STATE HEALTH REFORM IMPACT MODELING PROJECT

# Pennsylvania

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# BACKGROUND

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

The State Health Reform Impact Modeling Project (the Modeling Project) assesses the impact that healthcare reform will have on people living with HIV by compiling and analyzing Ryan White program and AIDS Drug Assistance Program (ADAP) data to predict the shift of uninsured people living with HIV from these discretionary programs to Medicaid or private insurance in all 50 states pursuant to the ACA. In addition, in 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 private insurance, 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 Pennsylvania, 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?

# PENNSYLVANIA

## PENNSYLVANIANS LIVING WITH HIV/AIDS

### UNMET NEED

In 2011, there were an estimated 31,856 Pennsylvanians living with diagnosed HIV/AIDS.[3] In 2008, an estimated 29-33% of Pennsylvanians with HIV/AIDS did not receive HIV-related primary medical care.[4] This proportion of individuals living with HIV/AIDS are not accounted for in the following modeling of those who will transition over to Medicaid or subsidized private insurance under the 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 PENNSYLVANIA

The Ryan White program provides federal funding to states to help fulfill the unmet medical and care needs of individuals living with HIV or AIDS. To be eligible for Ryan White-funded services in Pennsylvania, an individual must be a Pennsylvania resident diagnosed with HIV or AIDS and living at or below 200% of the annual federal poverty level (FPL).[5] In 2010, the Ryan White program served 53,195 duplicated clients in Pennsylvania.[6,7] Among these individuals, approximately 50% were insured by Medicaid, 19% by Medicare, and 13% by private insurance companies. Approximately 15% of the Pennsylvanians served by the Ryan White program are uninsured.

In 2010, Pennsylvania received $86,985,329 in Ryan White program funding. Approximately half (49.4%) of those funds were devoted to Ryan White Part B, of which 29.4% was spent on Base and Emerging Communities and 69.8% was spent on the AIDS Drug Assistance Program (ADAP).[8]

### ADAP IN PENNSYLVANIA

ADAP provides federal and state support to low-income HIV/AIDS patients otherwise unable to afford medications. In Pennsylvania, ADAP is administered by the HIV/AIDS component of the state's Special Pharmaceutical Benefits Program (SPBP).[9] SPBP assistance is available as a payer of last resort for Pennsylvanians living at or below 337% FPL, but who do not qualify for Medicaid.[10] In fiscal year 2010, Pennsylvania's ADAP provided assistance to 6,125 individuals.[11] In June 2011, Pennsylvania's ADAP served 4,299 clients, of whom 24% would be eligible for Medicaid under the expansion (if not already) and 21% would be eligible for a Basic Health Plan (BHP).[12]

In fiscal year 2010, Pennsylvania's total ADAP budget was $74,130,521; in fiscal year 2011, the budget dropped approximately 5% to $70,193,736.[13] Of that budget, $30,028,414 came from Ryan White Part B funding, $10,267,000 from state funds, and $29,898,322 from drug rebates and additional state and federal funds.[14]

## THE AFFORDABLE CARE ACT AND ITS IMPACT ON HIV+ PENNSYLVANIANS

### THE MEDICAID EXPANSION

Beginning in January 2014, the ACA expands Medicaid eligibility to most individuals under 65 years of age living below 133% of the federal poverty level (FPL).[15,*] Although the Department of Health & Human Services (HHS) cannot force states to comply with the expansion (by withdrawing existing federal medical funding), the federal government will cover 100% of the cost of newly eligible beneficiaries until 2016, and at least 90% thereafter.[16] Newly eligible enrollees will receive a benchmark benefit package that will include ten categories of essential health benefits (EHB), described in the "Essential Health Benefits" section.[17]

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

## THE BASIC HEALTH PLAN

The ACA provides an option for states to create a Basic Health Plan (BHP) that would be largely federally funded (the state would receive up to 95% of the premium credits an individual would have been entitled to for purchase of a plan on the exchange).[18] 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.[19] 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.[20] Cost sharing on BHPs can be subsidized, either for all beneficiaries or for those with specific chronic conditions (eg, HIV/AIDS).[21] 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

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.[22] Insurance exchanges will provide individuals and families with a choice of plans, tiered by actuarial values 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.[23] Because Pennsylvania did not submit a benchmark plan for purposes of defining EHB, the largest small-group plan in the state, the Aetna HMO (POS) plan, is now considered its default benchmark plan.

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.[24] 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 EHB, to be defined by the Secretary of HHS.[25] These EHB must include items and services within the following ten benefit categories[26]:

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.[27] The Centers for Medicare & Medicaid Services (CMS) 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.[28] 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.[29]

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

Given the ACA-instituted reforms, a large number of HIV+ individuals in Pennsylvania are expected to become eligible for public or subsidized private insurance in 2014, provided that Pennsylvania fully implements the law. An estimated 89% of the state's Ryan White program clients in 2010 were between 100-200% FPL, making them potentially eligible for either Medicaid or a BHP in 2014.[30] Among Pennsylvanians served by the state's ADA, 22% will be newly eligible for Medicaid following its expansion. An additional 26% of ADAP clients will be eligible for private insurance subsidies.

The percentage of Pennsylvania's ADAP clients who will be newly eligible for Medicaid (22%) is close to the national proportion of newly eligibles (29%), while the percentage expected to qualify for private insurance subsidies (26%) is considerably higher than the national proportion (15%) (Appendix A). This is likely because Pennsylvania's ADAP serves individuals with incomes up to 337% FPL.

# COMPARISON OF COVERED SERVICES UNDER RYAN WHITE, ADAP, MEDICAID, AND THE INSURANCE EXCHANGE

Since a significant number of HIV+ individuals in Pennsylvania who are currently served by the Ryan White program or ADAP are likely to be eligible for Medicaid or subsidized private insurance in 2014, it is important to assess the outcome of transitioning from the former programs to the latter. This assessment compares and contrasts the services and treatments that the Ryan White program, ADAP, Medicaid, and Pennsylvania's health insurance exchange would provide to HIV+ Pennsylvanians.

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

The Ryan White program funds both core medical services and support services for patients living with HIV/AIDS (see Appendix C for a breakdown of core medical 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 make accessing healthcare possible.

Many of the ancillary services provided by the Ryan White program are generally not covered by Medicaid or Pennsylvania's Benchmark Plan (although the latter two programs cover a broader range of medical services). While Pennsylvania does provide some additional ancillary services to low-income HIV+ individuals through its AIDS Waiver program, those services are limited to individuals whose illness has reached a level that requires care in a hospital, skilled nursing facility, or intermediate care facility.[31]

Accounting for gaps in coverage of ancillary services will be critical in transitioning beneficiaries onto Medicaid and the insurance exchanges in order to ensure that health status does not deteriorate (eg, due to lack of access to transportation to a health clinic, proper nutrition, and stable housing that keeps people off the streets).

Table 1 provides a comparison of covered services between Pennsylvania's Ryan White program (as of 2010), Medicaid (as of 2012), and Pennsylvania's largest small-group market plan, which will serve as the default benchmark plan for the state insurance exchange.

**Table 1. Ryan White, Medicaid, and the Benchmark Plan Used to Define Essential Health Benefits: Covered Services**

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

| Covered Service | Ryan White[32] | Medicaid[33] | Aetna Health Maintenance Organization (POS) Small-Group Plan[34] |
|---|---|---|---|
| Home healthcare | X | X | X (limited) |
| Mental health | X | X | X (limited) |
| Substance abuse (outpatient) | X | X | X (limited) |
| Substance abuse (inpatient) | X | X | X (limited) |
| Medical case management | X | | |
| Community-based care | X | | |
| Ambulatory/outpatient care | X | X | X |
| Oral healthcare | X | X | |
| Early-intervention clinic | X | | |
| Intermediate care facilities for the mentally retarded | | X | |
| Ambulance | | X | X |
| Family planning | | X | |
| Durable medical equipment | | X | X ($2,500/year limit) |
| Hospital services | | X | X |
| Lab and x-ray services | | X | X |
| Nursing facility | | X | |
| Midwife/NP services | | X | |
| Private-duty nursing | | X | |
| Physician services | | X | X |
| Nonmedical case management services | X | | |
| Child care | X | | |
| Emergency financial assistance | X | | |
| Food bank/home-delivered meals | X | | |
| Housing services | X | | |
| Health education/risk reduction | X | | |
| Legal services | X | | |
| Linguistic services | X | | |
| Medical transportation | X | X | |
| Outreach services | X | | |
| Psychosocial support | X | | |
| Referral agencies | X | | |
| Treatment adherence counseling | X | | |
| Chiropractor | | X | X (20 visits/year) |

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**Table 1. (cont.)**

| | | |
|---|---|---|
| Podiatry | X | |
| Hospice | X | |
| Respiratory therapy | | |
| PT, OT, and speech therapy | | X<br>(30 visits/year for PT and OT combined; 30 visits/year for speech therapy) |
| Orthotics and prosthetics | | |
| Personal care | | |
| Home infusion therapy | | |

NP = nurse practitioner; PT = physical therapy; OT = occupational therapy.

As Table 1 indicates, the Ryan White program offers HIV+ individuals a number of ancillary services that Pennsylvania's Medical Assistance program and default benchmark plan do not cover, and are unlikely to be included as part of EHB, given existing federal guidance and proposed regulation.[35,36]

Since these ancillary services are important for the well-being of HIV+ individuals, those individuals who leave the Ryan White program for Medicaid or private insurance plans will be at a disadvantage if Ryan White wraparound services are unavailable.

## COMPARING COVERED MEDICATIONS UNDER ADAP, MEDICAID, AND THE BENCHMARK PLAN FOR THE EXCHANGE IN PENNSYLVANIA

ADAP provides funding for a robust drug formulary that is necessary to allow low-income individuals affordable access to a combination of drugs to treat HIV. All states participating in ADAP must cover at least one drug in every class of antiretroviral drugs; most cover all drugs in each class. Pennsylvania's ADAP, the Special Pharmaceutical Benefits Program (SPBP) – HIV/AIDS, covers almost all of the FDA-approved antiretroviral medications, many of the CDC-recommended "A1" medications for opportunistic infections, as well as a number of other medications, biologics, and devices.[37] Pennsylvania's Medical Assistance program also provides substantial pharmaceutical coverage, although its drug formulary is less extensive than SPBP's. Ensuing that Medicaid and plans sold on the exchange provide coverage for a sufficient number of antiretroviral medications will be critical to maintaining the health of Pennsylvanians living with HIV/AIDS.

Table 2 provides a comparison of the antiretroviral drug formularies included in Pennsylvania's ADAP and Medicaid programs, as well as Aetna's HMO (POS) small-group plan.

**Table 2. ADAP, Medicaid, and the Benchmark Plan Used to Define Essential Health Benefits: Drug Formularies**

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

| Drugs<br>(ART class indicated in bold; brand name in normal type; generic in italics) | ADAP[38] | Medicaid[39] | Aetna HMO (POS) Plan[40] |
|---|---|---|---|
| **Multiclass Combination Drugs** | **2 Drugs Covered** | **2 Drugs Covered** | **2 Drugs Covered** |
| Atripla (*efavirenz, emtricitabine, tenofovir disoproxil fumarate*) | X | X<br>(QL) | X<br>(tier 3) |
| Complera (*rilpivirine, emtricitabine, tenofovir disoproxil fumarate*) | X | X<br>(QL) | X<br>(tier 3) |
| Stribild (*elvitegravir, cobicistat, emtricitabine, tenofovir disoproxil fumarate*) | | | |
| **NRTIs** | **12 Drugs Covered** | **12 Drugs Covered** | **12 Drugs Covered** |
| Combivir (*zidovudine + lamivudine*) | X | X<br>(QL) | X<br>(generic tier 1; brand name tier 3) |

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**Table 2. (cont.)**

| | | | |
|---|---|---|---|
| Emtriva (*emtricitabine*) | X | X (QL) | X (tier 2) |
| Epivir (*lamivudine*) | X | X (QL) | X (generic tier 1; brand name tier 2) |
| Epzicom (*abacavir sulfate + lamivudine*) | X | X (QL) | X (tier 3) |
| Retrovir (*zidovudine*) | X | X (QL; NP) | X (generic tier 1; brand name tier 3) |
| Trizivir (*abacavir + zidovudine + lamivudine*) | X | X (QL; NP) | X (tier 3) |
| Truvada (*tenofovir DF + emtricitabine*) | X | X (QL) | X (tier 2) |
| Videx | X | X (QL) | X (tier 2) |
| Videx EC (*didanosine – delayed-release capsules*) | X | X (QL) | X (generic tier 1; brand name tier 3) |
| Viread (*tenofovir disoproxil fumarate DF*) | X | X (QL) | X (tier 2) |
| Zerit (*stavudine*) | X | X (QL; NP) | X (generic tier 1; brand name tier 3) |
| Ziagen (*abacavir*) | X | X (QL) | X (generic tier 1; brand name tier 3 & ST) |
| **NNRTIs** | **5 Drugs Covered** | **5 Drugs Covered** | **5 Drugs Covered** |
| Intelence (*etravirine*) | X | X (QL; NP) | X (tier 3) |
| Rescriptor (*delavirdine mesylate*) | X | X (QL; NP) | X (tier 3) |
| Sustiva (*efavirenz*) | X | X (QL) | X (tier 2) |
| Viramune (*nevirapine*) | X | X (QL; NP) | X (generic tier 1; brand name tier 3 & ST) |
| Edurant (*rilpivirine*) | X | X (QL; NP) | X (tier 3) |
| **Protease Inhibitors** | **9 Drugs Covered** | **9 Drugs Covered** | **9 Drugs Covered** |
| Aptivus (*tipranavir*) | X | X (QL; NP) | X (tier 2) |
| Crixivan (*indinavir sulfate*) | X | X (QL) | X (tier 3) |
| Invirase (*saquinavir mesylate*) | X | X (QL) | X (tier 3) |
| Kaletra (*lopinavir + ritonavir*) | X | X (QL) | X (tier 2) |
| Lexiva (*fosamprenavir*) | X | X (QL) | X (tier 2) |
| Norvir (*ritonavir*) | X | X (QL) | X (tier 2) |
| Prezista (*darunavir*) | X | X (QL) | X (tier 2) |
| Reyataz (*atazanavir sulfate*) | X | X (QL) | X (tier 2) |
| Viracept (*nelfinavir sulfate*) | X | X (QL; NP) | X (tier 3) |
| **Fusion Inhibitors** | **1 Drug Covered** | **1 Drug Covered** | **1 Drug Covered** |
| Fuzeon (*enfuvirtide*) | X | X (QL; NP) | X (tier 2) |
| **Entry Inhibitors – CCR-5 Coreceptor Antagonist** | **1 Drug Covered** | **1 Drug Covered** | **1 Drug Covered** |
| Selzentry (*maraviroc*) | X | X (QL) | X (tier 2) |

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**Table 2. (cont.)**

| HIV Integrase Strand Transfer Inhibitors | 1 Drug Covered | 1 Drug Covered | 1 Drug Covered |
|---|---|---|---|
| Isentress (*raltegravir*) | X | X (QL) | X (tier 3) |
| **"A1" Opportunistic Infection Medications** | **26 Drugs Covered** | **12 Drugs Covered** | **22 Drugs Covered** |
| Zovirax; *Acyclovir* | X | X (NP) | X (generic tier 1; brand name tier 3) |
| Fungizone; *Amphotericin B* | X | | |
| Zithromax; *Azithromycin* | X | X (NP) | X (generic tier 1; brand name tier 3) |
| Vistide; *Cidofovir* | X | | X (tier 3) |
| Biaxin; *Clarithromycin* | X | X (NP) | X (generic tier 1; brand name tier 3) |
| Cleocin; *Clindamycin* | X | X | X (tier 1) |
| *Ethambutol* | X | | X (tier 1) |
| Famvir; *Famciclovir* | X | X (NP) | X (generic tier 1; brand name tier 3; QL) |
| Diflucan; *Fluconazole* | X | X (brand name NP) | X (generic tier 1; brand name tier 3; PA; QL for 150 mg) |
| Ancobon; *Flucytosine* | X | X (brand name NP) | X (generic tier 1; brand name tier 3) |
| Foscavir; *Foscarnet* | X | | X (tier 1) |
| Cytovene; *Ganciclovir* | X | | X (generic tier 1; brand name tier 3) |
| Nydrazid; *Isoniazid* (*INH*) | X | | X (tier 1) |
| Sporanox; *Itraconazole* | X | X (NP) | |
| Wellcovorin; *Leucovorin calcium* | | | X (tier 1) |
| PEG-Intron; *Peg-Interferon alfa-2a* | | X (PA) | X (tier 2; PA) |
| Nebupent; *Pentamidine* | X | | X (tier 2) |
| Deltasone; *Prednisone* | X | | X (tier 1) |
| *Probenecid* | X | X | X (tier 1) |
| *Pyrazinamide (PZA)* | X | | X (tier 1) |
| Daraprim; *Pyrimethamine* | X | | X (tier 3; PA) |
| Virazole; Copegus; Rebetol; *Ribavirin* | X | X (NP) | X (generic tier 1; brand name tier 3) |
| Mycobutin; *Rifabutin* | X | | |
| Rifadin; *Rimactane; Rifampin* | X | | X (tier 1) |
| Microsulfon; *Sulfadiazine* | X | | |
| Bactrim; *Trimethoprim-sulfamethoxazole (TMP/SMX)* | X | | |
| Valtrex; *Valacyclovir* | X | X (NP) | X (generic tier 1; brand name tier 3 and ST) |
| Valcyte; *Valganciclovir* | X | | X (tier 2; QL) |

ADAP = AIDS Drug Assistance Program; ART = antiretroviral therapy; NNRTI = non-nucleoside reverse transcriptase inhibitors; NP = nurse practitioner; NRTI = nucleoside reverse transcriptase inhibitors; PA = prior authorization; QL = quantity limits apply; ST = step therapy required.

As Table 2 indicates, the HIV/AIDS-related pharmacy services covered by Pennsylvania's Medicaid program are far more limited than Pennsylvania's ADAP. Although Medicaid covers all of the antiretroviral medications covered by SPBP, several are non-preferred (requiring PA) and most are subject to monthly quantity limits (although beneficiaries with HIV/AIDS are exempt from these limits)[41-43] Furthermore, Medicaid covers significantly fewer drugs used to treat opportunistic infections than ADAP.[44]

On the other hand, Pennsylvania's benchmark plan, Aetna's small-group HMO (POS) plan, includes most HIV/AIDS-related medications on its drug formulary. Cost, however, may become prohibitive; most drugs required for comprehensive ART are tier 2 or 3, with copays for each 30-day refill as high as $75. Furthermore, two HIV/AIDS medications—Ziagen and Viramune—can only be prescribed as part of a step-therapy program, imposing a potential additional barrier for patients who require these specific medications (treatment must fail on another drug before coverage will be granted).

Ultimately, if Pennsylvanians living with HIV/AIDS are unable to access appropriate and affordable antiretrovirals and other medications through Medical Assistance or the insurance exchange, Ryan White and ADAP will continue to be necessary as payers of last resort.

# CONCLUSIONS AND NEXT STEPS

This report provides analyses of the Ryan White program, ADAP, Medicaid, and Pennsylvania's benchmark plan for purposes of defining essential health benefits (EHB) in the private market, 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 Pennsylvanians.

While much of the ACA has yet to be implemented, it is certain that large numbers of people living with HIV/AIDS will be newly eligible for health insurance in 2014, provided that Pennsylvania fully implements the law. Given that a significant proportion of uninsured ADAP clients would transition into Medicaid in Pennsylvania, expanding Medicaid is crucial to ensuring access to care and reducing transmission of HIV across the state.

At the same time, the Medicaid system must be ready and able to handle the needs of low-income people who have HIV/AIDS. This report provides an initial analysis of the capacity of the program to handle the needs of this influx of individuals living with HIV/AIDS. The Medicaid benefits that will be available to newly eligible beneficiaries, including those living with HIV/AIDS, have not yet been defined. As such, an analysis of the barriers to care that this population is likely to face (based upon the existing Medicaid program) is timely as states prepare for the transition to a possible 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/AIDS 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 Pennsylvania's current Medicaid program and are unlikely to be required EHB, given existing federal guidance.[45] HIV+ individuals who shift from the Ryan White program to Medicaid are therefore likely to have difficulty accessing a number of services currently available to them; and
2. Second, limitations on Medicaid recipients' pharmacy benefits may pose challenges for individuals in need of multiple branded prescriptions. Those living with HIV/AIDS are likely to exceed the maximum allowable number of monthly branded prescriptions covered by Medicaid. If the Medicaid plan available to newly eligible uses similar cost-containment strategies, which it likely will be able to do, ADAP remain a critical payer of last resort.[46]

Many other HIV+ Pennsylvanians currently receiving services through the Ryan White program will now be eligible for subsidies to purchase health insurance coverage through Pennsylvania's insurance exchange. It is therefore also essential that these private insurance plans provide a comprehensive range of services sufficient to meet the needs of Ryan White clients who transition into them. This report identified two challenges with respect to the state's benchmark plan, which will be used to define EHB for private insurance plans:

1. First, a number of services that are currently provided by the Ryan White program are not available under Pennsylvania's default benchmark plan, and are unlikely to be required EHB on the private market.[47] HIV+ individuals who shift from the Ryan White program to private insurance

plans on the exchange are therefore likely to have trouble accessing a number of services currently available to them; and

2. Second, the prescription drug under Pennsylvania's benchmark plan is not as comprehensive as the state's ADAP formulary and, further, imposes significant costs for HIV/AIDS medications. Because the prescription drug EHB is likely to mirror the number of drugs covered in a given class on the benchmark plan (requiring coverage of at least one drug per class if none are covered), HIV+ individuals shifting from ADAP to private insurance plans may have trouble accessing comprehensive antiretroviral therapy (ART).[48]

Thus, even with full implementation of the ACA, Pennsylvania is likely to experience ongoing demand for Ryan White and ADAP services to fill gaps in access to comprehensive ART. 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 Pennsylvanians.

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. Pennsylvania should extend Medicaid eligibility to all individuals living under 133% of the federal poverty level (FPL), pursuant to the ACA, in order to slow the transmission of HIV and make treatment accessible to thousands of individuals who currently lack care; and
2. Pennsylvania must ensure that Ryan White and ADAP services are available where Medicaid or private insurance coverage or affordability gaps exist (eg, transportation, nonmedical case management, food and nutrition, prohibitive cost sharing).

**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 the AIDS Drug Assistance Program (ADAP) who will be eligible for Medicaid in 2014, the following formula was used:

| | | |
|---|---|---|
| | **Total #** | ADAP clients being served in fiscal year 2010[49] |
| − | **est. #** | ADAP clients living above 133% FPL[50,†] |
| − | **est. #** | insured ADAP clients living below 133% FPL[‡] |
| − | **est. #** | ADAP clients who are undocumented immigrants living below 133% FPL in June 2011 |
| = | **Total #** | ADAP clients who will be newly eligible for Medicaid in 2014[§] |

Using data from Pennsylvania, 6,125 individuals were served by Pennsylvania's ADAP during fiscal year 2010. Of those, an estimated 63% (3858.75) of ADAP clients have incomes above 133% FPL. An estimated 24% (916.32) of ADAP clients are below 133% FPL and insured. Finally, we estimate that approximately 16.35 of the state's 140,000 undocumented immigrants in 2008 are uninsured, have incomes below 133% FPL, and are served by ADAP. Thus, the calculation for Pennsylvania is:

| | | |
|---|---|---|
| | **6,125** | ADAP clients served in fiscal year 2010 |
| − | **3,858.75** | ADAP clients with incomes above 133% FPL |
| − | **916.32** | insured ADAP clients with incomes below 133% FPL |
| − | **16.35** | uninsured undocumented immigrants with incomes below 133% FPL |
| = | **1,334** | ADAP clients who will be newly eligible for Medicaid in 2014; this constitutes 22% of the ADAP clients served in fiscal year 2010 |

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

| State | # ADAP Clients Newly Eligible for Medicaid | % ADAP Clients 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.[51] The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages sum to greater than 100% for Maryland and Ohio and hence are not workable for the calculations.

The percentages of ADAP clients who will be newly

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

‡ See Methodology for Distribution of Insured ADAP Clients by Income.

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

eligible for Medicaid in 2014 vary considerably from state to state. These differences can be explained by the different eligibility standards currently in place for ADAP eligibility within each state, as well as by the differences in estimated percentages of undocumented immigrants in each state. For instance, states with higher-than-average newly eligible Medicaid beneficiaries may currently require that ADAP recipients have no other sources of insurance (eg, Virginia). On the other hand, states with lower-than-average newly eligibles have higher insurance rates all around (eg, Massachusetts) or other public assistance programs that supplement ADAP. In sum, NASTAD's data do not capture all groups of people living with HIV/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 being served in fiscal year 2010[52] |
| – | **est. #** | ADAP clients living below 133% FPL or above 400% FPL[53,**] |
| – | **est. #** | insured ADAP clients living between 133% and 400% FPL[54] |
| – | **est. #** | ADAP clients who are undocumented immigrants living between 133% and 400% FPL[55] |
| = | **Total #** | ADAP clients who will be eligible for subsidized private insurance |

In Pennsylvania, 6,125 individuals were served by ADAP during fiscal year 2010. Of those, 30% (1,837.50) of ADAP clients have incomes below 133%. We estimate that 44% (2,681.97) of ADAP clients have incomes between 139-400% FPL and are currently insured. We further estimate that approximately 38.83 of the state's 140,000 undocumented immigrants in 2008 are uninsured, have incomes between 133-400% FPL, and are served by ADAP. Thus, completing the calculation above for Pennsylvania's ADAP yields:

| | | |
|---|---|---|
| | **6,125** | ADAP clients served in fiscal year 2010 |
| – | **1,837.50** | ADAP clients living below 133% FPL or above 400% FPL |
| – | **2,681.97** | insured ADAP clients living between 133% and 400% FPL |
| – | **38.83** | estimated ADAP clients who are undocumented immigrants living between 133% and 400% FPL[56] |
| = | **1,567** | ADAP clients who will be eligible for subsidized private insurance, which constitutes 26% of ADAP clients served in fiscal year 2010 |

The calculation above 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** | **32,527** | **15%** |

Note: Data on the insurance status of ADAP clients in Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.[51] The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages sum to greater than 100% for Maryland and Ohio and hence are not workable for the calculations.

** 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

Estimating the proportion of insured ADAP clients falling into each income bracket 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.[57] The website lists insurance status for people beginning at 139% FPL instead of 133% FPL, but because of the ACA's 5% income disregard, the Medicaid expansion applies to all individuals living below 138% FPL, making this distinction irrelevant. The website also divides the 133-400% FPL income group into two groups: 133-250% FPL and 250-399% FPL. The number of insured adults and the total number of adults in these two groups were pooled in order to determine the percentage of adults living between 133-400% FPL who are insured.

   In Pennsylvania, 68% of adults living below 133% FPL are insured; 84% of adults living between 133-400% FPL are insured; and 96% living above 400% FPL are insured;

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

   In Pennsylvania, we gave the figure 68% the baseline number 1. 84% is 1.23 times 68%, and 96% is 1.40 times 68%. In other words, an adult in Pennsylvania with income between 133-400% FPL is 1.23 times more likely to be insured than an adult with income below 133% FPL, while an adult with income above 400% FPL is 1.40 times more likely to be insured;

3. Next, we 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.[58] 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 Pennsylvania, we estimated that about 3,920 of the state's 6,125 ADAP clients served in 2010 were insured. The insurance rate for ADAP clients in the state stood at 64% in 2011;

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

   In Pennsylvania, 24% of ADAP clients are living below 133% FPL, 57% are living between 133-400% FPL, and 6% are living above 400%; and finally

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

   We relied on two formulas:

**Formula 1:**

Number of insured clients in each group
= (relative likelihood of being insured)
x (proportion of income group)
x *a*

**Formula 2:**

Total number of insured ADAP clients
= (number of insured clients living below 133% FPL)
+ (number of insured clients living between 133-400% FPL)
+ (number of insured clients living above 400% FPL)

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

Thus, for Pennsylvania:

$$3{,}920 = (1 \times 0.24 \times a) + (1.23 \times 0.57 \times a) + (1.40 \times 0.60 \times a)$$

Solving for $a$,

$a = 3{,}818.02$

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

The estimated number of insured ADAP clients in Pennsylvania with,

Incomes below 133% FPL = 916
Incomes between 133-400% FPL = 2,682
Incomes above 400% FPL = 322

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 DC are prioritized. More recent or more detailed data available for a particular state has also been included.

### Ryan White Program Data

Demographic information about Ryan White program clients was culled from a number of sources. For the sake of continuity, the Federal Health Resources and Services Administration (HRSA) 2010 State Profiles were used for data about the Ryan White program. Where available, information from state departments of health has also been included. Demographic information for ADAP clients is most thoroughly documented by the National Alliance of State & Territorial AIDS Directors (NASTAD), and information from that organization has been provided for income and insurance status of ADAP clients. NASTAD's data for fiscal year 2010, fiscal year 2011, and June 2011 were used (fiscal year 2010 was necessary for states that did not report data in 2011). Because ADAP data compiled by NASTAD is 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 live between 100-133% 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 this 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. Where information is also available from state departments of health or HRSA, it has been provided.

Estimates of unmet need for people living with HIV/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 amongst states is limited. Where information about unmet need is available from other sources, it has also been included.

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

Income thresholds for ADAP eligibility, cost-containment measures in each state, and ADAP formularies are available from a variety of sources. The most common sources for this information are MEDICARE.GOV, 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

Because Pennsylvania did not submit a benchmark plan to HHS as a proposed benefit package for purposes of defining EHB for the state's exchange, Pennsylvania's largest small-group market plan, Aetna's Health Maintenance Organization (POS), is now the default benchmark plan. Data was collected from Aetna's website and from HHS's HEALTHCARE.GOV website.

## NOTES

Data for certain states were incomplete in the 2012 National ADAP Monitoring Project Annual Report; missing data were obtained from alternate sources:

- Data on the insurance status of ADAP clients Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.[59] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages 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 both 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 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 actually accessing ADAP services. Potential clients who are currently on ADAP waiting lists in several states are also not included in these calculations. Thus, the numbers provide a conservative estimate of ADAP beneficiaries who will transition onto Medicaid or into subsidized private insurance;
3. National data (NASTAD and HRSA) were used in calculations instead of state-specific data to ensure that these estimates could be compared across the states surveyed; and
4. The number of undocumented immigrants on ADAP is a rough estimate 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 above are our best estimates of the number and percentage of ADAP clients who will be newly eligible for Medicaid in 2014 (assuming full implementation of the ACA), and the number and percentage of ADAP clients 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 further information about the unmet need within states before attempting to make such calculations.

# APPENDIX C

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

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

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

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50. The estimated number of ADAP recipients who are on private insurance, Medicaid, and Medicare is determined for the purposes of this analysis from NASTAD's data for June 2011. The percentage of individuals in each state who were covered by private insurance, Medicaid, or Medicare in June 2011 will be used as the estimated percentage for FY2010 in making this calculation. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, August 2012 59 tbl. 14, *available at* http://www.nastad.org/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.

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53. The estimated number of ADAP recipients who are on private insurance, Medicaid, and Medicare is determined for the purposes of this analysis from NASTAD's data for June 2011. The percentage of individuals in each state who were covered by private insurance, Medicaid, or Medicare in June 2011 will be used as the estimated percentage for FY2010 in making this calculation. NASTAD, National ADAP Monitoring Project Annual Report, supra note 23, Table 14, p. 59.

54. This figure was calculated applying Kaiser's statewide insurance status by income level percentages to the number of ADAP clients by income level reported by NASTAD. 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 purposes of this analysis it is assumed that similar percentages existed throughout FY2010. Kaiser Family Foundation, Health Coverage & Uninsured, supra note 96; National ADAP Monitoring Project Annual Report, supra note 23, Table 13, p. 58.

55. The number of undocumented immigrants on ADAP in each state in FY2008 was extrapolated from Pew Research Center, supra note 97. This number, divided by the overall population of the state in 2008 (estimated at http://www.census.gov/popest/intercensal/state/state2010.html), provides the percentage that undocumented immigrants make up of the total population in the state. This percentage is then applied to the number of individuals enrolled in ADAP, and adjusted by the appropriate Kaiser and NASTAD percentages, to estimate how many ADAP beneficiaries will not be newly eligible for private insurance subsidies as a result of their immigration status. Id.; National ADAP Monitoring Project Annual Report, supra note 23, Tables 13-14, pp. 58-9.

56. The number of undocumented immigrants on ADAP in each state in FY2008 was extrapolated from Pew Research Center, supra note 97. This number, divided by the overall population of the state in 2008 (estimated at http://www.census.gov/popest/intercensal/state/state2010.html), provides the percentage that undocumented immigrants make up of the total population in the state. This percentage is then applied to the number of individuals enrolled in ADAP, and adjusted by the appropriate Kaiser and NASTAD percentages, to estimate how many ADAP beneficiaries will not be newly eligible for private insurance subsidies as a result of their immigration status. Id.; National ADAP Monitoring Project Annual Report, supra note 23, Tables 13-14, pp. 58-59.

57. http://www.statehealthfacts.org.

58. NASTAD, National ADAP Monitoring Project Annual Report, 2012, *available at* http://prod.nastad.dotnet-web1.advansiv.com/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.

59. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, May 2011 tbl. 11, *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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