STATE HEALTH REFORM IMPACT MODELING PROJECT

Kentucky

January 2013

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

BACKGROUND

The Patient Protection and Affordable Care Act (ACA) will dramatically change how people living with HIV access healthcare.[1] In states that fully implement the law (including expanding Medicaid), thousands of uninsured people living with HIV—many of whom currently receive care and treatment through the Ryan White program—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 into Medicaid will have on low-income people living with HIV.[2]

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

In Kentucky, 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?

KENTUCKY

KENTUCKIANS LIVING WITH HIV/AIDS

UNMET NEED

As of 2009, approximately 5,723 individuals were known to be living in Kentucky with HIV/AIDS (HIV+ aware).[3] 32% of those living with HIV did not receive any medical care in 2007, and an estimated 20% of HIV+ individuals are not diagnosed.[4,5] 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 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 KENTUCKY

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, Kentucky received $14,475,492 of Ryan White funding and served 4,788 duplicated clients in the state.[6-8] About 72% of the state's Ryan White funds were Part B grants, assigned based on HIV prevalence.[9] Of these, 34.6% covered core medical services, 63% went toward the AIDS Drug Assistance Program (ADAP), and the remainder went toward Minority Access Initiatives and Emerging Communities programs.[10]

ADAP IN KENTUCKY

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 Kentucky, one must be:

- A Kentucky resident diagnosed with HIV;[11]
- Living at or below 300% of the federal poverty level (FPL), with assets less than $10,000; and
- Ineligible for assistance from another third-party payer.[12]

Kentucky's ADAP is composed of three programs:

1. Kentucky AIDS Drug Assistance Program (KADAP) – providing medications through a mail order pharmacy;
2. Kentucky Health Insurance Continuation Program (KHICP) – providing payments, including premium reimbursement, to continue health insurance coverage for individuals at risk of losing employee health benefits or private-pay health insurance because of HIV-related disease; and
3. Kentucky Outpatient Health Care and Support Services Program – providing a wide range of community-based medical and non-medical support services, including physical and mental healthcare, housing, nutrition, and transportation services.

In addition to the eligibility criteria listed above, individuals enrolling in KHICP must have a Medicare Part D or a prescription rider as part of a health insurance policy, individual policies must cover HIV+ status, and family policies must cover at least two HIV+ family members.[13]

In fiscal year 2010, Kentucky's ADAP served 1,457 individuals.[14] The state's ADAP budget for the fiscal year 2011 was $10,222,985 (99% of which were federal funds).[15] In 2010, Kentucky's ADAP spent $9.5 million on prescription drugs and dispensing costs.[16]

THE ACA AND ITS IMPACT ON HIV+ KENTUCKIANS

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 & 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 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 into a plan with similar provider networks and administrative procedures.

SUBSIDIES FOR PRIVATE INSURANCE PREMIUMS, AND STATE-BASED INSURANCE EXCHANGES

The ACA requires states to establish state-run insurance exchanges, to partner with the federal government to set up a hybrid state-federal exchange, or to default into a federally facilitated exchange.[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] As a benchmark plan for purposes of defining EHB on the private market, Kentucky submitted the Anthem BlueCross BlueShield PPO plan.

For those purchasing coverage on an exchange, the ACA extends insurance premium credits to individuals and families living 100-400% 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.[26] 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 (April 2012), *available at* http://aspe.hhs.gov/hsp/11/ImmigrantAccess/Coverage/ib.pdf.

ESSENTIAL HEALTH BENEFITS

The ACA requires both Medicaid and private health insurance plans sold on state-based insurance exchanges to provide certain EHB, to be defined by the Secretary of HHS.[27] EHB must include items and services within the following ten benefit categories[28]:

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.[29] The Centers for Medicare & Medicaid Services (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.[30] This means that benefits provided by Medicaid will likely be more robust than on the private market. For example, the Social Security Act requires that a Medicaid benchmark plan cover any FDA-approved drugs with significant clinically meaningful therapeutic advantage over another.[31]

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 Kentucky are expected to become eligible for public or private insurance in 2014. An estimated 59% of the state's Ryan White program clients in 2010 were living at or below the FPL and an additional 22% were between 100-200% FPL, making them potentially eligible for either Medicaid or a BHP in 2014.[32] An estimated 42% of Kentucky's AIDS Drug Assistance Program (ADAP) clients will be eligible for Medicaid following its expansion, and 18% will be eligible for insurance credits (Appendix A). Finally, many of the over 1,800 HIV+ Kentuckians who are not receiving care or are undiagnosed will also likely be eligible for Medicaid, a BHP, or subsidized private insurance in 2014.

The percentage of Kentucky's ADAP clients who will be newly eligible for Medicaid based on income levels (42%) is higher than the national average, which stands at 29% (Appendix A). This is primarily because a very large proportion of ADAP clients (65% of the clients served in June 2011) live at or below 133% FPL,[33] and a high percentage lack any form of insurance (62%).[34]

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

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

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

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/AIDS treatment and care (eg, transportation, child care, nutrition). However, Medicaid and Kentucky's benchmark plan do not cover ancillary services and will not be required to under the ACA (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).

Table 1 provides a comparison of covered services between Kentucky's Ryan White and Medicaid programs as well as the Anthem BlueCross BlueShield PPO small-group market plan. With respect to Medicaid, the majority of Kentucky Medicaid recipients must enroll in one of five managed care plans, with variations in plan availability across geographic regions of the state as of January 2013. The plans include: Passport Health Plan, CoventryCares of Kentucky, Humana, Wellcare of Kentucky, and the Kentucky Spirit Health Plan.

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[35]	Medicaid[36,37]	Anthem BlueCross BlueShield PPO[38]
Ambulatory/Outpatient Care	X	X	X
Oral Healthcare	X	X	
Early-Intervention Clinics	X	X	
Home Healthcare	X	X (PA)	X (100 visits/yr)
Community-based Services	X		
Mental Health: Outpatient	X	X	X (30 visits/yr combined with outpatient SA treatment)
Mental Health: Inpatient		X	X (30 days/yr combined with inpatient SA treatment)
Substance Abuse: Outpatient	X		X (30 days/yr combined with outpatient MH services; limited to 2 treatments per lifetime)
Substance Abuse: Inpatient	X		X (30 days/yr combined with inpatient MH services; also limited to 2 treatments per lifetime)
Medical Case Management	X	X[39]	
Nonmedical Case Management	X		
Child Care Services	X		
Emergency Financial Assistance	X		
Food Bank/Home-delivered Meals	X		
Health Education/Risk Reduction	X		
Housing Services	X		
Legal Services	X		
Linguistics Services	X		

Continued on next page

Table 1. (continued)

Medical Transportation	X	X	
Outreach Services	X		
Permanency Planning	X		
Psychosocial Support Services	X		
Referral for Healthcare/Support Services	X		
Rehabilitation Services	X	X	X (20 visits/year)
Respite Care	X		
Treatment Adherence Counseling	X		
Hospital Inpatient		X (PA)	X
Prescription Drugs	X	X	X
Mental Retardation/Developmental Disability Services		X	X (Autism services)
Family Planning		X	
Obstetric and Prenatal Services		X	X
Nursing Home Care		X	X (90 days/yr)
Chiropractor Services		X	X (12 visits/yr)
Durable Medical Equipment		X (PA)	X
Hospice Care		X	X
Laboratory and Radiology Services		X	X
Renal Dialysis		X	
Vision Care		X	

PA = prior authorization; MH = mental health; SA = substance abuse.

As Table 1 illustrates, the Ryan White program provides a number of services that are not covered by Medicaid or the benchmark plan that will be used to determine EHB for the state's exchange (eg, emergency financial assistance, food-bank and meal delivery, and a variety of wraparound services from housing and legal assistance to child care). With respect to Medicaid, the majority of Kentucky's Medicaid recipients are required to enroll in a managed care organization (MCO), and most Kentucky MCOs offer similar benefits. Significantly, Kentucky MCOs do not cover treatment adherence counseling, respite care, or any of the wraparound services that are crucial to successful health outcomes for HIV+ individuals. In addition, only some of the MCOs automatically offer important case management services to individuals living with HIV/AIDS. Kentucky's medical care infrastructure also varies dramatically across geographic regions. Rural residents have difficulty finding specialists and transportation to appointments in clinics that are sometimes hours away from their homes, while urban Kentuckians struggle to obtain care at more accessible sites that are overwhelmed by a denser HIV+ population.[40] Unless the Medicaid benchmark plan (for newly eligible beneficiaries) provides comprehensive services, including nonmedical support services, Ryan White will continue to be essential to ensure that low-income HIV+ Kentuckians can access and stay in treatment.

Table 1 also demonstrates that coverage under the state's default benchmark plan, Anthem BlueCross BlueShield PPO, is far more limited for people living with HIV/AIDS than is Ryan White. Anthem PPO maintains stringent limits on some services and does not offer adult dental care, medical case management, or any supportive services.[41] Anthem also imposes significant cost-sharing, high annual out-of-pocket limits ($4,000 for individuals and $12,000 for families) and high deductibles ($2,500 per year for in-network individual care and $7,500 per year for in-network family care).[42] Individuals purchasing insurance on the exchange will continue to rely on Ryan White and ADAP to fill large gaps in both coverage and affordability.

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

ADAP provides funding for a robust drug formulary that is necessary to afford low-income individuals access to a combination of drugs to treat HIV/AIDS. All states participating in ADAP must cover at least one drug in every class of antiretroviral therapy (ART); most cover almost all drugs in each class. Medicaid's drug formulary is defined differently. Ensuring that Medicaid and plans sold on the exchange provide coverage for a sufficient number of antiretroviral medications and other drugs that are essential to ART will also be critical to maintaining the health of Kentuckians living with HIV/AIDS.

Table 2 provides a comparison of the antiretroviral and opportunistic-infection drug formularies included in the state's ADAP and traditional Medicaid program. The majority of Kentuckians are required to enroll in a Managed Care Plan (MCP) and each MCO or MCP maintains its own preferred drug list formulary. The formulary for Wellcare of Kentucky is used in Table 2 as a point of comparison for Kentucky's ADAP. Medicaid recipients in Kentucky are generally limited to a maximum of four prescriptions per month, but may receive additional medications if the prescription is for a drug that has an FDA indication to treat certain medical conditions, including HIV/AIDS.[43] Unfortunately, a formulary for Kentucky's benchmark plan, Anthem BlueCross BlueShield PPO, is not available to non-plan members. However, a summary of this plan submitted to the Center for Consumer Information and Insurance Oversight lists the number of drugs that will be covered under the plan by category and class. Information about the number of anti-HIV agents and other drugs that may be needed for HIV/AIDS-related illness is provided in Table 3.[44]

Table 2. ADAP Versus Medicaid: Covered Drugs[45]

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[46]**	**Medicaid[47]**
Multiclass Combination Drugs	**2 Drugs Covered**	**2 Drugs Covered**
Atripla; *efavirenz + emtricitabine + tenofovir DF*	X	X
Complera; *emtricitabine + rilpivirine + tenofovir disoproxil fumarate*	X	X
Stribild; *elvitegravir + cobicistat + emtricitabine + tenofovir disoproxil fumarate*		
NRTIs	**12 Drugs Covered**	**12 Drugs Covered**
Combivir; *zidovudine + lamivudine*	X	X
Emtriva; *emtricitabine*	X	X (QL)
Epivir; *lamivudine*	X	X
Epzicom; *abacavir sulfate + lamivudine*	X	X (QL)
Retrovir; *zidovudine*	X	X
Trizivir; *abacavir + zidovudine + lamivudine*	X	X (QL)
Truvada; *tenofovir DF + emtricitabine*	X	X (QL)
Videx; *didanosine (buffered versions)*	X	X
Videx EC; *didanosine (delayed–release capsules)*	X	X
Viread; *tenofovir disoproxil fumarate DF*	X	X
Zerit; *stavudine*	X	X
Ziagen; *abacavir*	X	X

Continued on next page

Table 2. (continued)

NNRTIs	5 Drugs Covered	5 Drugs Covered
Intelence; *etravirine*	X (PA)	X
Rescriptor; *delavirdine mesylate*	X	X
Sustiva; *efavirenz*	X	X
Viramune; *nevirapine*	X	X
Edurant; *rilpivirine*	X	X (QL)
Protease Inhibitors	**10 Drugs Covered**	**9 Drugs Covered**
Agenerase; *amprenavir*	X	
Aptivus; *tipranavir*	X (PA)	X
Crixivan; *indinavir sulfate*	X	X
Invirase; *saquinavir mesylate*	X	X
Kaletra; *lopinavir + ritonavir*	X	X
Lexiva; *fosamprenavir*	X	X (QL)
Norvir; *ritonavir*	X	X
Prezista; *darunavir*	X	X
Reyataz; *atazanavir sulfate*	X	X (QL)
Viracept; *nelfinavir sulfate*	X	X (QL)
Fusion Inhibitors	**1 Drug Covered**	**1 Drug Covered**
Fuzeon; *enfuvirtide*	X (PA)	X
Entry Inhibitors – CCR-5 Coreceptor Antagonist	**1 Drug Covered**	**1 Drug Covered**
Selzentry; *maraviroc*	X	X
HIV Integrase Strand Transfer Inhibitors	**1 Drug Covered**	**1 Drug Covered**
Isentress; *raltegravir*	X	X
"A1" Opportunistic Infection Medications	**18 Drugs Covered**	**24 Drugs Covered**
Ancobon; *flucytosine*		
Bactrim DS; *sulfamethoxazole/trimethoprim DS*	X	X
Biaxin; *clarithromycin*	X	X
Cleocin; *clindamycin*		X
Copegus: *ribavirin,* oral		X
Dapsone	X	X
Daraprim; *pyrimethamine*	X	X
Deltasone; *prednisone*	X	X
Diflucan; *fluconazole*	X	X
Famvir; *famciclovir*		
Foscavir; *foscarnet*		
Fungizone; *amphotericin B*		
INH; *isoniazid*	X	X
Megace; *megestrol*	X (PA)	X (QL)

Continued on next page

Table 2. (continued)

Mepron; *atovaquone*	X† (PA)	X
Myambutol; *ethambutol*	X	X
Mycobutin; *rifabutin*	X	X
NebuPent; *pentamidine*		
Nydrazid; *isoniazid, INH*	X	X
Pegasys: *peginterferon-alfa 2a*		X (PA)
PEG-Intron: *peginterferon-alfa 2b*		
Probenecid		X
Procrit; *erythropoietin*		X (PA)
Pyrazinamide (PZA)		X
Rifadin, Rimactane; *rifampin*	X	X
Sporanox; *itraconazole*		
Sulfadiazine – Oral	X	X (QL)
Valcyte; *valganciclovir*	X	
Valtrex; *valacyclovir*		X (QL)
VFEND; *voriconazole*		
Vistide; *cidofovir*		
Wellcovorin; *leucovorin*	X	X
Zithromax; *azithromycin*	X	X
Zovirax; *acyclovir*	X	X

PA = prior authorization; QL = quantity limited.

As Table 2 shows, most drugs used to treat HIV/AIDS available through ADAP are also available through Medicaid. However, management of HIV/AIDS diagnoses may require many and varied specific prescription drugs. Because not all prescriptions an individual may need are designated as HIV/AIDS drugs by the FDA, the four-prescription limit imposed on Medicaid recipients can pose problems for individuals who require multiple medications to treat opportunistic infections and other medical complications that frequently arise. Many drugs available through Medicaid are also subject to quantity limits, making it difficult to obtain the amount of medication an individual needs for successful treatment. In addition, because each MCO maintains its own formulary and a slightly distinct plan, HIV+ individuals who enroll in a plan without comprehensive information on formularies and coverage limits might not choose the plan best suited to them. It is important that ADAP continues to be available for HIV+ Kentuckians as a payer of last resort.

Kentucky's benchmark plan, Anthem BlueCross BlueShield PPO, does not have a publicly available drug formulary. Table 3 provides information on the number of drugs covered in each relevant class for people living with HIV/AIDS (including medications used to treat opportunistic infections and hepatitis).

† Available only for insured patients or through Bridges to Access program for patients living at or below 250% FPL.

Table 3. Number of Drugs by Category and Class Covered by the Benchmark Plan[48]

Category	Class	No. of Covered Drugs
Antivirals	Anti-HIV agents, non-nucleoside reverse transcriptase inhibitors	5
Antivirals	Anti-HIV agents, nucleoside and nucleotide reverse transcriptase inhibitors	8
Antivirals	Anti-HIV agents, protease inhibitors	9
Antivirals	Anti-HIV agents, other	3
Antivirals	Antihepatitis agents	12
Antifungals	Antifungal agents	24

As Table 3 illustrates, the failure to disclose the specific drugs that will be covered under the benchmark plan poses a challenge to HIV+ Kentuckians who will not be able to plan for treatment continuity without additional information. In addition, both ADAP and Medicaid in Kentucky cover 12 drugs in the nucleotide and nucleoside reverse transcriptase inhibitor class, while the benchmark plan will only cover eight drugs in this class. Because the prescription drug EHB currently only requires coverage of the number of drugs per class covered by a benchmark plan (or no less than one drug per class if none are covered), HIV+ individuals purchasing subsidized private insurance may lack access to comprehensive ART.[49]

In addition to lack of clarity with respect to prescription drugs, affordability of medication under the benchmark plan is also likely to be an issue for low-income Kentuckians. Anthem PPO imposes prior authorization requirements and step therapy programs for certain unspecified drugs.[50] It also has a tiered copay program for prescription drugs, with copays of $10-$40 for tiers 1-3 and a dramatic increase in expense for tier 4 specialty drugs (subject to 25% coinsurance with a maximum of $150 per prescription order and $2,500 per year out-of-pocket maximum).[51] It is likely that many of the drugs required by HIV+ individuals are classified as specialty drugs, which will subject low-income Kentuckians eligible to subsidized private insurance to high coinsurance burdens.

CONCLUSIONS AND NEXT STEPS

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

While much of the ACA has yet to be implemented, it is certain that large a number of people living with HIV/AIDS will be newly eligible for Medicaid. Given that a significant proportion of uninsured ADAP clients would transition into Medicaid in Kentucky, 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.

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

1. First, a number of services that are currently provided by the Ryan White program are not available under the state's current Medicaid program. Those newly eligible for Medicaid under the 2014 expansion may still require these wraparound services to maintain their health and quality of life. For instance, the Ryan White program, unlike traditional Medicaid, covers early-intervention clinics, respite and child care, risk reduction health education, medical and nonmedical case management, and treatment adherence counseling. Because Medicaid essential health benefits (EHB) (for newly eligible beneficiaries) will likely not require coverage of ancillary services, Ryan White will remain a critical payer of last resort to keep access to care channels open[52]; and

2. Second, Medicaid recipients who require more than four prescriptions per month may face difficulties obtaining medications if the US Food and Drug Administration (FDA) has not expressly indicated that all necessary drugs are used to treat HIV/AIDS. If the expanded Medicaid plan follows current cost-containment protocols (which federal guidance indicates it will be able to do), individuals with many prescriptions related to HIV/AIDS will struggle to access comprehensive antiretroviral therapy (ART).[53]

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

1. First, many of the services provided by the Ryan White program are not available under Anthem BlueCross BlueShield PPO, the state's benchmark plan, including case management; meal, housing, and childcare assistance; and community-based services. Furthermore, the benchmark plan imposes annual caps on some services and significant cost-sharing requirements and deductibles that will be difficult for low-income Kentuckians to afford. Those newly eligible for subsidized insurance purchased on the exchange in 2014 will still require the wraparound services provided by Ryan White to maintain their health and quality of life; and
2. Second, HIV+ individuals in Kentucky lack comprehensive information about the specific drugs that will be covered by the benchmark plan and will struggle to meet high cost-sharing requirements and deductibles with respect to prescription drugs. Because many plans in the private market will likely be required to cover only as many drugs per class as the benchmark plan (and no less than one per class), ADAP will be necessary to fill gaps in the plan formulary and as a payer of last resort to people living with HIV/AIDS.[54]

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

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

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

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

	Total #	ADAP clients being served in fiscal year 2010[55]
–	**est. #**	ADAP clients with incomes above 133% FPL[56,‡]
–	**est. #**	insured ADAP clients with incomes below 133% FPL[§]
–	**est. #**	ADAP clients who are uninsured undocumented immigrants with incomes below 133% FPL[57]
=	**Total #**	ADAP clients served who will be newly eligible for Medicaid in 2014

Using Kentucky as an example, 1,457 individuals were served by Kentucky's ADAP during fiscal year 2010. Of those, we estimate that 34% (495) of ADAP clients currently have incomes above 133% FPL. An estimated 333 of individuals living below 133% FPL are currently insured, and approximately 1% of the state population were undocumented immigrants in 2008 (10 ADAP individuals with incomes below 133% FPL). Thus the calculation for Kentucky is:

	1,457	ADAP clients served in fiscal year 2010
–	**495.38**	ADAP clients with incomes above 133% FPL
–	**332.57**	insured ADAP clients with incomes below 133% FPL
–	**9.87**	estimated uninsured undocumented immigrants with incomes below 133% FPL
=	**619**	individuals currently enrolled in ADAP who will be eligible for Medicaid in 2014, or 42% of those enrolled in Kentucky's ADAP in fiscal year 2010

‡ 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.

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

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

Note: Data on the insurance status of ADAP clients in Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.[58] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages of insured clients exceed 100% for Maryland and Ohio.)

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. 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[59]
–	**est. #**	ADAP clients living below 133% FPL[60]
–	**est. #**	ADAP clients living above 400% FPL[61,**]
–	**est. #**	insured ADAP clients living between 133-400% FPL[62,††]
–	**est. #**	undocumented ADAP clients living between 133-400% FPL[63]
=	**Total #**	ADAP clients who will be eligible for subsidized private insurance in 2014

** 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).

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

Again, using Kentucky as an example, 1,457 individuals were served by ADAP during fiscal year 2010 in Kentucky. Of those, we estimate that 65% (947) of ADAP clients have incomes below 133% or above 400% FPL. We further estimate that 48% (236) of individuals living between 133-400% FPL are currently insured. An estimated 1% of the state's population were undocumented immigrants in 2008. Applying this percentage to the individuals enrolled in Kentucky's ADAP computes to approximately five ADAP clients in Kentucky who are uninsured and undocumented immigrants living between 133-400% FPL. Thus, completing the calculation for Kentucky's ADAP yields:

	1,457	ADAP clients served in fiscal year 2010
−	**947.05**	ADAP clients living below 133% FPL or above 400% FPL
−	**235.65**	insured ADAP clients living between 133-400% FPL
−	**5.16**	ADAP clients who are undocumented immigrants living between 133-400% FPL
=	**269**	individuals currently enrolled in ADAP who will be eligible for private insurance subsidies in 2014 or 18% of those enrolled in Kentucky's ADAP in fiscal year 2010

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

State	# ADAP Clients 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	**37,527**	**15%**

Note: Data on the insurance status of ADAP clients in Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.[64] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages of insured clients exceed 100% for Maryland and Ohio.)

METHODOLOGY FOR DISTRIBUTION OF INSURED ADAP CLIENTS BY INCOME

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

1. The percentage of adults living below 133% FPL, between 133-400% FPL, and above 400% FPL in each state who are insured was determined using data available at the Kaiser Family Foundation's STATEHEALTHFACTS.ORG website. The website lists insurance status for people beginning at 139% FPL instead of 133% FPL, but because of the ACA's 5% income disregard, the Medicaid expansion applies to all individuals living below 138% FPL, making this distinction irrelevant. The website also divides the 133-400% FPL income group into two groups: 133-250% FPL and 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 Kentucky, 59% of adults living below 133% FPL are insured; 80% of adults living between 133-400% FPL are insured; and 95% 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 Kentucky, the figure 59% was given the baseline number 1. 80% is 1.35 times 59%, and 95% is 1.6 times 59%. Thus, in other words, an adult in Kentucky with income between 133-400% FPL is 1.35 times more likely to be insured than an adult with income below 133% FPL, while an adult with income above 400% FPL is 1.6 times more likely to be insured;

3. We then calculated the number of insured ADAP clients in each state, by referring to Tables 8 and 14 of the 2012 NASTAD National ADAP Monitoring Project Report.[65] 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 Kentucky, we estimated that about 568 of the state's 1,457 ADAP clients served in 2010 were insured;

4. In order to proportionately divide the number of insured ADAP clients among the three income groups listed 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 Kentucky, 65% of ADAP clients have incomes below 133% FPL, 34% have incomes between 133-400% FPL, and 0% have incomes above 400% FPL; and finally

5. We then treated the number of insured ADAP clients in each income group as a product of the relative likelihood of being insured (determined previously), and compared it with the 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 NASTAD Report lists the percentage of ADAP clients in each state who were covered by various kinds of insurance (Medicaid, Medicare, private insurance) in 2011. We added the different insurance percentages to estimate the number of ADAP clients in each state who were insured. This leads to an overestimation of the number of insured people in each state. Since a single ADAP client may be enrolled in multiple insurance plans (eg, Medicare and private insurance), adding up the insurance percentages may often result in double-counting a number of ADAP clients.

Thus, for Kentucky:

568

= (1 x 0.65 x *a*)

+ (1.35 x 0.34 x *a*)

+ (1.6 x 0.00 x *a*)

Solving for *a*,

a = 511.65

Applying the value of *a* determined above to Formula 1:

The estimated number of insured ADAP clients in Kentucky with,

Incomes below 133% FPL = 333
Incomes between 133-400% FPL = 236
Incomes 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 AIDS Drug Assistance Program (ADAP) clients is most thoroughly documented by the National Alliance of State & Territorial AIDS Directors (NASTAD), and information from that organization has been provided for income and insurance status of ADAP clients. NASTAD's data for fiscal years 2010 and 2011 and June 2011 were used (fiscal year 2010 was necessary for states that did not report data in 2011). Because ADAP data compiled by NASTAD are unduplicated, 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 fall between 100-133% of the federal poverty level (FPL). Since the expansion of Medicaid eligibility to those living under 133% FPL is a new development, there is a 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 will be used for estimates regarding people living with HIV/AIDS who will be newly eligible for Medicaid in 2014 at the end of this report. Information available from state departments of health or HRSA has also been provided.

Estimates of unmet need for people living with HIV/AIDS in each state are available in each state's Statewide Coordinated Statement of Need (SCSN). SCSNs must be provided by all states receiving Ryan White program funding, but different states provide SCSNs in different years, so 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. 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, the 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. The Kaiser Family Foundation's information on ADAP expenditures has also been included for information on the amount spent by ADAP services on insurance assistance and full prescription coverage.

Medicaid Coverage Data

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

Benchmark Plan Coverage Data

Kentucky's benchmark plan is BlueCross BlueShield Anthem PPO, the largest small-group plan in the state. Information about this plan was collected from BlueCross BlueShield's promotional materials, the plan's health certificate, and information submitted to the Center for Consumer Information and Insurance Oversight.

NOTES

Data for certain states were incomplete in the 2012 National ADAP Monitoring Project Annual Report; 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.[66] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages exceed 100% for Maryland and Ohio); and
- Data on the number of clients served by Mississippi's ADAP appear to be incorrect in NASTAD's Monitoring Report, as the number of clients served is listed as larger than the number of eligible ADAP clients in the state. The number listed was used in these calculations, and while the specific number of ADAP clients eligible for Medicaid and private insurance subsidies in Mississippi may not be reliable, the proportion of clients eligible for both programs was obtained in the same way as for other states.

CAVEATS AND ASSUMPTIONS

The estimates provided require a number of caveats and assumptions:

1. ADAP data (as opposed to Ryan White data) were used both to account for insurance status and to avoid double-counting individuals who may be enrolled in multiple Ryan White programs (ie, seeing multiple providers). The estimates presented here, therefore, are only for the proportion of ADAP clients who will be eligible for Medicaid and private insurance subsidies;
2. Data for ADAP clients served were used rather than data for clients enrolled because the number of individuals enrolled may exceed the actual number of clients accessing ADAP services. Potential clients who are currently on ADAP waiting lists in several states are also not included in these calculations. Thus, the numbers provide a conservative estimate of ADAP beneficiaries who will transition onto Medicaid or into subsidized private insurance;
3. National data (NASTAD and HRSA) were used in calculations instead of state-specific data to ensure that these estimates could be compared across the states surveyed; and 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/AIDS who will be newly eligible for Medicaid and insurance subsidies in 2014. While the percentages provided could be extrapolated to apply to the broader HIV/AIDS population in states, given the number of caveats and assumptions needed to arrive at this rough estimate, it would be better to obtain additional information about the unmet need within states before attempting to make such calculations.

APPENDIX C

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

- Outpatient and ambulatory care;
- 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 (2010).
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. http://hab.hrsa.gov/stateprofiles/2010/states/ky/hiv-aids-epidemic.htm#chart1.
4. Kentucky Ryan White 2009 Statewide Coordinated Statement of Need and Comprehensive Plan (January 2009) [hereinafter RYAN WHITE SCNCP] at 25, *available at* http://chfs.ky.gov/NR/rdonlyres/34AD565F-298C-484C-90C4-B31D10622542/0/2009KentuckySCSN.pdf.
5. Mi Chen et al. Prevalence of Undiagnosed HIV Infection Among Persons Aged ≥13 Years – National HIV Surveillance System, United States, 2005-2008, *MMWR* (June 15, 2012), *available at* http://www.cdc.gov/mmwr/pdf/other/su6102.pdf (*last visited* December 18, 2012).
6. Health Resources and Services Administration (HRSA), US Department of Health & Human Services, Kentucky, *available at* http://hab.hrsa.gov/stateprofiles/2010/states/ky/Program-Grantees-and-Funding.htm.
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. Health Resources and Services Administration (HRSA), US Department of Health & Human Services, Kentucky, *available at* http://hab.hrsa.gov/stateprofiles/2010/states/ky/Client-Characteristics.htm#chart1.
9. Health Resources and Services Administration (HRSA), US Department of Health & Human Services, Kentucky, *available at* http://hab.hrsa.gov/stateprofiles/2010/states/ky/Program-Grantees-and-Funding.htm.
10. Health Resources and Services Administration (HRSA), US Department of Health & Human Services, Kentucky, *available at* http://hab.hrsa.gov/stateprofiles/2010/states/ky/Program-Grantees-and-Funding.htm.
11. For participation in KADAP, medical documentation of HIV status must also include CD4 + T-cell count and viral load. *available at* http://chfs.ky.gov/dph/epi/HIVAIDS/services.htm.
12. Kentucky Cabinet for Health and Family Services, Department of Health: Financial Assistance Program *available at* http://chfs.ky.gov/dph/epi/HIVAIDS/services.htm.
13. Kentucky Cabinet for Health and Family Services, Department of Health: Financial Assistance Program *available at* http://chfs.ky.gov/dph/epi/HIVAIDS/services.htm.
14. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, 45, tbl. 8 [hereinafter NASTAD Report] (August 2012), *available at* http://www.nastad.org/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.
15. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, 32-33, tbl. 2 [hereinafter NASTAD Report] (August 2012), *available at* http://www.nastad.org/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.
16. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, 45, tbl. 8 [hereinafter NASTAD Report] (August 2012), *available at* http://www.nastad.org/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.
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. Affordable Care Act, tit. I, § 1401(a), 26 U.S.C. § 36(B) (Amendments 2010).
27. Affordable Care Act, tit. I § 1302(a), 42 U.S.C. §18022(a) (2010).
28. Affordable Care Act, tit. I, §1302(B), 42 U.S.C. § 18022(b) (2010).
29. 45 C.F.R. pts. 144, 147, 150, et al. (proposed November 26, 2012).
30. Letter from Cindy Mann, director, Centers for Medicare & Medicaid Services, to State Medicaid Director (November 26, 2012).
31. Social Security Act, 42 U.S.C. § 1927 (2010).
32. Health Resources and Services Administration (HRSA), US Department of Health & Human Services, Kentucky, *available at* http://hab.hrsa.gov/stateprofiles/2010/states/ky/Client-Characteristics.htm#chart6.
33. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, tbls. 13-14 [hereinafter NASTAD Report] (August 2012), *available at* http://www.nastad.org/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.
34. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, tbl. 11 [hereinafter NASTAD Report] (May 2011), *available at* http://www.nastad.org/Docs/020035_2011%20NASTAD%20National%20ADAP%20Monitoring%20Project%20Annual%20Report.pdf.
35. Health Resources and Services Administration (HRSA), US Department of Health & Human Services, Kentucky, *available at* http://hab.hrsa.gov/stateprofiles/2010/states/ky/Services-Utilization.htm.
36. Kentucky Cabinet for Health & Family Services, Department of Medicaid Services, Covered Services, *available at* http://chfs.ky.gov/dms/services.htm.
37. Kentucky Cabinet for Health & Family Services, Department for Medicaid Services, Kentucky Medicaid Member Information Page, Prior Authorization, *available at* http://chfs.ky.gov/NR/rdonlyres/542BDDCB-B328-46B7-AA46-21529D65DBED/0/PriorAuthorization.pdf.
38. Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, Proposed Kentucky EHB Benchmark Plan, http://cciio.cms.gov/resources/EHBBenchmark/proposed-ehb-benchmark-plan-kentucky.pdf.
39. The Managed Care Organizations (MCOs), Kentucky Spirit of Health, Wellcare of Kentucky, and the Passport Health Plan, provide case management and disease management services at no cost to individuals living with HIV/AIDS. Other MCOs operating in Kentucky do not explicitly offer similar services to HIV+ members. Wellcare, Member: Special Programs, *available at* https://kentucky.wellcare.com/member/special_programs; Your Guide to Passport Health Plan, *available at* http://www.passporthealthplan.com/pdf/member/eng/benefits/handbook.pdf; Kentucky Spirit Health Plan Member Handbook, at 40, *available at* http://www.kentuckyspirithealth.com/files/2011/09/Kentucky_Member_Handbook-2-6-12withcover.pdf.
40. Kentucky Ryan White 2009 Statewide Coordinated Statement of Need and Comprehensive Plan (January 2009) [hereinafter Ryan White SCNCP] at 30, 32. http://chfs.ky.gov/NR/rdonlyres/34AD565F-298C-484C-90C4-B31D10622542/0/2009KentuckySCSN.pdf.
41. Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, Proposed Kentucky EHB Benchmark Plan, http://cciio.cms.gov/resources/EHBBenchmark/proposed-ehb-benchmark-plan-kentucky.pdf.
42. BlueCross BlueShield Anthem Blue Access (PPO) Health Certificate, at M-11, *available at* http://insurance.ky.gov/Documents/kyppoanthem080612.pdf.
43. Letter to providers from the Commissioner of the Cabinet for Health and Family Services, Re: 4 Prescription Drug Limit Policy Clarification (February 24, 2006).
44. Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, Proposed Kentucky EHB Benchmark Plan, *available at* http://cciio.cms.gov/resources/EHBBenchmark/proposed-ehb-benchmark-plan-kentucky.pdf.

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

46. Kentucky AIDS Drug Assistance Program (October 2011), *available at* http://chfs.ky.gov/NR/rdonlyres/63CDF012-CCE9-44D6-916C-A3307AD054AA/0/KADAPFormulary101411.pdf.

47. Kentucky Medicaid Comprehensive Preferred Drug List (WellCare of Kentucky) (October 2012), *available at* https://kentucky.wellcare.com/WCAssets/kentucky/assets/ky_medicaid_pdl_10_2012.pdf.

48. Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, Proposed Kentucky EHB Benchmark Plan, *available at* http://cciio.cms.gov/resources/EHBBenchmark/proposed-ehb-benchmark-plan-kentucky.pdf.

49. 45 C.F.R. pts. 144, 147, 150, et al. (proposed November 26, 2012).

50. BlueCross BlueShield Anthem Blue Access (PPO) Health Certificate, at M-49, *available at* http://insurance.ky.gov/Documents/kyppoanthem080612.pdf.

51. BlueCross BlueShield Anthem Blue Access (PPO) Health Certificate, at M-21, *available at* http://insurance.ky.gov/Documents/kyppoanthem080612.pdf.

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

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

54. 45 C.F.R. pts. 144, 147, 150, et al. (proposed November 26, 2012).

55. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, 44-45, tbl. 8 [hereinafter NASTAD Report] (August 2012), *available at* http://www.nastad.org/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.

56. In order to estimate the number of ADAP enrollees whose income falls between 133% and 400% FPL, data from June 2011 was used. For the purpose of this analysis it is assumed that similar percentages existed throughout FY 2010. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, 50-51, tbls. 13-14 [hereinafter NASTAD Report] (August 2012), *available at* http://www.nastad.org/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.

57. The number of undocumented immigrants on ADAP in each state in FY 2009 will be 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 the 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. 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.

58. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, tbl. 11 (May 2011) [hereinafter NASTAD Report] (August 2012), *available at* http://www.nastad.org/Docs/highlight/2011429_Module%20One%20-%20National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20March%202011.pdf.

59. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, 44-45, tbl. 8 [hereinafter NASTAD Report] (August 2012), *available at* http://www.nastad.org/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.

60. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, 50-51, tbls. 13-14 [hereinafter NASTAD Report] (August 2012), *available at* http://www.nastad.org/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, 50-51, tbls. 13-14 [hereinafter NASTAD Report] (August 2012), *available at* http://www.nastad.org/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.

61. To estimate the number of insured ADAP clients, data was used from New York: Health Insurance Status by FPL available at http://www.statehealthfacts.org/profileind.jsp?cat=3&sub=177&rgn=34&cmprgn=1 and from NASTAD National ADAP Monitoring Project Annual Report, August 2012, Tables 13-14, pgs. 50-51.

62. The number of undocumented immigrants on ADAP in each state in FY 2009 will be 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 the 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. 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.

63. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, tbl. 11 (May 2011) [hereinafter NASTAD Report] (August 2012), *available at* http://www.nastad.org/Docs/highlight/2011429_Module%20One%20-%20National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20March%202011.pdf.

64. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report ,49, 51, tbls. 12, 14 [hereinafter NASTAD Report] (August 2012), *available at* http://www.nastad.org/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.

65. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, tbl. 11 (May 2011) [hereinafter NASTAD Report] (August 2012), *available at* http://www.nastad.org/Docs/highlight/2011429_Module%20One%20-%20National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20March%202011.pdf.

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

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

TAEP
Treatment Access Expansion Project

Center for Health Law and Policy Innovation
Harvard Law School

withinsight
A collaboration between the HIV community and Bristol-Myers Squibb