STATE HEALTH REFORM IMPACT MODELING PROJECT

Arkansas

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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 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 Arkansas, 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?

ARKANSAS

ARKANSANS LIVING WITH HIV OR AIDS

UNMET NEED

As of 2011, approximately 5,457 Arkansans were known to be living with HIV/AIDS (HIV+ aware).[3,4] As of 2008, 65.6% of HIV+ aware Arkansans had not accessed medical care in the past 12 months.[5] Moreover, national estimates predict that approximately 21% of individuals living with HIV have not been diagnosed.[6] 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 also be newly eligible for either private or public insurance in 2014.

THE RYAN WHITE PROGRAM IN ARKANSAS

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 treatment and care. In other words, it serves as a critical payer of last resort, filling gaps in healthcare and ancillary support services that are unmet by other charitable or funded healthcare services. In 2010, Arkansas received $10,483,936 in Ryan White funding,[7] and served 3,867 duplicated clients.[8,9] About 82% of the state's Ryan White funds were Part B grants, assigned based on prevalence of HIV in the state.[7] Of these, 41.4% covered core medical services ("base" funds), 50.4% went toward the AIDS Drug Assistance Program (ADAP), and 7.7% provided ADAP supplemental funding.[7]

ADAP IN ARKANSAS

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 Arkansas, one must be:

- An Arkansas resident diagnosed with HIV;
- Living at or below 200% of the federal poverty level (FPL); and
- Uninsured and in possession of a Medicaid denial letter, unless the person is receiving Medicare Part D.[10]

In fiscal year 2010, Arkansas' ADAP served 565 individuals.[11] The state's 2011 ADAP budget was $8,368,433, all of which came from federal funds.[12] In the previous fiscal year, Arkansas spent $5,382,557 on ADAP—approximately 97% of these funds were used to cover the full cost of ART, while about 0.3% of the funds went toward insurance assistance.[13,*]

THE ACA AND ITS IMPACT ON HIV+ ARKANSANS

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 federal Department of Health and Human Services (HHS) cannot force states to comply with the expansion (by withdrawing existing federal medical funding), the federal government will cover 100% of the cost of newly eligible beneficiaries until 2016, and at least 90% thereafter. 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.[15]

* $5,382,557 from Arkansas' 2010 ADAP budget went toward covering the full cost of ART, and another $14,002 went toward insurance assistance.

† Undocumented immigrants and 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.

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.[16] BHPs must cover at least the EHB and cannot exceed the cost sharing or premiums imposed by a plan the individual would otherwise purchase on an exchange.[17] Cost sharing on BHPs can be subsidized, either for all beneficiaries or for those with specific chronic conditions (eg, HIV/AIDS).[18] The federal government is expected to pay up to 95% of the premium credits for individuals enrolled in a BHP.[19] 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.[20] 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.[21]

The ACA extends insurance premium credits to individuals and families living below 400% FPL, such that eligible families' and individuals' premium contributions will be limited to 2.0-9.8% of their income, and imposes out-of-pocket spending caps to protect healthcare consumers from medical bankruptcy.[22]

ESSENTIAL HEALTH BENEFITS

The ACA requires both Medicaid plans and private health insurance plans sold on insurance exchanges to provide a minimum of EHB, to be defined by the Secretary of HHS.[23,28,29] EHB must include items and services within the following ten benefit categories[24]:

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.[25] The Centers for Medicare & 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.[26] 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.[27]

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 Arkansas are expected to become eligible for Medicaid or a BHP in 2014, provided that Arkansas fully implements the law. An estimated 32% 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.[9] More specifically, we estimate that 52.6% of Arkansas' AIDS Drug Assistance Program (ADAP) clients will be newly eligible for Medicaid, and 26% will be eligible for private insurance subsidies (see Appendix A). Finally, many HIV+ Arkansans who currently lack access to care are likely to also be eligible for Medicaid, a BHP, or subsidized private insurance in 2014.

The percentage of Arkansas' ADAP clients who will be newly eligible for Medicaid (52.6%) is considerably higher than the national proportion of newly eligibles (29%) because most individuals in the state's program are living below 133% FPL (65% in 2011) and many are uninsured.[‡] Nonetheless, the percentage of Arkansas' ADAP clients who are expected to qualify for private insurance subsidies (26%) is also higher than the national proportion (15%) because about one-third of the state's ADAP clients are living above 133% FPL (35% in 2011).

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

Since a significant number of HIV+ individuals in Arkansas who are currently served by the Ryan White program or AIDS Drug Assistance Program (ADAP) are likely to be eligible for Medicaid or subsidized private insurance in 2014, it is important to examine the benefits provided under each and the variation in cost sharing that beneficiaries would incur. This assessment compares and contrasts the services and treatments that the Ryan White program, ADAP, Medicaid, and Arkansas' benchmark plan currently or will provide to HIV+ Arkansans.

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

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 services versus support services). Both medical and ancillary services are critical to maintaining the health of low-income individuals who may not have access to necessities that facilitate effective HIV/AIDS treatment and care (eg, transportation, child care, nutrition). However, Medicaid and Arkansas' benchmark plan, which will determine essential health benefits (EHB) for private insurance sold on the state's exchange, do not cover ancillary services (although they cover a broader range of medical services). Accounting for the gaps between the Ryan White program and Medicaid or private insurance sold on the exchange will be critical in transitioning Ryan White beneficiaries onto Medicaid and private insurance while ensuring that their health status does not deteriorate (eg, due to lack of proper nutrition, access to transportation to a health clinic, stable housing).

Table 1 provides a comparison of covered services between Arkansas' Ryan White and Medicaid programs (as of 2010), as well as the benchmark plan proposed by Arkansas for purposes of defining EHB on an exchange (the Arkansas BlueCross BlueShield Health Advantage POS Plan, supplemented by the QualChoice Federal Plan Mental Health and Substance Abuse Benefits).

[‡] 81% of Arkansas' ADAP clients were uninsured in 2011. See Appendix A.

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[30]	Medicaid[31]	BlueCross BlueShield Health Advantage POS Plan and QualChoice Federal Plan Mental Health and Substance Abuse Benefits[32,33,34]
Home Health Care		X	X
Mental Health	X	X	X
Substance Abuse (outpatient)	X	X[34]	X
Substance Abuse (inpatient)		X[35]	X
Medical Case Management	X	§	X
Community-Based Care		X	
Ambulatory/Outpatient Care	X	X	X
Oral Health Care	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	X
Midwife/NP Services		X	X
Private Duty Nursing		X	
Physician Services		X	X
Non-Medical Case Management Services	X		
Child Care	X		
Emergency Financial Assistance	X		
Food Bank/Home Delivered Meals	X		
Housing Services			
Health Education/Risk Reduction	X		
Legal Services			
Linguistics Services	X		
Non-Emergency Medical Transportation	X	X	
Outreach Services			
Psychosocial Support	X		
Referral Agencies	X		
Treatment Adherence Counseling	X		
Chiropractor		X	X
Podiatry		X	X (foot care to prevent diabetes mellitus complications)
Hospice		X	X
Respiratory Therapy			
PT, OT, and Speech Therapy		X	X
Orthotics and Prosthetics		X[36]	X

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

§ Only available individuals younger than age 21 years (or referred as a result of a well-child check-up), individuals with a developmental disability, individuals aged 60 years or older, and pregnant individuals.

As Table 1 indicates, the Ryan White program offers HIV+ individuals a number of ancillary services that Medicaid and Arkansas' benchmark plan do not cover. Since these ancillary services are important for the well-being of HIV+ individuals, those individuals who leave the Ryan White program for Medicaid or private insurance plans are likely to be at a disadvantage if Ryan White wraparound services are unavailable.

Additionally, HIV+ individuals who leave the Ryan White program for private insurance plans might find the latter's cost-sharing requirements to be prohibitive. Arkansas' insurance exchange will offer a choice of plans, tiered by actuarial value of coverage: bronze plans (those for which subsidies are available) will only cover 70% of the actuarial value of services, meaning that patient cost sharing will be as high as 30% of the cost of care.[37] HIV+ individuals transitioning from Ryan White onto these plans may encounter difficulty with physician visit copays, particularly because of the frequency of specialist visits that antiretroviral therapy (ART) requires. Ryan White will remain a critical payer of last resort in this scenario.

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

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 (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 Arkansans living with HIV/AIDS.

Table 2 provides a comparison of the antiretroviral drug formularies included in the state's ADAP, Medicaid program, and the Arkansas BlueCross BlueShield Health Advantage POS Plan, supplemented by the QualChoice Federal Plan Mental Health and Substance Abuse Benefits (the benchmark plan proposed by Arkansas for purposes of defining EHB for plans sold on an exchange).

Table 2. ADAP Versus Medicaid and the Benchmark Plan: Covered Drugs[38]

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[39]**	**Medicaid[40,**]**	**BlueCross BlueShield Health Advantage POS Plan and QualChoice Federal Plan Mental Health and Substance Abuse Benefits[42]**
Multiclass Combination Drugs	**1 Drug Covered**	**3 Drugs Covered**	**3 Drugs Covered**
Atripla	X	X	X
Complera; *emtricitabine + rilpivirine + tenofovir disoproxil fumarate*		X	X
Stribild; *elvitegravir + cobicistat + emtricitabine + tenofovir disoproxil fumarate*		X	X
Entry Inhibitors - CCR-5 Coreceptor Antagonist	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Selzentry; *maraviroc*	X	X	X
Fusion Inhibitors	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Fuzeon; *enfuvirtide*	X	X	X
HIV Integrase Strand Transfer Inhibitors	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Isentress; *raltegravir*	X	X	X
NNRTI	**3 Drugs Covered**	**5 Drugs Covered**	**5 Drugs Covered**
Intelence; *etravirine*	X	X	X
Rescriptor; *delavirdine mesylate*		X	X
Sustiva; *efavirenz*	X	X	X
Viramune; *nevirapine*	X	X	X
Edurant; *rilpivirine*		X	X
NRTI	**12 Drugs Covered**	**12 Drugs Covered**	**12 Drugs Covered**
Combivir; *zidovudine + lamivudine*	X	X	X
Emtriva; *emtricitabine*	X	X	X
Epivir; *lamivudine*	X	X	X
Epzicom; *abacavir sulfate + lamivudine*	X	X	X
Retrovir; *zidovudine*	X	X	X
Trizivir; *abacavir + zidovudine + lamivudine*	X	X	X
Truvada; *tenofovir DF + emtricitabine*	X	X	X
Videx; *didanosine (buffered versions)*	X	X	X
Videx EC; *didanosine (delayed-release capsules)*	X	X	X
Viread; *tenofovir disoproxil fumarate DF*	X	X	X
Zerit; *stavudine*	X	X	X
Ziagen; *abacavir*	X	X	X

Continued on next page

** The Medicaid formulary is subject to change. See e-mail correspondence between Alisha Smith, Pharmacy Director, HealthCare Pharmacy and Amy Rosenberg, Associate Director, Center for Health Law and Policy Innovation of Harvard Law School (Oct. 11, 2012) (on file with author).

Table 2. (continued)

Protease Inhibitors	10 Drugs Covered	10 Drugs Covered	10 Drugs Covered
Agenerase; *amprenavir*	X	X	X
Aptivus; *tipranavir*	X	X	X
Crixivan; *indinavir sulfate*	X	X	X
Invirase; *saquinavir mesylate*	X	X	X
Kaletra; *lopinavir + ritonavir*	X	X	X
Lexiva; *fosamprenavir*	X	X	X
Norvir; *ritonavir*	X	X	X
Prezista; *darunavir*	X	X	X
Reyataz; *atazanavir sulfate*	X	X	X
Viracept; *nelfinavir sulfate*	X	X	X
"A1" Opportunistic Infection Medications	**19 Drugs Covered**	**26 Drugs Covered**	**Formulary Not Publicly Available[41,42]**
Ancobon; *flucytosine*		X	
Bactrim DS; *sulfamethoxazole/trimethoprim DS*	X (sulfamethoxazole/ trimethoprim DS only)	X	
Biaxin; *clarithromycin*	X (clarithromycin only)	X	
Cleocin; *clindamycin*		X	
Dapsone	X	X	
Daraprim; *pyrimethamine*	X	X	
Deltasone; *prednisone*	X	X	
Diflucan; *fluconazole*	X	X	
Famvir; *famciclovir*		X	
Foscavir; *foscarnet*		X	
Fungizone; *amphotericin B*		X	
INH; *isoniazid*		X	
Megace; *megestrol*	X (megestrol only)	X	
Mepron; *atovaquone*	X	Coverage unconfirmed[43]	
Myambutol; *ethambutol*	X (ethambutol only)	X	
Mycobutin; *rifabutin*	X	X	
NebuPent; *pentamidine*		X	
Probenecid		X	
Procrit; *epoetin alfa*		X	
Pyrazinamide (PZA)		X	
Sporanox; *itraconazole*	X (itraconazole only)	X	
Sulfadiazine – Oral	X	X	
Valcyte; valganciclovir	X	Coverage unconfirmed[43]	
Valtrex; *valacyclovir*	X	X	
VFEND; *voriconazole*	X	Coverage unconfirmed[43]	
Vistide; *cidofovir*	X	X	
Wellcovorin; *leucovorin*	X (leucovorin only)	X	
Zithromax; *azithromycin*	X (azithromycin only)	X	
Zovirax; *acyclovir*	X (acyclovir only)	X	

ADAP = AIDS Drug Assistance Program; ART = antiretroviral therapy; NNRTI = non-nucleoside reverse transcriptase inhibitors; NRTI = nucleoside reverse transcriptase inhibitors.

Table 2 indicates that Medicaid's formulary is at least as comprehensive as the formulary available under ADAP. However, Medicaid's formulary is not publicly available and is subject to change without notice.[37] Moreover, there is little publicly available information regarding prior authorization and other measures that might restrict Medicaid beneficiaries' access to the drugs listed in the table. It is also important to note that the analysis uses Arkansas' current Medicaid formulary; the benchmark plan for newly eligible beneficiaries has yet to be defined and may vary in important ways. If newly eligible Medicaid beneficiaries are subject to less comprehensive drug coverage than provided under Ryan White, ADAP will continue to be a critical payer of last resort.

Arkansas' benchmark plan for the exchange (BlueCross BlueShield Health Advantage POS Plan and QualChoice Federal Plan Mental Health and Substance Abuse Benefits) does not have a publicly available drug formulary.[41,42] Thus, it is similarly difficult to estimate the impact that a transition from ADAP to subsidized private insurance will have on low-income Arkansans living with HIV/AIDS. Regardless of its formulary, HIV+ beneficiaries will be subject to considerable prescription copays, given the number of drugs comprehensive ART requires. ADAP will remain critical as a payer of last resort for those for whom cost sharing becomes prohibitive.

CONCLUSIONS AND NEXT STEPS

This report provides analyses of the Ryan White program, AIDS Drug Assistance Program (ADAP), Medicaid, and the benchmark plan used to define 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 Arkansans.

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 onto Medicaid in Arkansas, 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 currently the state's only option to provide access to treatment for the thousands of HIV+ individuals in the state who currently lack access to care.

Nonetheless, the Medicaid system must be ready and able to handle the needs of low-income HIV+ people. Should Arkansas 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/AIDS. 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 services with existing Medicaid formularies allows for a baseline analysis of the needs of individuals living with HIV moving into the Medicaid system. This report identified two challenges:

1. First, a number of services that are currently provided by the Ryan White program are not available under the state's current Medicaid program. For instance, the Ryan White program, unlike Medicaid, covers early-intervention clinics and treatment adherence counseling. HIV+ individuals who shift from the Ryan White program to Medicaid are therefore likely to have trouble accessing a number of services currently available to them, and Ryan White will continue to be a critical payer of last resort to ensure that all individuals living with HIV have access to comprehensive antiretroviral treatment (ART); and
2. Second, while Medicaid's prescription drug list appears to be as comprehensive as ADAP's formulary, it is possible that Medicaid has measures in place that limit HIV+ individuals' access to multiple branded prescriptions. Because Medicaid plans for newly eligibles may use similar cost-containment strategies, this will be an ongoing concern.

It is also essential that private insurance plans on the Arkansas exchange provide a level and scope of services that are sufficient to meet the needs of HIV+ individuals 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 sold on the exchange:

1. First, a number of services that are currently provided by the Ryan White program are not available under Arkansas' benchmark plan. Moreover, cost-sharing requirements may prohibit low-income HIV+ individuals from accessing certain services available under private insurance plans on the exchange. HIV+ Arkansans transitioning from Ryan White to subsidized private insurance are therefore likely to have trouble accessing a number of services currently available to them; and
2. Second, while the benchmark's formulary for antiretroviral drugs is as comprehensive as the state's ADAP formulary, cost-sharing requirements are likely to restrict low-income HIV+ individuals' access to the multitude of prescription drugs they require for comprehensive ART. Moreover, coverage of drugs needed to treat opportunistic infections is not publicly available. Because EHB for private plans will likely be based on benchmark coverage, ADAP will continue to be essential to fill both coverage and affordability gaps.

There will remain an ongoing demand for Ryan White and ADAP services to fill the gaps left by Medicaid coverage or private health insurance 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 Arkansans.

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. Arkansas must adopt the Medicaid expansion, pursuant to the ACA, extending 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. Arkansas must ensure that Ryan White and ADAP services are available where Medicaid or private insurance coverage gaps exist (eg, transportation, nonmedical case management, food and nutrition) or where cost sharing makes coverage prohibitive.

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[11]
–	**est. #**	ADAP clients living above 133% FPL[44,††]
–	**est. #**	insured ADAP clients living below 133% FPL
–	**est. #**	ADAP clients who are undocumented immigrants living below 133% FPL in June 2011[45]
=	**Total #**	ADAP clients who will be newly eligible for Medicaid in 2014[‡‡]

Arkansas' ADAP served 565 clients in 2010. Of those, an estimated 197.75 (35%) were living above 133% FPL. Also, we estimated that 60.70 insured ADAP clients had income below 133% FPL. Nearly 2% of the state population was composed of undocumented immigrants in 2008 (amounting to approximately 7.65 ADAP clients with income below 133% FPL). Thus, the calculation for Arkansas is:

	565	ADAP clients being served in fiscal year 2010
–	**197.75**	ADAP clients with incomes above 133% FPL
–	**60.70**	insured ADAP clients with incomes below 133% FPL
–	**7.65**	undocumented immigrants with incomes below 133% FPL in June 2011
=	**299**	ADAP clients who will be newly eligible for Medicaid in 2014; or 52.9% of ADAP clients served in the 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	% Fiscal Year 2010 ADAP Clients
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 regarding the percentage of insured ADAP clients in the states of Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.[46] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky and the percentages sum to greater than 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).

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

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

Private Insurance Subsidy Estimates

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

	Total #	ADAP clients being served in fiscal year 2010[11]
–	**est. #**	ADAP clients living below 133% FPL[48,§§]
–	**est. #**	ADAP clients living above 400% FPL[48]
–	**est. #**	insured ADAP clients living between 133-400% FPL[47]
–	**est. #**	ADAP clients who are undocumented immigrants living between 133-400% FPL[45]
=	**Total #**	ADAP clients who will be newly eligible for subsidized private insurance[***]

Arkansas' ADAP served 565 clients in 2010. Of those, an estimated 367.25 (65%) of ADAP clients had incomes below 133% FPL (there are no ADAP clients in the state with incomes above 400% FPL). This leaves 35% (197.75) of ADAP clients with incomes between 133-400% FPL, since Arkansas has no ADAP clients living above 400% FPL. We also estimate that there were 46.65 insured ADAP clients with incomes between 133-400% FPL. Approximately 2% of Arkansas' population was composed of undocumented immigrants in 2008 (4.07 ADAP clients with incomes between 133-400% FPL). Thus, the calculation for Arkansas is:

	565	ADAP clients being served in June 2011
–	**367.25**	ADAP clients with incomes below 133% FPL or above 400% FPL
–	**46.65**	estimated insured ADAP clients with incomes between 133-400% FPL
–	**4.07**	uninsured undocumented immigrants with incomes between 133-400% FPL in June 2011
=	**147**	ADAP clients who will be eligible for insurance subsidies in 2014; or 26% of ADAP clients being served in fiscal year 2010

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

State	# ADAP Clients 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 the states of Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.[49] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky and the percentages sum to greater than 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).

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

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 statuses 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 Arkansas, 53% of adults living below 133% FPL are insured, 76% of adults living between 133-400% FPL are insured, and 91% 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, the figure for the insurance rate for adults living below 133% FPL was given the baseline number 1, and the insurance rates for the other income groups were calculated to be multiples of this baseline.

   In Arkansas, the figure 53% was given the baseline number 1; 76% is 1.43 times 53%, and 91% is 1.71 times 53%. In other words, an adult in Arkansas with income between 133-400% FPL is 1.43 times more likely to be insured than an adult with income below 133% FPL, while an adult with income above 400% FPL is 1.71 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 (2012 NASTAD Report).[48] 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 (from Table 14), we attempted to estimate the number of insured ADAP clients in each state.[†††]

   In Arkansas, we estimated that about 107.35 of the state's 1,763 ADAP clients served in 2010 were insured. The insurance rate for ADAP clients in that state stood at 19% 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 income above 400% FPL.

   In Arkansas, about 65% of ADAP clients have incomes below 133% FPL, 35% have income between 133-400% FPL, and no clients have incomes above 400% FPL; and finally

5. The number of insured ADAP clients in each income group in a state was viewed as a product of the relative likelihood of being insured (determined previously), the relative proportion of clients in that income group among the total clients (based on the percentage of ADAP clients in each income group), and 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*

[†††] 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.

Formula 2:

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

Thus, for Arkansas:

107.35
= (1 x 0.64 x *a*)
+ (1.43 x 0.35 x *a*)
+ (1.71 x 0 x *a*)

Solving for *a*,

$a = 93.39$

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

The estimated number of insured ADAP clients in Arkansas with,

Incomes below 133% FPL = 60.70
Incomes between 133-400% FPL = 46.65
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 among state profiles, and to ensure that data among states are comparable, data sources that provide information for all 21 states and the District of Columbia (DC) were prioritized. More recent or more detailed data available for a particular state have also been included.

Ryan White Program Data

Demographic information about Ryan White program clients was culled from a number of sources. For the sake of continuity, the Federal Health Resources and Services Administration (HRSA) 2010 State Profiles were used for data about the Ryan White program. Where available, information from state departments of health has also been included. Demographic information for AIDS Drug Assistance Program (ADAP) clients is most thoroughly documented by the National Alliance of State & 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/AIDS. Data from June 2011 provide information on how many people living with HIV/AIDS 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/AIDS in each state are available in each state's Statewide Coordinated Statement of Need (SCSN). SCSNs must be provided by all states receiving Ryan White program funding, but different states provide SCSNs in different years, so comparability 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/AIDS, as well as limitations that may impede access to needed services.

Benchmark Plan Coverage Data

The Arkansas Insurance Department has recommended that the state's benchmark plan, for the purpose of determining essential health benefits in the Arkansas private health insurance exchange, be the Arkansas BlueCross BlueShield Health Advantage (POS) Plan, supplemented by QualChoice Federal Plan Mental Health and Substance Abuse Benefits, Arkansas Child Health Insurance Plan's (CHIP) AR Kids First for Pediatric Dental benefits, and Arkansas BlueCross BlueShield Federal Pediatric Vision Plan (BCBS Blue Vision – High).[33] Data were collected from BlueCross BlueShield of Arkansas' website and from an Arkansas Insurance Department analysis of benefits offered by the plan.

NOTES

Data for certain states were incomplete in the 2012 National ADAP Monitoring Project Annual Report[38]; 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.[49] (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 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; and
4. The number of undocumented immigrants on ADAP is a rough estimate extrapolated from estimates of the overall number of undocumented immigrants in the state as a whole as of 2008. It is possible that this estimate either overestimates or underestimates the actual number of undocumented immigrants currently served by ADAP.

With these caveats and assumptions in mind, the figures discussed are our best estimates of the number and percentage of ADAP clients who will be newly eligible for Medicaid in 2014 (assuming full implementation of the ACA) and the number and percentage of ADAP clients 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;
- 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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Treatment Access Expansion Project

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A collaboration between the HIV community and Bristol-Myers Squibb