STATE HEALTH REFORM IMPACT MODELING PROJECT

New Jersey

January 2013

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

BACKGROUND

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

The State Health Reform Impact Modeling Project (the Modeling Project) assesses the impact that healthcare reform will have on people living with HIV by compiling and analyzing Ryan White program and AIDS Drug Assistance Program (ADAP) data to predict the shift of uninsured people living with HIV from these discretionary programs to Medicaid or private insurance in all 50 states pursuant to the ACA. In addition, for 21 states and the District of Columbia (DC), the Modeling Project compiles and analyzes detailed budgets and benefits guidelines to assess the services provided by the Ryan White program, ADAP, Medicaid, and plans sold on an exchange, in order to estimate the impact that a transition into Medicaid will have on low-income people living with HIV.[2]

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

In New Jersey, the Modeling Project focuses on four state-specific inquiries:

1. What demographic information is available about Ryan White program and ADAP clients?
2. How many ADAP clients will be newly eligible for Medicaid or private insurance subsidies in 2014?
3. What services are currently available to people living with HIV under the Ryan White program versus Medicaid or plans to be sold on an exchange, and what gaps in services currently exist?
4. Given the current Ryan White, Medicaid, and private insurance coverage, what are the likely outcomes of a transition from one program to another in 2014?

NEW JERSEY

NEW JERSEYANS LIVING WITH HIV/AIDS

UNMET NEED

As of June 2012, at least 36,192 New Jerseyans were living and diagnosed with HIV (HIV+ aware), over 19,000 of whom had progressed to develop AIDS (as of 2009).[3,4] An estimated 2,200 were infected in 2010, 21% of whom are undiagnosed.[5,6] This proportion of New Jerseyans living with HIV are not accounted for in the following modeling of those 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 NEW JERSEY

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, New Jersey received $82,351,901 of Ryan White funding,[7] and served 32,899 duplicated clients.[8,9] About 54% of the state's Ryan White funds were Part B grants (assigned based on HIV prevalence in the state).[10] Of these, 72% went toward the AIDS Drug Assistance Program (ADAP).[11]

ADAP IN NEW JERSEY

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

- A New Jersey resident for ≥30 days;
- Living ≤500% of the federal poverty level (FPL);
- Without other insurance that would cover the ADAP covered drug(s); and
- In possession of a physician's letter attesting to medical need for ADAP-covered drug(s).[12]

In fiscal year 2010, New Jersey's ADAP served 6,555 individuals and spent $87,869,590 on prescription drugs (excluding dispensing costs) and $5,814,648 on insurance premium/cost-sharing support (through the Health Insurance Continuation Program).[13-15] Its fiscal year 2011 budget was $31,615,321 (92% of which were federal funds).[16]

THE ACA AND ITS IMPACT ON HIV+ NEW JERSEYANS

THE MEDICAID EXPANSION

Beginning in January 2014, the ACA expands Medicaid eligibility to most individuals under 65 years of age living below 133% FPL.[17,*] Although the Department of Health & Human Services (HHS) cannot force states to comply with the expansion (by withdrawing existing federal medical funding), the federal government will cover 100% of the cost of newly eligible beneficiaries until 2016, and at least 90% thereafter.[18] Newly eligible enrollees will receive a benchmark benefit package that will include ten categories of essential health benefits (EHB), described in the "Essential Health Benefits" section.[19]

[*] All undocumented immigrants as well as lawfully residing immigrant adults who have been in the country 5 years or less will not be eligible for Medicaid coverage. US Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation, The Affordable Care Act: Coverage Implications and Issues for Immigrant Families 7 (Apr. 2012), *available at* http://aspe.hhs.gov/hsp/11/ImmigrantAccess/Coverage/ib.pdf.

THE BASIC HEALTH PLAN

The ACA provides an option for states to create a Basic Health Plan (BHP) that would be largely federally funded (the state would receive up to 95% of the premium credits an individual would have been entitled to for purchase of a plan on the exchange).[20] A BHP would cover most individuals under 65 years of age living between 133-200% FPL as well as legal residents who do not qualify for Medicaid because of the 5-year residency requirement.[21] BHPs must cover at least the EHB and have the same actuarial value of coverage as a bronze plan the individual might otherwise purchase on an exchange.[22] Cost sharing on BHPs can be subsidized, either for all beneficiaries or for those with specific chronic conditions (eg, HIV/AIDS).[23] In addition to improved affordability, BHPs can minimize "churning" on and off Medicaid as individuals fluctuate around 133% FPL. Because state Medicaid offices can design and manage BHPs, these individuals would more easily transition into a plan with similar provider networks and administrative procedures.

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

The ACA requires states to establish state-run insurance exchanges, to partner with the federal government to set up a hybrid state-federal exchange, or to default into a federally facilitated exchange.[24] Insurance exchanges will provide individuals and families with a choice of plans, tiered by actuarial value of coverage (bronze, silver, gold, and platinum). Each plan available on an exchange must, at a minimum, adhere to a state-defined and federally approved list of EHB; these benefits are discussed in the following section. All exchanges will be operational January 1, 2014.[25]

Because New Jersey did not submit a benchmark plan for purposes of defining EHB in the private market, BlueCross BlueShield Horizon HMO (the largest small-group plan in the state) is its default benchmark plan.[26]

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

ESSENTIAL HEALTH BENEFITS

The ACA requires both Medicaid plans and private health insurance plans sold on state-based insurance exchanges to provide certain EHB, to be defined by the Secretary of HHS.[28] EHB must include items and services within the following ten benefit categories:[29]

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.[30] The Centers for Medicare & Medicaid (CMS) 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.[31] This means that benefits provided by Medicaid will likely be more robust than on the private market. For example, the Social Security Act requires that a Medicaid benchmark plan cover any FDA-approved drugs with significant clinically meaningful therapeutic advantage over another.[32]

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 New Jersey are expected to become eligible for Medicaid or a BHP; an estimated 61% of the state's Ryan White clients were living at or below the FPL in 2010 (compared with only 11% of the state population at large). An additional 13% were living below 200% FPL, making 74% likely eligible for public insurance in 2014.[33] We estimate that approximately 29% of New Jersey's ADAP clients will be eligible for Medicaid following its expansion and 26% will be eligible for insurance credits (Appendix A). In addition, many of the HIV+ New Jersey residents who are not yet diagnosed are also likely to be newly eligible for Medicaid, a BHP, or subsidized private health insurance, but not included in these estimates.

The percentage of New Jersey's ADAP clients who will be newly eligible for Medicaid based on income (29%) is equal to the national proportion (also 29%; Appendix A). This is because New Jersey, like most states, currently requires most individuals to be not only low-income but also disabled, in order to qualify for Medicaid.[34]

The percentage of ADAP clients in New Jersey who will be eligible for subsidized private insurance in 2014 (26%) is higher than the national proportion (15%; Appendix A). This is likely, in part, because of the number of underinsured individuals in the state. For example, in 2011, 25% of the state's ADAP clients had private insurance and were still able to demonstrate medical need for uncovered antiretroviral therapy (ART).[35]

The expansion of Medicaid, BHPs, and insurance subsidies to HIV+ New Jerseyans will also be crucial to reducing racial and ethnic health disparities across the state. Minorities account for 77% of people living with HIV in New Jersey, and at least 82% of the state's ADAP clients served in 2010 were African American or Hispanic (672 clients did not report race).[36,37]

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

Since a significant number of HIV+ individuals in New Jersey who are currently served by the Ryan White program or ADAP are likely to be eligible for public or private insurance in 2014, it is important to assess the outcome of transitioning clients on to these programs. This assessment compares and contrasts the services and treatments that the Ryan White program, ADAP, Medicaid, and New Jersey's benchmark plan currently or will provide to HIV+ New Jerseyans.

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

The Ryan White program funds both core medical services and support services for patients living with HIV/AIDS (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/AIDS treatment and care (eg, transportation, child care, nonmedical nutrition). However, Medicaid and New Jersey's benchmark plan, which will largely determine the scope of 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, or stable housing).

Table 1 provides a comparison of covered services available under the state's Ryan White program (as of 2010), Medicaid, and Horizon HMO, New Jersey's default benchmark plan for purposes of defining EHB in the private market.

Table 1. Ryan White Versus Medicaid and the Benchmark Plan: Covered Services

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

Covered Service	Ryan White[38]	Medicaid[39]	Horizon HMO[40]
Ambulatory/Outpatient Care	X	X	X ($20 per visit beyond annual preventive)
Diagnostic tests		X	X ($20 copay)
Oral Healthcare	X	X	
Early-Intervention Services	X		
Home Healthcare	X	X	X (PA)
Community-based Services	X		
Medical Case Management	X		
Nonmedical Case Management	X		
Mental Health: Outpatient	X	X (psychologist only)	X ($20 copay; cognitive therapy limited to 30 visits per year – inclusive of OT, PT, or speech therapy sessions)[41]
Mental Health: Inpatient			X (PA)[42]
Substance Abuse: Outpatient	X		X ($20 copay)[43]
Substance Abuse: Inpatient	X	X (residential treatment centers)	X (PA)[44]
Child Care Services	X		
Emergency Financial Assistance	X		
Food Bank/Home-Delivered Meals	X		
Nutritional Counseling	X		
Health Education/Risk Reduction	X		
Housing Services	X		
Legal Services	X		
Linguistics Services	X		X
Nonemergency Medical Transportation	X	X	
Outreach Services	X		
Permanency Planning	X		
Psychosocial Support Services	X	X	
Referral for Healthcare/ Support Services	X		
Rehabilitation Services	X		X (PA)
Respite Care	X		
Treatment Adherence Counseling	X		
Hospital (inpatient)		X	X
Prescription Drugs	X	X	X (50% coinsurance)
Mental Retardation/ Developmental Disability Services			
Family Planning		X	

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Table 1. (continued)

Obstetric and Prenatal Services	X	X ($25 per visit; waived for pre- and postnatal care after initial visit)
PT; OT; Speech Therapy	X	X ($20 copay; limited to 30 combined visits per year)
Nursing Home Care	X	
Skilled Nursing Care	X	X (PA)
HIV Adult Day Health Care		

As Table 1 illustrates, the Ryan White program provides a number of services that are not covered by Medicaid or by the benchmark plan that will be used to determine EHB for the state's exchange (eg, emergency financial assistance, food-bank and meal delivery, and a variety of wraparound services from housing and legal assistance to risk reduction education). These types of services will likely not be required EHB on Medicaid or private plans, given existing federal guidance and proposed regulation.[45,46]

Moreover, Horizon HMO subjects beneficiaries to moderate cost-sharing requirements that can become a prohibitive additive effect on low-income patients who require many more services than the average individual (Horizon caps annual out-of-pocket costs at $5,000 per individual, or $10,000 per family).[47] This makes continuation of the Ryan White program particularly important to the large numbers of HIV+ New Jerseyans who will be eligible for subsidized insurance on the state's healthcare exchange (Appendix A).

COMPARING ADAP, MEDICAID, AND THE BENCHMARK PLAN FOR THE EXCHANGE IN NEW JERSEY

ADAP provides funding for a robust drug formulary that is necessary to afford low-income individuals access to a combination of drugs to treat HIV/AIDS. All states participating in ADAP must cover at least one drug in every class of antiretroviral therapy (ART); most cover almost all drugs in each class. Medicaid's drug formulary is defined differently, although federal guidance indicates that its formulary for newly eligible beneficiaries must cover any drug that has superior clinical efficacy over another.[48] 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 New Jerseyans living with HIV/AIDS.

Table 2 provides a comparison of the antiretroviral drug formularies included in the state's ADAP, Medicaid, and Horizon HMO formularies.

Table 2. ADAP Versus Medicaid and the Benchmark Plan Used to Define Essential Health Benefits: Covered Drugs[49]

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[50]**	**Medicaid[51]**	**Horizon HMO**
Multiclass Combination Drugs	**3 Drugs Covered**	**3 Drugs Covered**	**2 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	

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Table 2. (continued)

NRTIs	12 Drugs Covered	12 Drugs Covered	12 Drugs Covered
Combivir; *zidovudine + lamivudine*	X	X	X (tier 3)
Emtriva; *emtricitabine*	X	X	X (tier 2)
Epivir; *lamivudine*	X	X	X (generic tier 1; brand name tier 3)
Epzicom; *abacavir sulfate + lamivudine*	X	X	X (tier 2)
Retrovir; *zidovudine*	X	X	X (generic tier 1; brand name tier 3)
Trizivir; *abacavir + zidovudine + lamivudine*	X	X	X (tier 2)
Truvada; *tenofovir DF + emtricitabine*	X	X	X (tier 2; PA)
Videx; *didanosine (buffered versions)*	X	X	X (generic tier 1; brand name tier 2)
Videx EC; *didanosine (delayed–release capsules)*	X	X	X (generic tier 1; brand name tier 3)
Viread; *tenofovir disoproxil fumarate DF*	X	X	X (tier 2)
Zerit; *stavudine*	X	X	X (generic tier 1; brand name tier 3)
Ziagen; *abacavir*	X	X	X (tier 2)
NNRTIs	**5 Drugs Covered**	**5 Drugs Covered**	**3 Drugs Covered**
Intelence; *etravirine*	X	X	X (tier 2)
Rescriptor; *delavirdine mesylate*	X	X	X (tier 3)
Sustiva; *efavirenz*	X	X	
Viramune; *nevirapine*	X	X	
Edurant; *rilpivirine*	X (PA)[52]	X	X (tier 2)
Protease Inhibitors	**10 Drugs Covered**	**10 Drugs Covered**	**9 Drugs Covered**
Agenerase; *amprenavir*	X	X	
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; tablets tier 3)
Prezista; *darunavir*	X	X	X (tier 2)
Reyataz; *atazanavir sulfate*	X	X	X (tier 2)
Viracept; *nelfinavir sulfate*	X	X	X (tier 2)
Fusion Inhibitors	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Fuzeon; *enfuvirtide*	X	X	X (tier 2; SP; QL)

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Table 2. (continued)

Entry Inhibitors – CCR-5 Coreceptor Antagonist	1 Drug Covered	1 Drug Covered	1 Drug Covered
Selzentry; *maraviroc*	X	X	X (tier 2; PA; QL)
HIV Integrase Strand Transfer Inhibitors	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Isentress; *raltegravir*	X	X	X (tier 2)
"A1" Opportunistic Infection Medications	**30 Drugs Covered**	**30 Drugs Covered**	**28 Drugs Covered**
Ancobon; *flucytosine*	X	X	X (generic tier 1; brand name tier 3)
Bactrim DS; *sulfamethoxazole/trimethoprim DS*	X	X	X (generic tier 1; brand name tier 3)
Biaxin; *clarithromycin*	X	X	X (generic tier 1; brand name tier 3; QL)
Cleocin; *clindamycin*	X	X	X (generic tier 1; 75 mg brand name tier 2; other dosages tier 3)
Dapsone	X	X	X (tier 1)
Daraprim; *pyrimethamine*	X	X	X (tier 2)
Deltasone; *prednisone*	X	X	X (tier 1; oral concentrate tier 2; oral solution tier 3)
Diflucan; *fluconazole*	X	X	X (generic tier 1; brand name tier 3)
Famvir; *famciclovir*	X	X	X (generic tier 1; brand name tier 3)
Foscavir; *foscarnet*	X	X	X (generic tier 1; brand name tier 3)
Fungizone; *amphotericin B*	X	X	
INH; *isoniazid*	X	X	X (tier 1)
Megace; *megestrol*	X	X	X (generic tier 1; brand name 400 mL tier 2; 5 mL tier 3)
Mepron; *atovaquone*	X	X	X (tier 2)
Myambutol; *ethambutol*	X	X	X (generic tier 1; brand name tier 3)
Mycobutin; *rifabutin*	X	X	X (tier 2)
NebuPent; *pentamidine*	X	X	X (tier 2)
Probenecid	X	X	X (tier 1)
Procrit; *erythropoietin*	X	X	X (tier 2)
Pyrazinamide (PZA)	X	X	X (tier 3)
Rifadin; *rifampin*	X	X	X (generic tier 1; brand name tier 3)
Sporanox; *itraconazole*	X	X	X (tier 1)
Sulfadiazine	X	X	X (tier 1)

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Table 2. (continued)

Valcyte; *valganciclovir*	X	X	X (tier 2)
Valtrex; *valacyclovir*	X	X	X (generic tier 1; brand name tier 3)
VFEND; *voriconazole*	X	X	X (generic tier 1; brand name tier 3)
Vistide; *cidofovir*	X	X	
Wellcovorin; *leucovorin*	X	X	X (tier 1)
Zithromax; *azithromycin*	X	X	X (generic tier 1; brand name tier 3; QL)
Zovirax; *acyclovir*	X	X	X (generic tier 1; brand name tier 3)

PA = prior authorization; QL = quantity limited

As table 2 indicates, both New Jersey's Medicaid and ADAP formularies are comprehensive. New Jersey maintains an open formulary (excluding cosmetic drugs, vitamins, cough and cold medications, and erectile dysfunction treatment), although patients must fail on a first-line treatment before accessing a second-line drug.[53,54] Importantly, ADAP clients can seamlessly transition over to Medicaid and back without experiencing any gaps in drug coverage.[55] Medicaid plans available to newly eligible beneficiaries in 2014 will likely be as comprehensive as the current plan (federal guidance indicates that any FDA-approved drug with significant clinically meaningful therapeutic advantage over another must be covered).[56] Nonetheless, the Medicaid plan for newly eligible beneficiaries may implement increased cost-containment measures (eg, prior authorization, quantity limits).[57] In this case, ADAP will remain critical to support the health of low-income individuals living with HIV/AIDS.[58]

Horizon HMO also has a relatively comprehensive formulary, but imposes considerable cost-sharing requirements on beneficiaries. All drugs are subject to 50% coinsurance, meaning that patients are subject to high copays for tier 2 and 3 drugs, which can become prohibitive for low-income patients requiring multiple prescriptions per month.[59] 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).[60] Thus, assuming the proposed rule is adopted, plans in New Jersey must cover at least the number of drugs in each class listed above for the Horizon HMO plan. Further, utilization review will be permissible (Horizon HMO reserves the right to require prior authorization for any prescription),[61] and cost sharing may be prohibitive on any plan. ADAP will continue to be an essential payer of last resort in this scenario.

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), enumerating the benefits covered under each, and the implications of transitioning individuals living with HIV/AIDS onto Medicaid or private insurance. This report is intended to assist lawmakers in implementing the Patient Protection and Affordable Care Act (ACA) in a manner that serves the needs of low-income New Jerseyans living with HIV/AIDS.

While much of the ACA has yet to be implemented, it is certain that large numbers of people living with HIV/AIDS will be newly eligible for public or private insurance in 2014. Given that a significant proportion of uninsured ADAP clients would transition into Medicaid in New Jersey, 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 available option to provide access to treatment for the thousands of HIV+ individuals in the state who currently lack access to care.

In that vein, the Medicaid system must be ready and able to handle the needs of low-income people who have HIV/AIDS. This report provides an initial analysis of the capacity of New Jersey's Medicaid program to handle the needs of individuals living with HIV/AIDS when the state expands coverage in 2014. 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 the Medicaid expansion. Comparing current Ryan White program and ADAP services with existing Medicaid formularies allows for a baseline analysis of the needs of individuals living with HIV/AIDS moving onto the Medicaid system. This report identified two challenges:

1. First, a number of services that are currently provided by the Ryan White program are not available under the state's current Medicaid program. Those newly eligible for Medicaid under the 2014 expansion may still require these wraparound services to maintain their health and quality of life (eg, treatment adherence or nutritional counseling, outreach services, rehabilitation). Because Medicaid plans available to newly eligible beneficiaries are unlikely to include these types of ancillary services as EHB, Ryan White will likely remain critical to fill in gaps, thereby facilitating access to care;[62] and
2. Second, prior authorization requirements create barriers to accessing comprehensive prescription drug treatment. Because EHB regulations will likely permit similar cost-containment techniques, ADAP will remain essential as a payer of last resort for those individuals who cannot access critical medications.[63]

It is essential that private insurance plans on New Jersey's exchange also provide a comprehensive scope of services that is sufficient to meet the needs of Ryan White clients who transition into these plans. This report indentified 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 New Jersey's default benchmark plan, Horizon HMO. Although plans sold on the exchange must adhere to EHB requirements, these will unlikely require coverage of ancillary (nonmedical) services.[64] HIV+ individuals who shift from the Ryan White program to private insurance plans are therefore likely to have trouble accessing a number of services currently available to them; and
2. Second, cost sharing will be problematic for many low-income individuals living with HIV/AIDS, who require multiple provider visits and several prescriptions per month (many of which are brand name). Because Horizon HMO imposes 50% cost sharing on all beneficiaries, affordability is likely to be a problem for those moving onto subsidized private insurance. ADAP prescription benefits or cost sharing support may remain critical in this scenario.

There will remain an ongoing demand for Ryan White and ADAP services to fill the gaps left by Medicaid coverage for low-income people living with HIV/AIDS. Identifying these gaps and structuring these programs to efficiently work together from the start is fiscally prudent and necessary to secure the health of individuals living with HIV/AIDS in the state.

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

1. New Jersey must adopt the Medicaid expansion pursuant to the ACA and extend Medicaid eligibility to all individuals living under 133% FPL in order to slow the transmission of HIV and make treatment accessible to thousands of individuals who currently lack care; and
2. New Jersey must ensure that Ryan White and ADAP services are available where coverage or affordability gaps exist (eg, nonmedical case management, food and nutrition, or sparse formularies), particularly for low-income state residents who use subsidies to buy insurance plans on the exchange.

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APPENDIX A

2014 STATE-SPECIFIC ESTIMATES

Medicaid Estimates

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

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

	Total #	ADAP clients being served in fiscal year 2010[65]
–	**est. #**	ADAP clients with incomes above 133% FPL[66,†]
–	**est. #**	insured ADAP clients with incomes below 133% FPL
–	**est. #**	ADAP clients who are uninsured undocumented immigrants with incomes below 133% FPL[67]
=	**Total #**	ADAP clients served who will be newly eligible for Medicaid in 2014

In New Jersey, ADAP served 7,235 individuals in fiscal year 2010. We estimate that 58% of those clients (4,196), are living above 133% FPL. An estimated 10% (752) of individuals living below 133% FPL are currently insured, and approximately 5.96% of the state's population were undocumented in 2008 (185 ADAP individuals with incomes below 133% FPL). Thus, the calculation for New Jersey is:

	7,235	ADAP clients in fiscal year 2010
–	**4,196.30**	ADAP clients with incomes above 133% FPL
–	**752.26**	insured ADAP clients with incomes below 133% FPL in fiscal year 2010
–	**185.33**	estimated uninsured undocumented immigrants with incomes below 133% FPL on ADAP
=	**2,101**	individuals currently enrolled in ADAP who will be eligible for Medicaid in 2014, or 20% of those enrolled in New Jersey's ADAP 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 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.[68] (The 2010 NASTAD report is missing data for North Carolina and Kentucky, and the percentages of insured clients exceeded 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).

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 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, this report does not capture all groups of people living with HIV/AIDS who may be eligible for Medicaid in 2014.

Private Insurance Subsidy Estimates

To estimate the number of people currently using ADAP who will be eligible for private insurance subsidies through health insurance exchanges, the following formula was used:

	Total #	ADAP clients served in fiscal year 2010[69]
–	**est. #**	ADAP clients living below 133% FPL[70]
–	**est. #**	ADAP clients living above 400% FPL[71,‡]
–	**est. #**	insured ADAP clients living between 133-400% FPL[72]
–	**est. #**	undocumented ADAP clients living between 133-400% FPL[73]
=	**Total #**	ADAP clients who will be eligible for subsidized private insurance in 2014

Again, in New Jersey, ADAP served 7,235 individuals in fiscal year 2010. Of those, we estimate that 58% (4,196) were living below 133% or above 400% FPL. We further estimate that 13% (974) of those living between 133-400% were insured. As estimated, 5.96% of the state's population were undocumented as of 2008. Applying this percentage to the individuals enrolled in New Jersey's ADAP computes to approximately 185 ADAP clients in New Jersey who are uninsured and undocumented immigrants living between 133-400% FPL. Thus, completing the calculation above for New Jersey's ADAP yields:

	7,235	ADAP clients in fiscal year 2010
–	**4,196.30**	ADAP clients with incomes below 133% FPL or above 400% FPL
–	**974.39**	insured ADAP clients living between 133-400% FPL
–	**185.33**	estimated undocumented immigrants on ADAP with incomes living between 133-400% FPL
=	**1,879**	individuals currently enrolled in ADAP who will be eligible for private insurance subsidies in 2014 or 21% of those enrolled in New Jersey's ADAP in fiscal year 2010

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

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

Note: Data on the insurance status of ADAP clients in Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.[74] (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).

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 insured adults living below 133% FPL, between 133-400% FPL, and above 400% FPL in each state 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 together in order to determine the percentage of adults living between 133-400% FPL who are insured.

   In New Jersey, for example, 56% of adults living below 133% FPL are insured; 72% of adults living between 133-400% FPL are insured; and 94% 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.

   For example, in New Jersey, the figure 56% was given the baseline number 1.72% is 1.3 times 56%, and 94% is 1.7 times 56%. In other words, an adult in New Jersey with income between 133% FPL and 400% FPL is 1.3 times more likely to be insured than an adult with income below 133% FPL, while an adult with income above 400% FPL is 1.7 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.[75] 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 New Jersey, we estimated that about 2,171 of the state's 7,235 ADAP clients served in 2010 were insured. The insurance rate for ADAP clients in that state stood at 30% in 2011.

4. In order to proportionately divide the number of insured ADAP clients among the three income groups listed above, the percentage of a state's ADAP clients who fall in each income group was required. Table 13 of the 2012 NASTAD Report shows the percentage of ADAP clients in most states who have incomes below 133% FPL, incomes between 133-400% FPL, and incomes above 400% FPL.

   In New Jersey, 43% of ADAP clients have incomes below 133% FPL, 43% have incomes between 133-400% FPL, and about 15% have incomes above 400% FPL.

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 result in double-counting a number of ADAP clients.

Thus, for New Jersey:

$$7{,}235 = (1 \times 0.56 \times a) + (1.14 \times 0.56 \times a) + (1.35 \times 0.15 \times a)$$

Solving for a,

$a = 5{,}167.86$

Applying the value of a determined above to Formula 1:

The estimated number of insured ADAP clients in New Jersey with,

Incomes below 133% FPL = 752
Incomes between 133-400% FPL = 974
Incomes above 400% FPL = 444

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 between states is comparable, data sources that provide information for all 21 states and DC are prioritized. Where more recent or more detailed data is available for a particular state, it has 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 ADAP clients is most thoroughly documented by the National Alliance of State & Territorial AIDS Directors (NASTAD), and information from that organization has been provided for income and insurance status of ADAP clients. NASTAD's data for fiscal year 2010, fiscal year 2011, and June 2011 was used (fiscal year 2010 was necessary for states that did not report data in 2011). Because ADAP data compiled by NASTAD is unduplicated, it is one of the most reliable sources of information about demographic information for people living with HIV/AIDS. Data from June 2011 provide information on how many people living with HIV/AIDS currently enrolled in ADAP fall between 100% and 133% of 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% and 133% of FPL. NASTAD provides the only reliable source of this data to date. NASTAD's ADAP information will be used for estimates regarding people living with HIV/AIDS who will be newly eligible for Medicaid in 2014 at the end of this report. Where information is also available from state departments of health or HRSA, it has been provided.

Estimates of unmet need for people living with HIV in each state are available in each state's Statewide Coordinated Statement of Need (SCSN). SCSNs must be provided by all states receiving Ryan White program funding, but different states provide SCSNs in different years, so all data is not from the same year. Where information about unmet need is available from other sources, it has also been included.

Information on current services covered by the Ryan White program is available from HRSA and the SCSNs, and this data has been included in each state profile. Where more detailed information is available, it has been included in the profiles.

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

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

Medicaid Coverage Data

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

Benchmark Plan Coverage Data

Horizon HMO is New Jersey's default benchmark plan, as the largest small-group plan in the state's market. Data on this plan was collected from publicly available information on Horizon's small-group plans in the state.

NOTES

Data for certain states was incomplete in the 2012 National ADAP Monitoring Project Annual Report, so missing data was obtained from alternative sources:

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

CAVEATS AND ASSUMPTIONS

The estimates provided require a number of caveats and assumptions:

1. ADAP data (as opposed to Ryan White data) were used both to account for insurance status and to avoid double-counting individuals (ie, those who see multiple Ryan White 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 actually accessing ADAP services. Potential clients who are currently on ADAP waiting lists in several states are also not included in these calculations. Thus, the numbers provide a conservative estimate of ADAP beneficiaries who will transition onto Medicaid or into subsidized private insurance;
3. National data (NASTAD and HRSA) were used in calculations instead of state-specific data to ensure that these estimates could be compared across the states surveyed; and
4. The number of undocumented immigrants on ADAP is a rough estimate, extrapolating 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 on ADAP.

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

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

APPENDIX C

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

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

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

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

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

67. The number of undocumented immigrants on ADAP in each state in fiscal year 2009 will be extrapolated from the Pew Research Center's report, A Portrait of Unauthorized Immigrants in the United States. *See* A Portrait of Unauthorized Immigrants in the United States, Pew Research Center (April 14, 2009), *available at* http://pewhispanic.org/files/reports/107.pdf. This report provides the estimated number of undocumented immigrants in each state for 2008. This number, divided by the overall population of the state in 2008, provides the percentage that undocumented immigrants make up of the total population in the state. See Population Estimates, US Census Bureau, *available at* http://www.census.gov/popest/data/state/totals/2011/index.html. This percentage is then applied to the number of individuals enrolled in ADAP to estimate how many ADAP beneficiaries will not be newly eligible for private insurance subsidies as a result of their immigration status.

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

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

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

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

72. To estimate the number of insured ADAP clients, data was used from New Jersey: Health Insurance Status by FPL, *available at* http://www.statehealthfacts.org/profileind.jsp?cat=3&sub=177&rgn=32, and from NASTAD National ADAP Monitoring Project Annual Report, August 2012, Tables 13-14, pp. 50-51.

73. The number of undocumented immigrants using ADAP in each state in fiscal year 2009 will be extrapolated from the Pew Research Center's report, A Portrait of Unauthorized Immigrants in the United States. *See* A Portrait of Unauthorized Immigrants in the United States, Pew Research Center (April 14, 2009), *available at* http://pewhispanic.org/files/reports/107.pdf. This report provides the estimated number of undocumented immigrants in each state for 2008. This number, divided by the overall population of the state in 2008, provides the percentage that undocumented immigrants make up of the total population in the state. See Population Estimates, US Census Bureau, *available at* http://www.census.gov/popest/data/state/totals/2011/index.html. This percentage is then applied to the number of individuals enrolled in ADAP to estimate how many ADAP beneficiaries will not be newly eligible for private insurance subsidies as a result of their immigration status.

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

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

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

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

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