79 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.[62] 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 Georgia, we estimated that about 296 of the state's 5,919 ADAP clients served in 2010 were insured. The insurance rate for ADAP clients in the state stood at 5% in 2011;

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 Georgia, 72% of ADAP clients are living below 133% FPL, 42% are living between 133-400% FPL, and 0% are living above 400%; 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 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 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 Georgia:

295.95
= (1 x 0.72 x *a*)
+ (1.48 x 0.42 x *a*)
+ (1.79 x 0.00 x *a*)

Solving for *a*,

a = 220.83

Applying that value to Formula 1:

The estimated number of insured ADAP clients in Georgia with,

Income below 133% FPL = 159
Income between 133-400% FPL = 137
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 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 the 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 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 is 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% FPL. Since the expansion of Medicaid eligibility to those living under 133% FPL is a new development, there is a relative dearth of data regarding the number of HIV+ individuals currently living between 100-133% of the federal poverty level (FPL). NASTAD provides the only reliable source of this 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. Where information is also available from state departments of health or HRSA, it has been provided.

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 comparability amongst states is limited. Where information about unmet need is available from other sources, it 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. Where more detailed information is available, it has been included in the profiles.

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 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/AIDS as well as limitations that may impede access to needed services.

Benchmark Plan Coverage Data

Because Georgia did not submit a benchmark plan to the US Department of Health and Human Services as a proposed benefit package for purposes of defining essential health benefits (EHB) for the state's exchange, Georgia's largest small group plan, BlueCross BlueShield Healthcare Plan of Georgia POS is now the default benchmark plan. Data were collected from the BlueCross BlueShield website, the Centers for Medicare & Medicaid Services website on EHB benchmark plans, and from HHS's HEALTHCARE.GOV website.

NOTES

Data for certain states was incomplete in the 2012 National ADAP Monitoring Project Annual Report; 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.[63] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages exceed 100% for Maryland and Ohio).
- Data on the number of clients served by Mississippi's ADAP program appears 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 both to account for insurance status and to avoid double-counting individuals who may be enrolled in multiple Ryan White programs (ie, those who are seeing multiple providers). The estimates presented here, therefore, are only for the proportion of ADAP clients that 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 actually 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 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 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 further 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).

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54. The estimated number of ADAP recipients who are on private insurance, Medicaid, and Medicare is determined for the purposes of this analysis from NASTAD's data for June 2011. The percentage of individuals in each state who were covered by private insurance, Medicaid, or Medicare in June 2011 will be used as the estimated percentage for fiscal year 2010 in making this calculation. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, August 2012 59 tbl. 14, *available at* http://www.nastad.org/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.

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56. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, August 2012 53 tbl. 8, *available at* http://www.nastad.org/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.

57. The estimated number of ADAP recipients who are on private insurance, Medicaid, and Medicare is determined for the purposes of this analysis from NASTAD's data for June 2011. The percentage of individuals in each state who were covered by private insurance, Medicaid, or Medicare in June 2011 will be used as the estimated percentage for fiscal year 2010 in making this calculation. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, August 2012 59 tbl. 14, *available at* http://www.nastad.org/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.

58. This figure was calculated applying KFF's statewide insurance status by income level percentages to the number of ADAP clients by income level reported by NASTAD. In order to estimate the number of ADAP enrollees whose incomes fall between 133-400% FPL, data from June 2011 were used. For the purposes of this analysis it is assumed that similar percentages existed throughout FY2010. Kaiser Family Foundation, Health Coverage & the Uninsured, *available at* http://www.kff.org/uninsured/index.cfm (*last visited* Dec. 13, 2012) and National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, August 2012 58 tbl. 13, *available at* http://www.nastad.org/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.

59. The number of undocumented immigrants on ADAP in each state in fiscal year 2009 was extrapolated from the Pew Research Center's report, A Portrait of Unauthorized Immigrants in the United States. *See* A Portrait of Unauthorized Immigrants in the United States, Pew Research Center (April 14, 2009), *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, provides the percentage that undocumented immigrants make up of the total population in the state. *See* Population Estimates, US Census Bureau, *available at* http://www.census.gov/popest/data/state/totals/2011/index.html (*last visited* October 25, 2012). 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.

60. The number of undocumented immigrants on ADAP in each state in fiscal year 2009 was extrapolated from the Pew Research Center's report, A Portrait of Unauthorized Immigrants in the United States. *See* A Portrait of Unauthorized Immigrants in the United States, Pew Research Center (April 14, 2009), *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, provides the percentage that undocumented immigrants make up of the total population in the state. *See* Population Estimates, US Census Bureau, *available at* http://www.census.gov/popest/data/state/totals/2011/index.html (*last visited* October 25, 2012). 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.

61. statehealthfacts.org, Kaiser Family Foundation, *available at* http://www.statehealthfacts.org (last visited December 13, 2012).

62. 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.

63. 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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TAEP
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Center for Health Law and Policy Innovation
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