STATE HEALTH REFORM IMPACT MODELING PROJECT

Maryland

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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) 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 the 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 numerical results for each state and DC, as well as income modeling, are available in Appendix A. See Appendix B for additional modeling data collection methodology, notes, and a summary of the limitations of the modeling process.

In Maryland, 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 and Medicaid programs, what are the likely outcomes of a transition from one program to another in 2014?

MARYLAND

MARYLANDERS LIVING WITH HIV/AIDS

UNMET NEED

As of 2010, approximately 29,080 Marylanders were known to be living with HIV/AIDS (HIV+ aware).[3] An additional 6,000-9,000 were estimated to be HIV+ but undiagnosed.[4] This proportion of individuals living with HIV/AIDS are not accounted for in the following modeling of the number of individuals who will transition over to Medicaid or subsidized private insurance under the Patient Protection and Affordable Care Act (ACA) because they are not currently receiving pharmaceutical treatment through the Ryan White program. Nonetheless, it is likely that nearly all will also be newly eligible for either private or public insurance in 2014.

THE RYAN WHITE PROGRAM IN MARYLAND

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, Maryland received $65,438,856 of Ryan White funding,[5] and served 22,788 duplicated clients.[6,7]

About 59.2% of the state's Ryan White funds were Part B grants, assigned based on prevalence of HIV in the state.[8] Of these, 23.3% covered core medical services, and 75.5% went toward the AIDS Drug Assistance Program (ADAP).[9]

ADAP IN MARYLAND

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 Maryland, one must be:

- A Maryland resident diagnosed with HIV;
- Living at or below 500% of the federal poverty level (FPL); and
- Be ineligible for Maryland Medical Assistance (Medicaid) or Primary Adult Care.[10]

In the fiscal year 2010, Maryland's ADAP served 6,238 individuals.[11] The state's 2011 ADAP budget was $59,338,057 (100% federal funding).[12] In the previous fiscal year, Maryland spent $49,676,176 on ADAP—approximately 52.3% of these funds were used to cover the full cost of antiretroviral treatment,* while about 40.5% of the funds went toward insurance assistance.[13]

* Excluding dispensing costs.

THE ACA AND ITS IMPACT ON HIV+ MARYLANDERS

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% federal poverty level (FPL).[14,†] Although the Department of Health and Human Services (HHS) cannot force states to comply with the expansion (by withdrawing existing federal medical funding), the federal government will cover 100% of the cost of newly eligible beneficiaries until 2016, and at least 90% thereafter.[15] Newly eligible enrollees will receive a benchmark benefits package that will include ten categories of essential health benefits (EHB), described in the following section.[16]

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).[17] 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.[18] BHPs must cover at least the EHB and have the same actuarial value of coverage as a bronze plan that the individual might otherwise purchase on an exchange.[19] Cost-sharing on BHPs can be subsidized, either for all beneficiaries or for those with specific chronic conditions (eg, HIV/AIDS).[20] 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.[21] 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.[22] As a benchmark plan for purposes of defining EHB, Maryland selected the CareFirst State of Maryland PPO for state employees.

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.[23] 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 And 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 insurance exchanges to provide a minimum of EHB, to be defined by the Secretary of HHS.[24] EHB must include items and services within the following ten benefit categories[25]:

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.[26] The Centers for Medicare and Medicaid Services 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.[27] 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.[28]

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

Given the ACA-instituted reforms, a number of HIV+ individuals in Maryland are expected to become eligible for Medicaid, a BHP, or private insurance subsidies in 2014, provided that the state fully implements the law. An estimated 17% of Maryland's Ryan White program clients in 2010 were between 100-200% FPL, making them potentially eligible for either Medicaid or a BHP in 2014.[29] We estimate that 22% of Maryland's ADAP clients will be eligible for Medicaid following its expansion (if they were not already eligible), and 27.6% will be eligible for private insurance subsidies (see Appendix A).

The percentage of Maryland's ADAP clients who will be newly eligible for Medicaid (22%) is slightly lower than the national average, which stands at 28.9% (see Appendix A). This is in part because 35% of Maryland's ADAP clientele is made up of people with income below 133% FPL, but also because about one-half of the state's ADAP clients are insured.‡

The percentage of Maryland's ADAP clients who are expected to qualify for private insurance subsidies (27.6%) is higher than the national average, which stands at 15%, probably because about one-half of Maryland's ADAP clients have income between 133-400% FPL (see Appendix A).

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

Since a number of HIV+ individuals in Maryland 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 Maryland's health insurance exchange currently provide to HIV+ Marylanders.

‡ 52% of Maryland's ADAP clients were insured in 2011. *See* Endnote 12.

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

The Ryan White Program funds both core medical and support services for patients living with HIV (see Appendix C for a breakdown of core medical versus support services).[§] Both medical and ancillary services are critical to maintaining the health of low-income individuals who may not have access to many necessities that affect access to HIV treatment and care (eg, transportation, child care, nutrition). However, Medicaid and Maryland's benchmark plan, which will determine essential health benefits (EHB) for private insurance sold on the state's exchange, do not cover many ancillary services (although they cover a broader range of medical services).

Accounting for the gaps between the Ryan White program and Medicaid or private insurance sold on the exchange will be critical in transitioning Ryan White beneficiaries onto Medicaid and private insurance, while ensuring that their health status does not deteriorate (eg, due to lack of proper nutrition, access to transportation to a health clinic, or stable housing).

Table 1 provides a comparison of covered services between Maryland's Ryan White and Medicaid programs (as of 2010), as well as the benchmark plan selected for purposes of defining EHB.

Table 1. Ryan White Versus Medicaid, and the Base-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[30]	Medicaid[31]	Benchmark Plan (CareFirst Maryland PPO for State Employees)[32]
Home health care		X	X (limited to 120 visits/yr; home health aid limited to 40 visits/yr)
Mental health	X	X	X
Substance abuse (outpatient)	X	X	X
Substance abuse (inpatient)		X	X
Medical case management	X	X	
Community-based care		X	
Ambulatory/outpatient care	X	X	X
Oral health care	X		
Early intervention clinic	X	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
Nursing facility		X	X (max 180 days/yr)

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[§] Note that although home healthcare services are supported under Ryan White, there are no funded programs in Maryland.

Table 1. (continued)

Midwife/NP services		X	X
Private duty nursing			
Physician services		X	X
Non-medical case management services	X		
Child care	X	X	
Emergency financial assistance	X		
Food bank/home delivered meals	X		
Housing services	X		
Health education/risk reduction	X		
Legal services	X		
Linguistics services	X		
Medical transportation	X	X	
Outreach services	X		
Psychosocial support	X		
Referral agencies	X		
Treatment adherence counseling	X		
Chiropractor			X (MN spinal manipulation only)
Podiatry		X	X (medical conditions only)
Hospice		X	X (respite limit of 14 days/yr)
Respiratory therapy		X	
PT, OT, and speech therapy		X	X (limit 50 days/yr; limit does not apply to some speech services)
Orthotics and prosthetics		X	X

MN = medically necessary; OT = occupational therapy; PT = physical therapy.

As Table 1 indicates, the Ryan White program offers HIV+ individuals a number of ancillary services that Medicaid and Maryland's benchmark plan (for determining insurance exchange EHB) do not cover. For example, although Maryland's benchmark plan is similar in aggregate coverage, the Ryan White program's structural approach is still likely superior for those living with HIV. For example, Maryland's benchmark program covers physical therapy and podiatry, but it does not cover health education or medical transportation. Ryan White is designed to meet the special integrative needs of patients with HIV, while other health plans simply are not designed with specific populations in mind. Since these ancillary services will not be required EHB, pursuant to federal guidance and proposed regulation, those individuals who leave the Ryan White program for Medicaid for private insurance plans are likely to be at a disadvantage.[33,34]

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

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

Table 2 provides a comparison of the antiretroviral drug formularies included in the state's ADAP and Medicaid programs, as well as the benchmark plan selected for purposes of defining EHB.

Table 2: ADAP Versus Medicaid and the Base-Benchmark plan: Covered Drugs[35]

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[36]	Medicaid (PA required for most brand name medications)[37]	CareFirst Maryland PPO for State Employees[38]
Multiclass Combination Drugs	**3 Drugs Covered**	**3 Drugs Covered**	**3 Drugs Covered**
Atripla; *efavirenz + emtricitabine + tenofovir DF*	X	X	X (tier 2)
Complera; *emtricitabine + rilpivirine + tenofovir disoproxil fumarate*	X	X	X (tier 2)
Stribild; *elvitegravir + cobicistat + emtricitabine + tenofovir disoproxil fumarate*	X	X	X (tier 2)
Entry Inhibitors - CCR-5 Coreceptor Antagonist	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Selzentry; *maraviroc*	X	X	X (tier 2)
Fusion Inhibitors	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Fuzeon; *enfuvirtide*	X (prior authorization required)	X	X (tier 2)
HIV Integrase Strand Transfer Inhibitors	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Isentress; *raltegravir*	X		X (tier 2)
NNRTI	**5 Drugs Covered**	**5 Drugs Covered**	**5 Drugs Covered**
Intelence; *etravirine*	X	X	X (tier 2)
Rescriptor; *delavirdine mesylate*	X	X	X (tier 2)
Sustiva; *efavirenz*	X	X	X (tier 2)
Viramune; nevirapine	X	X (generic preferred)	X (tier 1)
Edurant; *rilpivirine*	X	X	X (tier 2)

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Table 2. (continued)

NRTI	11 Drugs Covered	12 Drugs Covered	12 Drugs Covered
Combivir; *zidovudine + lamivudine*	X	X (generic preferred)	X (tier 1)
Emtriva; *emtricitabine*	X	X	X (tier 2)
Epivir; *lamivudine*	X	X (generic preferred)	X (tier 1)
Epzicom; *abacavir sulfate + lamivudine*	X	X	X (tier 2)
Retrovir; *zidovudine*	X	X (generic preferred)	X (tier 1)
Trizivir; *abacavir + zidovudine + lamivudine*	X	X	X (tier 2)
Truvada; *tenofovir DF + emtricitabine*	X	X	X (tier 2)
Videx; *didanosine (buffered versions)*	X	X	X (tier 1)
Videx EC; *didanosine (delayed–release capsules)*		X	X (tier 2)
Viread; *tenofovir disoproxil fumarate DF*	X	X	X (tier 2)
Zerit; *stavudine*	X	X	X (tier 1)
Ziagen; abacavir	X	X (generic preferred)	X (tier 2)
Protease Inhibitors	**9 Drugs Covered**	**9 Drugs Covered**	**10 Drugs Covered**
Agenerase; *amprenavir*			X (tier 3)
Aptivus; *tipranavir*	X	X	X (tier 2)
Crixivan; *indinavir sulfate*	X	X	X (tier 2)
Invirase; *saquinavir mesylate*	X	X	X (tier 2)
Kaletra; *lopinavir + ritonavir*	X	X	X (tier 2)
Lexiva; *fosamprenavir*	X	X	X (tier 2)
Norvir; *ritonavir*	X	X	X (tier 2)
Prezista; *darunavir*	X	X	X (tier 2)
Reyataz; *atazanavir sulfate*	X	X	X (tier 2)
Viracept; *nelfinavir sulfate*	X	X	X (tier 2)
"A1" OI Treatments**	**26 Drugs Covered**	**29 Drugs Covered**	**29 Drugs Covered**
Ancobon; *flucytosine*	X	X (PA Required)	X (tier 3)
Bactrim DS; *sulfamethoxazole/trimethoprim DS*	X	X (generic preferred)	X (tier 1)
Biaxin; *clarithromycin*	X	X (PA Required)	X (tier 1)

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** Opportunistic treatments.

Table 2. (continued)

Cleocin; *clindamycin*	X	X (generic preferred)	X (tier 1)
Dapsone	X	X	X (tier 3)
Daraprim; *pyrimethamine*	X	X	X (tier 3)
Deltasone; *prednisone*	X	X	X (tier 3)
Diflucan; fluconazole	X	X (generic preferred)	X (tier 1)
Famvir; *famciclovir*	X	X (PA)	X (tier 3)
Foscavir; *foscarnet*	X	X	X (tier 3)
Fungizone; *amphotericin B*	X	X	X (tier 3)
INH; *isoniazid*	X	X	X (tier 1)
Megace; *megestrol*	X	X	X (tier 3)
Mepron; *atovaquone*		X	X (tier 1)
Myambutol; *ethambutol*	X	X (generic preferred)	X (tier 1)
Mycobutin; *rifabutin*	X	X (generic preferred)	X (tier 3)
NebuPent; *pentamidine*	X	X	X (tier 3)
Probenecid		X	X (tier 3)
Procrit; *epoetin alfa*	X (prior approval required)	X	X (tier 2)
Rifater; *pyrazinamide (PZA)*	X	X	X (tier 3)
Sporanox; *itraconazole*	X	X (PA)	X (tier 1)
Sulfadiazine – *Oral*	X	X	X (tier 1)
Valcyte; *valganciclovir*	X	X	X (tier 1)
Valtrex; *valacyclovir*	X	X	X (tier 1)
VFEND; *voriconazole*		X (PA)	X (tier 3)
Vistide; *cidofovir*	X	X	X (tier 3)
Wellcovorin; *leucovorin*	X	X	X (tier 3)
Zithromax; *azithromycin*	X	X (generic preferred)	X (tier 1)
Zovirax; *acyclovir*	X	X (generic preferred)	X (tier 2)

As Table 2 indicates, Medicaid's formulary is limited, posing a potential problem for people living with HIV. For example, prior approval is required for several ADAP covered drugs and for almost all brand name medications. Although federal guidance indicates that Medicaid plans available to newly eligible beneficiaries must include comprehensive drug coverage, utilization review will continue to be a cost-control tactic available to the state (newly eligible beneficiaries will be guaranteed access to any US Food and Drug Administration-approved drugs with significant clinically meaningful therapeutic advantage over another but medical necessity remains in the purview of plan managers).[39]

Maryland's benchmark plan—CareFirst State of Maryland PPO—has a comprehensive formulary that makes all drugs available, but imposes cost-sharing that may be prohibitive, particularly if an individual requires brand name drugs (tiers 2 or 3). 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).[40] Thus, assuming the proposed rule is adopted, plans in Maryland must cover only the number of drugs in each class listed above (or one per class in the case where none are covered on the benchmark plan).

If people living with HIV are unable to access appropriate ART through Medicaid or the Exchange, Ryan White and ADAP will continue to be necessary as payers of last resort.

CONCLUSIONS AND NEXT STEPS

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

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). Given that a significant proportion of uninsured ADAP clients would transition into Medicaid in Maryland, implementing the ACA's expansion option is crucial to ensuring access to care and reducing transmission of HIV across the state. In other words, expanding Medicaid is the state's only currently available option to provide access to treatment for the thousands of HIV+ individuals in the state who currently lack access to care.

Nonetheless, the Medicaid system must be ready and able to handle the needs of low-income people who have HIV. Should Maryland 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.

The Medicaid benefits that will be available to newly eligible beneficiaries, including those living with HIV, 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 Medicaid. Comparing current Ryan White and ADAP programs with existing Medicaid formularies allows for a baseline analysis of the needs of individuals living with HIV moving into the Medicaid system. This report identified two challenges:

1. First, a number of services that are currently provided by the Ryan White program are not available under the state's current Medicaid program, and will not be required EHB for newly eligibles, pursuant to federal guidance issued thus far (eg, health/risk reduction education or treatment adherence counseling).[41] HIV+ individuals who shift from the Ryan White program to Medicaid may struggle to stay in care if nonmedical barriers are not addressed.
2. Second, limitations on Medicaid recipients' pharmacy benefits may pose challenges for individuals in need of branded prescriptions. Those living with HIV are likely to face challenges with prior authorization when seeking branded prescriptions covered by Medicaid, given that such cost-containment strategies will be applied to newly eligible beneficiaries.[42]

It is essential that private insurance plans on the Maryland Exchange provide a level and scope of services that is sufficient to meet the needs of ADAP clients who may transition to 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, a large number of services that are currently provided by the Ryan White Program are not available under Maryland's benchmark plan. 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.
2. Second, many prescription drugs necessary for ART are tier 2 or tier 3 drugs, meaning that significant cost-sharing will be imposed on HIV+ beneficiaries purchasing coverage on the exchange. HIV+ individuals shifting from ADAP to private insurance plans may therefore have trouble accessing certain drugs.

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

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

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

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APPENDIX A

2014 STATE-SPECIFIC ESTIMATES

Medicaid Estimates

The Patient Protection and Affordable Care Act (ACA) directs states to extend Medicaid eligibility to all individuals living below 133% 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 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[43]
–	**est. #**	ADAP clients with income above 133% FPL[44,††]
–	**est. #**	insured ADAP clients with income below 133% FPL[‡‡]
–	**est. #**	ADAP clients who are undocumented immigrants with incomes below 133% FPL in June 2011[45]
=	**Total #**	ADAP clients who will be newly eligible for Medicaid in 2014 [§§,***]

Maryland's ADAP served 6,238 individuals in 2010. Of those, we estimate that 3,680 (59%) ADAP clients have income above 133% FPL. We also estimate that there were 1,071 insured ADAP clients with income below 133% FPL. Approximately 4.2% of the state population was composed of undocumented immigrants in 2008 (amounting to approximately 93 ADAP clients with income below 133% FPL). Thus, the calculation for Maryland is:

	6,238	ADAP clients being served in fiscal year 2010
–	**3,680**	ADAP clients with income above 133% FPL
–	**1,071**	insured ADAP clients with income below 133% FPL
–	**93**	undocumented immigrants with incomes below 133% FPL in June 2011
=	**1,394**	ADAP clients who will be newly eligible for Medicaid in 2014; or 22.3% of ADAP clients served in the 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 Appendix A. for a description of the method used to estimate the distribution of insured ADAP clients in Maryland by income group.

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

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

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

State	# ADAP Clients Newly Eligible for Medicaid	% ADAP Clients Newly Eligible for Medicaid
Alabama	1,345	76%
Arkansas	299	53%
California	12,274	31%
DC	1,124	41%
Florida	7,321	51%
Georgia	3,075	52%
Illinois	4,374	68%
Kentucky	619	42%
Louisiana	No data available	No data available
Maryland	1,394	22%
Massachusetts	1,400	21%
Mississippi	1,008	68%
New Jersey	2,101	29%
New York	4,233	20%
North Carolina	3,476	62%
Ohio	1,287	37%
Pennsylvania	1,334	22%
South Carolina	1,428	39%
Tennessee	2,505	60%
Texas	8,797	53%
Virginia	2,690	66%
Wisconsin	696	40%
United States	**62,971**	**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.[52] 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.

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[46]
–	**est. #**	ADAP clients living below 133% FPL[47,†††]
–	**est. #**	ADAP clients living above 400% FPL[48]
–	**est. #**	insured ADAP clients living between 133-400% FPL[‡‡‡,49]
–	**est. #**	ADAP clients who are undocumented immigrants living between 133-400% FPL[50]
=	**Total #**	ADAP clients who will be newly eligible for subsidized private insurance

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

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

Maryland's ADAP served 6,238 individuals in fiscal year 2010. Of those, we estimate that 2,183 (35%) of ADAP clients have income below 133% FPL or above 400% FPL. This leaves 65% (4,054) of ADAP clients with income between 133% FPL and 400% FPL. We also estimate that there were 2,173 insured ADAP clients with income between 133-400% FPL. Approximately 4.2% of Maryland's population was composed of undocumented immigrants in 2008 (156 ADAP clients with incomes between 133-400% FPL). Thus, the calculation for Maryland is:

	6,238	ADAP clients served in fiscal year 2010
–	**2,183**	ADAP clients with incomes below 133% FPL or above 400% FPL
–	**2,173**	estimated insured ADAP clients with incomes between 133-400% FPL
–	**156**	uninsured undocumented immigrants with incomes between 133-400% FPL
=	**1,726**	ADAP clients who will be eligible for insurance subsidies in 2014; or 27.7% of ADAP clients being 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 Insurance Subsidies	% ADAP Clients Eligible for Insurance 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%**

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.[52] (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 Maryland, 63% of adults living below 133% FPL are insured; 76% of adults living between 133-400% FPL are insured; and 96% 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 Maryland, the figure 63% was given the baseline number 1. 76% is 1.2 times 63%, and 96% is 1.5 times 63%. Thus, in other words, an adult in Alabama with income between 133% FPL and 400% FPL is 1.2 times more likely to be insured than an adult with income below 133% FPL, while an adult with income above 400% FPL is 1.5 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.[51] 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 Maryland, we estimated that about 3,243.8 of the state's 6,238 ADAP clients served in 2010 were insured. The insurance rate for ADAP clients in that state stood at 65% in 2011;

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 income below 133% FPL, income between 133-400% FPL, and income above 400% FPL.

   In Maryland, 35% of ADAP clients are living below 133% FPL, 59% have income between 133-400% FPL, and no clients have income above 400% FPL; and finally

5. We then treated the number of insured ADAP clients in each income group as a product of the relative likelihood of being insured (determined above), 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 *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 Maryland:

88.15
= (1 x 0.35 x *a*)
+ (1.2 x 0.59 x *a*)
+ (1.50 x 0.00 x *a*)

Solving for *a*,

$a = 3060.05$

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

The estimated number of insured ADAP clients in Maryland with,

Income below 133% FPL = 1,071.0
Income between 133-400% FPL = 2,172.7
Income above 400% FPL = 0

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

APPENDIX B

DATA COLLECTION METHODOLOGY

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

Ryan White Program Data

Demographic information about Ryan White program clients was culled from a number of sources. For the sake of continuity, the Federal Health Resources and Services Administration (HRSA) 2010 State Profiles were used for data about the Ryan White program. Income, race/ethnicity, gender, and insurance status for 2008 are available from HRSA and have been provided for each state. 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 and Territorial AIDS Directors (NASTAD), and information from that organization has been provided for income, race/ethnicity, gender, and insurance status of ADAP clients. NASTAD's data are for fiscal year 2010 and June 2011. Because ADAP data compiled by NASTAD are unduplicated, it is one of the most reliable sources of information about demographic information for people living with HIV. Data from June 2011 provide information on how many people living with HIV currently enrolled in ADAP fall between 100-133% of federal poverty level (FPL). Since the expansion of Medicaid eligibility to those under 133% is a relatively new development, there is a relative dearth of data regarding the number of individuals whose incomes are between 100-133% of FPL and 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 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 needs for people living with HIV in each state are available in each state's Statewide Coordinated Statement of Need (SCSN). SCSNs must be provided by all states receiving Ryan White program funding, but different states provide SCSNs in different years, so all data are not from the same year. Information about unmet need available from other sources has also been included.

Information on current services covered by the Ryan White program is available from HRSA and the SCSNs, and these data have been included in each state profile. This data are relatively general, enumerating the services offered by the Ryan White program in each state, as well as the most utilized services and the services each state has identified as priorities for funding in the future. More detailed information was included in the profiles if it was available.

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

Ryan White program budget allocations are also available from a number of sources, and information from the Kaiser Family Foundation has been included in every profile for the sake of consistency among states. ADAP budget information is available from NASTAD. The fiscal year 2010 total budget is available, and expenditures are broken down by NASTAD for fiscal year 2010. 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, as well as limitations that may impede access to needed services.

Benchmark Plan Coverage Data

In September 2012, the Maryland Health Care Reform Coordinating Council voted to use the CareFirst State of Maryland PPO as the official benchmark plan in defining EHB in the state. Data were collected from CareFirst's website (a subsidiary of BlueCross BlueShield), and from a Maryland Insurance Administration analysis of benefits offered by the plan.

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.[53] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages of the insured exceed 100% for Maryland and Ohio.); and
- Data on the number of clients served by Mississippi's ADAP program appear to be incorrect in NASTAD's Monitoring Report, as the number of clients served is listed as larger than the number of eligible ADAP clients in the state. The number listed was used in these calculations, and while the specific number of ADAP clients eligible for Medicaid and private insurance subsidies in Mississippi may not be reliable, the proportion of clients eligible for both programs was obtained in the same way as that 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 because they are the most reliable and are able to provide information on individuals who are uninsured or underinsured without double-counting individuals who may be enrolled in multiple Ryan White programs. 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 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 services.
3. It is possible that some individuals fall into more than one term in the equations listed previously. For instance, an individual might have an income above 133% FPL and also be insured. The possibility of double-counting some individuals is not accounted for in these calculations.
4. These calculations assume that insurance status is equally distributed across income levels. In all likelihood, those above 133% FPL have a higher rate of insurance. This possibility was also not accounted for in the calculations.
5. The terms in the equation used represent data that are available for every state and were chosen over state-specific data to ensure that these estimates could be compared across the states surveyed. While state-specific data may exist in some states, data do not exist in the same format in all states studied and different methodologies may have been used, so comparing such data across states would be of little analytical value.
6. 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 in 2008. It is possible that this estimate either overestimates or underestimates the actual number of undocumented immigrants currently on ADAP.

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

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

APPENDIX C

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

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

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

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TAEP
Treatment Access Expansion Project

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