STATE HEALTH REFORM IMPACT MODELING PROJECT

Wisconsin

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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 into Medicaid will have on low-income people living with HIV.[2]

Information on the numerical results for each state and DC, as well as income modeling, are available in Appendix A. See Appendix B for additional modeling methodology, notes, and a summary of the limitations of the modeling process.

In Wisconsin, 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?

WISCONSIN

WISCONSINITES LIVING WITH HIV/AIDS

UNMET NEED

As of 2011, approximately 6,550 Wisconsinites were known to be living with HIV/AIDS (HIV+ aware).[3] An additional 1,750 were estimated to be HIV+ but undiagnosed.[4] Undiagnosed individuals are not accounted for in the following modeling of those who will transition over to Medicaid or subsidized private insurance under the Patient Protection and Affordable Care Act (ACA) because they are not currently receiving pharmaceutical treatment through the Ryan White program. Nonetheless, it is likely that nearly all will also be newly eligible for either private or public insurance in 2014.

THE RYAN WHITE PROGRAM IN WISCONSIN

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, Wisconsin received $12,957,724 of Ryan White funding,[5] and served 6,696 duplicated clients.[6,7] About 72% of the state's Ryan White funds were Part B grants, assigned based on prevalence of HIV in the state.[8] Of these, 42.6% covered core medical services, 1.2% was supplemental funding, and 55.8% went toward the AIDS Drug Assistance Program (ADAP).[9]

ADAP IN WISCONSIN

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

1. A Wisconsin resident diagnosed with HIV;
2. Living at or below 300% of the federal poverty level (FPL); and
3. Living without access to sufficient third-party payment for treatment.[10]

In the fiscal year 2010, Wisconsin's ADAP served 1,754 individuals.[11] The state's 2011 ADAP budget was $17,370,799 (92% federal funding).[12] In the previous fiscal year, Wisconsin spent $16,968,222 on ADAP—approximately 55.5% of these funds were used to cover prescription drugs (excluding dispensing costs), and about 43.5% of the funds went toward insurance assistance (eg, copay, premium, and deductable support).[13]

THE ACA AND ITS IMPACT ON HIV+ WISCONSINITES

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).[14,*] 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.[15] 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.[16]

*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 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 purchase a plan on the exchange).[17] 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.[18] BHPs must cover at least the EHB and have the same actuarial value of coverage as a bronze plan that the individual might otherwise purchase on an exchange.[19] Cost-sharing on BHPs can be subsidized, either for all beneficiaries or for those with specific chronic conditions (eg, HIV/AIDS).[20] In addition to improved affordability, BHPs can minimize "churning" on and off Medicaid as individuals fluctuate around 133% FPL. Because state Medicaid offices can design and manage BHPs, these individuals would more easily transition into a plan with similar provider networks and administrative procedures.

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

The ACA requires states to establish state-run insurance exchanges, to partner with the federal government to set up a hybrid state-federal exchange, or to default into a federally facilitated exchange.[21] Insurance exchanges will provide individuals and families with a choice of plans, tiered by actuarial value of coverage (bronze, silver, gold, and platinum). Each plan available on an exchange must, at a minimum, adhere to a state-defined and federally approved list of EHB; these benefits are discussed in the following section. All exchanges will be operational January 1, 2014.[22]

Because Wisconsin did not submit a benchmark plan for purposes of defining EHB in the private market, UnitedHealthcare's Choice Plus Definity HAS Plan (the largest small-group plan in the state) is its default benchmark plan.[23]

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 insurance exchanges to provide a minimum of essential health benefits (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.

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 OR INSURANCE CREDITS IN 2014

Given the ACA-instituted reforms, a large number of HIV+ individuals in Wisconsin are expected to become eligible for public or private insurance in 2014, provided that Wisconsin fully implements the law.

An estimated 20% 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] We estimate that 40% of Wisconsin's ADAP clients will be eligible for Medicaid following its expansion (if they were not already eligible) and that 23% will be eligible for private insurance subsidies (Appendix A). Moreover, many of the nearly 2,000 undiagnosed Wisconsinites living with HIV will also be newly eligible for public or subsidized private insurance in 2014, creating tremendous opportunity for the state to expand antiretroviral therapy (ART), thereby improving health outcomes and reducing transmission of disease.

The percentage of Wisconsin's ADAP clients who will be newly eligible for Medicaid (40%) is higher than the national average, which stands at 29% (Appendix A). This is because 60% of Wisconsin's ADAP clientele live below 133% FPL, and most are uninsured.

The percentage of Wisconsin's ADAP clients who are expected to qualify for private insurance subsidies (23%) is higher than the national average, which stands at 15%, probably because 40% of Wisconsin's ADAP clients are living between 133-400% FPL, the income range eligible for these subsidies (Appendix A).

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

Since many HIV+ individuals in Wisconsin 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, Medicaid, and Wisconsin's benchmark plan for purposes of defining essential health benefits (EHB) on the private market currently provide to HIV+ Wisconsinites.

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

The Ryan White program funds both core medical and support services for patients living with HIV/AIDS (see Appendix C for a breakdown of core medical versus support services). Both medical and ancillary services are critical to maintaining the health of low-income individuals who may not have access to many necessities that affect access to HIV/AIDS treatment and care (eg, transportation, child care, nutrition). However, Medicaid and Wisconsin's benchmark plan, which will determine EHB for private insurance sold on the state's exchange, do not cover many 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 Wisconsin's Ryan White and Medicaid programs (as of 2010) as well as the benchmark plan selected for purposes of defining EHB.

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[31]	Medicaid[32]	UnitedHealthcare Choice Plus Definity HSA Plan[33]
Home healthcare		X	X (60 visits per year)
Mental health	X	X	X
Substance abuse (outpatient)	X	X	X
Substance abuse (inpatient)		X	X
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
Hospital services		X	X
Lab and X-ray services		X	X
Nursing facility		X	
Midwife/NP services		X	X
Private-duty nursing		X	
Physician services		X	X
Nonmedical case management services	X		
Child care	X	X	
Emergency financial assistance	X		
Food bank/home-delivered meals	X		
Housing services	X		
Health education/risk reduction	X		
Legal services	X		
Linguistics services	X		
Medical transportation	X	X	
Outreach services	X		
Psychosocial support	X		
Referral agencies	X		
Treatment adherence counseling	X		
Chiropractor		X	X (manipulative treatment only)
Podiatry		X	X
Hospice		X	X
Respiratory therapy		X	
PT, OT, and speech therapy		X	X (20 days/yr each; speech as a result of injury only)
Orthotics and prosthetics			X ($2,500 limit)

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

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 private market (eg, emergency financial assistance, food-bank and meal delivery, and a variety of wrap-around services from housing and legal assistance to child care). These ancillary services are important for the well-being of HIV+ individuals, but are unlikely to be required EHB (on both the public and private market) pursuant to current federal guidance and proposed regulation.[34,35] Thus, individuals who leave the Ryan White program for Medicaid for private insurance plans are likely to be at a disadvantage unless wrap-around services remain available.

Moreover, UnitedHealthcare's benchmark plan imposes cost-sharing requirements that may make comprehensive care prohibitive for low-income individuals living with HIV/AIDS. Deductibles can range from $250 to $5,000 annually, with $30 copays or up to 20% co-insurance for services provided.[36]

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

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

Table 2 provides a comparison of the antiretroviral drug formularies included in the state's ADAP and Medicaid program, as well as the benchmark plan selected for purposes of defining EHB.

Table 2. ADAP Versus Medicaid and the Base-Benchmark Plan: Covered Drugs[37]

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[38]**	**Medicaid[39]**	**UnitedHealthcare Choice Plus Definity HSA Plan A92NS[40]**
Multiclass Combination Drugs	**2 Drugs Covered**	**3 Drugs Covered**	**1 Drug Covered**
Atripla; *efavirenz + emtricitabine + tenofovir DF*	X	X	X (tier 2)
Complera; *emtricitabine + rilpivirine + tenofovir disoproxil fumarate*	X	X	
Stribild; *elvitegravir + cobicistat + emtricitabine + tenofovir disoproxil fumarate*		X (PA required)	
Entry Inhibitors – CCR-5 Coreceptor Antagonist	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Selzentry; *maraviroc*	X	X (PA)	X (tier 2)
Fusion Inhibitors	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Fuzeon; *enfuvirtide*	X	X (PA)	X (tier 2)
HIV Integrase Strand Transfer Inhibitors	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Isentress; *raltegravir*	X	X	X (tier 2)

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Table 2. (cont.)

NNRTIs	5 Drugs Covered	5 Drugs Covered	4 Drugs Covered
Intelence; *etravirine*	X	X (PA)	X (tier 2)
Rescriptor; *delavirdine mesylate*	X	X (PA)	X (tier 2)
Sustiva; *efavirenz*	X	X	X (tier 2)
Viramune; *nevirapine*	X	X	X (tier 1)
Edurant; *rilpivirine*	X	X	
NRTIs	**12 Drugs Covered**	**9 Drugs Covered**	**11 Drugs Covered**
Combivir; *zidovudine + lamivudine*	X	X	X (tier 1)
Emtriva; *emtricitabine*	X	X	X (tier 2)
Epivir; *lamivudine*	X	X	X (tier 2)
Epzicom; *abacavir sulfate + lamivudine*	X	X	X (tier 2)
Retrovir; *zidovudine*	X		X (tier 1)
Trizivir; *abacavir + zidovudine + lamivudine*	X	X	X (tier 2)
Truvada; *tenofovir DF + emtricitabine*	X	X	X (tier 2)
Videx; *didanosine (buffered versions)*	X	X	
Videx EC; *didanosine (delayed-release capsules)*	X		X (tier 1)
Viread; *tenofovir disoproxil fumarate DF*	X	X	X (tier 2)
Zerit; *stavudine*	X		X (tier 1)
Ziagen; *abacavir*	X	X	X (tier 2)
Protease Inhibitors	**9 Drugs Covered**	**9 Drugs Covered**	**9 Drugs Covered**
Agenerase; *amprenavir*			
Aptivus; *tipranavir*	X	X (PA)	X (tier 2)
Crixivan; *indinavir sulfate*	X	X	X (tier 2)
Invirase; *saquinavir mesylate*	X	X	X (tier 2)
Kaletra; *lopinavir + ritonavir*	X	X	X (tier 2)
Lexiva; *fosamprenavir*	X	X	X (tier 2)
Norvir; *ritonavir*	X	X	X (tier 2)
Prezista; *darunavir*	X	X	X (tier 2)
Reyataz; *atazanavir sulfate*	X	X	X (tier 2)
Viracept; *nelfinavir sulfate*	X	X (PA)	X (tier 2)

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Table 2. (cont.)

"A1" OI† Treatments	21 Drugs Covered	24 Drugs Covered	24 Drugs Covered
Ancobon; *flucytosine*		X (PA)	X (tier 1; QL)
Bactrim DS; *sulfamethoxazole/trimethoprim DS*	X		X (tier 2)
Biaxin; *clarithromycin*	X	X	X (tier 1)
Cleocin; *clindamycin*	X	X	X (tier 1)
Dapsone	X		X (tier 2)
Daraprim; *pyrimethamine*	X		X (tier 2)
Deltasone; *prednisone*		X	X (tier 1)
Diflucan; *fluconazole*	X	X	X (tier 1)
Famvir; *famciclovir*	X	X	X (tier 2; QL)
Foscavir; *foscarnet*	X		
Fungizone; *amphotericin B*	X		
INH; *isoniazid*			X (tier 1)
Megace; *megestrol*			X (tier 1)
Mepron; *atovaquone*	X		X (tier 2)
Myambutol; *ethambutol*	X		X (tier 1)
Mycobutin; *rifabutin*	X		
Nebuent; *pentamidine*	X		X (tier 2)
Probenecid		X	X
Procrit; *epoetin alfa*		X	X (tier 2, QL)
Ritater; *Pyrazinamide (PZA)*		X	X (tier 2)
Sporanox; *itraconazole*	X	X (PA)	X (tier 2; QL)
Sulfadiazine – Oral	X		
Valcyte; *valganciclovir*	X		X (tier 2; QL)
Valtrex; *valacyclovir*	X	X	X (QL)
VFEND; voriconazole		X (PA)	X (tier 1; QL)
Vistide; *cidofovir*	X		
Wellcovorin; *leucovorin*	X		X (tier 1)
Zithromax; *azithromycin*	X	X	X (tier 1)
Zovirax; *acyclovir*	X	X	X (tier 1)

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

†Opportunistic treatments.

As Table 2 indicates, Wisconsin's current Medicaid formulary is limited, posing a potential problem for people living with HIV. For example, prior approval is required for several drugs that are important to comprehensive ART, while others are not covered at all. Although the Medicaid plan for newly eligibles is required to provide any clinically advantageous drug, cost-containment strategies such as prior authorization may disrupt access to treatment.[41]

Moreover, UnitedHealthcare's Choice Plus Definity HSA Plan has a limited formulary and imposes cost-sharing responsibilities on beneficiaries that may prove prohibitive for individuals requiring multiple prescriptions per month. Moreover, all antiretroviral drugs must be obtained through a specialty pharmacy network, which will have negative implications on the prescription drug EHB for the private market if this specialty formulary is not included in the benchmark analysis.[42] Assuming that it is, current regulation indicates that each plan on Wisconsin's exchange will have to cover at least the number of drugs in each class covered above, or one per class in the case that no drug is covered.[43] If individuals are unable to access comprehensive ART in the private market, wrap-around ADAP coverage will remain crucial.

CONCLUSIONS AND NEXT STEPS

This report provides analyses of the Ryan White program, the AIDS Drug Assistance Program (ADAP), Medicaid, and essential health benefits (EHB) under the Patient Protection and Affordable Care Act (ACA), 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 law makers in implementing the ACA in a manner that serves the needs of Wisconsinites.

While much of the ACA has yet to be implemented, it is certain that a large number of people living with HIV/AIDS will be newly eligible for Medicaid under the law's income eligibility standard (extending eligibility to individuals living under 133% of the federal poverty level [FPL]). Given that a significant proportion of uninsured ADAP clients would transition into Medicaid in Wisconsin, 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.

At the same time, Medicaid must be ready and able to handle the needs of low-income people who have HIV/AIDS. Should Wisconsin 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. Comparing current Ryan White and ADAP services with existing Medicaid formularies allows for a baseline analysis of the needs of individuals living with HIV/AIDS moving into the Medicaid system. This report identified two challenges:

- First, a number of services that are currently provided by the Ryan White program are not available under the state's current Medicaid program, and will likely not be manadated EHB for newly eligibles (eg, health education/risk reduction and treatment adherence counseling).[44] HIV+ individuals who shift from the Ryan White program onto Medicaid are therefore likely to have trouble accessing a number of services currently available to them; and
- Second, those living with HIV/AIDS are likely to face challenges with prior authorization when seeking branded prescriptions covered by Medicaid. Because these cost containment strategies will likely remain permissible on plans available to newly eligible beneficiaries, Ryan White may remain a crucial payer of last resort.[45]

It is essential that private insurance plans on the Wisconsin exchange provide a level and scope of services that is sufficient to meet the needs of ADAP clients who may transition to these plans. This report identified two challenges with respect to the state's benchmark plan, which will be used to define EHB for private insurance plans:

- First, a large number of services that are currently provided by the Ryan White program are not available under Wisconsin's benchmark plan, and are unlikely to be required EHB, pursuant to existing proposed regulation.[46] HIV+ individuals who shift from the Ryan White program to subsidized private insurance are therefore likely to have trouble accessing a number of services currently available to them; and
- Second, Wisconsin's benchmark formulary is limited. Unless proposed regulation changes significantly, plans on the private market will not have to cover all antiretroviral drugs necessary for comprehensive antiretroviral therapy (ART), but rather only the number covered in each class by the benchmark plan.[47] Moreover, private plans will impose cost-sharing requirements, similar

to the benchmark plan illustrated above. ADAP may continue to be a crucial payer of last resort for low-income individuals requiring multiple branded prescriptions per month.

There will remain an ongoing demand for Ryan White and ADAP services to fill the gaps left by Medicaid coverage for low-income people living with HIV/AIDS. Identifying these gaps and structuring these programs to efficiently work together from the start is not only fiscally prudent, but also necessary to secure the health of Wisconsinites and slow the transmission of HIV.

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. Adopting the Medicaid expansion, pursuant to the ACA, Wisconsin must extend Medicaid eligibility to *all* individuals living under 133% FPL in order to slow the transmission of HIV and make treatment accessible to thousands of individuals who currently lack care; and
2. Wisconsin 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, or 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[48]
–	**est. #**	ADAP clients with incomes above 133% FPL [49,‡]
–	**est. #**	insured ADAP clients with incomes below 133% FPL[§]
–	**est. #**	ADAP clients who are undocumented immigrants with incomes below 133% FPL in June 2011[50]
=	**Total #**	ADAP clients who will be newly eligible for Medicaid in 2014[**,††]

Wisconsin's ADAP served 1,754 individuals in 2010. Of those, we estimate that 701 (40%) of ADAP clients have incomes above 133% FPL. We also estimate that there were 341 insured ADAP clients with incomes below 133% FPL. Approximately 1% of the state population was composed of undocumented immigrants in 2008 (amounting to approximately 16 ADAP clients with incomes below 133% FPL). Thus, the calculation for Wisconsin is:

	1,754	ADAP clients being served in fiscal year 2010
–	**701**	ADAP clients with incomes above 133% FPL
–	**341**	insured ADAP clients with incomes below 133% FPL
–	**16**	undocumented immigrants with incomes below 133% FPL in June 2011
=	**696**	ADAP cients who will be newly eligible for Medicaid in 2014, or 40% of ADAP clients served in the fiscal year 2010

‡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 Appendix A for a description of the method used to estimate the distribution of insured ADAP clients in Wisconsin by income group.

**The final estimate provided is likely be somewhat higher than the actual number of ADAP clients who will be newly eligible for Medicaid, since the formula does not account for insured ADAP clients whose incomes fall below 133% FPL – these clients will not be newly eligible for Medicaid in 2014. The number of insured clients with incomes below 133% FPL is likely to vary by state.

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

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

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

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[51]
–	**est. #**	ADAP clients living below 133% FPL[52, ‡‡]
–	**est. #**	ADAP clients living above 400% FPL[53]
–	**est. #**	of insured ADAP clients living between 133-400% FPL[54,§§]
–	**est. #**	ADAP clients who are undocumented immigrants living between 133-400% FPL[55]
=	**Total #**	ADAP clients who will be newly eligible for subsidized private insurance

Wisconsin's ADAP served 1,754 individuals in fiscal year 2010. Of those, we estimate that 1,052 (60%) of ADAP clients have income below 133% FPL or above 400% FPL. This leaves 40% (701) of ADAP clients with incomes between 133-400% FPL. We also estimate that there were 291 insured ADAP clients with incomes between 133-400% FPL. Approximately 1% of Wisconsin's population was composed of undocumented immigrants in 2008 (10 ADAP clients with incomes between 133-400% FPL). Thus, the calculation for Wisconsin is:

	1,754	ADAP clients served in fiscal year 2010
–	**1,052**	ADAP clients with incomes below 133% FPL or above 400% FPL
–	**291**	estimated insured ADAP clients with incomes between 133-400% FPL
–	**10**	uninsured undocumented immigrants with incomes between 133-400% FPL
=	**401**	ADAP clients who will be eligible for insurance subsidies in 2014, or 23% of ADAP clients being served in fiscal year 2010

‡‡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) number of clients served in fiscal year 2010 (acquired from Table 8 of the same report).

§§See Appendix A for a description of the method used to estimate the distribution of insured ADAP clients in Wisconsin by income group.

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

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

METHODOLOGY FOR DISTRIBUTION OF INSURED ADAP CLIENTS BY INCOME

Distributing insured ADAP clients by income in each state required several steps:

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

   In Wisconsin, 67% of adults living below 133% FPL are insured; 86% 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

***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 often result in double-counting a number of ADAP clients.

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 Wisconsin, the figure 67% was given the baseline number 1; 86% is 1.28 times 67%, and 96% is 1.43 times 67%. Thus, in other words, an adult in Wisconsin with income between 133-400% FPL is 1.28 times more likely to be insured than an adult with income below 133% FPL, while an adult with income above 400% FPL is 1.43 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.[56] 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 Wisconsin, we estimated that about 631.4 of the state's 1,754 ADAP clients served in 2010 were insured. The insurance rate for ADAP clients in that state stood at 36% in 2011;

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

   In Wisconsin, 60% of ADAP clients are living below 133% FPL, 40% have incomes between 133%-400% FPL, and no clients have incomes 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)

Thus, for Wisconsin:

631.4
= (1 x 0.60 x *a*)
+ (1.28 x 0.40 x *a*)
+ (1.43 x 0.00 x *a*)

Solving for *a*,

$a = 568.04$

Applying the determined value of *a* to Formula 1:

The estimated number of insured ADAP clients in Wisconsin with,

Incomes below 133% FPL = 340.8
Incomes between 133-400% FPL = 290.66
Incomes above 400% FPL = 0

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

APPENDIX B

DATA COLLECTION METHODOLOGY

In the interest of consistency 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) are 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. Income, race/ethnicity, gender, and insurance status for 2008 are available from HRSA and have been provided for each state. Where available, information from state departments of health has also been included. Demographic information for AIDS Drug Assistance Program (ADAP) clients is most thoroughly documented by the National Alliance of State & Territorial AIDS Directors (NASTAD), and information from that organization has been provided for income, race/ethnicity, gender, and insurance status of ADAP clients. NASTAD's data are for fiscal year 2010 and June 2011. Because ADAP data compiled by NASTAD are unduplicated, it is one of the most reliable sources of information about demographic information for people living with HIV/AIDS. Data from June 2011 provide information on how many people living with HIV/AIDS currently enrolled in ADAP fall between 100-133% of the federal poverty level (FPL). Since the expansion of Medicaid eligibility to those living under 133% FPL is a relatively new development, there is a dearth of data regarding the number of individuals whose incomes are between 100-133% FPL and NASTAD provides the only reliable source of these data to date. NASTAD's ADAP information will be used for estimates regarding people living with HIV/AIDS who will be newly eligible for Medicaid in 2014 at the end of this report. Information available from state departments of health or HRSA has also been provided.

Estimates of unmet need for people living with HIV/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 all data are not from the same year. 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. These data are relatively general, enumerating the services offered by the Ryan White Program in each state, as well as the most utilized services and the services each state has identified as priorities for funding in the future. 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. The fiscal year 2010 total budget is available, and expenditures are broken down by NASTAD for fiscal year 2010. This information is provided in each state profile. Kaiser Family Foundation's information on ADAP expenditures has also been included for information on the amount spent by ADAP services on insurance assistance and full prescription coverage.

Medicaid Coverage Data

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

Benchmark Plan Coverage Data

In November 2012, Wisconsin Governor Scott Walker notified federal officials that Wisconsin would elect to default to a federally facilitated health insurance exchange. Because Wisconsin did not recommend a benchmark plan, the state's benchmark EHB plan

will default to the largest small-group plan in the state, UnitedHealthcare's Choice Plus Definity HSA Plan.[57] Data were collected from UnitedHealthcare's website and from the Centers for Medicaid & Medicare Service's analysis of benefits offered by the plan

NOTES

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

- Data on the insurance status of ADAP clients in Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.[58] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages of insured clients exceed 100% for Maryland and Ohio.); and
- Data on the number of clients served by Mississippi's ADAP appear to be incorrect in NASTAD's Monitoring Report, as the number of clients served is listed as larger than the number of eligible ADAP clients in the state. The number listed was used in these calculations, and while the specific number of ADAP clients eligible for Medicaid and private insurance subsidies in Mississippi may not be reliable, the proportion of clients eligible for both programs was obtained in the same way as for other states.

CAVEATS AND ASSUMPTIONS

The estimates provided require a number of caveats and assumptions:

1. ADAP data (as opposed to Ryan White data) were used because it is the most reliable and most able to provide information on individuals who are uninsured or underinsured without double-counting individuals who may be enrolled in multiple Ryan White programs. 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 services;
3. It is possible that some individuals fall into more than one term in the equations above. For instance, an individual might have an income above 133% FPL and also be insured. The possibility of double-counting some individuals is not accounted for in these calculations;
4. These calculations assume that insurance status is equally distributed across income levels. In all likelihood, those above 133% FPL have a higher rate of insurance. This possibility was also not accounted for in the calculations;
5. The terms in the equation used represent data that are available for every state, and were chosen over state-specific data to ensure that these estimates could be compared across the states surveyed. While state-specific data may exist in some states, it does not exist in the same format in all states studied and different methodologies may have been used in obtaining it, so comparing such data across states would be of little analytical value; and finally
6. 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 in 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/AIDS who will be newly eligible for Medicaid and insurance subsidies in 2014. While the percentages provided could be extrapolated to apply to the broader HIV/AIDS population in states, given the number of caveats and assumptions needed to arrive at this rough estimate, it would be better to obtain additional information about the unmet need within states before attempting to make such calculations.

APPENDIX C

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

- Outpatient and ambulatory care;
- 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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Treatment Access Expansion Project

Center for Health Law and Policy Innovation
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withinsight
A collaboration between the HIV community and Bristol-Myers Squibb