STATE HEALTH REFORM IMPACT MODELING PROJECT

North Carolina

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BACKGROUND

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

The State Health Reform Impact Modeling Project (the Modeling Project) assesses the impact that healthcare reform will have on people living with HIV by compiling and analyzing Ryan White program and AIDS Drug Assistance Program (ADAP) data to predict the shift of uninsured people living with HIV from these discretionary programs to Medicaid or private insurance in all 50 states pursuant to the ACA. In addition, for 21 states and the District of Columbia (DC), the Modeling Project compiles and analyzes detailed budgets and benefit guidelines to assess the services provided by the Ryan White program, ADAP, Medicaid, and plans sold on an exchange, in order to estimate the impact that a transition onto Medicaid or private subsidized insurance 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 North Carolina, 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 current Ryan White, Medicaid, and private insurance coverage, what are the likely outcomes of a transition from one program to another in 2014?

NORTH CAROLINA

NORTH CAROLINIANS LIVING WITH HIV/AIDS

UNMET NEED

In 2010, 23% (8,050) of the estimated 35,000 North Carolinians living with HIV/AIDS (including undiagnosed individuals) were not in care (27% of those living with HIV and 18% of those living with AIDS).[3] This 23% of the state's epidemic 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 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 NORTH CAROLINA

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 treatment and care. In other words, it serves as a critical payer of last resort, filling gaps in healthcare and ancillary support services that are unmet by all other charitable or funded healthcare services. In 2010, North Carolina received $54,572,289 in Ryan White funding,[4] and served 21,338 duplicated clients.[5,*] About 71% of the state's Ryan White funds were Part B grants, assigned based on prevalence of HIV in the state.[5] Of these, approximately 30% covered core medical services, 1% covered supplemental services, 54.4% went toward the AIDS Drug Assistance Program (ADAP), and 8.3% provided ADAP supplemental funding.[5]

ADAP IN NORTH CAROLINA

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

- A North Carolina resident diagnosed with HIV;
- Living at or below 300% of the federal poverty level (FPL);
- Lacking access to third-party coverage of medications beyond what is covered by Medicare;[†] and
- Taking one or more prescription(s) included in the ADAP formulary.[6]

In fiscal year 2010, North Carolina's ADAP served 5,586 individuals.[7] The state's 2011 ADAP budget was $57,516,959 ($28,899,713 in federal funds).[8] In the previous fiscal year, North Carolina spent $45,575,214 on ADAP—approximately 99% of these funds were used to cover the full cost of ART, while less than 1% of the funds went toward insurance assistance.[9]

[*] 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).

[†] If Medicare and ADAP eligible, enrollment in Medicare Part D is required.

THE ACA AND ITS IMPACT ON HIV+ NORTH CAROLINIANS

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% of the federal poverty level (FPL).[10,‡] Although the federal 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. Newly eligible enrollees will receive a benchmark benefits package that must include at least ten categories of essential health benefits (EHB), described in the "Essential Health Benefits" section.[11]

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).[12] 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 r equirement.[13] 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.[11] Cost sharing on BHPs can be subsidized, either for all beneficiaries or for those with specific chronic conditions (eg, HIV/AIDS).[14] 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.[15] 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 "Essential Health Benefits" section. All exchanges will be operational January 1, 2014.[16]

Because North Carolina has neither enacted legislation to create a state-based exchange nor submitted a benchmark plan to the HHS for purposes of defining benefits offered on the exchange, the largest small-group plan in the state (BlueCross BlueShield Blue Options) has become the default benchmark plan for purposes of defining EHB.

For those purchasing coverage on an exchange, the ACA extends insurance premium credits to individuals and families living below 400% FPL, to ensure that premiums do not exceed 2.0-9.8% of household income, and imposes out-of-pocket spending caps to protect healthcare consumers from medical bankruptcy.[17] 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. 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. *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 a minimum of EHB, to be defined by the Secretary of HHS.[18] EHB must include items and services within the following ten benefit categories:

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.[19] 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 for under the Social Security Act.[20] 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.[21]

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

Given the ACA-instituted reforms, a large number of HIV+ individuals in North Carolina are expected to become eligible for public or private insurance in 2014, provided that North Carolina fully implements the law. An estimated 21% of the state's Ryan White program clients in 2010 were living between 100-200% FPL, making them potentially eligible for either Medicaid or a BHP in 2014.[4] An estimated 62% of North Carolina's ADAP clients will be eligible for Medicaid following its expansion, and an additional 11% are estimated to be eligible for private insurance subsidies (see Appendix A). Finally, many of the estimated 8,050 HIV+ North Carolinians who did not access care in 2011 are likely to become eligible for Medicaid or a BHP in 2014, given the assumption that a significant number of these individuals are living near the FPL.

The percentage of North Carolina's ADAP clients who will be newly eligible for Medicaid (62%) is considerably higher than the national proportion of newly eligibles (29%). This is primarily because North Carolina's ADAP mostly serves individuals with income below 133% FPL (approximately 83% of the state's ADAP clients were below 133% FPL in 2011), but also because the state's ADAP clients are almost entirely uninsured. A total of 525,102 North Carolinians are expected to be newly eligible for Medicaid in 2014, compared with fewer than 3,500 living with HIV.[22]

The percentage of North Carolina's ADAP clients who are expected to qualify for private insurance subsidies (11%) is lower than the national proportion of newly eligibles (15%), probably because North Carolina's ADAP serves few individuals with income above 133% FPL (only about 17% of the state's ADAP clients had income above that threshold in 2011).

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

Since a significant number of HIV+ individuals in North Carolina who are currently served by the Ryan White program or the 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 North Carolina's health insurance exchange currently or will provide to HIV+ North Carolinians.

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

The Ryan White program funds both core medical services and support services for patients living with HIV (see Appendix C for a breakdown of core medical services versus support services). Both medical and ancillary services are critical to maintaining the health of low-income individuals who may not have access to many necessities that facilitate effective HIV treatment and care (eg, transportation, child care, nutrition). However, Medicaid and North Carolina's benchmark plan, which will determine essential health benefits (EHB) for private insurance sold on the state's exchange, do not cover ancillary services (although they cover a broader range of medical services). Accounting for the gaps between the Ryan White program and Medicaid or private insurance sold on the exchange will be critical in transitioning Ryan White beneficiaries onto Medicaid and private insurance while ensuring that health status does not deteriorate (eg, due to lack of proper nutrition, access to transportation to a health clinic, stable housing).

Table 1 provides a comparison of covered services among North Carolina's Ryan White program (as of 2010), Medicaid, and the largest small-group plan in the state (the default benchmark plan used for purposes of defining EHB on an exchange, given that North Carolina did not submit its own benchmark plan for review).

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[23]	Medicaid[24]	BlueCross BlueShield NC Blue Options[25,§]
Routine Physical Exams			X
Immunizations			X
Home Health Care	X	X	X (PA; excludes cooking, housekeeping, meal preparation)
HPV/Cervical Cancer Screening			X
Ovarian Cancer Surveillance Tests			X (for at risk women aged over 25 years only)
Prostate Cancer Screening			X
Colorectal Cancer Screening			X
Diabetes Screening, Education, Monitoring			X
STI and HIV Screening			X
Domestic Violence Screening and Counseling			X
Hepatitis B Screening			X (for pregnant women only)
Depression Screening			X

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§ Coverage of any service deemed not medically necessary can be denied.

Table 1. (continued)

Mental Health	X	X (one diagnostic assessment per year)	X
Inpatient Mental Health		X (PA for inpatient behavioral health)	X
Substance Abuse (outpatient)	X	X (PA)	X
Substance Abuse (inpatient)	X	X (PA unless crisis; max 24 hours per episode)	X
Medical Case Management	X	X	
Community Based Care	X	X	
Ambulatory/Outpatient Care	X	X	X
Oral Health Care	X	X	
Early Intervention Clinic	X		
Immediate Care Facilities for the Mentally Retarded		X	
Ambulance		X	
Family Planning		X	X
Durable Medical Equipment		X	X
Hearing Aids			X
Hospital Services		X (PA)	X
Cardiac Rehab			X
Lab and X-ray Services		X**	X
Eyeglasses Related to Accident, Surgery, or Medical Condition			X
Routine Vision Exams			X
Nursing Facility		X	X
Midwife/NP Services		X	
Private Duty Nursing		X	X
Physician Services		X††	
Non-Medical Case Management Services			
Child Care	X		
Emergency Financial Assistance	X		
Food Bank/Home Delivered Meals	X		
Nutritional counseling			X
Medical Foods (Food Supplements, Formulas, or Special Foods)	X		X
Housing Services	X		
Health Education/Risk Reduction	X		
Legal Services	X		
Linguistic Services	X		
Non-Emergency Medical Transportation	X	X	

** HIV tropism assay is covered if: (1) the recipient has had treatment failure on at least two other highly active antiretroviral therapy (HAART) regimens; (2) has limited or no other treatment options; (3) the assay is used to confirm CCR5-tropic HIV-1 infection prior to initiation of CCR5 coreceptor antagonist; (4) viral load is at least 1,000 copies/mL; or (5) the recipient is exhibiting virologic failure on a CCR5 coreceptor antagonist. North Carolina Division of Medical Assistance, HIV Tropism Assay Medicaid and Health Choice Clinical Coverage Policy No: 1S-2, *available at* http://www.ncdhhs.gov/dma/mp/1S-2.pdf (last visited Sept. 4, 2012). Medicaid also covers genotyping and phenotyping for HIV Drug Resistance Testing. NC DHHS, Division of Medical Assistance, Laboratory Services: Genotyping and Phenotyping for HIV Drug Resistance Testing, http://www.ncdhhs.gov/dma/mp/1S-1.pdf.

†† While most Medicaid beneficiaries are limited to a given number of physician visits per year, exemptions are available to HIV+ patients specifically or to all patients with life-threatening illness (per documentation by primary care provider). NC DHHS, Adult Medicaid Manual MA-2905, Medicaid Covered Services, *available at* http://info.dhhs.state.nc.us/olm/manuals/dma/abd/man/MA2905-01.htm.

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Table 1. (continued)

Outreach Services	X		
Psychosocial Support	X		
Referral Agencies	X		
Treatment Adherence Counseling	X		
Chiropractor		X	X
Podiatry		X	
Hospice		X	X (excludes cooking, housekeeping, meal preparation)
Respiratory Therapy		X	
PT, OT, and Speech Therapy		X	
Orthotics and Prosthetics		X	
Personal Care		X	
Home Infusion Therapy		X	

HPV = human papillomavirus; NP = nurse practitioner; OT = occupational therapy; PA = prior authorization; PT = physical therapy; STI = sexually transmitted infection.

As Table 1 indicates, the Ryan White program offers HIV+ individuals a number of ancillary services that Medicaid and North Carolina's default benchmark plan do not cover. Since these ancillary services are important for the well-being of HIV+ individuals, those individuals who leave the Ryan White program for Medicaid or for a private insurance plan are likely to be at a disadvantage. However, it is worth noting that current Medicaid beneficiaries are now enrolling in Community Care of North Carolina/Carolina ACCESS, a managed care plan that specializes in long-term disease management (and is considered a national model of a patient-centered medical home).[22] Newly eligible individuals who have access to similar case management strategies may obtain nonmedical benefits similar to those offered by Ryan White.

COMPARING ADAP, MEDICAID, AND THE BENCHMARK PLAN FOR THE EXCHANGE IN NORTH CAROLINA

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 North Carolinians 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 largest small-group market plan in the state (the benchmark plan used for purposes of defining EHB for plans sold on an exchange).

Table 2. ADAP Versus Medicaid and the Benchmark Plan: Covered Drugs[26]

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[5]**	**Medicaid[27]**	**BlueCross BlueShield NC Blue Options‡**
Multiclass Combination Drugs	**3 drugs covered**	**2 drugs covered**	**3 drugs covered**
Atripla; *efavirenz + emtricitabine + tenofovir DF*	X	X	X
Complera; *emtricitabine + rilpivirine + tenofovir disoproxil fumarate*	X	X	X

‡ Individual and families subject to $10,000 maximum independent deductible; copayments for prescription drugs do not count toward this deductible.

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Table 2. (continued)

Stribild; *elvitegravir + cobicistat + emtricitabine + tenofovir disoproxil fumarate*	X		X
NRTIs	**11 drugs covered**	**11 drugs covered**	**12 drugs covered**
Combivir; *zidovudine + lamivudine*	X	X	X
Emtriva; *emtricitabine*	X	X	X
Epivir; *lamivudine*	X	X	X
Epzicom; *abacavir sulfate + lamivudine*	X	X	X
Retrovir; *zidovudine*	X	X	X
Trizivir; *abacavir + zidovudine + lamivudine*	X	X	X
Truvada; *tenofovir DF + emtricitabine*	X	X	X
Videx; *didanosine (buffered versions)*	X	X	X
Videx EC; *didanosine (delayed-release capsules)*			X
Viread; *tenofovir disoproxil fumarate DF*	X	X	X
Zerit; *stavudine*	X	X	X
Ziagen; *abacavir*	X	X	X
NNRTIs	**5 drugs covered**	**5 drugs covered**	**5 drugs covered**
Intelence; *etravirine*	X	X	X
Rescriptor; *delavirdine mesylate*	X	X	X
Sustiva; *efavirenz*	X	X	X
Viramune; *nevirapine*	X	X	X
Edurant; *rilpivirine*	X	X	X
Protease Inhibitors	**10 drugs covered**	**10 drugs covered**	**10 drugs covered**
Agenerase; *amprenavir*	X	X	X
Aptivus; *tipranavir*	X	X	X
Crixivan; *indinivir sulfate*	X	X	X
Invirase; *saquinavir mesylate*	X	X	X
Kaletra; *lopinavir + ritonavir*	X	X	X
Lexiva; *fosamprenavir*	X	X	X
Norvir; *ritonavir*	X	X	X
Prezista; *darunavir*	X	X	X
Reyataz; *atazanavir sulfate*	X	X	X
Viracept; *nelfinavir sulfate*	X	X	X
Fusion Inhibitors	**1 drug covered**	**1 drug covered**	**1 drug covered**
Fuzeon; *enfuvirtide*	X	X	X
Entry Inhibitors – CCR-5 Coreceptor Antagonist	**1 drug covered**	**1 drug covered**	**1 drug covered**
Selzentry; *maraviroc*	X (PA)	X (PA)	X
HIV Integrase Strand Transfer Inhibitors	**1 drug covered**	**1 drug covered**	**1 drug covered**
Isentress; raltegravir	X	X	X
"A1" Opportunistic Infection Medications	**21 drugs covered**	**12 drugs covered**	**30 drugs covered**

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Table 2. (continued)

Ancobon; *flucytosine*		X (PA)	X
Bactrim DS; *sulfamethoxazole/ trimethoprim DS*	X (generic required if available)	X (generic required if available)	X
Biaxin; *clarithromycin*	X (generic required if available)	X (generic required if available)	X
Cleocin; *clindamycin*	X (generic required if available)	X	X
Dapsone	X (PA; generic required if available)		X
Daraprim; *pyrimethamine*	X (generic required if available)		X
Deltasone; *prednisone*			X
Diflucan; *fluconazole*	X (generic required if available)	X (generic required if available)	X
Famvir; *famciclovir*	X (generic required if available)	X (generic required if available)	X
Foscavir; *foscarnet*			X
Fungizone; *amphotericin B*			X
Megace; *megestrol*		X (generic required if available)	X
Mepron; *atovaquone*	X (PA; generic required if available)		X
Myambutol; *ethambutol*	X (generic required if available)		X
Mycobutin; *rifabutin*	X (generic required if available)		X
NebuPent; *pentamidine*	X (generic required if available)		X
Nydrazid; *isoniazid, INH*	X		X
Probenecid			X
Procrit; *erythropoetin*	X (clinical criteria applies; generic required if available)	X	X
Pyrazinamide (PZA)			X
Rifadin, Rimactane; *rifampin*	X		X
Sporanox; *itraconazole*	X		X
Sulfadiazine – Oral	X		X
Valcyte; *valganciclovir*	X (generic required if available)		X

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Table 2. (continued)

Valtrex; *valacyclovir*	X (generic required if available)	X (generic required if available)	X
VFEND; *voriconazole*		X (PA)	X
Vistide; *cidofovir*			X
Wellcovorin; *leucovorin*	X (generic required if available)		X
Zithromax; *azithromycin*	X (generic required if available)	X (PA or generic required if available)	X
Zovirax; *acyclovir*	X (generic required if available)	X (generic required if available)	X

ART = antiretroviral therapy; NNRTI = non-nucleoside reverse transcriptase inhibitors; NRTI = nucleoside reverse transcriptase inhibitors; PA = prior authorization.

As Table 2 indicates, Medicaid's formulary is comparable to ADAP's with respect to antiretroviral medications (aside from requiring prior authorization for several drugs), but offers significantly less coverage of drugs needed to treat opportunistic infections. Conversely, North Carolina's default benchmark plan used to define EHB for the exchange is comprehensive when it comes to antiretroviral drugs and for medications prescribed for patients with opportunistic infections. Moreover, none are subject to quantity limitations or require step therapy or prior authorization.[28] However, BlueCross BlueShield does reserve the right to conduct utilization review, an often masked process. In addition, the plan imposes cost sharing that may be prohibitive for some individuals: $10 for each generic refill and 25% of the cost of each brand-name refill are charged to the patient.[29] These practices can delay or inhibit access to lifesaving drugs for North Carolinians living with HIV.

It is important to note that this analysis uses North Carolina's current Medicaid formula, which will not necessarily apply to newly eligible beneficiaries under the ACA (newly eligible beneficiaries will be guaranteed access to any US Food and Drug Administration–approved drugs with significant clinically meaningful therapeutic advantage over another). Because the Department of Health and Human Services has yet to define EHB for Medicaid, benefits available to newly eligible beneficiaries cannot be assessed at this time.

If people living with HIV are unable to access appropriate ART through Medicaid or the exchange (eg, if the EHB for Medicaid or qualified health plans are not defined to include comprehensive coverage of antiretroviral and opportunistic drugs and/or cost sharing is prohibitive), 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, the AIDS Drug Assistance Program (ADAP), Medicaid, and essential health benefits (EHB) under the Patient Protection and Affordable Care Act (ACA), enumerating the benefits covered under each, and the implications of transitioning individuals living with HIV onto Medicaid or private insurance. This report is intended to assist state legislators in implementing the ACA in a manner that serves the needs of North Carolinians.

While much of the ACA has yet to be implemented, it is certain that large numbers of people living with HIV would be newly eligible for Medicaid if North Carolina fully implements the ACA. Given that a significant proportion of uninsured ADAP clients would transition onto Medicaid in North Carolina, implementing the ACA's expansion provision 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. Should North Carolina elect to expand its Medicaid program, this report provides an initial analysis of the capacity of the program to handle the needs of this influx of individuals living with HIV. Comparing current Ryan White and ADAP programs

with existing Medicaid formularies allows for a baseline analysis of the needs of individuals living with HIV moving onto the Medicaid system. This report identified three 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. Medicaid EHB are unlikely to include these benefits.*** HIV+ individuals who shift from the Ryan White program to Medicaid are therefore likely to have trouble accessing a number of nonmedical, but essential, ancillary services currently available to them, and Ryan White will continue to be a critical payer of last resort to ensure that all individuals living with HIV have access to comprehensive ART;
2. Second, limitations on Medicaid recipients' pharmacy benefits may pose challenges for individuals in need of multiple branded prescriptions. Those living with HIV are likely to require medication for opportunistic infections not covered by Medicaid. Protections included in federal guidance must be strictly construed,*** and
3. Third, North Carolina's healthcare workforce currently lacks the capacity to provide for the influx of patients living with chronic disease (including HIV) that will occur with the full implementation of the ACA.[22] The state must actively promote entry into the healthcare field.

It is essential that private insurance plans on the North Carolina exchange also provide a comprehensive scope of services sufficient to meet the needs of Ryan White clients who 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 number of services that are currently provided by the Ryan White program are not available under North Carolina's default benchmark plan and will not likely be required EHB.[30]. HIV+ individuals who shift from the Ryan White program to private insurance plans on the exchange are therefore likely to have trouble accessing a number of services currently available to them and that are essential for appropriate HIV care; and
2. Second, cost sharing on the exchange may be prohibitive for low-income individuals living with HIV, thus requiring multiple specialist visits and prescription refills. Moreover, beneficiaries are subject to utilization review, which may jeopardize access to comprehensive ART; HIV+ individuals shifting from ADAP to private insurance plans may have trouble accessing certain critical medications. Proposed EHB regulations do not prohibit such cost sharing, and are unlikely to ameliorate this challenge.[30]

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 are not only fiscally prudent but also necessary to secure the health of North Carolinians.

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. North Carolina must adopt the Medicaid expansion, pursuant to the ACA, extending eligibility to all individuals living under 133% of the federal poverty level in order to slow the transmission of HIV and make treatment accessible to thousands of individuals who currently lack care. On a federal level, expansion would bring in over $5 billion in 2014, expanding access to nearly 500,000 uninsured individuals (including those living with HIV),[31] and
2. North Carolina 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) or where cost sharing makes meaningful coverage prohibitive.

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

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APPENDIX A

2014 STATE-SPECIFIC ESTIMATES

Medicaid Estimates

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

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

	Total #	ADAP clients being served in fiscal year 2010[6]
–	**est. #**	ADAP clients with income above 133% FPL[32,§§]
–	**est. #**	insured ADAP clients with income below 133% FPL[***]
–	**est. #**	undocumented ADAP clients living below 133% FPL in June 2011
=	**Total #**	of ADAP clients who will be newly eligible for Medicaid in 2014[†††,‡‡‡]

North Carolina's ADAP served 5,586 individuals in 2010. Of those, we estimate that 950 (17%) are living above 133% FPL. We also estimate that there are 991 insured ADAP clients living below 133% FPL. Approximately 4% of North Carolinians were undocumented as of 2008 (amounting to approximately 170 undocumented ADAP clients living below 133% FPL). Thus, the calculation for North Carolina is:

	5,586	ADAP clients served in fiscal year 2010
–	**949.62**	ADAP clients with income above 133% FPL
–	**990.94**	insured ADAP clients with income below 133% FPL
–	**169.52**	undocumented immigrants with incomes below 133% FPL in June 2011
=	**3,476**	ADAP clients who will be newly eligible for Medicaid in 2014; or approximately 62% of ADAP clients served in fiscal year 2010

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

State	#ADAP Clients Newly Eligible	% ADAP Clients Newly Eligible
Alabama	1,345	76%
Arkansas	299	53%
California	12,274	31%
DC	1,124	41%
Florida	7,321	51%
Georgia	3,075	52%
Illinois	4,374	68%
Kentucky	619	42%
Louisiana	no data available	no data available
Maryland	1,394	22%
Massachusetts	1,400	21%
Mississippi	1,008	68%
New Jersey	2,101	29%
New York	4,233	20%
North Carolina	3,476	62%
Ohio	1,287	37%
Pennsylvania	1,336	22%
South Carolina	1,428	39%
Tennessee	2,505	60%
Texas	8,797	53%
Virginia	2,690	66%
Wisconsin	696	40%
United States	**62,971**	**29%**

Note: Data 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.[33] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages of insured clients exceed 100% for Maryland and Ohio.)

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

[***] *See* Appendix A for a description of the method used to estimate the distribution of insured ADAP clients in North Carolina by income group.

[†††] The final estimate provided is likely to 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 2010-11.

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 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[6]
–	**est. #**	ADAP clients living below 133% FPL[26,§§§]
–	**est. #**	ADAP clients living above 400% FPL[26]
–	**est. #**	insured ADAP clients living between 133-400% FPL[34,****]
–	**est. #**	ADAP clients who are undocumented immigrants living between 133-400% FPL[††††]
=	**Total #**	ADAP clients who will be newly eligible for subsidized private insurance

North Carolina's ADAP served 5,586 individuals in fiscal year 2010. Of those, we estimate that 4,636 (83%) were living below 133% FPL or above 400% FPL. This leaves 17% (950) of ADAP clients living between 133-400% FPL. We also estimate that there were 294 insured ADAP clients with income between 133-400% FPL. Approximately 4% of North Carolina's population was undocumented as of 2008 (35 ADAP clients living between 133-400% FPL). Thus, the calculation for North Carolina is:

	5,586	ADAP clients served in fiscal year 2010
–	**4,636.38**	ADAP clients with incomes below 133% FPL or above 400% FPL
–	**293.84**	estimated insured ADAP clients with incomes between 133-400% FPL
–	**34.72**	uninsured undocumented immigrants with incomes between 133-400% FPL in June 2011
=	**621**	ADAP clients who will be eligible for insurance subsidies in 2014; or 11% 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:

State	#ADAP Clients Eligible for 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.[27] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages of insured clients exceed 100% for Maryland and Ohio.)

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

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

†††† The number of undocumented immigrants on ADAP in each state in fiscal year 2009 was extrapolated from the Pew Research Center's Report, *A Portrait of Unauthorized Immigrants in the United States, available at* http://pewhispanic.org/files/reports/107.pdf. This report provides the estimated number of undocumented immigrants in each state for 2008. This number, divided by the overall population of the state in 2008 (estimated at http://www.census.gov/popest/data/state/totals/2011/index.html), provides the percentage that undocumented immigrants make up of the total population in the state. This percentage is then applied to the number of individuals enrolled in ADAP to estimate how many ADAP beneficiaries will not be newly eligible for private insurance subsidies as a result of their immigration status.

METHODOLOGY FOR DISTRIBUTION OF INSURED ADAP CLIENTS BY INCOME

Estimating the proportion of insured ADAP clients falling into each income bracket required several steps (national data were used for interstate comparability purposes):

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

   In North Carolina, 53% of adults living below 133% FPL are insured, 77% of adults living between 133-400% FPL are insured, and 93% living above 400% FPL are insured;

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

   In North Carolina, we gave the figure 53% the baseline number 1. 77% is 1.45 times 53%, and 93% is 1.76 times 77%. In other words, an adult in North Carolina with income between 133-400% FPL is 1.45 times more likely to be insured than an adult with income below 133% FPL, while an adult with income above 400% FPL is 1.76 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.[35] 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 North Carolina, 2011 NASTAD data were used as an imperfect substitute, due to the lack of data in the 2012 report.)

   In North Carolina, we estimated that about 1,285 of the state's 5,586 ADAP clients served in 2010 were insured. The insurance rate for ADAP clients in that state stood at 23% 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 North Carolina, 83% of ADAP clients are living below 133% FPL, 17% are living between 133-400% FPL, and none are living above 400%; and finally

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

   We relied on two formulas:

Formula 1:

Number of insured clients in each group

= (relative likelihood of being insured)

x (proportion of income group)

x *a*

‡‡‡‡ The 2011 and 2012 NASTAD National ADAP Monitoring Project Reports list the percentage of ADAP clients in each state covered by various kinds of insurance. We added the different insurance percentages to estimate the number of ADAP clients in each state who were insured. This leads to an overestimation of the number of insured people in each state: since a single ADAP client may be enrolled in multiple insurance plans (eg, Medicare and private insurance), adding up the insurance percentages may often result in double-counting a number of ADAP clients.

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)

Thus, for North Carolina:

1,284

= (1 x 0.83 x *a*)

+ (1.45 x 0.17 x *a*)

+ (1.76 x 0 x *a*)

Solving for *a*,

$a = 1{,}192.8$

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

The estimated number of insured ADAP clients in North Carolina with,

Income below 133% FPL = 990
Income between 133-400% FPL = 294
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

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 and Territorial AIDS Directors (NASTAD), and information from that organization has been provided for income and insurance status of ADAP clients. NASTAD's data for fiscal years2010 and 2011 and June 2011 were used (fiscal year 2010 was necessary for states that did not report data in 2011). Because ADAP data compiled by NASTAD are unduplicated (ie, patients are not double-counted by multiple providers), it is one of the most reliable sources of information about demographic information for people living with HIV. Data from June 2011 provide information on how many people living with HIV currently enrolled in ADAP live between 100-133% of the federal poverty level (FPL). Since the expansion of Medicaid eligibility to those living under 133% FPL is a new development, there is a relative dearth of data regarding the number of HIV+ individuals currently living between 100-133% FPL. NASTAD provides the only reliable source of these data to date. NASTAD's ADAP information was used for estimates regarding people living with HIV who are newly eligible for Medicaid in 2014 at the end of this report. Information available from state departments of health or Health Resources and Services Administration (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 comparability among states is limited. Information about unmet need available from other sources has also been included.

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

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

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

Because North Carolina did not submit a benchmark plan to the Department of Health and Human Services (HHS) as a proposed benefits package for purposes of defining essential health benefits (EHB) for the state's exchange, North Carolina's largest small-group market plan is now the default benchmark plan (BlueCross BlueShield NC: Blue Options). Data were collected from Analysis of Benchmark Plan Options for the Essential Health Benefits Package of North Carolina, prepared by Oliver Wyman and Manatt Health Solutions for the North Carolina Department of Insurance, and from the BlueCross BlueShield NC Blue Options Blue Book and Specialty Pharmaceutical List.

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.[36] (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 for other states, for interstate comparability reasons.

CAVEATS AND ASSUMPTIONS

The estimates provided require a number of caveats and assumptions:

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

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

These estimates are for ADAP recipients only, and are of limited analytical assistance in determining percentages of all people living with HIV 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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