STATE HEALTH REFORM IMPACT MODELING PROJECT

New York

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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 programs 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 York, 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 YORK

NEW YORKERS LIVING WITH HIV/AIDS

UNMET NEED

New York ranks first among all 50 states in percentage of its population living with HIV/AIDS.[3,*] As of 2010, approximately 201,613 individuals were known to be living in New York with HIV/AIDS (HIV+ aware).[4] More than one-third (approximately 34.5%) of HIV+ aware New Yorkers did not receive medical care in 2010.[5] Moreover, approximately 35,000 New York residents are estimated to be HIV+ but undiagnosed,[6] and 32% of new HIV/AIDS cases in New York are late diagnoses (diagnosed with AIDS within 12 months of the first positive HIV test).[7] This proportion of New Yorkers living with HIV (the undiagnosed and those not in care) 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 YORK

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 York received $342,175,610 of Ryan White funding,[8] and served 130,627 duplicated clients in the state.[9,10] About 48% of the state's Ryan White funds were Part B grants.[11] Of these, 25.7% covered core medical services, 72.8% went toward the AIDS Drug Assistance Program (ADAP), 0.9% went to Minority Access Initiatives, and 0.3% went toward Emerging Communities programs.[12] Finally, 37.6% of the state's Ryan White funds were Part A grants, distributed to Eligible Metropolitan Areas and Transitional Grant Areas[†] within the state.[13]

ADAP IN NEW YORK

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 New York, one must be:

- A New York resident diagnosed with HIV; and
- Living at or below 435% of the federal poverty level (FPL), without liquid assets greater than $25,000.[14]

The Ryan White program provides the majority of funding for the HIV Uninsured Care Programs in New York, which include:

- ADAP—covering prescription drugs only;
- ADAP Plus—covering prescription drugs as well as primary care services;
- HIV Home Care—covering home care nursing, medications, supplies, and some medical equipment for those who have chronic medical dependency due to physical or cognitive impairment related to HIV/AIDS; and
- ADAP Plus Insurance Continuation Program (APIC)—subsidizing health insurance premiums for ADAP-eligible insured clients experiencing financial hardship due to coverage.[15]

In fiscal year 2010, New York's ADAP served 21,691 individuals.[16] The state's ADAP budget for fiscal year 2011 was $283,500,000 (85% of which were federal funds).[17] Of New York's ADAP 2010 budget, 85% was spent on prescription drugs and 9% on insurance assistance (APIC).[18]

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[*] Only the District of Columbia has a higher percentage of its population (2.7%) living with HIV/AIDS. The Kaiser Family Foundation (KFF), HIV/AIDS Policy Fact Sheet: The HIV/AIDS Epidemic in Washington, DC, http://www.kff.org/hivaids/upload/8335.pdf (*last visited* October 23, 2012).

[†] New York City and Nassau/Suffolk counties are EMAs. Dutchess County was previously designated as a TGA.

THE ACA AND ITS IMPACT ON HIV+ NEW YORKERS

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).[19,‡] Although the US Department of Health & Human Services (HHS) cannot force states to comply with the expansion (by withdrawing existing federal medical funding), the federal government will cover 100% of the cost of newly eligible beneficiaries until 2016, and at least 90% thereafter.[20] Newly eligible enrollees will receive a benchmark benefits package that will include ten categories of essential health benefits (EHB), described in the "Essential Health Benefits" section.[21]

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).[22] 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.[23] BHPs must cover at least the EHB and have the same actuarial value of coverage as a bronze plan that the individual might otherwise purchase on an exchange.[24] Cost sharing on BHPs can be subsidized, either for all beneficiaries or for those with specific chronic conditions (eg, HIV/AIDS).[25] 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.[26] 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.[27] As a benchmark plan for purposes of defining EHB, New York selected the Oxford EPO plan.[28]

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

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

ESSENTIAL HEALTH BENEFITS

The ACA requires both Medicaid and private health insurance plans sold on state-based insurance exchanges to provide certain EHB, to be defined by the Secretary of HHS.[30] EHB must include items and services within the following ten benefit categories[31]:

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.[32] The Centers for Medicare & Medicaid Services has indicated that the HHS rule on EHB will also apply to newly eligible Medicaid beneficiaries, in addition to the protections provided under the Social Security Act.[33] 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.[34]

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

New York State is committed to expanding Medicaid and establishing a health benefit exchange consistent with ACA mandates.[35] Given the ACA-instituted reforms, a large number of HIV+ individuals in New York are expected to become eligible for Medicaid or a BHP; an estimated 49% of the state's Ryan White program clients in 2010 were living at or below the FPL, and an additional 13% were between 100-200% FPL, making them potentially eligible for either program in 2014.[36] Approximately 20% of New York's AIDS Drug Assistance Program (ADAP) clients will be eligible for Medicaid following its expansion, and 21% will be eligible for insurance credits (see Appendix A). In addition, many of the 42,643 HIV+ New Yorkers who were estimated in 2011 to have not accessed any HIV-related medical care in the past 12 months[37] are also likely to be newly eligible for Medicaid, a BHP, or subsidized private health insurance.

The percentage of New York's ADAP clients who will be newly eligible for Medicaid based on income levels (20%) is lower than the national proportion, which stands at 29% (Appendix A). This is primarily because New York already bases Medicaid eligibility on income (in addition to other categories), although the cap is significantly below the FPL.[38] With its Ryan White Part B federal funding, New York has also established comprehensive HIV Uninsured Care Programs, which means the percentage of low-income HIV+ New Yorkers receiving some care is much higher than in other states. However, New York residents still need increased access to coverage and ADAP benefits. One-third of ADAP clients live below the FPL in New York, and nearly one-half lack access to coverage, including Medicaid.[39]

The expansion of Medicaid, BHPs, and insurance subsidies to HIV+ New Yorkers will also be crucial to reducing racial and ethnic health disparities across the state; 64% of ADAP clients served in June 2011 and 80.7% of Ryan White clients served in 2010 were African American or Hispanic.[40,41]

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

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

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

The Ryan White program funds both core medical and support services for patients living with HIV/AIDS (see Appendix C for a breakdown of core medical versus support services). Both medical and ancillary services are critical to maintaining the health of low-income individuals who may not have access to many necessities that facilitate effective HIV/AIDS treatment and care (eg, transportation, child care, nonmedical nutrition). However, Medicaid and New York's benchmark plan, which will largely determine the scope of 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, or stable housing).

Table 1 provides a comparison of covered services between New York's Ryan White and Medicaid programs (as of 2010) as well as the Oxford EPO plan, the state's selected benchmark plan.[42] In 2010, New York began requiring most HIV+ Medicaid beneficiaries to choose a managed care plan, although they can apply for an exemption.[43] New York has also created HIV Special Needs Plans (SNPs) within Medicaid that address the particular needs of HIV+ New Yorkers. SNPs are currently only available to state residents residing within New York City (where 78% of HIV+ New Yorkers reside).[44]

As Table 1 indicates, the Ryan White program covers critical services for low-income people living with HIV/AIDS, many of which are not available to people covered by Medicaid or New York's base-benchmark plan (eg, legal, linguistic, and housing services; food bank access; home-delivered meals; and emergency financial assistance). Since these ancillary services are important for the well being of people living with HIV/AIDS, as well as being critical to retention in care, those individuals who transition from the Ryan White program onto Medicaid or private insurance plans are likely to be at a disadvantage.

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

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[45]	Medicaid[46]	Oxford EPO[47,48]
Ambulatory/Outpatient Care	X	X	X
Oral Healthcare	X	X	
Early-Intervention Services	X		
Home Healthcare	X	X	X (40 visits/yr)
Community-based Services	X		
Medical Case Management	X	X	
Nonmedical Case Management	X	X (SNPs/NYC only)	
Mental Health Services	X	X	X
Substance Abuse: Outpatient	X	X	X
Substance Abuse: Inpatient	X	X	X
Child Care Services	X		
Emergency Financial Assistance	X		
Food Bank/Home-delivered Meals	X		
Health Education/Risk Reduction	X	X (SNPs/NYC only)	
Housing Services	X		
Legal Services	X		
Linguistics Services	X		
Nonemergency Medical Transportation	X	X	
Outreach Services	X		
Permanency Planning	X		
Psychosocial Support Services	X		
Referral for Healthcare/ Support Services	X	X	
Rehabilitation Services	X		X
Respite Care	X		
Treatment Adherence Counseling	X	X (SNPs/NYC only)	
Hospital (Inpatient)		X	X
Prescription Drugs	X	X	X
Mental Retardation/Developmental Disability Services		X	
Family Planning		X	X
Obstetric and Prenatal Services		X	X
Nursing Home Care		X	X (200 days/yr)
HIV Adult Day Healthcare		X	

NYC = New York City; SNPs = Special Needs Plans

As Table 1 illustrates, the Ryan White program provides a number of services that are not covered by Medicaid or the benchmark plan that will be used to determine EHB for the state's exchange (eg, emergency financial assistance, food-bank and meal delivery, and a variety of wraparound services from housing and legal assistance to health education). These types of services will likely not be required EHB on Medicaid or private plans, given existing federal guidance and proposed regulation.[49,50]

Moreover, Oxford EPO includes high deductibles ($2,500 per year for an individual) and cost-sharing requirements.[51] This makes continuation of the Ryan White program particularly important to the large numbers of HIV+ New Yorkers 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 YORK

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 (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 New Yorkers living with HIV/AIDS.

Table 2 provides a comparison of the antiretroviral drug formularies included in the state's ADAP, Medicaid, and Oxford EPO plan (the state's proposed benchmark plan).[52] Drug formularies may differ across the various Medicaid managed care plans available for the state. Included below are medications that appear on the state's fee-for-service Medicaid program and the Oxford EPO three-tier program prescription drug list. The Oxford EPO three-tier formulary does not include any ART drugs. UnitedHealthcare, the parent company for all of New York's Oxford small-group plans, maintains a specialty pharmacy program (SPP) for individuals who require these medications. However, according to UnitedHealthcare promotional materials, the SPP does not render prescription drugs more affordable if they do not appear on the member's plan formulary.[53,§] Therefore, despite the SPP, antiretroviral medications are likely not affordable for low-income Oxford EPO members (Table 2 illustrates which drugs are covered only by the SPP and thus subject to the highest cost-sharing requirements).

Table 2. ADAP Versus Medicaid and the Benchmark Plan Used to Define Essential Health Benefits: Covered Drugs[54]

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[55]**	**Medicaid[56]**	**Oxford EPO[57,58]**
Multiclass Combination Drugs	**2 Drugs Covered**	**3 Drugs Covered**	**1 Drug Covered**
Atripla; *efavirenz + emtricitabine + tenofovir DF*	X	X	SPP
Complera; *emtricitabine + rilpivirine + tenofovir disoproxil fumarate*	X	X	
Stribild; *elvitegravir + cobicistat + emtricitabine + tenofovir disoproxil fumarate*		X	
NRTIs	**12 Drugs Covered**	**12 Drugs Covered**	**10 Drugs Covered**
Combivir; *zidovudine + lamivudine*	X	X	SPP
Emtriva; *emtricitabine*	X	X	SPP
Epivir; *lamivudine*	X	X	X (tier 2; SPP)
Epzicom; *abacavir sulfate + lamivudine*	X	X	
Retrovir; *zidovudine*	X	X (PA)	SPP
Trizivir; *abacavir + zidovudine + lamivudine*	X	X	
Truvada; *tenofovir DF + emtricitabine*	X	X	SPP
Videx; *didanosine (buffered versions)*	X	X (PA)	SPP

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§ SPP denotes drugs that appeared on the specialty pharmacy program list for HIV/AIDS.

Table 2. (continued)

Videx EC; *didanosine (delayed-release capsules)*	X	X (PA)	SPP
Viread; *tenofovir disoproxil fumarate DF*	X	X	SPP
Zerit; *stavudine*	X	X (PA)	SPP
Ziagen; *abacavir*	X	X	SPP
NNRTIs	**5 Drugs Covered**	**5 Drugs Covered**	**4 Drugs Covered**
Edurant; *rilpivirine*	X	X	
Intelence; *etravirine*	X	X	SPP
Rescriptor; *delavirdine mesylate*	X	X	SPP
Sustiva; *efavirenz*	X	X	SPP
Viramune; *nevirapine*	X	X	SPP
Protease Inhibitors	**10 Drugs Covered**	**9 Drugs Covered**	**9 Drugs Covered**
Agenerase; *amprenavir*	X		
Aptivus; *tipranavir*	X (PA)	X	SPP
Crixivan; *indinavir sulfate*	X	X	SPP
Invirase; *saquinavir mesylate*	X	X	SPP
Kaletra; *lopinavir + ritonavir*	X	X	SPP
Lexiva; *fosamprenavir*	X	X	SPP
Norvir; *ritonavir*	X	X	SPP
Prezista; *darunavir*	X	X	SPP
Reyataz; *atazanavir sulfate*	X	X	SPP
Viracept; *nelfinavir sulfate*	X	X	SPP
Fusion Inhibitors	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Fuzeon; *enfuvirtide*	X (PA)	X	SPP
Entry Inhibitors – CCR-5 Coreceptor Antagonist	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Selzentry; *maraviroc*	X (PA)	X	SPP
HIV Integrase Strand Transfer Inhibitors	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Isentress; *raltegravir*	X	X	SPP
"A1" Opportunistic Infection Medications	**28 Drugs Covered**	**30 Drugs Covered**	**12 Drugs Covered**
Ancobon; *flucytosine*	X	X	
Bactrim DS; *sulfamethoxazole/trimethoprim DS*	X	X	X (tier 1)
Biaxin; *clarithromycin*	X	X	X (tier 2)
Cleocin; *clindamycin*	X	X	X (tier 1)
Dapsone	X	X	X (tier 2)
Daraprim; *pyrimethamine*	X	X	
Deltasone; *prednisone*	X	X	
Diflucan; *fluconazole*	X	X	X (tier 1)
Famvir; *famciclovir*		X (PA)	

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Table 2. (continued)

Foscavir; *foscarnet*	X	X	
Fungizone; *amphotericin B*	X	X	
INH; *isoniazid*	X	X	
Megace; *megestrol*	X	X	X (tier 1)
Mepron; *atovaquone*	X (PA)	X	
Myambutol; *ethambutol*	X	X	
Mycobutin; *rifabutin*	X	X	
NebuPent; *pentamidine*	X	X	
Probenecid	X	X	
Procrit; *erythropoietin*		X	
Pyrazinamide (PZA)	X	X	
Rifadin, *Rimactane; rifampin*	X	X	
Sporanox; *itraconazole*	X	X (PA)	X (tier 1)
Sulfadiazine	X	X	X (tier 1)
Valcyte; *valganciclovir*	X	X	
Valtrex; *valacyclovir*	X	X (PA)	X (QL; tier 1)
VFEND; *voriconazole*	X	X	X (tier 1)
Vistide; *cidofovir*	X	X	
Wellcovorin; *leucovorin*	X	X	
Zithromax; *azithromycin*	X	X	X (tier 1)
Zovirax; *acyclovir*	X	X	X (tier 1)

ADAP = AIDS Drug Assistance Program; ART = antiretroviral therapy; NNRTI = non-nucleoside reverse transcriptase inhibitors; NRTI = nucleoside reverse transcriptase inhibitors; PA = prior authorization; QL = quantity limited

As Table 2 indicates, both New York's Medicaid and ADAP have comprehensive formularies, although some drugs on both formularies require prior authorization. However, New Yorkers living with HIV/AIDS who are Medicaid eligible may be required to enroll in a managed care organization (MCO) if they do not already have a treating physician and do not apply for an exemption. Each MCO maintains its own list of covered drugs, which is similar to the Medicaid fee-for-service drug formulary but may be more limited in scope or impose limits on the quantities of drugs or number of prescriptions filled. For example, New York Catholic Health Plan (Fidelis Care) requires prior authorization after four antiretroviral prescriptions per month and limits the quantities available within 1 year for many HIV/AIDS-related drugs.[59] If the Medicaid plan for newly eligible beneficiaries includes similar cost-containment measures, which federal guidance permits, ADAP will remain critical to support the health of low-income New Yorkers living with HIV/AIDS.[60]

Oxford EPO, New York's benchmark plan for its exchange, has a very limited formulary. It includes a tiered prescription drug program, which imposes high cost sharing for medications classified as tier 2 or 3. Moreover, the SPP, a formulary created for complicated medical conditions requiring medications that cost more than $250 per prescription (eg, HIV/AIDS), imposes even higher copays on the beneficiary.[61] The SPP offers treatment adherence counseling and advice on how to maximize plan prescription drug benefits, but does not specify whether or how it makes necessary medications affordable for HIV+ individuals when the medications do not appear on the plan formulary.[62] Because management of HIV/AIDS diagnoses may require many and varied specific prescription drugs, prescription drug coverage on the exchange could pose challenges for people living with HIV/AIDS (eg, high copays could make prescription drugs prohibitively expensive). ADAP will continue to be an essential payer of last resort for low-income New Yorkers living with HIV/AIDS in this scenario.

CONCLUSIONS AND NEXT STEPS

This report provides analyses of the Ryan White program, the AIDS Drug Assistance Program (ADAP), Medicaid, and the 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 New Yorkers.

While much of the ACA has yet to be implemented, it is certain that a large number of people living with HIV/AIDS will be newly eligible for Medicaid. Given that a significant proportion of uninsured ADAP clients would transition onto Medicaid in New York, 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 are HIV+. This report provides an initial analysis of the capacity of New York'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 on the existing Medicaid program) is timely as states prepare for the transition to the Medicaid expansion. Comparing current Ryan White and ADAP services with existing Medicaid formularies allows for a baseline analysis of the needs of individuals living with HIV/AIDS moving into the Medicaid system. This report identified 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. Those newly eligible for Medicaid under the 2014 expansion may still require these wraparound services to maintain their health and quality of life. For instance, the Ryan White program, unlike traditional Medicaid, covers early-intervention clinics, medical and nonmedical case management, and treatment adherence counseling. New Yorkers living outside of New York City do not have access to Medicaid's HIV Special Needs Plan that provides some of these essential ancillary services. Unless Medicaid's EHB are defined to include these supports, Ryan White will remain essential for newly eligible individuals;
2. Second, New York has an extremely high number of HIV+ aware residents who are not accessing care (approximately 34.5%, or more than 42,500 individuals in 2010). Many of these individuals will likely be eligible for Medicaid, a BHP, or an insurance subsidy in 2014. Meeting the full range of needs of this population once they come into care will require the wraparound services available only through Ryan White. Despite the relatively comprehensive care available to HIV+ New Yorkers and efforts to increase awareness and expand access to testing, 32% of New Yorkers newly diagnosed with HIV have either concurrent diagnoses of AIDS or are diagnosed with AIDS within 12 months.[63] This means that a high proportion of the approximately 35,000 undiagnosed HIV+ New Yorkers will come into care with high medical and nonmedical needs, and the immediate availability of a coordinated continuum of services will be essential to maintaining an optimal level of health for these individuals; and
3. Third, prior authorization requirements and prescription quantity limitations included in Medicaid MCO formularies create barriers to accessing comprehensive prescription drug treatment.[64] Most Medicaid beneficiaries, including HIV+ individuals, are required to enroll in these plans. 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.[65]

It is essential that private insurance plans on New York's exchange 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 York's benchmark plan, Oxford EPO. Although plans sold on the exchange must adhere to EHB requirements, these will unlikely require coverage of ancillary (nonmedical) services.[66] 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, comprehensive information on prescription drug benefits available to current Oxford EPO beneficiaries is not publicly available. Oxford small-group plans (which have publicly available formularies) do not cover any antiretroviral drugs. Although some drugs commonly used to treat opportunistic infections associated with HIV/AIDS are covered, even these may be rendered unaffordable due to high copays, deductibles, and cost-sharing requirements. Although the specialty pharmacy program includes medications used to treat HIV/AIDS, no details are available about how this program makes necessary medications available or affordable for individuals enrolled in New York's chosen benchmark plan. New Yorkers purchasing health insurance on the exchange with insurance subsidies may require ADAP prescription benefits to obtain affordable comprehensive antiretroviral therapy.

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 New Yorkers.

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 York must continue to move forward with its plan to adopt the Medicaid expansion pursuant to the ACA and extend Medicaid eligibility to all individuals living under 133% of the federal poverty level (FPL) in order to slow the transmission of HIV and make treatment accessible to thousands of individuals who currently lack care. New York must make the special benefits of Medicaid SNPs available to all New Yorkers, rather than only residents of New York City; and
2. New York 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.

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

APPENDIX A

2014 STATE-SPECIFIC ESTIMATES

Medicaid Estimates

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

To estimate the number of individuals currently using ADAP who will be eligible for Medicaid in 2014, the following formula was used:

	Total #	ADAP clients being served in fiscal year 2010[67]
–	**est. #**	ADAP clients with incomes above 133% FPL[68,**]
–	**est. #**	insured ADAP clients with incomes below 133% FPL
–	**est. #**	ADAP clients who are uninsured undocumented immigrants with incomes below 133% FPL[69]
=	**Total #**	ADAP clients served who will be newly eligible for Medicaid in 2014

In New York, ADAP served 21,691 individuals in fiscal year 2010. We estimate that 56% of those clients (12,147), are living above 133% FPL. An estimated 22.5% (4,889) of individuals living below 133% FPL are currently insured, and approximately 4.53% of the state's population were undocumented in 2008 (423 ADAP individuals with incomes below 133% FPL). Thus, the calculation for New York is:

	21,691	ADAP clients in fiscal year 2010
–	**12,146.96**	ADAP clients with incomes above 133% FPL
–	**4,888.74**	insured ADAP clients with incomes below 133% FPL in fiscal year 2010
–	**422.60**	uninsured undocumented immigrants with incomes below 133% FPL on ADAP
=	**4,232**	individuals currently enrolled in ADAP who will be eligible for Medicaid in 2014, or 20% of those enrolled in New York's ADAP 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 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	**62,780**	**29%**

Note: Data on the insurance status of ADAP clients in Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.[70] (The 2010 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).

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[71]
–	**est. #**	ADAP clients living below 133% FPL[72]
–	**est. #**	ADAP clients living above 400% FPL[73,††]
–	**est. #**	insured ADAP clients living between 133-400% FPL[74]
–	**est. #**	undocumented ADAP clients living between 133-400% FPL[75]
=	**Total #**	ADAP clients who will be eligible for subsidized private insurance in 2014

Again, in New York, ADAP served 21,691 individuals in fiscal year 2010. Of those, we estimate that 44% (9,544) were living below 133% or above 400% FPL. We further estimate that 32.7% (7,104) were insured. As estimated 4.53% of the state's population were undocumented as of 2008. Applying this percentage to the individuals enrolled in New York's ADAP computes to approximately 541 ADAP clients in New York who are uninsured and undocumented immigrants living between 133-400% FPL. Thus, completing the calculation above for New York's ADAP yields:

	21,691	ADAP clients in fiscal year 2010
–	**9,544.04**	ADAP clients with incomes below 133% FPL or above 400% FPL
–	**7,104.24**	insured ADAP clients living between 133-400% FPL
–	**540.54**	undocumented immigrants on ADAP with incomes between 133% - 400% FPL
=	**4,502**	individuals currently enrolled in ADAP who will be eligible for private insurance subsidies in 2014 or 21% of those enrolled in New York's ADAP program in fiscal year 2010

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

State	# ADAP Clients Eligible for Subsidies	% ADAP Clients Eligible for Subsidies
Alabama	305	17%
Arkansas	147	26%
California	8,580	22%
DC	829	30%
Florida	4,134	29%
Georgia	1,404	24%
Illinois	1,127	17%
Kentucky	269	18%
Louisiana	No data available	No data available
Maryland	1,726	28%
Massachusetts	932	14%
Mississippi	384	26%
New Jersey	1,879	26%
New York	4,502	21%
North Carolina	621	11%
Ohio	901	26%
Pennsylvania	1,567	26%
South Carolina	1,091	30%
Tennessee	1,531	37%
Texas	4,301	26%
Virginia	896	22%
Wisconsin	401	23%
United States	**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.[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.)

[††] 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. First, 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 New York, the figure 56% was given the baseline number 1. 79% is 1.14 times 56%, and 94% is 1.35 times 56%. Thus, in other words, an adult in New York with income between 133-400% FPL is 1.14 times more likely to be insured than an adult with income below 133% FPL, while an adult with income above 400% FPL is 1.35 times more likely to be insured;

2. 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.[77] 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 York, we estimated that about 12,147 of the state's 21,691 ADAP clients served in 2010 were insured. The insurance rate for ADAP clients in that state stood at 56% in 2011;

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

   In New York, 43% of ADAP clients have incomes below 133% FPL, 55% have incomes between 133-400% FPL, and only about 1% have incomes above 400% FPL; and finally

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

   We relied on two formulas:

Formula 1:

Number of insured clients in each group

= (relative likelihood of being insured)

x (proportion of income group)

x *a*

Formula 2:

Total number of insured ADAP clients

= (number of insured clients living below 133% FPL)

\+ (number of insured clients living between 133-400% FPL)

\+ (number of insured clients living above 400% FPL)

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

Thus, for New York:

$$12{,}146.96 = (1 \times 0.43 \times a) + (1.14 \times 0.55 \times a) + (1.35 \times 0.001 \times a)$$

Solving for a,

$a = 11{,}369.19$

Applying the value of a determined above to Formula 1:

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

Incomes below 133% FPL = 4,889
Incomes between 133-400% FPL = 7,104
Incomes above 400% FPL = 154

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

APPENDIX B

DATA COLLECTION METHODOLOGY

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

Ryan White Program Data

Demographic information about Ryan White program clients was culled from a number of sources. For the sake of continuity, the Federal Health Resources and Services Administration (HRSA) 2010 State Profiles were used for data about the Ryan White program. Where available, information from state departments of health has also been included. Demographic information for AIDS Drug Assistance Program (ADAP) clients is most thoroughly documented by the National Alliance of State & Territorial AIDS Directors (NASTAD), and information from that organization has been provided for income and insurance status of ADAP clients. NASTAD's data for fiscal years 2010 and 2011 and June 2011 were used (fiscal year 2010 was necessary for states that did not report data in 2011). Because ADAP data compiled by NASTAD are unduplicated (ie, patients are not double-counted by multiple providers), it is one of the most reliable sources of information about demographic information for people living with HIV/AIDS. Data from June 2011 provide information on how many people living with HIV/AIDS currently enrolled in ADAP fall between 100-133% of 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/AIDS 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 need for people living with HIV/AIDS in each state are available in each state's Statewide Coordinated Statement of Need (SCSN). SCSNs must be provided by all states receiving Ryan White program funding, but different states provide SCSNs in different years, so comparability among states is limited. Information about unmet need is available from other sources has also been included.

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

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

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

Medicaid Coverage Data

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

Benchmark Plan Coverage Data

New York submitted UnitedHealthcare's Oxford EPO small-group plan for consideration as its benchmark plan. Data on this plan were collected from the report submitted to the state by the Milliman, Inc. consulting group and from publicly available information on Oxford small-group plans in the state.

NOTES

Data for certain states were incomplete in the 2012 National ADAP Monitoring Project Annual Report, so 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.[78] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages of insured clients exceed 100% for Maryland and Ohio.); and
- Data on the number of clients served by Mississippi's ADAP appear to be incorrect in NASTAD's Monitoring Report, as the number of clients served is listed as larger than the number of eligible ADAP clients in the state. The number listed was used in these calculations, and while the specific number of ADAP clients eligible for Medicaid and private insurance subsidies in Mississippi may not be reliable, the proportion of clients eligible for both programs was obtained in the same way as for other states, 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 on ADAP.

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

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

APPENDIX C

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

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

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

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66. 45 C.F.R. pts. 144, 147, 150, et al. (proposed November 26, 2012).

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

68. 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 FY 2010. Report, 50-51, tbls. 13-14 [hereinafter NASTAD Report] (August 2012), *available at* http://www.nastad.org/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.

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

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

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

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

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

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

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

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

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

78. 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.

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