STATE HEALTH REFORM IMPACT MODELING PROJECT

South Carolina

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Prepared by the Center for Health Law and Policy Innovation of Harvard Law School
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BACKGROUND

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

The State Health Reform Impact Modeling Project (the Modeling Project) assesses the impact that healthcare reform will have on people living with HIV by compiling and analyzing Ryan White program and AIDS Drug Assistance Program (ADAP) data to predict the shift of uninsured people living with HIV from these discretionary programs to Medicaid or private insurance in all 50 states pursuant to the ACA. In addition, for 21 states and the District of Columbia (DC), the Modeling Project compiles and analyzes detailed budgets and 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 onto 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 South Carolina, the Modeling Project focuses on four state-specific inquiries:

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

SOUTH CAROLINA

SOUTH CAROLINIANS LIVING WITH HIV/AIDS

UNMET NEED

As of 2010, approximately 16,378 individuals were known to be living in South Carolina with HIV/AIDS (HIV + aware).[3] Of this group, 38% did not receive any medical care in 2010.[4] Moreover, approximately 4,353 additional residents are estimated to be HIV + but undiagnosed.[5] This proportion of the state's epidemic (the undiagnosed and those not in care) are not accounted for in the following modeling of the number of individuals who will transition over to Medicaid or subsidized private insurance under the Patient Protection and Affordable Care Act (ACA) because they are not currently receiving pharmaceutical treatment through the Ryan White program. Nonetheless, it is likely that nearly all will be newly eligible for either private or public insurance in 2014.

THE RYAN WHITE PROGRAM IN SOUTH CAROLINA

The Ryan White program is a discretionary, federally funded program providing HIV-related services across the United States to those who do not have other means of accessing HIV/AIDS treatment and care. In 2010, South Carolina received $35,585,652 of Ryan White funding[6] and served 13,087 duplicated clients in the state.[7,8] About 80% of the state's Ryan White funds were Part B grants.[9] Of these, 40.3% covered core medical services, 57.8% went toward the AIDS Drug Assistance Program (ADAP), and the remainder went toward Minority Access Initiatives and Emerging Communities programs.[10,35]

ADAP IN SOUTH CAROLINA

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

1. A South Carolina resident diagnosed with HIV;
2. Living at or below 300% of the federal poverty level (FPL); and
3. Ineligible for Medicaid or Medicare Part D.[11]

South Carolina's ADAP is composed of three programs:

1. The Drug Dispensing Program (DDP): Provides medications through a mail-order pharmacy;
2. The Insurance Assistance Program (IAP): Reimburses insurance premiums, copays, and deductibles for low-income individuals with private insurance; and
3. The Medicare D Assistance Program (MAP): Assists with Medicare Part D copays and deductibles, including during a coverage gap or donut hole.

Individuals living up to 550% FPL may enroll in IAP and MAP.[12]

In fiscal year 2010, South Carolina's ADAP served 3,697 individuals.[13,34] The state's ADAP budget for fiscal year 2011 was $27,856,243 (83% of which were federal funds).[14] Of South Carolina's ADAP 2010 budget, 86% was spent on prescription drugs and 6.4% on insurance assistance.[15]

THE ACA AND ITS IMPACT ON HIV+ SOUTH CAROLINIANS

THE MEDICAID EXPANSION

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

THE BASIC HEALTH PLAN

The ACA also provides additional federal medical funding to states that create a Basic Health Plan (BHP), covering 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.[18] 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.[19] Cost sharing on BHPs can be subsidized, either for all beneficiaries or for those with specific chronic conditions (eg, HIV/AIDS).[20] The federal government is expected to pay up to 95% of the premium credits for individuals enrolled in a BHP.[21]

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

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.[22] Eligible individuals and families can employ these credits to purchase a private health insurance plan at an insurance exchange.

Exchanges will be operational January 1, 2014.[23] States can elect to set up state-run exchanges, partner with the federal government to set up a hybrid state-federal exchange, or default into federally facilitated exchanges.[24] Each exchange 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-based list of EHB; these benefits are discussed in the following section.

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.[25] 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.

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

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 and Medicaid Services has indicated that the HHS rule on EHB will also apply to newly eligible Medicaid beneficiaries, in addition to the protections provided for under the Social Security Act.[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 US Food and Drug Administration–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 OR INSURANCE CREDITS IN 2014

Given the ACA-instituted reforms, a large number of HIV+ individuals in South Carolina are expected to become eligible for Medicaid or a BHP in 2014. An estimated 68% of the state's Ryan White program clients in 2010 were living at or below the FPL and an additional 22% were between 100-200% FPL, making them potentially eligible for either Medicaid or a BHP in 2014.[30] An estimated 39% of South Carolina's ADAP clients will be eligible for Medicaid following its expansion, and 30% will be eligible for insurance credits (see Appendix A). Finally, many of the over 10,000 HIV+ South Carolinians who are not receiving care or are undiagnosed will also likely be eligible for Medicaid, a BHP, or subsidized private insurance in 2014.

The percentage of South Carolina's ADAP clients who will be newly eligible for Medicaid based on income levels (39%) is higher than the national average, which stands at 29% (see Appendix A). This is primarily because a large proportion of ADAP clients (52% of the clients served in June 2011) live at or below 133% FPL, and a very high percentage lack any form of insurance (71%).[31]

The expansion of Medicaid, BHPs, and insurance subsidies to HIV+ South Carolinians will also be crucial to reducing racial and ethnic health disparities across the state. Of ADAP clients served in June 2011 and of Ryan White clients served in 2010, 65% and 73% were African American, respectively.[32,33,38]

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

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

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

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, nutrition). However, Medicaid and South Carolina's default benchmark plan 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 their health status does not deteriorate (eg, due to lack of proper nutrition, access to transportation to a health clinic, or stable housing).

Table 1 provides a comparison of covered services between South Carolina's Ryan White and Medicaid programs (as of 2010) as well as the BlueCross BlueShield Business Blue Complete small-group market plan (the benchmark plan used for purposes of determining EHB on an exchange, given that South Carolina did not submit its own benchmark plan for review).[30,37]

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[36]	Medicaid[37]	BlueCross BlueShield Business Blue Complete[40]
Ambulatory/Outpatient Care	X	X	X
Oral Health Care	X	X	
Early Intervention Clinics	X	X	
Home Health Care	X		X
Community Based Services	X	X	
Mental Health Services	X	X	X (annual cap)
Medical Case Management	X	X	
Case Management (non-medical)	X	X	
Substance Abuse: Outpatient	X	X	X (annual cap)
Substance Abuse: Inpatient	X	X	X (annual cap)
Child Care Services	X		
Emergency Financial Assistance	X		
Food Bank/Home Delivered Meals	X		
Health Education/Risk Reduction	X		
Housing Services	X		
Legal Services	X		
Linguistics Services	X		
Medical Transportation	X	X	
Outreach Services	X		
Permanency Planning	X		
Psychosocial Support Services	X		
Referral for Health Care/Support Services	X	X	
Rehabilitation Services	X		X (annual cap)
Respite Care	X		
Treatment Adherence Counseling	X		
Hospital Inpatient	X	X	X (PA)
Prescription Drugs	X	X	X
Mental Retardation/Developmental Disability Services		X	
Family Planning		X	
Obstetric and Pre-Natal Services		X	X
Nursing Home Care		X	

PA = prior authorization.

As Table 1 illustrates, the Ryan White program provides a number of services that are not covered by Medicaid or the benchmark plan that will be used to determine EHB for the state's exchange (eg, emergency financial assistance, food-bank and meal delivery, and a variety of wrap-around services from housing and legal assistance to child care). With respect to Medicaid, although the majority of South Carolina's Medicaid recipients are required to enroll in a managed care organization (MCO),[41] HIV+ individuals may participate in a home- and community-based waived program in lieu of an MCO.[39,40] Under this Waiver program, these individuals receive enhanced community- and home-based services aimed at increasing continuity in care, including targeted case management (similar to the support services Part B providers offer in conjunction with the antiretroviral therapy [ART] patients receive from Ryan White or otherwise contracted physicians).[42,47] Because the Medicaid benchmark plan (for newly eligible beneficiaries) is unlikely to be required to cover comprehensive services, including non-medical support services, Ryan White will continue to be essential to ensure that low-income HIV+ South Carolinians can access and stay in treatment.*

Table 1 also demonstrates that coverage under the state's default benchmark plan, BlueCross BlueShield Business Blue Complete, is far more limited for people living with HIV than is Ryan White. Business Blue Complete also imposes significant cost sharing on beneficiaries, including a minimum $250 deductible, up to $60 copay per specialist visit, and up to $200 per month for specialty drugs.[40] Individuals purchasing insurance on the exchange will continue to rely on Ryan White and ADAP to fill large gaps in both coverage and affordability.

Another challenge for South Carolina is that its systems of care for people living with HIV/AIDS are operating at capacity.[43] The expansion of Medicaid pursuant to the ACA is likely to result in a great number of HIV+ South Carolinians seeking care, putting additional stress on these systems. Care providers and case managers are carrying high caseloads, and there is already a shortage of non-medical services that encourage HIV+ individuals to enter and remain in care (eg, housing support, transportation, and comprehensive case management). In addition, many services for people living with HIV/AIDS that are covered by Medicaid are provided by Ryan White–funded agencies.[44] Continued robust funding for Ryan White programs and availability of Ryan White program services is critical for the HIV+ population in South Carolina.

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

ADAP provides funding for a robust drug formulary that is necessary to afford low-income individuals access to a combination of drugs to treat HIV. All states participating in ADAP must cover at least one drug in every class of ART; most cover almost all drugs in each class. Medicaid's drug formulary is defined differently. Ensuring that Medicaid and plans sold on the exchange provide coverage for a sufficient number of antiretroviral medications and other drugs that are essential to ART will also be critical to maintaining the health of South Carolinians living with HIV.

Table 2 provides a comparison of the antiretroviral and opportunistic infection drug formularies included in the state's ADAP and traditional Medicaid program. South Carolina's Medicaid has a non-formulary pharmacy services program, meaning that most rebated pharmaceuticals are routinely covered by Medicaid, although some drugs are subject to quantity limits.[45] Plans available to newly eligibles will be similarly comprehensive in coverage, but may also impose cost containment strategies that restrict access to care.* Medicaid recipients in the state are generally limited to a maximum number of four prescriptions per month, but South Carolinians living with HIV/AIDS may receive additional medications if essential to the individual's treatment plan.[46] Unfortunately, a formulary for South Carolina's default benchmark plan, BlueCross BlueShield Business Blue Complete, is not available to non-plan members. However, a summary of this plan submitted to the Center for Consumer Information and Insurance Oversight lists the number of drugs that will be covered under the plan by category and class. Information about the number of anti-HIV agents and other drugs that may be needed for HIV/AIDS-related illness is provided in Table 3.[50]

* Letter from Cindy Mann, Director, Centers for Medicare & Medicaid Services, to State Medicaid Director (November 20, 2012).

Table 2. ADAP Versus Medicaid: Covered Drugs[51]

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[52]	Medicaid[48,53]
Multiclass Combination Drugs	**3 drugs covered**	**3 drugs covered**
Atripla; *efavirenz + emtricitabine + tenofovir DF*	X	X
Complera; *emtricitabine + rilpivirine + tenofovir disoproxil fumarate*	X	X
Stribild; *elvitegravir + cobicistat + emtricitabine + tenofovir disoproxil fumarate*	X	X
NRTIs	**13 Drugs Covered**	**13 Drugs Covered**
Combivir; *zidovudine + lamivudine*	X	X
Emtriva; *emtricitabine*	X	X
Epivir; *lamivudine*	X	X
Epzicom; *abacavir, lamivudine*	X	X
Epzicom; *abacavir sulfate + lamivudine*	X (PA)	X
Retrovir; *zidovudine*	X	X
Trizivir; *abacavir + zidovudine + lamivudine*	X (PA)	X
Truvada; *tenofovir DF + emtricitabine*	X	X
Videx; *didanosine (buffered versions)*	X	X
Videx EC; *didanosine (delayed-release capsules)*	X	X
Viread; *tenofovir disoproxil fumarate DF*	X	X
Zerit; *stavudine*	X	X
Ziagen; *abacavir*	X (PA)	X
NNRTIs	**5 Drugs Covered**	**5 Drugs Covered**
Intelence; *etravirine*	X	X
Rescriptor; *delavirdine mesylate*	X	X
Sustiva; *efavirenz*	X	X
Viramune; *nevirapine*	X	X
Edurant; *rilpivirine*	X	X
Protease Inhibitors	**9 Drugs Covered**	**9 Drugs Covered**
Agenerase; *amprenavir*		
Aptivus; *tipranavir*	X	X
Crixivan; *indinavir sulfate*	X	X
Invirase; *saquinavir mesylate*	X	X
Kaletra; *lopinavir + ritonavir*	X	X
Lexiva; *fosamprenavir*	X	X
Norvir; *ritonavir*	X	X
Prezista; *darunavir*	X	X
Reyataz; *atazanavir sulfate*	X	X
Viracept; *nelfinavir sulfate*	X	X

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Table 2. (continued)

Fusion Inhibitors	1 Drug Covered	1 Drug Covered
Fuzeon; *enfuvirtide*	X (PA)	X (QL)
Entry Inhibitors – CCR-5 Coreceptor Antagonist	**1 Drug Covered**	**1 Drug Covered**
Selzentry; *maraviroc*	X (PA)	X
HIV Integrase Strand Transfer Inhibitors	**1 Drug Covered**	**1 Drug Covered**
Isentress; *raltegravir*	X	X
"A1" Opportunistic Infection Medications	**21 Drugs Covered**	**31 Drugs Covered**
Ancobon; *flucytosine*		X
Bactrim DS; sulfamethoxazole/trimethoprim DS	X	X
Biaxin; *clarithromycin*	X	X
Cleocin; *clindamycin*	X	X
Copegus: *ribavirin*, oral	X (PA)	X
Dapsone	X	X
Daraprim; *pyrimethamine*	X	X
Deltasone; *prednisone*	X	X
Diflucan; *fluconazole*	X	X (QL)
Famvir; *famciclovir*	X	X
Foscavir; *foscarnet*		X
Fungizone; *amphotericin B*		
INH; *isoniazid*		
Megace; *megestrol*		X
Mepron; *atovaquone*	X	X
Myambutol; *ethambutol*	X	X
Mycobutin; *rifabutin*	X	X
NebuPent; *pentamidine*		X
Nydrazid; *isoniazid, INH*		
Pegasys; *peginterferon-alfa 2a*	X (PA)	X
PEG-Intron; *peginterferon-alfa 2b*	X (PA)	X
Probenecid		X
Procrit; *erythropoietin*		X (PA)
Pyrazinamide (PZA)		X
Rifadin, Rimactane; *rifampin*		X
Sporanox; *itraconazole*		X
Sulfadiazine – Oral	X	X
Valcyte; *valganciclovir*	X	X
Valtrex; *valacyclovir*	X	X
VFEND; voriconazole	X	X
Vistide; *cidofovir*		X

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Table 2. (continued)

Wellcovorin; *leucovorin*	X	X
Zithromax; *azithromycin*	X	X
Zovirax; *acyclovir*	X	X

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

As Table 2 shows, most drugs used to treat HIV/AIDS available through ADAP are also available through Medicaid. However, management of HIV/AIDS diagnoses may require many and varied specific prescription drugs. Beyond the four-prescription limit imposed on other Medicaid recipients, HIV+ individuals may only receive additional override prescriptions if they are deemed essential to the treatment plan by the dispensing pharmacist.[51,54] This may pose problems for individuals who are denied increased pharmacy benefits based on this criteria. In South Carolina, individuals receiving Medicaid or Medicare Part D benefits are categorically ineligible for ADAP programs. This means that if Medicaid expands, more South Carolinians who were clients of ADAP will be subject to a new and potentially more burdensome regime for administration of prescription drugs under Medicaid without recourse to ADAP as a payer of last resort. In order to adequately assess the impact of Medicaid expansion on new recipients, it will be essential to closely examine issues experienced by HIV+ individuals currently covered by Medicaid with respect to obtaining prescription drugs.[49]

South Carolina's benchmark plan, BlueCross BlueShield Business Blue Complete, does not have a publicly available drug formulary. Thus, Table 3 provides information on the number of drugs covered in each relevant class for people living with HIV/AIDS (including medications used to treat opportunistic infections, antihepatitis agents, and antifungal agents).

Table 3. Number of Drugs by Category and Class Covered by the Benchmark Plan[52,55]

Drug Category	Drug Class	No. of Covered Drugs
Antivirals	Anti-HIV agents, non-nucleoside reverse transcriptase inhibitor	5
Antivirals	Anti-HIV agents, nucleoside and nucleotide reverse transcriptase inhibitors	8
Antivirals	Anti-HIV agents, protease inhibitors	9
Antivirals	Anti-HIV agents, other	3
Antivirals	Antihepatitis agents	12
Antivirals	Antifungal agents	24

As Table 3 illustrates, the failure to disclose the specific drugs that will be covered under the benchmark plan poses a challenge to HIV+ South Carolinians who will not be able to plan for treatment continuity without additional information. In addition, both ADAP and Medicaid in South Carolina cover 12 drugs in the nucleotide and nucleoside reverse transcriptase inhibitor class, while the benchmark plan will only cover 8 drugs in this class. Providers and HIV+ individuals cannot be sure that the benchmark plan will cover any multiclass combination drugs, fusion inhibitors, entry inhibitors, or HIV strand integrase inhibitors. The prescription drug EHB will likely be based on the number per class covered by the benchmark plan, requiring coverage of only one drug per class where none are covered.** Thus, scant coverage by the benchmark plan may threaten access to comprehensive ART in the private market.

In addition to lack of clarity with respect to prescription drugs, affordability of medication under the benchmark plan is also likely to be an issue for low-income South Carolinians. Business Blue Complete imposes significant cost sharing on beneficiaries, including a minimum $250 deductible and up to $200 per month for specialty drugs.[57] Finally, the benchmark plan may be subject to some prescription drug programs that apply to many of the plans offered by BlueCross BlueShield in the state, such as a drug management program that imposes prior authorization requirements for some drugs, quantity limits, dose restrictions, and step-therapy requirements.[56,57]

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

CONCLUSIONS AND NEXT STEPS

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

While much of the ACA has yet to be implemented, it is certain that a large number of people living with HIV will be newly eligible for Medicaid. Given that a significant proportion of uninsured ADAP clients would transition into Medicaid in South Carolina, 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 currently available option to provide access to treatment for the thousands of HIV+ individuals in the state who currently lack access to care.

In that vein, the Medicaid system must be ready and able to handle the needs of low-income people who are HIV+. Should South Carolina elect to expand its Medicaid program, this report provides an initial analysis of the capacity of the program to handle the needs of this influx of individuals living with HIV. The Medicaid benefits that will be available to newly eligible beneficiaries, including those living with HIV, have not yet been defined. As such, an analysis of the barriers to care that this population is likely to face (based on the existing Medicaid program) is timely as states prepare for the transition to Medicaid. 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 three challenges:

1. First, a number of services that are currently provided by the Ryan White program are not available under the state's current Medicaid program. Those newly eligible for Medicaid under the 2014 expansion may still require these wrap-around services to maintain their health and quality of life. For instance, the Ryan White program, unlike traditional Medicaid, covers early intervention clinics, respite and child care, risk-reduction health education, medical and non-medical case management, and treatment adherence counseling;
2. Second, continued robust Ryan White funding is necessary to maintain current levels of basic medical treatment to the HIV+ population in South Carolina because many South Carolinians receive services covered by Medicaid at agencies and centers funded by Ryan White program dollars. Because the systems of care for HIV+ individuals in South Carolina are estimated to be at capacity, any major change in Ryan White program resources will seriously jeopardize the state's efforts to provide comprehensive care to those living with HIV/AIDS who are currently utilizing available services as well as engage unconnected individuals; and
3. Third, South Carolinians who transition from ADAP to Medicaid in 2014 will no longer have access to any ADAP services under current ADAP eligibility criteria. Of South Carolinians currently receiving ADAP services, 39% will likely transition to Medicaid coverage if the state fully implements the ACA. More information is needed about difficulties that HIV+ individuals with Medicaid coverage may face when attempting to obtain more than four prescriptions per month. ADAP is not available in South Carolina to Medicaid recipients as a payer of last resort.

It is essential that private insurance plans on the South Carolina exchange provide a comprehensive scope of services that is sufficient to meet the needs of Ryan White clients who transition into these plans. This report identified two challenges with respect to the state's benchmark plan, which will be used to define essential health benefits (EHB) for private insurance plans:

1. First, many of the services provided by the Ryan White program are not available under BlueCross BlueShield Business Blue Complete, the state's default benchmark plan, including case management; meal, housing, and childcare assistance; and community-based services. Furthermore, the benchmark plan imposes annual caps on some services and significant cost-sharing requirements and deductibles that will be difficult for low-income South Carolinians to afford. Those newly eligible for subsidized insurance purchased on the exchange in 2014 will still require the wrap-around services provided by Ryan White to maintain their health and quality of life; and

2. Second, HIV + individuals in South Carolina lack comprehensive information about the specific drugs that will be covered by the benchmark plan and will struggle to meet high cost-sharing requirements and deductibles with respect to prescription drugs. ADAP will be necessary to fill gaps in the plan formulary and as a payer of last resort to people living with HIV/AIDS who cannot afford necessary medications even with insurance purchased on the exchange.

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 fiscally prudent and necessary to secure the health of South Carolinians.

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

1. South Carolina must adopt the Medicaid expansion pursuant to the ACA, and must extend Medicaid eligibility to all individuals living under 133% of the federal poverty level in order to slow the transmission of HIV and make treatment accessible to thousands of individuals who currently lack care; and
2. South Carolina must ensure that Ryan White and ADAP services are available where Medicaid or private insurance coverage or affordability gaps exist (eg, non-medical case management, food and nutrition, copays, premiums).

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

APPENDIX A

2014 STATE-SPECIFIC ESTIMATES

Medicaid Estimates

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

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

	Total #	ADAP clients served in fiscal year 2010[58]
−	**est. #**	ADAP clients with income above 133% FPL[59,†]
−	**est. #**	insured ADAP clients with income below 133% FPL[‡]
−	**est. #**	ADAP clients who are uninsured undocumented immigrants with incomes below 133% FPL[60]
=	**Total #**	ADAP clients served in fiscal year 2010 who will be newly eligible for Medicaid in 2014

Using South Carolina as an example, 3,697 individuals were served by South Carolina's ADAP during fiscal year 2010. Of those, we estimate that 48% (1,775) of ADAP clients currently have incomes above 133% FPL. An estimated 12.5% (461) of individuals living below 133% FPL are currently insured, and approximately 1.54% of the state population were undocumented immigrants in 2008 (30 ADAP individuals with incomes below 133% FPL). Thus, the calculation for South Carolina is:

	3,697	ADAP clients in fiscal year 2010
−	**1,774.56**	ADAP clients living above 133% FPL
−	**464.39**	insured ADAP clients with incomes below 133% FPL in fiscal year 2010
−	**29.57**	estimated uninsured undocumented immigrants with incomes below 133% FPL on ADAP
=	**1,428**	individuals currently enrolled in ADAP who will be eligible for Medicaid in 2014, or 39% of those enrolled in South Carolina's ADAP in fiscal year 2010

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

State	# ADAP Clients Newly Eligible	% ADAP Clients Newly Eligible
Alabama	1,345	76%
Arkansas	299	53%
California	12,274	31%
DC	1,124	41%
Florida	7,321	51%
Georgia	3,075	52%
Illinois	4,374	68%
Kentucky	619	42%
Louisiana	no data available	no data available
Maryland	1,394	22%
Massachusetts	1,400	21%
Mississippi	1,008	68%
New Jersey	2,101	29%
New York	4,233	20%
North Carolina	3,476	62%
Ohio	1,287	37%
Pennsylvania	1,334	22%
South Carolina	1,428	39%
Tennessee	2,505	60%
Texas	8,797	53%
Virginia	2,690	66%
Wisconsin	696	40%
United States	**62,971**	**29%**

Note: Data on the insurance status of ADAP clients in Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.[61] (The 2010 NASTAD report is missing data for North Carolina and Kentucky, and the percentages of insured clients exceed 100% for Maryland and Ohio.)

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

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

The percentages of ADAP clients who will be newly eligible for Medicaid in 2014 vary considerably from state to state. These differences can be explained by the different eligibility standards currently in place for ADAP within each state, as well as by the differences in estimated percentages of undocumented immigrants in each state. For instance, states with higher than average newly eligible Medicaid beneficiaries may currently require that ADAP recipients have no other sources of insurance (eg, Virginia). On the other hand, states with lower than average newly eligibles have higher insurance rates all around (eg, Massachusetts) or other public assistance programs that supplement ADAP. In sum, NASTAD'S data do not capture all groups of people living with HIV who may be eligible for Medicaid in 2014.

Private Insurance Subsidy Estimates

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

	Total #	ADAP clients served in fiscal year 2010[62]
–	**est. #**	ADAP clients living below 133% FPL[63]
–	**est. #**	ADAP clients living above 400% FPL[64,§]
–	**est. #**	of insured ADAP clients living between 133-400% FPL[65,**]
–	**est. #**	uninsured undocumented ADAP clients living between 133-400% FPL[66]
=	**Total #**	ADAP clients who will be eligible for subsidized private insurance in 2014

Again, using South Carolina as an example, 3,697 individuals were served by ADAP during fiscal year 2010 in South Carolina. Of those, we estimate that 54% (1,996) ADAP clients have incomes below 133% or above 400% FPL. We further estimate that 16% (580) of individuals living between 133-400% FPL are currently insured. An estimated 1.54% of the state population were undocumented immigrants in 2008. Applying this percentage to the individuals enrolled in South Carolina's ADAP computes to approximately 26 ADAP clients in South Carolina who are uninsured and undocumented immigrants living between 133-400% FPL. Thus, completing the calculation for South Carolina's ADAP program yields:

	3,697	ADAP clients in fiscal year 2010
–	**1,996.38**	ADAP clients with incomes below 133% FPL or above 400% FPL
–	**583.55**	insured ADAP clients living between 133-400% FPL
–	**26.16**	estimated undocumented immigrants on ADAP with incomes living between 133-400% FPL
=	**1,091**	individuals currently enrolled in ADAP who will be eligible for private insurance subsidies in 2014 or 30% of those enrolled in South Carolina's ADAP program in fiscal year 2010

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

State	# ADAP Clients Eligible for Subsidies	% ADAP Clients Eligible for Subsidies
Alabama	305	17%
Arkansas	147	26%
California	8,580	22%
DC	829	30%
Florida	4,134	29%
Georgia	1,404	24%
Illinois	1,127	17%
Kentucky	269	18%
Louisiana	no data available	no data available
Maryland	1,726	28%
Massachusetts	932	14%
Mississippi	384	26%
New Jersey	1,879	26%
New York	4,502	21%
North Carolina	621	11%
Ohio	901	26%
Pennsylvania	1,567	26%
South Carolina	1,091	30%
Tennessee	1,531	37%
Texas	4,301	26%
Virginia	896	22%
Wisconsin	401	23%
United States	**32,758**	**15%**

Note: Data on the insurance status of ADAP clients in Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.[67] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages of insured clients exceed 100% for Maryland and Ohio.)

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

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

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 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 South Carolina, 53% of adults living below 133% FPL are insured, 73% of adults living between 133-400% FPL are insured, and 93% living above 400% FPL are insured;

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

   In South Carolina, the figure 53% was given the baseline number 1. 73% is 1.42 times 53%, and 93% is 1.77 times 53%. Thus, in other words, an adult in South Carolina with income between 133-400% FPL is 1.42 times more likely to be insured than an adult with income below 133% FPL, while an adult with income above 400% FPL is 1.77 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.[68] 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 South Carolina, we estimated that about 1,080 of the state's 3,697 ADAP clients served in 2010 were insured. The insurance rate for ADAP clients in that state stood at 29% 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 South Carolina, 52% of ADAP clients have income below 133% FPL, 46% have income between 133-400% FPL and only about 2% 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 previously), and compared it with the relative proportion of clients in that income group among the total clients (based on the percentage of ADAP clients in each income group), along with a weighing factor called *a*.

We relied on two formulas:

Formula 1:

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

Formula 2:

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

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

Thus, for South Carolina:

$$
\begin{aligned}
& 1{,}080 \\
= \; & (1 \times 0.52 \times a) \\
+ \; & (1.42 \times 0.46 \times a) \\
+ \; & (1.77 \times 0.02 \times a)
\end{aligned}
$$

Solving for *a*,

$a = 893.07$

Applying the value of a determined previously to

Formula 1:

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

Income below 133% FPL = 464

Income between 133-400% FPL = 584

Income above 400% FPL = 32

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

APPENDIX B

DATA COLLECTION METHODOLOGY

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

Ryan White Program Data

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

Estimates of unmet needs for people living with HIV in each state are available in each state's Statewide Coordinated Statement of Need (SCSN). SCSNs must be provided by all states receiving Ryan White program funding, but different states provide SCSNs in different years, so comparability among states is limited. Information about unmet need available from other sources has also been included.

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

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

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

Medicaid Coverage Data

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

Benchmark Plan Coverage Data

South Carolina failed to submit a benchmark plan for consideration. The largest small-group plan in the state (the default benchmark plan) is BlueCross BlueShield Business Blue Complete. No independent analysis of this plan was available, and the data included here were collected from BlueCross BlueShield's promotional materials.

NOTES

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

- Data on the insurance status of ADAP clients in Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.[69] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages of the insured exceed 100% for Maryland and Ohio.); and
- Data on the number of clients served by Mississippi's ADAP program appear to be incorrect in NASTAD's Monitoring Report, as the number of clients served is listed as larger than the number of eligible ADAP clients in the state. The number listed was used in these calculations, and while the specific number of ADAP clients eligible for Medicaid and private insurance subsidies in Mississippi may not be reliable, the proportion of clients eligible for both programs was obtained in the same way as for other states, for interstate comparability reasons.

CAVEATS AND ASSUMPTIONS

The estimates provided require a number of caveats and assumptions:

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

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

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

APPENDIX C

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

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

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

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

60. The number of undocumented immigrants on ADAP in each state in fiscal year 2009 will be extrapolated from the Pew Research Center's report, "A Portrait of Unauthorized Immigrants in the United States." *See A Portrait of Unauthorized Immigrants in the United States,* Pew Research Center (April 14, 2009), *available at* http://pewhispanic.org/files/reports/107.pdf. This report provides the estimated number of undocumented immigrants in each state for 2008. This number, divided by the overall population of the state in 2008, provides the percentage that undocumented immigrants make up of the total population in the state. *See Population Estimates,* U.S. 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.

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

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

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

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

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

66. The number of undocumented immigrants on ADAP in each state in fiscal year 2009 will be extrapolated from the Pew Research Center's report, "A Portrait of Unauthorized Immigrants in the United States." *See A Portrait of Unauthorized Immigrants in the United States,* Pew Research Center. (April 14, 2009), *available at* http://pewhispanic.org/files/reports/107.pdf. This report provides the estimated number of undocumented immigrants in each state for 2008. This number, divided by the overall population of the state in 2008, provides the percentage that undocumented immigrants make up of the total population in the state. *See Population Estimates*, U.S. 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.

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

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

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

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TAEP
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Center for Health Law and Policy Innovation
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