STATE HEALTH REFORM IMPACT MODELING PROJECT

Ohio

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 Ohio, the Modeling Project focuses on four state-specific inquiries:

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

OHIO

OHIOANS LIVING WITH HIV OR AIDS

UNMET NEED

In 2011, 1,013 Ohioans were diagnosed with HIV, 242 of whom had AIDS within a year of diagnoses.[3] There are currently nearly 18,000 Ohioans living and diagnosed with HIV (HIV+ aware); 8,602 of these individuals have AIDS.[4] In 2010, 39% of HIV+ aware individuals (6,754) did not receive any HIV primary care.[5] This is an underestimate of unmet need; individuals are counted as being "in care" if they merely receive a CD4 count or viral load test.[6] National estimates project that 20% of individuals living with HIV have not been tested.[7]

This proportion of Ohioans living with HIV (those not in care or undiagnosed) 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 OHIO

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, Ohio received $34,889,606 of Ryan White funding[8] and served 16,822 duplicated clients.[9,10] About 72% of the state's Ryan White Funds were Part B grants (assigned based on HIV prevalence in the state).[11] Of these, 65% went toward the AIDS Drug Assistance Program (ADAP).[12]

ADAP IN OHIO

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

1. A Ohio resident diagnosed with HIV; and
2. Living ≤300% of the federal poverty level (FPL).[13]

In fiscal year 2010, Ohio's ADAP served 4,850 individuals and spent $14,247,464 on prescription drugs (excluding dispensing costs) and $4,993,446 on insurance premium/cost-sharing support.[14,15] Its fiscal year 2011 budget was $15,066,049 (64% of which were federal funds).[16]

THE ACA AND ITS IMPACT ON HIV+ OHIOANS

THE MEDICAID EXPANSION

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

THE BASIC HEALTH PLAN

The ACA provides an option for states to create a Basic Health Plan (BHP) that would be largely federally funded (the state would receive up to 95% of the premium credits an individual would have been entitled to for purchase of a plan on the exchange).[20] A BHP would cover most individuals under 65 years of age living between 133-200% FPL as well as legal residents who do not qualify for Medicaid because of

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

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 Ohio did not submit a benchmark plan for purposes of defining EHB in the private market, the Anthem BlueCross BlueShield's Community Insurance Company (the largest small-group plan in the state), is its default benchmark plan.[26,27]

For those purchasing coverage on an exchange, the ACA extends insurance premium credits to individuals and families living between 100-400% FPL, to ensure that premiums do not exceed 2.0-9.8% of household income, and imposes out-of-pocket spending caps to protect healthcare consumers from medical bankruptcy.[28] 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 and private health insurance plans sold on state-based insurance exchanges to provide certain EHB, to be defined by the Secretary of HHS.[29] EHB must include items and services within the following ten benefit categories[30]:

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.[31] The Centers for Medicare and Medicaid Services has indicated that the HHS rule on EHB will also apply to newly eligible Medicaid beneficiaries, in addition to the protections provided under the Social Security Act.[32] This means that benefits provided by Medicaid will likely be more robust than on the private market. For example, the Social Security Act requires that a Medicaid benchmark plan cover any US Food and Drug Administration-approved drugs with significant clinically meaningful therapeutic advantage over another.[33]

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 Ohio are expected to become eligible for Medicaid or a BHP; an estimated 47% of the state's Ryan White clients were living at or below the FPL in 2010 (compared with only 20% of the state population at large).[34,35] An additional 19% were living below 200% FPL, making 66% likely eligible for public insurance in 2014.[36] We estimate that approximately 37% of Ohio'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+ Ohioans who are not yet diagnosed or not in care are also likely to be newly eligible for public or private subsidized private health insurance, but not included in these estimates.

The percentage of Ohio's ADAP clients who will be newly eligible for Medicaid based on income (37%) is higher than the national proportion (29%; Appendix A). This is because Ohio requires most individuals to be very low-income (under 64% FPL), but also disabled, in order to qualify for Medicaid (working disabled adults may earn up to 250% FPL and still qualify).[37]

The percentage of ADAP clients in Ohio 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 insured individuals in the program (38% in 2011).[38]

The expansion of Medicaid, BHPs, and insurance subsidies to HIV+ Ohioans will also be crucial to reducing racial and ethnic health disparities across the state. 53% of new diagnoses in 2010 were African-American or Hispanic, and minorities account for at least 47% of the state's ADAP clients (1,092 clients did not report race in 2010).[39,40]

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

Since a significant number of HIV+ individuals in Ohio who are currently served by the Ryan White program or AIDS Drug Assistance Program (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 Ohio's benchmark plan currently or will provide to HIV+ Ohioans.

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

The Ryan White program funds both core medical and support services for patients living with HIV (see Appendix C for a breakdown of core medical versus support services). Both medical and ancillary services are critical to maintaining the health of low-income individuals who may not have access to many necessities that facilitate effective HIV treatment and care (eg, transportation, child care, nonmedical nutrition). However, Medicaid and Ohio'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 the Anthem BlueCross BlueShield's Community Insurance Company, Ohio'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[41]	Medicaid[42]	Anthem BlueCross BlueShield Community Insurance Co.[43]
Ambulatory/Outpatient Care	X	X (24 physician visits/year)	X (physician and facility fee)
Diagnostic tests		X	X

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† There are two community insurance company plans, Lumenos and a PPO. Both are assessed here – benefits are the same, although cost sharing is slightly higher on the PPO plan.

Table 1. (continued)

Oral Healthcare	X	X	
Early Intervention Services	X		
Home Healthcare	X	X	X (limited)
Community-based Services	X	X	
Medical Case Management	X		
Non-Medical Case Management	X		
Mental Health: Outpatient	X	X (25 visits/year; 8 hrs of psychological testing/year)	X (limited)
Mental Health: Inpatient			X (limited)
Substance Abuse: Outpatient	X	X (limited; varies by county)	X (limited)
Substance Abuse: Inpatient	X		X (limited)
Child Care Services	X		
Emergency Financial Assistance	X		
Food Bank/Home-Delivered Meals	X		
Nutritional counseling			no weight loss program
Health Education/Risk Reduction	X		
Housing Services	X		
Legal Services	X		
Linguistics Services	X		
Non-Emergency Medical Transportation	X	X (available via county departments of job and family services)	
Outreach Services	X		
Permanency Planning	X		
Psychosocial Support Services	X		
Referral for Healthcare/Support Services	X		
Rehabilitation Services	X		X (limited)
Respite Care	X		
Treatment Adherence Counseling	X		
Hospital (inpatient)		X (PA)	X (physician and hospital facilty fee)
Prescription Drugs		X	X
Mental Retardation/Developmental Disability Services		X	
Family Planning		X	X
Obstetric and Pre-natal Services		X	X
PT; OT; Speech Therapy		X (30 visits per year each)	X
Nursing Home Care		X	
Skilled Nursing Care		X	X (limited)
HIV Adult Day Health Care			

PA = prior authorization.

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 wrap-around 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.[44,45]

The Anthem BlueCross BlueShield plan not only lacks coverage of ancillary services that support access to medical care, but also subjects beneficiaries to moderate cost-sharing requirements that can have a prohibitive additive effect on low-income individuals living with HIV who require more frequent services than many patients. Coinsurance can be as high as 40%, and copays range from $20 to $30 per visit.[46] Caps on annual out-of-pocket costs are as high as $10,000 per individual, or $20,000 per family (although plans vary widely),[47] Lack of access to ancillary services and high cost-sharing both make continuation of the Ryan White program particularly important to low-income HIV+ Ohioans who will be eligible for subsidized insurance on the state's health care exchange.

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

ADAP provides funding for a robust drug formulary that is necessary to afford low-income individuals access to a combination of drugs to treat HIV. All states participating in ADAP must cover at least one drug in every class of 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 Ohioans living with HIV.

Table 2 provides a comparison of the antiretroviral drug formularies included in the state's ADAP, Medicaid, and Anthem BlueCross BlueShield Community Insurance Company formularies.‡

Table 2: ADAP Versus Medicaid and the Base-Benchmark Plan: 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]	**Anthem BlueCross BlueShield Community Insurance Co.**[52]
Multi-class Combination Drugs	**3 Drugs Covered**	**3 Drugs Covered**	**3 Drugs Covered**
Atripla; *efavirenz + emtricitabine + tenofovir DF*	X	X	X (tier 2)
Complera; *emtricitabine + rilpivirine + tenofovir disoproxil fumarate*	X	X	X (tier 2)
Stribild; *elvitegravir + cobicistat + emtricitabine + tenofovir disoproxil fumarate*	X	X	X (tier 2)
NRTIs	**11 Drugs Covered**	**12 Drugs Covered**	**12 Drugs Covered**
Combivir; *zidovudine + lamivudine*	X	X (PA for generic)	X (generic tier 1; brand name tier 2)
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 3)
Retrovir; *zidovudine*	X		X (generic tier 1; brand name tier 2)

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‡ There are two community insurance company plans, Lumenos and a PPO. Both are assessed here – benefits are the same, although cost sharing is slightly higher on the PPO plan.

Table 2. (continued)

Trizivir; *abacavir + zidovudine + lamivudine*	X	X	X (tier 2)
Truvada; *tenofovir DF + emtricitabine*	X	X	X (tier 2)
Videx; *didanosine (buffered versions)*		X	X (generic tier 1; brand name tier 2)
Videx EC; *didanosine (delayed-release capsules)*			X (generic tier 1; brand name tier 3)
Viread; *tenofovir disoproxil fumarate DF*	X	X	X (tier 2)
Zerit; *stavudine*	X	X (PA for some dosages)	X (generic tier 1; brand name tier 3)
Ziagen; *abacavir*	X	X (PA for some dosages)	X (generic tier 1; brand name tier 2)
NNRTIs	**5 Drugs Covered**	**5 Drugs Covered**	**5 Drugs Covered**
Edurant; *rilpivirine*	X	X	X (tier 2)
Intelence; *etravirine*	X	X	X (tier 3)
Rescriptor; *delavirdine mesylate*	X	X	X (tier 2)
Sustiva; *efavirenz*	X	X	X (tier 2)
Viramune; *nevirapine*	X	X	X (generic tier 1; brand name tier 3)
Protease Inhibitors	**10 Drugs Covered**	**8 Drugs Covered**	**10 Drugs Covered**
Agenerase; *amprenavir*	X		X
Aptivus; *tipranavir*	X		X (tier 2)
Crixivan; *indinavir sulfate*	X	X	X (tier 3)
Invirase; *saquinavir mesylate*	X	X	X (tier 2)
Kaletra; *lopinavir + ritonavir*	X	X	X (tier 2)
Lexiva; *fosamprenavir*	X	X	X (tier 2)
Norvir; *ritonavir*	X	X	X (tier 2)
Prezista; *darunavir*	X	X	X (tier 3)
Reyataz; *atazanavir sulfate*	X	X	X (tier 2)
Viracept; *nelfinavir sulfate*	X	X	X (tier 2)
Entry Inhibitors - CCR-5 Co-receptor Antagonist	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Selzentry; *maraviroc*	X (PA)	X	X (tier 3)
Fusion Inhibitors	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Fuzeon; *enfuvirtide*	X	X	X (tier 2)
HIV Integrase Strand Transfer Inhibitors	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Isentress; *raltegravir*	X	X	X (tier 3)

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Table 2. (continued)

"A1" Opportunistic Infection Medications	16 Drugs Covered	30 Drugs Covered	30 Drugs Covered
Ancobon; *flucytosine*		X	X (tier 1)
Bactrim DS; *sulfamethoxazole/trimethoprim DS*	X	X (PA for some dosages)	X (tier 1)
Biaxin; *clarithromycin*		X (PA for brand name)	X (tier 3)
Cleocin; *clindamycin*		X (PA for some dosages)	X (generic tier 1, brand name tier 3)
Dapsone	X	X	X (tier 2)
Daraprim; *pyrimethamine*	X	X	X (tier 2)
Deltasone; *prednisone*		X	X (tier 1)
Diflucan; *fluconazole*	X	X (PA for some dosages)	X (tier 1)
Famvir; *famciclovir*		X (PA)	X (tier 1)
Foscavir; *foscarnet*		X	X (tier 3)
Fungizone; *amphotericin B*		X (PA)	X (tier 3)
INH; *isoniazid*	X	X	X (tier 1)
Megace; *megestrol*		X	X (tier 1)
Mepron; *atovaquone*	X (PA)	X	X (tier 2)
Myambutol; *ethambutol*	X	X	X (generic tier 1, brand name tier 3)
Mycobutin; *rifabutin*		X	X (tier 2)
NebuPent; *pentamidine*	X	X	X (tier 2)
Probenecid		X	X (tier 1)
Procrit; *erythropoietin*	X (QL)	X (PA)	X (tier 3; PA)
Pyrazinamide (PZA)		X	X (tier 1)
Rifadin; *rifampin*		X (PA for some dosages)	X (tier 1)
Sporanox; *itraconazole*	X	X (PA)	X (generic tier 1; brand name tier 3 PA)
Sulfadiazine	X	X	X (tier 1)
Valcyte; *valganciclovir*	X	X	X (tabs tier 2; solution tier 3)
Valtrex; *valacyclovir*	X	X	X (generic tier 1; brand name tier 3)
VFEND; voriconazole		X (PA)	X (generic tier 1; brand name tier 3 and PA)

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Vistide; *cidofovir*		X (PA)	X (tier 3)
Wellcovorin; *leucovorin*	X	X (PA)	X (tier 1)
Zithromax; *azithromycin*	X	X (PA)	X (generic tier 1; brand name tier 3; QL)
Zovirax; *acyclovir*	X	X (PA required for some dosages)	X (generic tier 1; brand name tier 2)

PA = prior authorization (requires a medication exception form under ADAP); QL = quantity limited.

As table 2 indicates, Ohio's Medicaid program offers more comprehensive drug coverage than ADAP, although it imposes a $2 to $3 copay for many refills.[53] Medicaid plans available to newly eligible beneficiaries in 2014 will likely be as comprehensive as the current plan (federal guidance indicates that any US Food and Drug Administration (FDA) approved drug with significant clinically meaningful therapeutic advantage over another must be covered).[54] Nonetheless, the Medicaid plan for newly eligible beneficiaries may implement increased cost-containment measures (eg, prior authorization, quantity limits).[55] In this case, ADAP will remain critical to support the health of low-income individuals living with HIV.[56]

Anthem BlueCross BlueShield has an open, tiered formulary. This means that beneficiaries have access to any drug, but some impose significantly higher cost-sharing on the patient than others.[57] 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).[58] Thus, assuming the proposed rule is adopted, plans in Ohio must cover at least the number of drugs in each class listed above for the Anthem plan. Nonetheless, utilization review will be permissible and cost-sharing may be prohibitive on any plan. ADAP will continue to be an essential payer of last resort in these scenarios.

CONCLUSIONS AND NEXT STEPS

This report provides analyses of the Ryan White program, 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 onto Medicaid or private insurance. This report is intended to assist law makers in implementing the Patient Protection and Affordable Care Act (ACA) in a manner that serves the needs of low-income Ohioans living with HIV.

While much of the ACA has yet to be implemented, it is certain that large numbers of people living with HIV 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 Ohio, 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 positive 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. This report provides an initial analysis of the capacity of Ohio's Medicaid program to handle the needs of individuals living with HIV 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 and ADAP programs with existing Medicaid formularies allows for a baseline analysis of the needs of individuals living with HIV moving into the Medicaid system. This report identified two challenges:

1. First, a number of services that are currently provided by the Ryan White program are not available under the state's current Medicaid program. Those newly eligible for Medicaid under the 2014 expansion may still require these wrap-around 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.[59]; 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.[60]

It is essential that private insurance plans on Ohio'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 Ohio's default benchmark plan, Anthem BlueCross BlueShield Community Savings Company. Although plans sold on the exchange must adhere to EHB requirements, these will unlikely require coverage of ancillary (nonmedical) services.[61] HIV+ individuals who shift from the Ryan White program to subsidized 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, who require multiple provider visits and several prescriptions per month (many of which are brand name). Because Anthem BlueCross BlueShield Community Savings Company imposes 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. Identifying these gaps and structuring these programs to efficiently work together from the start is not only fiscally prudent, but also necessary to secure the health of individuals living with HIV 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 on Ohio:

1. Ohio must adopt the Medicaid expansion pursuant to the ACA and extend Medicaid eligibility to all individuals living under 133% FPL in order to improve health outcomes, make treatment accessible to thousands of individuals who currently lack care, and slow the transmission of HIV; and
2. Ohio 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 an exchange.

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

APPENDIX A

2014 STATE-SPECIFIC ESTIMATES

Medicaid Estimates

The ACA directs states to extend Medicaid eligibility to all individuals living below 133% 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[62]
−	**est. #**	ADAP clients with income above 133% FPL [63,§]
−	**est. #**	insured ADAP clients with income below 133% FPL
−	**est. #**	ADAP clients who are uninsured undocumented immigrants with incomes below 133% FPL[64]
=	**Total #**	ADAP clients who will be newly eligible for Medicaid in 2014

In Ohio, ADAP served 3,464 individuals in fiscal year 2010. We estimate that 45% of those clients (1,559), are living above 133% FPL. An estimated 17% (602) of individuals living below 133% FPL are currently insured, and approximately 0.82% of the state's population were undocumented in 2008 (16 ADAP individuals with incomes below 133% FPL). Thus, the calculation for Ohio is:

	3,464	ADAP clients in fiscal year 2010
−	**1,558.80**	ADAP clients with income above 133% FPL
−	**602.08**	insured ADAP clients with income below 133% FPL
−	**15.63**	estimated uninsured undocumented immigrants with incomes below 133% FPL on ADAP
=	**1,287**	individuals currently enrolled in ADAP who will be eligible for Medicaid in 2014, or 37% of those enrolled in Ohio's ADAP in fiscal year 2010

The calculation above 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%
Ohio	2,690	66%
Ohio	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.[65] (The 2010 NASTAD report is missing data for North Carolina and Kentucky, and the percentages of insured clients exceed 100% for Maryland and Ohio).

The percentages of ADAP clients who will be newly eligible for Medicaid in 2014 vary considerably from state to state. These differences can be explained by the different eligibility standards currently in place for ADAP 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

§ 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).

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 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[66]
–	**est. #**	ADAP clients living below 133% FPL[67]
–	**est. #**	ADAP clients living above 400% FPL[68,**]
–	**est. #**	of insured ADAP clients living between 133-400% FPL[69]
–	**est. #**	undocumented ADAP clients living between 133-400% FPL[70]
=	**Total #**	ADAP clients who will be eligible for subsidized private insurance in 2014

Again, in Ohio, ADAP served 3,464 individuals in fiscal year 2010. Of those, we estimate that 55% (1,905) were living below 133% or above 400% FPL. We further estimate that 19% (645) of those living between 133-400% were insured. As estimated 0.82% of the state's population were undocumented as of 2008. Applying this percentage to the individuals enrolled in Ohio's ADAP Program computes to approximately 13 ADAP clients in Ohio who are uninsured and undocumented immigrants living between 133-400% FPL. Thus, completing the calculation above for Ohio's ADAP program yields:

	3.464	ADAP clients served in fiscal year 2010
–	**1,905.20**	ADAP clients with incomes below 133% FPL or above 400% FPL
–	**644.96**	insured ADAP clients living between 133-400% FPL
–	**12.79**	estimated undocumented immigrants on ADAP with incomes living between 133-400% FPL
=	**901**	individuals currently enrolled in ADAP who will be eligible for private insurance subsidies in 2014 or 26% of those enrolled in Ohio's ADAP program in fiscal year 2010

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

State	# ADAP Clients Newly Eligible for Subsidies	% ADAP Clients Newly 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.[71] (The 2012 NASTAD Report is missing data for North Carolina, 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 adults living below 133% FPL, between 133-400% FPL, and above 400% FPL in each state who are insured was determined using data available at the Kaiser Family Foundation's STATEHEALTHFACTS.ORG website. The website lists insurance status for people beginning at 139% FPL instead of 133% FPL, but because of the ACA's 5% income disregard, the Medicaid expansion applies to all individuals living below 138% FPL, making this distinction irrelevant. The website also divides the 133-400% FPL income group into two groups: 133-250% FPL and 251-399% FPL. The number of insured adults, and the total number of adults in these two groups were pooled in order to determine the percentage of adults living between 133-400% FPL who are insured.

   In Ohio, 62% of adults living below 133% FPL are insured; 81% of adults living between 133-400% FPL are insured; and 96% living above 400% FPL are insured;

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

   For example, in Ohio, the figure 62% was given the baseline number 1. 81% is 1.31 times 62%, and 96% is 1.55 times 62%. In other words, an adult in Ohio with income between 133% FPL and 400% FPL is 1.31 times more likely to be insured than an adult with income below 133% FPL, while an adult with income above 400% FPL is 1.55 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.[72] 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 client who are insured in each state (Table 14), we attempted to estimate the number of insured ADAP clients in each state.[††]

   In Ohio, we estimated that about 1,247 of the state's 3,464 ADAP clients served in 2010 were insured. The insurance rate for ADAP clients in that state stood at 36% in 2011;

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

   In Ohio, 55% of ADAP clients have income below 133% FPL, 45% have income between 133-400% FPL, and none have income above 400% FPL; and finally

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

a = 1,094.69

Applying the determined value of a to Formula 1:

The estimated number of insured ADAP clients in Ohio with,

Income below 133% FPL = 602.08
Income between 133-400% FPL = 644.95
Income above 400% FPL = 0

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

APPENDIX B

DATA COLLECTION METHODOLOGY

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

Ryan White Program Data

Demographic information about Ryan White program clients was culled from a number of sources. For the sake of continuity, the Federal Health Resources and Services Administration (HRSA) 2010 State Profiles were used for data about the Ryan White program. Where available, information from state departments of health has also been included. Demographic information for AIDS Drug Assistance Program (ADAP) clients is most thoroughly documented by the National Alliance of State and Territorial AIDS Directors (NASTAD), and information from that organization has been provided for income and insurance status of ADAP clients. NASTAD's data for fiscal years 2010 and 2011 and June 2011 were used (fiscal year 2010 was necessary for states that did not report data in 2011). Because ADAP data compiled by NASTAD are unduplicated, it is one of the most reliable sources of information about demographic information for people living with HIV. Data from June 2011 provide information on how many people living with HIV currently enrolled in ADAP fall between 100-133% of federal poverty level (FPL). Since the expansion of Medicaid eligibility to those under 133% is a relatively new development, there is a relative dearth of data regarding the number of individuals whose incomes are between 100-133% of FPL. NASTAD provides the only reliable source of these data to date. NASTAD's ADAP information will be used for estimates regarding people living with HIV who will be newly eligible for Medicaid in 2014 at the end of this report. Information available from state departments of health or HRSA has also been provided.

Estimates of unmet 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 are not from the same year. Information about unmet need 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 profile if it was available.

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

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

Medicaid Coverage Data

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

Benchmark Plan Coverage Data

Anthem BlueCross BlueShield Community Savings Company is Ohio's default benchmark plan, as the largest small-group plan in the state's market. Data on this plan were collected from publicly available information on Anthem's 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.[73] (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 program appear to be incorrect in NASTAD's Monitoring Report, as the number of clients served is listed as larger than the number of eligible ADAP clients in the state. The number listed was used in these calculations, and while the specific number of ADAP clients eligible for Medicaid and private insurance subsidies in Mississippi may not be reliable, the proportion of clients eligible for both programs was obtained in the same way as that for other states, for 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 that will be eligible for Medicaid and private insurance subsidies;
2. Data for ADAP clients served were used rather than data for clients enrolled because the number of individuals enrolled may exceed the actual number of clients accessing ADAP services. Potential clients who are currently on ADAP waiting lists in several states are also not included in these calculations. Thus, the numbers provide a conservative estimate of ADAP beneficiaries who will transition onto Medicaid or into subsidized private insurance;
3. National data (NASTAD and HRSA) were used in calculations instead of state-specific data to ensure that these estimates could be compared across the states surveyed; and
4. The number of undocumented immigrants on ADAP is a rough estimate extrapolated from estimates of the overall number of undocumented immigrants in the state as a whole as of 2008. It is possible that this estimate either overestimates or underestimates the actual number of undocumented immigrants currently served by ADAP.

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

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

APPENDIX C

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

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

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

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63. In order to estimate the number of ADAP enrollees whose income falls between 133% and 400% FPL, data from June 2011 was used. For the purpose of this analysis it is assumed that similar percentages existed throughout FY 2010. NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS (NASTAD), NATIONAL ADAP MONITORING PROJECT ANNUAL REPORT, 50-51, Tables 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.

64. The number of undocumented immigrants on ADAP in each state in FY2009 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.

65. NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS (NASTAD), NATIONAL ADAP MONITORING PROJECT ANNUAL REPORT, Table 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.

66. NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS (NASTAD), NATIONAL ADAP MONITORING PROJECT ANNUAL REPORT, 44-45, Table 8 [hereinafter NASTAD REPORT] (August 2012), *available at* http://www.nastad.org/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.

67. NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS (NASTAD), NATIONAL ADAP MONITORING PROJECT ANNUAL REPORT, 50-51, Tables 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.

68. NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS (NASTAD), NATIONAL ADAP MONITORING PROJECT ANNUAL REPORT, 50-51, Tables 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. 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, pg. 50-51.

70. 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.

71. NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS (NASTAD), NATIONAL ADAP MONITORING PROJECT ANNUAL REPORT, Table 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.

72. NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS (NASTAD), NATIONAL ADAP MONITORING PROJECT ANNUAL REPORT, ,49, 51, Tables 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.

73. NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS (NASTAD), NATIONAL ADAP MONITORING PROJECT ANNUAL REPORT, Table 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

TAEP
Treatment Access Expansion Project

Center for Health Law and Policy Innovation
Harvard Law School

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