STATE HEALTH REFORM IMPACT MODELING PROJECT:

Estimating the Transition of People Living with HIV/AIDS to Medicaid or Subsidized Private Health Insurance through the Patient Protection and Affordable Care Act

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1 BACKGROUND

The Patient Protection and Affordable Care Act (ACA) will expand access to healthcare for millions of Americans, allowing many previously uninsured individuals to obtain health insurance coverage through Medicaid or subsidized private insurance. Changes to the healthcare landscape for people living with HIV are particularly important because many have been denied coverage due to disease status. Under the ACA, people living with HIV are now guaranteed the right to purchase private insurance, often with subsidies, if not eligible to move into the Medicaid system.

Estimating the exact proportion of people living with HIV who will move into Medicaid or subsidized insurance nationally and in each state is difficult, because data collection methods differ by state, and income data are not readily available. The most reliable data that are consistent across states are in the National Alliance of State and Territorial AIDS Directors (NASTAD) monitoring reports,[1] which focus on the AIDS Drug Assistance Program (ADAP) client population. ADAP serves tens of thousands of people living with HIV every month, and is meant as a last resort for those who cannot otherwise obtain the medications they need. While ADAP represents only a subset of low-income individuals living with HIV, the estimates culled from the NASTAD monitoring reports give a sense of how dramatic a change healthcare reform represents for people living with HIV and highlight that the impact differs state by state based on current and existing state policies. Since states that decline to expand their Medicaid programs will not lose current federal Medicaid matching funds,[2] targeted state advocacy highlighting the profound impact of expanding Medicaid on access to care for people living with HIV is crucial. The estimates contained in this report examine how ADAP enrollment will change as healthcare reform is implemented, both through the expansion of Medicaid and the introduction of subsidized private insurance.[3]

As shown by the estimates below, proportions of newly eligible individuals will vary significantly from state to state. Variations depend on several factors:

- the use of § 1115 Waivers;
- the existence of insurance assistance programs;
- current insurance rates;
- ADAP eligibility requirements; and
- current Medicaid income eligibility criteria.

The differences between the states highlight the need for state-specific health reform implementation strategies, particularly in those states where a great proportion of ADAP clients will be newly eligible for Medicaid and/or private insurance subsidies. In addition, the data indicate that all states must be prepared to vigorously defend their Ryan White programs, including ADAP. Even after full implementation of the ACA, the Ryan White programs will remain essential to state efforts to meet the care and treatment needs of people living with HIV who remain ineligible for Medicaid and subsidized private health insurance, to address ongoing unmet core health and service needs, and to address gaps in insurance affordability. The results of this research should inform legislators, providers, and advocates on the way the healthcare landscape will change in each state and provide vital information on how states can best prepare for the changes ahead.

2 METHODS

The study population for this report constitutes people living with HIV in the U.S. with incomes below 400% of the federal poverty level (FPL) enrolled in ADAP. State data on demographics, current access to healthcare services, and the ways in which access is expected to improve were compiled and analyzed using qualitative and statistical methods. Monitoring reports from NASTAD,[4] which focus on the ADAP client population, were used for all income level and insurance status data of ADAP clients. The Pew Research Center's data on undocumented immigrants were used, in conjunction with U.S. census information, to estimate the proportion of undocumented immigrants in each state's ADAP.[5] Data on the income level, insurance status, and immigration status of ADAP clients in all fifty states were aggregated to estimate the proportion of ADAP clients in each state who will be eligible for Medicaid or subsidized private health insurance when the ACA is fully implemented.

Public insurance programs in eighteen states[6] were analyzed to provide a more thorough understanding of what these estimates mean for people living with HIV. Data analyzed include:

- demographic information;
- services available through Ryan White and Medicaid;
- Ryan White budget allocation; and
- information on Medicaid managed care.

These data provide detailed information as to how the healthcare landscape for people living with HIV in these states will change as a result of the ACA. Gaps in access to care, treatment and essential support services are likely to persist even after ACA implementation.

3 MEDICAID ELIGIBILITY ESTIMATES

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

Total # of ADAP clients served in FY2010[7]

– Estimated # of ADAP clients with incomes above 133% FPL[8]

– Estimated # of insured ADAP recipients in FY 2010 whose incomes are below 133% FPL[9]

– Estimated # of ADAP clients who are uninsured undocumented immigrants with incomes below 133% FPL in FY2010[10]

= # of ADAP clients who will be newly eligible for Medicaid

Using Alabama as an example, 1,763 individuals were served by Alabama's ADAP during FY2010. Of those, we estimate that 19%, or 335 ADAP clients, have incomes above 133% FPL. We further estimate that 5% (71) of ADAP clients are currently insured. Undocumented immigrants comprised an estimated 2.1% of the general population of Alabama in 2008. Applying this percentage (2.1%) to the individuals enrolled in Alabama's ADAP computes to approximately 28 people. Thus, completing the calculation above for Alabama's ADAP yields:

1,763 ADAP clients in FY2010[11]

– 335 ADAP clients with incomes above 133% FPL[12]

– 71 insured ADAP clients with incomes below 133% FPL in FY2010[13]

– 28 estimated uninsured undocumented immigrants with incomes below 133% FPL on ADAP[14]

= 1,328 individuals currently enrolled in ADAP who will be eligible for Medicaid in 2014, or 75.3% of those enrolled in Alabama's ADAP in FY2010.

The calculation above was done similarly for all 50 states. The results of the calculations are summarized in Appendix 1.

4 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. Note: this calculation assumes a state's expansion of Medicaid up to 133% FPL, per the ACA. If a state does not expand, individuals living between 100-133% FPL will also be eligible for private insurance subsidies.

Total # of ADAP clients served in FY2010

– Estimated # of ADAP clients with incomes below 133% FPL or above 400% FPL

– Estimated # of insured ADAP recipients in FY2010 whose incomes are between 133% and 400% FPL

– Estimated # of ADAP clients who are uninsured undocumented immigrants in FY2010 with incomes between 133% and 400% FPL

= # of ADAP clients who will be newly eligible for subsidized private insurance

Using Alabama as an example again, 1,763 individuals were served by ADAP during FY2010. Of those, we estimate that 81% (1,428) of ADAP clients have incomes below 133% or above 400% FPL. We further estimate that 23% (77) of those individuals are currently insured. Undocumented immigrants made up approximately 2.1% of the general population of Alabama in 2008. Applying this percentage (2.1%) to the individuals enrolled in Alabama's ADAP computes to approximately 5 ADAP clients in Alabama who are uninsured and undocumented immigrants with incomes between 133% and 400% FPL.

Thus, completing the calculation above for Alabama's ADAP yields:

1,763 ADAP clients in FY2010

– 1,428 ADAP clients with incomes below 133% FPL or above 400% FPL

– 17 insured ADAP clients in FY2010

– 7 estimated uninsured undocumented immigrants on ADAP with incomes below 133% FPL and above 400% FPL

= 312 individuals currently enrolled in ADAP who will be eligible for private insurance subsidies in 2014, or 17.7% of those enrolled in Alabama's ADAP program in FY2010.

The calculation above was done similarly for all 50 states. The results of the calculations are summarized in Appendix 1.

5 KEY FINDINGS

The mean estimates of ADAP clients newly eligible for Medicaid or subsidized private insurance range widely, meaning that the national average does not paint a completely accurate picture of how the healthcare landscape will change for people living with HIV in 2014.

- The mean national percentage (national average) of ADAP clients who will be newly eligible for Medicaid in 2014 is 34%. The percentages range from 1.2% to 80.1%.
- The mean national percentage of ADAP clients who will be newly eligible for insurance subsidies in 2014 is 21.6%. The percentages range from 0.5% to 47%.

A quartile approach allows for a more nuanced look at the changes in store over the coming years.

- The average estimate of people living with HIV who will be moving into Medicaid in 2014 in the top quartile of states is 63.3%, and ranges from 50.2% to 80.1% states with the most restrictive ADAP eligibility requirements.
- The average estimate of people living with HIV who will be moving into Medicaid in the bottom quartile of states is 7.5%, and ranges from 1.2% to 15.7% states with less restrictive ADAP eligibility requirements.
- The average estimate of people living with HIV who will be eligible for private subsidized insurance in the top quartile of states is 35.6%, and ranges from 31.1% to 47%.
- The average estimate of people living with HIV who will be eligible for private subsidized insurance in the bottom quartile of states is 4.7%, and ranges from 0.5% to 13.5%.

The great variance in estimates between states indicates that three goals must simultaneously be pursued, nationally and to varying degrees within each state, to ensure access to care for people living with HIV.

1. Medicaid must prepare to meet the needs of the large influx of people living with HIV who will be entering these programs in 2014;
2. Subsidized private health insurance plans sold through Exchanges must also prepare to meet the needs of people living with HIV who will be enrolling in these insurance plans in 2014; and
3. The Ryan White Program, including the ADAP, must continue to play a vital role in ensuring that people living with HIV who remain ineligible for both Medicaid and subsidized private insurance are not left behind. The Ryan White Program will be needed to address basic service and affordability challenges for people living with HIV that will remain even after full implementation of the ACA.

Several factors play a role in determining the proportion of clients who will be newly eligible for Medicaid or subsidized private insurance in 2014.

1. Existing state healthcare coverage rates help explain differences in estimates between states.
   - » States with high rates of insured individuals have lower estimated rates of individuals who will be newly eligible for private insurance subsidies because individuals must be uninsured to qualify for this program.
   - » Similarly, states with higher Medicaid income eligibility levels, or with existing Medicaid expansion programs (e.g., § 1115 Waivers), have lower estimated rates of individuals newly transitioning into Medicaid.

   For example, Oregon, New Mexico, and Massachusetts have very high insurance rates in their ADAPs; (only 2% of Oregon and New Mexico ADAP clients were reported as uninsured in FY2010, and 4% were uninsured in Massachusetts), and fell in the bottom quartile for both Medicaid and subsidized private insurance eligibility.
2. ADAP income eligibility influences estimates.
   - » State estimates will be most accurate for states with a 400% FPL income eligibility standard for ADAP enrollment, because all beneficiaries reflected therein fall within the income requirements for either Medicaid or subsidized private insurance.
   - » To the extent that states have lower ADAP income eligibility requirements (i.e., below 400% FPL), the estimates understate the proportion of HIV-positive individuals who will be newly eligible for insurance subsidies. For example, the estimate for a state with a 200% FPL income eligibility standard will not account for those newly eligible for private subsidized health insurance with incomes between 201%-400% FPL.
3. Small sample sizes reduce the reliability of estimates. ADAP enrollment is very small in some states, and the small sample size may have produced less reliable estimates of how the healthcare landscape for those states will change. For instance, Alaska's ADAP only served 121 clients in FY2010 and North Dakota's only served 60 in FY2011.
4. The estimates provided here focus on ADAP clients, and do not address the overall proportion of people living with HIV who will transition to Medicaid and subsidized private insurance in 2014. Since many caveats and assumptions are required to arrive at the estimates provided here, further information is needed before these estimates can be extrapolated to states' broader HIV populations.

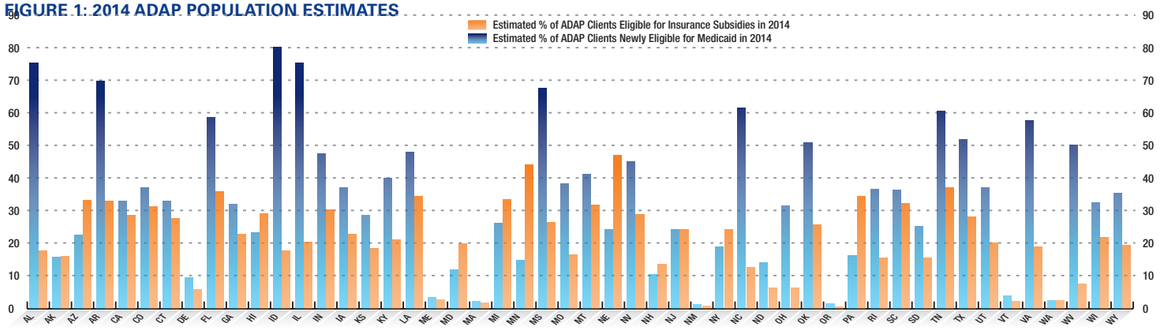
5. The research detailed here makes it clear that the Ryan White Program plays a pivotal role in ensuring access to care for people living with HIV. The Ryan White Program will be needed even beyond full implementation of the ACA to fill gaps in care, treatment, and essential support services, as well as to close gaps in affordability.

   For example, Massachusetts implemented both a Medicaid expansion and a subsidized private health insurance program in its 2006 state health reform. Yet Massachusetts continues to use its Ryan White Program to provide access to core health and support services (e.g., dental care, vision care, case management, and transportation services) and uses ADAP primarily to address gaps in affordability. In part, as a result of a well-coordinated program of health reform and Ryan White, 72% of Massachusetts' residents living with HIV have suppressed viral loads (compared to about 28% nationally). In addition, between 2005 & 2008, HIV diagnoses fell by 37% in Massachusetts versus an 8% national increase, and between 2002 and 2008 Massachusetts AIDS mortality rates decreased by 42% compared to 24% nationally.

6 CHANGES AHEAD IN 2014

The following chart combines estimates for Medicaid and subsidized private insurance in the 50 states to display an overall picture of how the healthcare landscape will be changing for people living with HIV in 2014 as the ACA is implemented. For the vast majority of states, more ADAP clients will be newly eligible for Medicaid than for subsidized private insurance (assuming states adopt the Medicaid expansion provision of the law). This chart demonstrates that different states will face starkly different changes to the healthcare landscape for people living with HIV as healthcare reform is implemented.

FIGURE 1: 2014 ADAP POPULATION ESTIMATES



7 MEDICAID

The proportion of ADAP clients who will be newly eligible for Medicaid in 2014 differs significantly between states. The mean (national average of these estimates) is 34%. Estimates range from 1.2% to 80.1%, demonstrating the large differences between states.

Several factors contribute to high estimates of newly eligible Medicaid beneficiaries in some states:

- restrictive income eligibility standards for Medicaid;
- lack of optional state Medicaid expansions (e.g., § 1115 Waivers);
- requirements that individuals not have any other third-party insurance coverage to qualify for ADAP (e.g., Virginia);
- higher overall poverty levels in a state; and
- enrollment that is skewed in favor of the lowest income brackets.

Conversely, the estimates for some states are significantly lower than average. This is due to:

- higher public insurance rates, in part due to § 1115 Medicaid Waivers (e.g., New Mexico, Oregon, Massachusetts, Washington, Maine, and Vermont);
- small population size (e.g., Alaska); and
- availability of alternative HIV assistance programs serving clients who would otherwise enroll in ADAP (e.g., the Pennsylvania AdultBasic Program).[15] NASTAD's data does not capture these groups of people who may be eligible for Medicaid in 2014 which can help explain the low estimates for these states those currently eligible for Medicaid only because of a § 1115 Waiver will be considered newly eligible in 2015.

8 PRIVATE INSURANCE SUBSIDIES

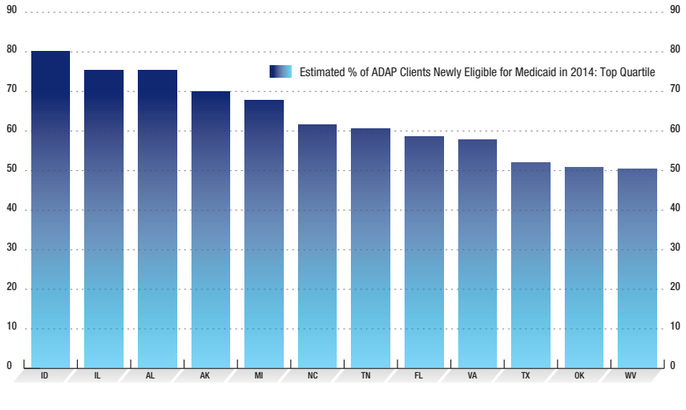
The proportion of ADAP clients who will be newly eligible for subsidized private health insurance in 2014 also varies considerably from state to state. The mean national estimate is 21.2%, and the estimates range from 0.5% to 47%. Several states have significantly lower estimates: Delaware, Maine, Massachusetts, New Mexico, North Dakota, Oklahoma, Oregon, Vermont, Washington, and West Virginia have averages more than 10% lower than the mean. As with estimates for Medicaid, the low estimates for Delaware, Maine, Massachusetts, New Mexico, Vermont, Washington, and Oregon may be due to the high rates of insured ADAP clients within those states. Since the vast majority of people in these states are already insured, fewer people living with HIV are likely to qualify for subsidies to purchase new insurance in 2014. However, it is important to note that in many of these states, ADAP plays a major role in ensuring access to prescription drugs for those who are underinsured or already insured but cannot afford pharmaceutical cost-sharing requirements. Therefore, it will be important to protect ADAP even after full implementation of the ACA to ensure continuity of care, as both underinsured and insured individuals will not be eligible for the Medicaid expansion or subsidized private insurance.

Limits of statistical modeling may explain the low estimate for North Dakota. Few clients are served by North Dakota's ADAP to begin with (60 clients in June 2011), so modeling for that state may not present a clear picture of who will be eligible for Medicaid in 2014. Oklahoma's and West Virginia's ADAPs cover primarily individuals with incomes below 133% FPL, which could help explain the lower proportion of clients in these states that will be eligible for subsidized private insurance.

9 ESTIMATES BY TOP AND BOTTOM QUARTILE

Mean estimates suggest that a significant proportion of ADAP beneficiaries will be newly eligible for Medicaid or subsidized private insurance in 2014. Nonetheless, that average does not capture important differences between the states, which encompass a wide range (from 1.2% to 80% for newly eligible Medicaid clients and 0.5% to 47% for subsidized private insurance). In other words, low estimates for some states obscure the high proportion of people living with HIV in other states that will transition from ADAP to Medicaid or subsidized private insurance in 2014. In order to more accurately represent these significant differences between states, the estimates have been broken down by top and bottom quartile below. The quartile approach shows that while very few people living with HIV will transition from ADAP to Medicaid or subsidized private insurance in a few states, other states will see a significant influx of people living with HIV moving into these programs.

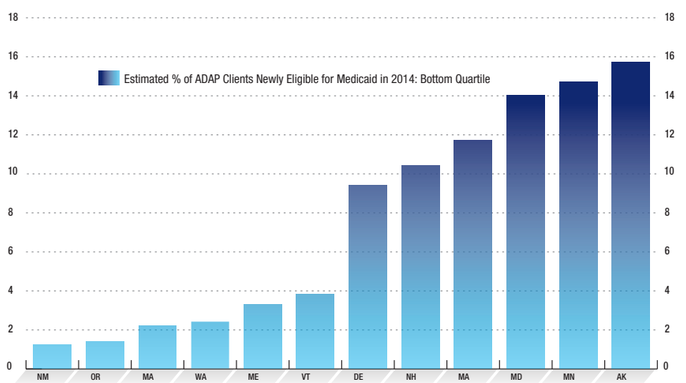
FIGURE 2: ESTIMATED % OF ADAP CLIENTS NEWLY ELIGIBLE FOR MEDICAID IN 2014: TOP QUARTILE



The states in Figure 2 have the highest estimates of people living with HIV who will be moving into Medicaid in 2014. Their estimates are significantly higher than the average (the average estimate for this quartile is 63.3%, almost double the national average), and range from 50.2% to 80.1%. These high estimates indicate that the Medicaid programs in these states must prepare to serve a significant influx of people living with HIV beginning in 2014.

STATE EXAMPLE: ALABAMA | Alabama's ADAP primarily serves individuals with incomes below 133% FPL (81% of its clients in June 2010 had incomes below 133% FPL), and its clients have extremely low rates of insurance (only 5% of clients served were insured in June 2010). Alabama's high estimate is likely due to its high poverty rates and low insurance rates. Since a large proportion of Alabama's ADAP clients will be moving into Medicaid as healthcare reform is implemented, healthcare reform implementation in Alabama must include working to ensure that the Medicaid system in the state is ready for this significant influx of people living with HIV.

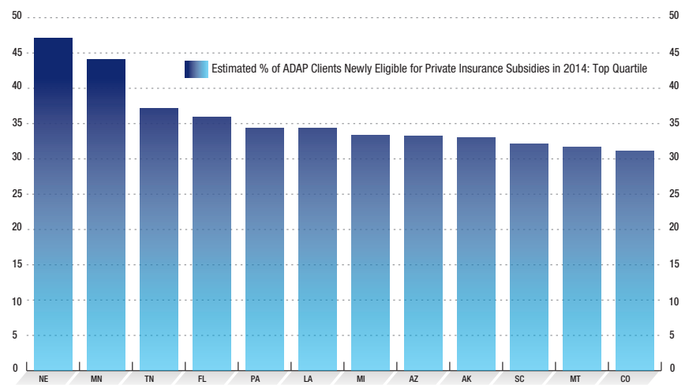
FIGURE 3: ESTIMATED % OF ADAP CLIENTS NEWLY ELIGIBLE FOR MEDICAID IN 2014: BOTTOM QUARTILE



The states in Figure 3 have the lowest estimates of people living with HIV who will be moving from ADAP to Medicaid. The average rate for the states in this bottom quartile is 7.5%, and ranges from 1.2% to 15.7%. While fewer people living with HIV in these states are likely to move into Medicaid in 2014, this outcome for the bottom quartile demonstrates the continuing importance of government support for Ryan White Program.

STATE EXAMPLE: MASSACHUSETTS | Massachusetts uses a § 1115 Waiver to expand access to Medicaid and subsidies to support access to private health insurance. By doing so it has dramatically increased both the number and proportion of people enrolled in private and public health insurance in the state. Due to Massachusetts' early experience with healthcare reform, only 4% of Massachusetts' ADAP clients were uninsured in June 2010. Yet, despite high rates of coverage, ADAP continues to play an essential role for people living with HIV, by providing access to core health and social services not provided in the Medicaid program and by subsidizing cost sharing requirements of private health plans. ADAP expenditures in the state have dramatically shifted from providing full payment for HIV medications to insurance co-payment and premium assistance for ADAP clients.

FIGURE 4: ESTIMATED % OF ADAP CLIENTS NEWLY ELIGIBLE FOR PRIVATE INSURANCE SUBSIDIES IN 2014: TOP QUARTILE



The states in Figure 4 all fall in the top quartile of estimates for the proportion of ADAP clients who will be eligible for private insurance subsidies in 2014. The average for the top quartile is 35.6%, almost fifteen percentage points higher than the national average. These estimates range from 31.1% to 47%. In the top quartile states, significant proportions of the ADAP population will be eligible to transition to subsidized private insurance. Since private insurance companies have a long record of denying coverage to people living with HIV, it will be important for the top quartile states to ensure that private insurance plans rise to the challenge of meeting the needs of people living with HIV who will be eligible for subsidized private insurance.

STATE EXAMPLE: PENNSYLVANIA | The estimate of the proportion of Pennsylvania's ADAP population that will be eligible for subsidized private insurance, 34.3%, is significantly higher than the national average. Characteristics of the ADAP population in Pennsylvania can help to explain its high estimate, as 57% of the state's ADAP clients have incomes between 133% and 400% FPL compared to 24% with incomes below 133%. Combined with a relatively high rate of uninsured clients (68%), many of Pennsylvania's ADAP clients fall into the category of people who will be eligible for private insurance subsidies.

FIGURE 5: ESTIMATED % OF ADAP CLIENTS ELIGIBLE FOR PRIVATE INSURANCE SUBSIDIES IN 2014: BOTTOM QUARTILE

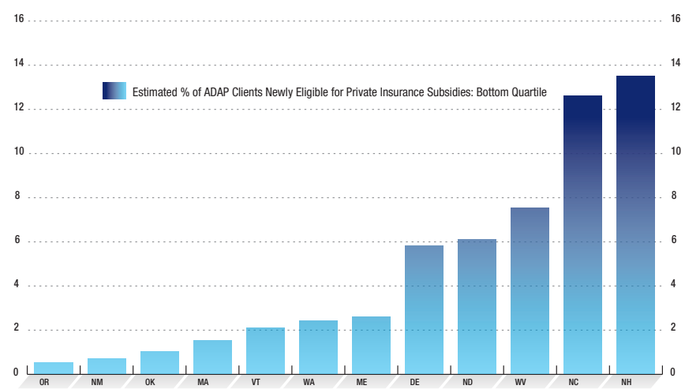


Figure 5 displays the bottom quartile of estimates for the proportion of ADAP clients who will be eligible to move into subsidized private insurance in 2014. The average of the estimates here is 4.7% - less than a quarter of the national average. Estimates in the bottom quartile range from 0.5% to 13.5%; these states will not see a large influx of ADAP clients moving into subsidized private insurance. Many of the states in the bottom quartile for subsidized private insurance are also in the bottom quartile for Medicaid (e.g., Oregon, New Mexico, Massachusetts, Vermont, Washington, Maine, Delaware, North Dakota, and New Hampshire). Since individuals who are already insured are not newly eligible for Medicaid in 2014 and are also ineligible for subsidized private insurance, the overlap of states in these two categories indicates that their low estimates are largely a function of high insurance rates in these states. Oklahoma, West Virginia, and North Carolina are not in the bottom quartile of estimates for Medicaid eligibility, and it appears from the data that their low estimates are the result of the lower income of their ADAP populations.

STATE EXAMPLE: NEW MEXICO | New Mexico's estimates, for both its newly eligible Medicaid population and its subsidized private insurance population, are markedly lower than the national averages: 1.2% of its ADAP population is expected to be newly eligible for Medicaid, and 0.7% for subsidized private insurance. The key factor that appears to play a role in New Mexico's small estimates is the very large proportion of its ADAP population that is already insured (90%). New Mexico has an Insurance Assistance Program that is partially funded through ADAP and partially funded by State General Funds; many of its ADAP clients are insured and will not be newly eligible for Medicaid or private insurance under the ACA. Nevertheless, much like Massachusetts' experience, Ryan White Program funding is essential to the function of New Mexico's strategy for treating low-income people living with HIV.

Looking at the estimates through a quartile approach sheds light on the profound changes some states' healthcare landscapes will be undergoing in the coming years, and also highlights the importance of maintaining ADAP for clients who will remain in the program or rely on the program to provide access to core services and to provide financial assistance in meeting premium and co-payment obligations even after healthcare reform implementation. The healthcare landscape for people living with HIV is changing dramatically, and the results of this study show how essential it is to maintain existing programs for low-income people living with HIV while striving to ensure that new programs rise to the challenge of meeting the needs of HIV-positive clients who will begin using their services.

10 HEALTHCARE REFORM AND THE RYAN WHITE PROGRAM

The current status of the Ryan White Program in states that have expanded access to care through § 1115 Waivers and other Medicaid and insurance-based reforms demonstrates the ongoing and important role played by the Ryan White Program. Expansions in coverage often lead to a reduced role for the Ryan White Program, but it continues to be essential as a gap-filler to ensure that people living with HIV can access the care they need. For example, since Massachusetts implemented its § 1115 Waiver, ADAP expenditures in the state have gradually shifted from an emphasis on full-pay for drugs to co-pays and premium assistance. The Ryan White Program also supports access to essential health and social services that are typically not provided by state Medicaid programs or through private health insurance.

TABLE 1: MASSACHUSETTS ADAP EXPENDITURES BY CATEGORY[16]

	FULL PAY	CO-PAY	PREMIUMS
FY2002	$7,947,832.29	$648,030.26	$1,120,512.14
FY2009	$4,695,780.40	$2,567,789.28	$8,835,835.67

As Table 1 demonstrates, ADAP continues to play a key role in helping people living with HIV in Massachusetts access care, though the primary role for ADAP has changed in the state. As more ADAP clients nationwide transition to Medicaid and private insurance as a result of healthcare reform, similar changes are likely to occur in other states. The Ryan White Program will continue to have an essential role in filling gaps in access to care by providing essential core services not provided through healthcare reform and addressing affordability issues for people living with HIV. The current and future status of the Ryan White Program is inextricably linked with continued access to care for people living with HIV, and the estimates provided here demonstrate that the Ryan White Program will be essential in ensuring continuous access to essential services for people living with HIV even as healthcare reform is implemented.

11 NOTES

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

1. Data regarding June 2011 client income level for Georgia and Louisiana were incomplete in the 2012 report. Because previous recent NASTAD reports were also incomplete, national averages were used in the income calculations for these states.
2. Data regarding the insurance status of clients were incomplete in the 2012 report for Georgia, Minnesota, New Jersey, and Utah. Because previous recent NASTAD reports were also incomplete, national averages were used for insurance status in the calculations.
3. Data for Nebraska's ADAP client income breakdown were incomplete in the 2012 report but available in the 2011 report. The 2011 data were used for Nebraska's income breakdown.
4. Data for insurance status of ADAP clients in Kentucky, Louisiana, North Carolina, and North Dakota were incomplete in the 2012 report but available in the 2011 report. The 2011 report data were used in the calculations for these states.
5. 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; while the specific number of ADAP clients eligible for Medicaid and private insurance subsidies in Mississippi may not be reliable, the proportion of clients eligible for both programs was obtained in the same way as that for other states.

12 CAVEATS AND ASSUMPTIONS

The estimates provided require a number of caveats and assumptions:

1. ADAP data (as opposed to broader Ryan White Program data) were used 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 that will be eligible for Medicaid and private insurance subsidies.
2. Data for ADAP clients served were used rather than data for clients enrolled, because the number of individuals enrolled may over-count the actual number of clients actually accessing ADAP services. Potential clients who are currently on ADAP waiting lists in several states are also not included in these calculations. Thus, the numbers in this report provide a conservative estimate of newly eligible beneficiaries.
3. It is possible that some individuals fall into more than one category 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.
5. These calculations assume that each state will fully implement the ACA, including the Medicaid expansion.
6. The terms in the equation used represent data that are available for every state, and were chosen over state-specific data to allow for interstate comparisons. While state-specific data may exist in some states, they vary in formatting and methodology; comparing such data would be of little analytical value.
7. The number of undocumented immigrants on ADAP is a rough estimate extrapolating from estimates of the overall number of undocumented immigrants in the state as a whole in 2008. It is possible that this over or underestimates the actual number of undocumented immigrants currently on ADAP.

With these caveats and assumptions in mind, the figures above provide useful estimates of the number and percentage of ADAP clients who will be newly eligible for Medicaid in 2014, 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, given the number of caveats and assumptions needed to arrive at this rough estimate, it would be better to obtain further information about the unmet need within states before attempting to make such calculations.

13 CONCLUSIONS

A significant proportion of uninsured individuals living with HIV will have access to healthcare through Medicaid or subsidized private insurance upon implementation of the ACA. Several factors play a role in determining the proportion of clients who will be newly eligible for Medicaid or subsidized private insurance, including the current use of § 1115 Waivers, insurance assistance programs, and expansive or restrictive Medicaid income eligibility criteria. As a result, the proportion of newly eligible individuals will vary significantly from state to state. Moreover, since not all states have committed to expanding their Medicaid programs, disparities between states' abilities to provide access to healthcare for people living with HIV may be divergent. Despite state variations, the ACA provides important opportunities for bringing most people living with HIV into public and private healthcare systems. The results of this research should inform legislators, providers, and advocates on the way the healthcare landscape will change in each state and provide vital information on how states can best prepare for the changes ahead and meet the care and treatment needs of people living with HIV.

14 APPENDIX 1

Estimated Percentages of ADAP Clients Who Will Be Newly Eligible for Medicaid or Private Insurance in 2014

TABLE 1: ESTIMATED ADAP CLIENTS NEWLY ELIGIBLE FOR MEDICAID

STATE	ESTIMATED NUMBER OF CLIENTS	PERCENTAGE OF CLIENTS NEWLY ELIGIBLE FOR MEDICAID
Alabama	1328	75.3%
Alaska	19	15.7%
Arizona	365	22.5%
Arkansas	395	69.8%
California	12982	32.9%
Colorado	1108	37.1%
Connecticut	796	32.9%
Delaware	112	9.4%
Florida	8364	58.5%
Georgia	1891	32.0%
Hawaii	90	23.2%
Idaho	151	80.1%
Illinois	4853	75.3%
Indiana	974	47.3%
Iowa	214	37.1%
Kansas	344	28.6%
Kentucky	581	39.9%
Louisiana	1707	48.0%
Maine	15	3.3%
Maryland	731	11.7%
Massachusetts	142	2.2%
Michigan	702	26.1%
Minnesota	193	14.7%
Mississippi	9787	67.6%
Missouri	5534	38.2%
Montana	60	41.1%
Nebraska	136	24.2%
Nevada	537	45.1%
New Hampshire	47	10.4%
New Jersey	1749	24.2%
New Mexico	10	1.2%
New York	4085	18.8%
North Carolina	3434	61.5%
North Dakota	15	14.0%
Ohio	1084	31.3%
Oklahoma	778	50.7%
Oregon	43	1.4%
Pennsylvania	989	16.1%
Rhode Island	311	36.6%
South Carolina	1343	36.3%
South Dakota	36	25.1%
Tennessee	2527	60.5%
Texas	8670	51.9%
Utah	171	37.1%
Vermont	10	3.8%
Virginia	2341	57.7%
Washington	104	2.4%
West Virginia	175	50.2%
Wisconsin	570	32.5%
Wyoming	38	35.2%

TABLE 2: ESTIMATED ADAP CLIENTS NEWLY ELIGIBLE FOR INSURANCE SUBSIDIES IN 2014

STATE	ESTIMATED NUMBER OF CLIENTS	PERCENTAGE OF CLIENTS ELIGIBLE FOR INSURANCE SUBSIDIES
Alabama	312	17.7%
Alaska	19	15.8%
Arizona	539	33.2%
Arkansas	186	32.9%
California	11268	28.5%
Colorado	927	31.1%
Connecticut	663	27.5%
Delaware	69	5.8%
Florida	5126	35.8%
Georgia	1351	22.8%
Hawaii	111	28.9%
Idaho	33	17.6%
Illinois	1306	20.3%
Indiana	623	30.2%
Iowa	131	22.6%
Kansas	220	18.3%
Kentucky	304	20.9%
Louisiana	1219	34.3%
Maine	12	2.6%
Maryland	1231	19.7%
Massachusetts	96	1.5%
Michigan	895	33.3%
Minnesota	580	44.0%
Mississippi	3806	26.3%
Missouri	1262	38.2%
Montana	46	31.6%
Nebraska	264	47.0%
Nevada	343	28.8%
New Hampshire	61	13.5%
New Jersey	1749	24.2%
New Mexico	6	0.7%
New York	5224	24.1%
North Carolina	703	12.6%
North Dakota	6	6.1%
Ohio	887	25.6%
Oklahoma	16	1.0%
Oregon	16	0.5%
Pennsylvania	2101	34.3%
Rhode Island	131	15.5%
South Carolina	1188	32.1%
South Dakota	22	15.4%
Tennessee	1549	37.1%
Texas	4614	28.0%
Utah	92	20.0%
Vermont	5	2.1%
Virginia	759	18.7%
Washington	104	2.4%
West Virginia	26	7.5%
Wisconsin	380	21.7%
Wyoming	21	19.2%

[1] Murray C. Penner & Britten Pund, National Alliance of State and Territorial AIDS Directors, *National ADAP Monitoring Project (January 2012)*, available at: http://www.nastad.org/Docs/023037_Module%20One%20-%20National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20January%202012.pdf.

[2] In *National Federation of Independent Business v. Sebelius*, No. 11-393, slip op. at 45 (U.S., June 28, 2012) the Supreme Court ruled that the Secretary of Health and Human Services cannot withdraw all federal Medicaid funding from states that do not comply with the ACA's Medicaid Expansion. The Court's ruling functionally makes the expansion optional for states, since their current Medicaid funding cannot be withdrawn if they refuse to expand.

[3] The District of Columbia, the Federated States of Micronesia, Guam, the Marshall Islands, the Northern Mariana Islands, Puerto Rico, and the Republic of Palau all appear in the *National ADAP Monitoring Project* (Penner & Pund, 2012), but estimates have not been provided for these territories. The data in the Project report is incomplete for these territories, and using national data to estimate their newly eligible populations would add little analytic value to work presented here.

[4] *National ADAP Monitoring Project* (Penner & Pund, 2012).

[5] The number of undocumented immigrants enrolled in the AIDS Drug Assistance Program (ADAP) in each state in fiscal year 2009 was extrapolated from a Pew Research Center report based on 2008 data. See Jeffrey S. Passel & D'Vera Cohn, *A Portrait of Unauthorized Immigrants in the United States* (Washington, DC, Pew Hispanic Center April 14, 2009), available at: http://pewhispanic.org/files/reports/107.pdf (last visited May 18, 2012). An estimated number of undocumented immigrants is provided for each state. This number, divided by the overall population of the state in 2008 (estimated at: http://www.census.gov/popest/data/state/asrh/2008/SC-EST2008-03.html), provides an estimate of undocumented immigrants compared with each state's total population. This percentage is then applied to the number of individuals enrolled in the state ADAP to estimate how many current ADAP clients in the state will not be newly eligible for private insurance subsidies because of undocumented immigration status.

[6] The eighteen states examined more closely were Arkansas, Alabama, California, Florida, Georgia, Illinois, Louisiana, Maryland, Massachusetts, Mississippi, New Jersey, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Texas, and Virginia.

[7] The number of ADAP clients in FY2010 is obtained from the *National ADAP Monitoring Project* (Penner & Pund, 2012), Table 8, pg. 53.

[8] *National ADAP Monitoring Project* (Penner & Pund, 2012), Table 13, pg. 58. In order to estimate the number of ADAP enrollees whose incomes fall above 133% FPL, data from June 2011 was used. It is assumed that similar percentages existed throughout FY 2010.

[9] The estimated number of ADAP recipients who are on private insurance, Medicaid, and Medicare is determined for the purposes of this analysis from NASTAD's data for June 2011, available on page 59 of the *National ADAP Monitoring Project* (Penner & Pund, 2012). The percentage of individuals in each state who were covered by private insurance, Medicaid, or Medicare in June 2011 will be used as the estimated percentage for FY2010 in making this calculation.

[10] The number of undocumented immigrants on ADAP in each state in FY2009 is extrapolated from *A Portrait of Unauthorized Immigrants in the United States* (Passell & Cohn, 2009). This report provides the estimated number of undocumented immigrants in each state for 2008. This number, divided by the overall population of each state in 2008 (estimated at http://www.census.gov/popest/data/state/asrh/2008/SC-EST2008-03.html), provides the percentage that undocumented immigrants make up of the total population in the state. This percentage is then applied to the number of individuals enrolled in ADAP to estimate how many ADAP beneficiaries will not be newly eligible for Medicaid in 2014 as a result of their immigration status.

[11] The number of ADAP clients in FY2010 is obtained from the *National ADAP Monitoring Project* (Penner & Pund, 2012), Table 8, pg. 53.

[12] *National ADAP Monitoring Project* (Penner & Pund, 2012), Table 13, pg. 58. In order to estimate the number of ADAP enrollees whose incomes fall between 133% and 400% FPL, data from June 2011 was used. For the purposes of this analysis it is assumed that similar percentages existed throughout FY 2010.

[13] The estimated number of ADAP recipients who are on private insurance, Medicaid, and Medicare is determined for the purposes of this analysis from NASTAD's data for June 2011, available on page 59 of the *National ADAP Monitoring Project* (Penner & Pund, 2012). The percentage of individuals in each state who were covered by private insurance, Medicaid, or Medicare in June 2011 will be used as the estimated percentage for FY2009 in making this calculation.

[14] The number of undocumented immigrants on ADAP in each state in FY2009 is extrapolated from *A Portrait of Unauthorized Immigrants in the United States* (Passell & Cohn, 2009). 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 (estimated at http://www.census.gov/popest/data/state/asrh/2008/SC-EST2008-03.html), provides the percentage that undocumented immigrants make up of the total population in the state. This percentage is then applied to the number of individuals enrolled in ADAP to estimate how many ADAP beneficiaries will not be newly eligible for private insurance subsidies as a result of their immigration status.

[15] Pennsylvania Health Access Network, PHAN Hosts State-Wide Call on *AdultBasic*, available at: http://pahealthaccess.org/blog/phan-hosts-state-wide-call-adultbasic (last visited August 23, 2012).

[16] Rockwell, Annette. Massachusetts Department of Public Health, Office of HIV/AIDS. 2010 National ADAP Meeting. July 8, 2010.

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