STATE HEALTH REFORM IMPACT MODELING PROJECT

Louisiana

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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 benefit guidelines to assess the services provided by the Ryan White program, ADAP, Medicaid, and plans sold on an exchange, in order to estimate the impact that a transition onto Medicaid or private subsidized insurance 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 Louisiana, 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 current Ryan White, Medicaid, and private insurance coverage programs, what are the likely outcomes of a transition from one program to another in 2014?

LOUISIANA

LOUISIANIANS LIVING WITH HIV/AIDS

UNMET NEED

As of 2010, 36% of people diagnosed with HIV (6,364 individuals) were not receiving any HIV-related medical care.[3] This is an underestimate, as the state considers a patient to be in care if the patient has at least one CD4 or viral load test within a 12-month period.[4,*] Because untreated and/or undiagnosed patients are not part of the Ryan White program or ADAP, they are not counted in the Modeling Project's estimation of newly eligibles for Medicaid or private subsidized insurance in 2014, but it is likely that most of these individuals will also be newly eligible for insurance in 2014.

THE RYAN WHITE PROGRAM IN LOUISIANA

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 all other charitable or funded healthcare services. In 2010, Louisiana received $47,240,428 of Ryan White funding[5] and served 19,933 duplicated clients.[6] About 54.0% of the state's Ryan White funds were Part B grants, assigned based on prevalence of HIV in the state.[7] Of these, approximately 24.1% covered core medical services ("base" funds), 60.2% went toward the AIDS Drug Assistance Program (ADAP), and 9.2% provided ADAP supplemental funding.[8]

ADAP IN LOUISIANA

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

- Be a Louisiana resident (US citizenship not required);
- Have an HIV diagnosis;
- Have an annual household income at or below 300% of the federal poverty level (FPL);
- Have no third-party provider[†] for drugs listed on the LA ADAP formulary;
- Have a current prescription from a Louisiana-licensed clinician for a medication listed on the LA ADAP formulary; and
- Not have financial assets that exceed $4,000, not including one car and one house.[9]

As of June 2011, 1,938 individuals were enrolled in LA ADAP.[10] The state's fiscal year 2011 ADAP budget was $20,012,105, all of which were federal funds.[11] Louisiana, unlike many states, does not make a state contribution to ADAP. Approximately 92.3% of these funds were used to cover the cost of prescription drugs, 2.0% was used to cover prescription dispensing costs, and the remaining 5.7% was used to provide insurance assistance to cover copayments and deductibles.[12]

Individuals who have not used LA ADAP services for 6 months are automatically unenrolled from the program.[13] To reenroll, individuals must apply as new clients and wait to be admitted.[14] In the meantime, they can access Patient Assistance Programs (PAPs) run by pharmaceutical manufacturers, which may provide free or low-cost HIV medication, and they are added to the LA ADAP Unmet Need list.[15,16]

In an effort to contain ADAP expenditures, the Louisiana Department of Health and Hospitals (DHH) placed a moratorium on entrance into the program as of January 1, 2010.[17] The program had experienced increased utilization, due in part to expanded HIV testing, efforts to link patients to care, and a growing number of individuals suffering from the economic downturn.[18] Consequently, there is currently a waitlist for LA ADAP, although some may receive ART through PAPs, to the extent that charitable antiviral drug assistance is provided.[19] Since January 2010, at least 70% of the waitlist has moved onto ADAP.[20] As of September 2012, there were 56 individuals on the LA ADAP waitlist (a number that would have been larger but for the fiscal year 2012 ADAP emergency

[*] This definition of "in care" is a technical definition used by the Louisiana STD/HIV Program's Surveillance Unit to track HIV patients. Some patients may fall within this definition even if their medical needs are not met (eg, a patient who has been tested and diagnosed with HIV, but never receives ART when clinically appropriate).
[†] Third-party providers that will disqualify someone from the LA ADAP include, but are not limited to, Medicaid, Medicare, individual insurance, group insurance, Federal Pre-existing Condition Insurance Plan (PCIP), COBRA, and LA Health Plan.

funding provided to the state).[21] DHH also instituted other cost-saving measures, such as eliminating primary medical care contracts and decreasing budgets for community-based organizations.[22]

THE ACA AND ITS IMPACT ON HIV+ LOUISIANIANS

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).[23,§] 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 base-benchmark benefits package that must include at least ten categories of essential health benefits (EHB), described in the "Essential Health Benefits" section.

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.[24] 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.[25] Cost sharing on BHPs can be subsidized, either for all beneficiaries or for those with specific chronic conditions (eg, HIV/AIDS).[26] The federal government is expected to pay up to 95% of the premium credits for individuals enrolled in a BHP.[27] 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 onto 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.[28] 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 paragraphs. All exchanges will be operational January 1, 2014.[29]

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.[30]

Because Louisiana has neither enacted legislation to create a state-based exchange nor submitted a base-benchmark plan to the federal HHS for purposes of defining benefits offered on the exchange, the largest small-group plan in the state (BlueCross BlueShield of Louisiana GroupCare PPO) has become the default base-benchmark plan for purposes of defining EHB.[**]

[§] 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 & 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.

[**] Although the Louisiana DHH declared it would prevent the federal HHS from submitting the state to a default plan, this report presumes that BlueCross BlueShield of Louisiana GroupCare PPO will be used to determine EHB for the exchange. See Letter from State of Louisiana, Department of Health & Hospitals, Office of the Secretary to Kathleen Sebelius, Secretary, Department Health & Human Services (Sept. 27, 2012).

ESSENTIAL HEALTH BENEFITS

The ACA requires both Medicaid plans and private health insurance plans sold on state-based insurance exchanges to provide a minimum of EHB, to be defined by the Secretary of HHS.[31] EHB must include items and services within the following ten benefit categories[32]:

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.[33] The Centers for Medicare and Medicaid Services has indicated that the HHS rule on EHB will also apply to newly eligible Medicaid beneficiaries, in addition to the protections provided for under the Social Security Act.[34] 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.[35]

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+ Louisianans are expected to become eligible for public or private insurance in 2014, provided that Louisiana fully implements the law.

An estimated 74% of the state's nearly 20,000 Ryan White clients in 2010 were living at or below 200% FPL, making them potentially eligible for either Medicaid or a BHP.[36] More specifically, approximately 68% of over 3,000 Louisianan AIDS Drug Assistance Program (ADAP) clients will be eligible for Medicaid following its expansion (see Appendix A) and 9.3% would be eligible for a BHP.[37,38] Finally, many of the estimated 6,364 Louisianans living with HIV/AIDS and who have not received HIV-related medical care are likely to become eligible for Medicaid or private insurance in 2014.

These numbers are significant because the majority of individuals receiving support from these programs are African American (70% of Ryan White recipients[39] and 60-64% of ADAP beneficiaries in 2011).[40,41] Implementing Medicaid in a way that ensures continuity in access to services will be critical to reducing health disparities. Moreover, an increasing proportion of these individuals are uninsured, making them perfect candidates for Medicaid or subsidized private insurance (41% of Ryan White clients were uninsured in 2010[42] and 87% of ADAP beneficiaries were uninsured in 2010).[43]

The percentage of Louisiana's ADAP clients who will be newly eligible for Medicaid (68%) is much higher than the total proportion of Americans who will be newly eligible, which stands at approximately 29% (see Appendix A). This is because Louisiana's ADAP primarily serves individuals with incomes below 100% FPL (as many as 84% of the state's ADAP clients were living below 100% FPL in 2011).[44]

The percentage of Louisiana's ADAP clients who will be newly eligible for private insurance subsidies (8%) is lower than the total proportion of Americans who will be newly eligible for subsidies, which stands at approximately 15% (see Appendix A). This is due to the relatively small group of ADAP clients served who have incomes above 133% FPL (approximately 11% of ADAP clients served in 2011 were living between 134-300% FPL).[45]

A COMPARISON OF SERVICES PROVIDED BY RYAN WHITE, ADAP, MEDICAID, AND THE EXCHANGE TO HIV+ LOUISIANIANS

Since a significant number of HIV + individuals in Louisiana who are currently served by the Ryan White program or AIDS Drug Assistance Program (ADAP) are likely to be eligible for Medicaid in 2014, it is important to assess the outcome of transitioning from the former programs to Medicaid. This assessment compares and contrasts the services and treatments that the Ryan White program, ADAP, and Medicaid currently provide to HIV + Louisianans. Forthcoming federal guidance on the essential health benefits (EHB) that newly eligible Medicaid beneficiaries are guaranteed under the Patient Protection and Affordable Care Act (ACA) will affect the scope of coverage provided in 2014.

COMPARING RYAN WHITE, MEDICAID, AND THE BASE-BENCHMARK PLAN FOR THE EXCHANGE IN LOUISIANA

The Ryan White program funds both core medical and support services for patients living with HIV (see Appendix C for a breakdown of core medical versus support services). Both medical and ancillary services are critical to maintaining the health of low-income individuals who may not have access to many necessities that facilitate effective HIV treatment and care (eg, transportation, child care, nutrition). However, Medicaid and Louisiana's base-benchmark plan, which will determine 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 or private insurance while ensuring that health status does not deteriorate (eg, due to lack of proper nutrition or stable housing). For example, individuals with HIV have identified dental and eye care, transportation, and housing as a few of the gaps in care in Louisiana.[46]

As of 2012, Louisiana Medicaid beneficiaries have been shifting into Bayou Health plans, the state's new Medicaid administrator. Bayou Health allows Medicaid recipients to select from five different managed care health plans: Amerigroup, Community Health Solutions, LaCare, Louisiana Healthcare Connections, and UnitedHealthcare.[47] Certain services, such as pharmacy or hospice services, have been carved out from some of the Bayou Health plans and will continue to be covered through traditional fee-for-service Medicaid.[48]

Table 1 provides a comparison of covered services among Louisiana's Ryan White and Bayou Health plans, as well as the largest small-group market plan in the state (the default base-benchmark plan used for purposes of defining EHB).

Table 1. Ryan White Versus Medicaid and the Base-Benchmark Plan: Covered Services

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

Covered Service	Ryan White[49]	Medicaid (Bayou Health Plans)[50]	BlueCross BlueShield of Louisiana GroupCare PPO[51]
Home Health Care	X	X (PA; some programs impose annual limits)	X
Mental Health	X	X	X
Substance Abuse (outpatient)	X	LaCare only	X
Substance Abuse (inpatient)		Amerigroup and LaCare only	X
Medical Case Management	X	Amerigroup and Community Health Solutions only	
Community-based Care	X	X	

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Table 2. (continued)

Ambulatory/Outpatient Care	X	X	X
Oral Health Care	X	X (PA; some plans limited to annual exam)	
Early Intervention Clinic	X		
Nonmedical Case Management Services	X		
Child Care	X		
Emergency Financial Assistance	X		
Food Bank/Home Delivered Meals	X		
Housing Services	X		
Health Education/Risk Reduction	X	Community Health Solutions only (school-based individualized education)	
Legal Services	X		
Linguistic Services	X		
Nonemergency Medical Transportation	X	X	
Outreach Services	X		
Psychosocial Support	X		
Referral Agencies	X		
Treatment Adherence Counseling	X		
Family Planning Services and Supplies		X	
Hospital Services (outpatient)		X (some plans require PA)	X
Hospital Services (inpatient)		X (some plans require PA)	X
Rural Health Clinic Services		X	
Hospice Services		Community Health Solutions and UnitedHealthcare only (through Medicaid)	X
Lab and X-ray Services		X (some plans require PA)	X
Prescription Drugs	X	X (Community Health Solutions and UnitedHealthcare through Medicaid)	X
Vision Care		LaCare only	
Long-term Personal Care Service		UnitedHealthcare only	
Midwife/NP Services		X	X (limited benefits)
Private Duty Nursing		Amerigroup only	X
Physician Services		X	X
Chiropractor		Amerigroup only	X
Podiatry		Amerigroup, LaCare, LA Healthcare Connections, and UnitedHealthcare only (PA)	
Mental Health Rehabilitation		Amerigroup, LaCare, and UnitedHealthcare only	
PT, OT, and Speech Therapy		Amerigroup, LaCare, LA Healthcare Connections, and UnitedHealthcare only (PA sometimes)	
Hearing Instruments and Related Audiology		Amerigroup, LaCare, and UnitedHealthcare only (some plans require PA)	X (limited benefits)
STD Clinic Services		Amerigroup, LA Healthcare Connections, and UnitedHealthcare only	
Durable Medical Equipment		X (PA)	X

NP = nurse practitioner; OT = occupational therapy; PA = prior authorization; PT = physical therapy; STD = sexually transmitted disease.

As Table 1 indicates, the Ryan White program covers critical services for low-income people living with HIV/AIDS, many of which are not available to people covered by Bayou Health plans or Louisiana's base-benchmark plan (eg, legal, linguistic, and housing services; food bank access; home-delivered meals; and emergency financial assistance). Since these ancillary services are important for the well being of people living with HIV/AIDS, as well as being critical to retention in care, those individuals who transition from the Ryan White program onto Bayou Health or private insurance plans are likely to be at a disadvantage.

COMPARING ADAP, MEDICAID, AND THE BASE-BENCHMARK PLAN FOR THE EXCHANGE IN LOUISIANA

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 antiretroviral therapy (ART); most cover almost all drugs in each class. Medicaid's drug formulary is defined differently (and its formulary for newly eligible individuals has yet to be defined). Ensuring that Medicaid and plans sold on the exchange provide coverage for a sufficient number of antiretroviral medications will also be critical to maintaining the health of Louisianans living with HIV/AIDS.

Table 2 provides a comparison of the antiretroviral drug formularies included in Louisiana's ADAP (LA ADAP) and Medicaid programs, as well as the largest small-group market plan in the state (the base-benchmark plan used for purposes of defining EHB for plans sold on an exchange).

Table 2: ADAP Versus Medicaid and the Base-Benchmark Plan: Covered Drugs[52]

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[53]**	**Medicaid[54,55,††]**	**BlueCross BlueShield of Louisiana—GroupCare PPO[56]**
Multiclass Combination Drugs	**3 Drugs Covered**	**3 Drugs Covered**	**1 Drug Ccovered**
Atripla; *efavirenz + emtricitabine + tenofovir DF*	X	X	X (tier 2)
Complera; *emtricitabine + rilpivirine + tenofovir*	X	X	
Stribild; *elvitegravir + cobicistat + emtricitabine + tenofovir*	X	X	
NRTIs	**12 Drugs Covered**	**11 Drugs Covered**	**9 Drugs Covered**
Combivir; *lamivudine, zidovudine*	X (Combivir preferred)	X	X (tier 2)
Emtriva; *emtricitabine*	X	X	X (tier 2)
Epivir; *lamivudine*	X	X	X (tier 2)
Epzicom; *abacavir, lamivudine*	X	X	
Hivid; *zalcitabine + dideoxycytidine (ddC)*	X		
Retrovir; *zidovudine*	X	X	X (tier 1)
Trizivir; *abacavir + zidovudine + lamivudine*	X	X	X (tier 2)
Truvada; *tenofovir DF + emtricitabine*	X	X	X (tier 2)
Videx EC; *didanosine (delayed-release capsules)*	X	X	

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†† This is the drug coverage provided by Louisiana Medicaid. Only Community Health Solutions and UnitedHealthcare use Louisiana Medicaid for the pharmacy benefits. The remaining three managed care plans have their own formularies.

Table 2. (continued)

NRTIs	12 Drugs Covered	11 Drugs Covered	9 Drugs Covered
Viread; *tenofovir disoproxil fumarate DF*	X	X	X (tier 2)
Zerit; *stavudine*	X	X	X (tier 1)
Ziagen; *abacavir*	X	X	X (tier 2)
NNRTIs	**5 Drugs Covered**	**5 Drugs Covered**	**2 Drugs Covered**
Edurant; *rilpivirine*	X	X	
Intelence; *etravirine*	X	X	
Rescriptor; *delavirdine mesylate*	X	X	
Sustiva; *efavirenz*	X	X	X (tier 2)
Viramune; *nevirapine*	X	X	X (tier 2)
Protease Inhibitors	**10 Drugs Covered**	**9 Drugs Covered**	**3 Drugs Covered**
Agenerase; *amprenavir*	X		
Aptivus; *tipranavir*	X	X	
Crixivan; *indinavir sulfate*	X	X	
Fortovase; *saquinavir*	X		
Invirase; *saquinavir mesylate*	X	X	
Kaletra; *lopinavir + ritonavir*	X	X	
Lexiva; *fosamprenavir*	X	X	X (tier 2)
Norvir; *ritonavir*	X	X	
Prezista; *darunavir*	X	X	X (tier 2)
Reyataz; *atazanavir sulfate*	X	X	X (tier 2)
Viracept; *nelfinavir sulfate*	X	X	
Fusion Inhibitors	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Fuzeon; *enfuvirtide*	X	X	X (tier 2; specialty drug)
Entry Inhibitors – CCR-5 Coreceptor Antagonist	**1 Drug Covered**	**1 Drug Covered**	**No Drugs Covered**
Selzentry; *maraviroc*	X	X	
HIV Integrase Strand Transfer Inhibitors	**1 Drug Covered**	**1 Drug Covered**	**No Drugs Covered**
Isentress; *raltegravir*	X	X	
"A1" Opportunistic Infection Medications	**31 Drugs Covered**	**33 Drugs Covered**	**17 Drugs Covered**
Ancobon; *flucytosine*	X (Ancobon preferred)	X	
Bactrim; *sulfamethoxazole/trimethoprim DS*	X	X	X (tier 1)
Biaxin; *clarithromycin*	X	X	X (tier 1)
Cleocin; *clindamycin*	X	X	X (tier 1)
Cytovene; *ganciclovir*	X	X	
Dapsone	X	X	X (tier 2)
Daraprim; *pyrimethamine*	X	X	

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Table 2. (continued)

"A1" Opportunistic Infection Medications	31 Drugs Covered	33 Drugs Covered	17 Drugs Covered
Deltasone; *prednisone*	X (Sterapred instead of Deltasone)	X (prednisone only)	X (tier 1)
Diflucan; *fluconazole*	X (Diflucan preferred)	X	X (tier 1; quantity-per-dispensing applies)
Famvir; *famciclovir*	X	X (generic only)	X (tier 1; quantity-per-dispensing applies)
Foscavir; *foscarnet*	X	X (foscarnet only)	
Fungizone; *amphotericin B*	X	X	
Megace; *megestrol*		X (megestrol only)	
Mepron; *atovaquone*	X	X	X (tier 2)
Myambutol; *ethambutol*	X	X	
Mycobutin; *rifabutin*	X	X	X (tier 2)
NebuPent; *pentamidine*	X	X	X (tier 2)
Nydrazid, Lanizid; *isoniazid, INH*	X	X (isoniazid, INH only)	X (tier 2)
Probenecid	X	X	
Procrit; *erythropoetin*		X	
Pyrazinamide (PZA)	X	X	
Rifadin, Rimactane; *rifampin*	X	X (Rifadin only)	X (tier 1)
Sporanox; *itraconazole*	X	X	X (tier 1; QPD)
Sulfadiazine – Oral	X	X	
Valcyte; *valganciclovir*	X	X	
Valtrex; *valacyclovir*	X	X	X (tier 1; QPD applies)
VFEND; *voriconazole*		X	
Virazole, Rebetol, Copegus; *ribavirin*	X	X	X (tier 1; QPD applies; specialty drug)
Vistide; *cidofovir*	X	X	
Vitamin B6; *pyridoxine*	X	X (pyridoxine only)	
Vitravene; *fomivirsen*	X		
Wellcovorin; *leucovorin*	X	X (leucovorin only)	
Zithromax; *azithromycin*	X (Zithromax preferred)	X	X (tier 1)
Zovirax; *acyclovir*	X	X	X (tier 1)

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

Unless otherwise indicated, LA ADAP requires that generic medications be dispensed whenever possible.[57] Clients can pick up a 30-day supply of as many ADAP prescriptions as medically indicated (without cost sharing) at any of the ten Louisiana State University Medical Center Outpatient pharmacies.[58,59]

Three of the five Bayou Health plans have independent formularies and manage their pharmacy services independently. Two programs, Community Health Solutions and UnitedHealthcare, still use the Medicaid formulary, listed in Table 2, and are run through Louisiana Medicaid.[60] Medicaid's pharmacy services cover a comparable number of HIV prescription drugs as LA ADAP. The Louisiana Medicaid Pharmacy Benefits Management Program (LMPBM) is the first state-owned and administered Medicaid pharmacy benefits program in the country.[61] LMPBM has a preferred drug list for specific therapeutic classes; HIV and antiretroviral prescription drugs are not included on this list, which means that all HIV prescription drugs require prior authorization (PA).[62,63] Prescription drugs that are on the Medicaid formulary and require PA will be reimbursed by Medicaid if the provider follows the PA process properly.[64] Patients are required to make a $0.50-$3.00 copayment.[65] Further, Medicaid patients are limited to receiving four prescription drugs per month unless the provider includes a "Medically Necessary Override" with the prescription.[66] Individuals under 21 years of age, individuals living in long-term care facilities, or pregnant women are not required to pay copayments and can have an unlimited number of prescriptions reimbursed.[67] Patients who are dual eligible (eligible for both Medicare and Medicaid) do not get Medicaid prescription drug benefits, as they must get their prescription drugs through Medicare Part D.[68] Because management of HIV/AIDS may require many and varied prescription drugs, Medicaid's current formulary could pose challenges for people living with HIV/AIDS; ART alone often consists of three or more drugs, and people living with HIV/AIDS frequently suffer from comorbid conditions (eg, cardiovascular disease, migraines, diabetes). Unless Medicaid meets the needs of individuals living with HIV/AIDS, Ryan White and ADAP will remain important for wrap-around services and coverage.

Amerigroup, LaCare, and Louisiana Healthcare Connections beneficiaries are guaranteed access to all antiretroviral and opportunistic infection drugs covered by Medicaid (as listed in Table 2).[69] While managed care organization formularies may vary, these Bayou Health plans must cover medically necessary ART.[70] Furthermore, the plans may not restrict beneficiaries to less than four drugs per month and may not impose higher cost sharing than traditional Medicaid.[71,72]

As Table 2 indicates, Louisiana's base-benchmark plan, BlueCross BlueShield of Louisiana—GroupCare PPO, has a more restrictive formulary than the ADAP or Medicaid formularies for both ART and opportunistic infection medications. On this plan, individuals living with HIV/AIDS will face significant limitations both in terms of coverage and cost sharing (tier 2 and 3 drugs are assigned higher copayments, as are specialty drugs, which must be dispensed through specialty pharmacies or a patient's medical provider).[73]

COMMUNITY HEALTH CENTERS

The ACA has provided Louisiana with $41.8 million to fund new and existing community health centers (CHCs).[74] Additionally, centers in New Orleans and Gonzales have each been awarded $80,000 in Health Center Planning grants.[75] All CHCs in Louisiana (107 as of 2010) provide primary care services, and 63% provide HIV preventive care.[76] There is also one designated AIDS Education and Training Center in Louisiana, which is a National Center for HIV Care in Minority Communities.[77] One Louisiana health center, NO/AIDS Task Force, has used ACA funds to transform from an HIV clinic to a full-service CHC.[78] At NO/AIDS Task Force, individuals living with HIV/AIDS can have their primary care needs met, as well as receive case management, housing assistance, meal delivery and food pantry services, and counseling on mental and behavioral health.[79] CHCs can go beyond providing basic healthcare to people living with HIV/AIDS to help ensure successful linkage to and retention in care.

CONCLUSIONS AND NEXT STEPS

This report provides analyses of the Ryan White program, AIDS Drug Assistance Program (ADAP), Medicaid, and essential health benefits (EHB) under the Patient Protection and Affordable Care Act (ACA), enumerating the benefits covered under each, and the implications of transitioning individuals living with HIV onto Medicaid or private insurance. This report is intended to assist state legislators in implementing the ACA in a manner that serves the needs of Louisianans.

While much of the ACA has yet to be implemented, it is certain that a large number of people living with HIV will be newly eligible for Medicaid. Given that a significant proportion of uninsured ADAP clients would transition onto Medicaid in Louisiana, implementing the ACA's expansion provision is crucial to ensuring access to care and reducing transmission of HIV across the state. In other words, expanding Medicaid is the state's only currently available option to provide access to treatment for the thousands of HIV+ individuals in the state who currently lack access to care.

In that vein, the Medicaid system must be ready and able to handle the needs of low-income people who have HIV/AIDS. Should Louisiana 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. Comparing Ryan White and ADAP with existing Medicaid formularies allows for a baseline analysis of the needs of individuals living with HIV/AIDS moving onto the Medicaid or exchange 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, which may reduce the ability of those living with HIV/AIDS to access services and further lower retention in care. For instance, the Ryan White program, unlike Medicaid, covers non-medical case management, food bank services, and treatment adherence counseling. Medicaid EHB are unlikely to include these benefits.[80] HIV+ individuals who shift from the Ryan White program onto Medicaid are therefore likely to have trouble accessing a number of services currently available to them, and Ryan White will continue to be a critical payer of last resort.
2. Second, limitations on Medicaid recipients' pharmacy benefits may pose significant challenges for individuals in need of multiple prescriptions. Those living with HIV are likely to exceed the maximum allowable number of monthly prescriptions covered by Medicaid. Moreover, Medicaid plans for newly eligibles are likely to use similar cost-containment strategies.[80]

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

1. First, a number of services that are currently provided by the Ryan White program are not available under Louisiana's default base-benchmark plan. HIV+ individuals who shift from the Ryan White program to private insurance plans on the exchange are therefore likely to have trouble accessing a number of services currently available to them.
2. Second, the prescription drug list for HIV+ individuals under Louisiana's base-benchmark plan is not as comprehensive as the state's ADAP formulary with respect to antiretroviral drugs or medications needed to treat opportunistic infections. Thus, HIV+ individuals shifting from ADAP to private insurance plans may have trouble accessing certain critical medications, seeing as EHB will likely be based on benchmark coverage.[81]

There will remain an ongoing demand for Ryan White and ADAP services, to fill the gaps left by Medicaid coverage and private insurance 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 Louisianans and slow the spread of HIV.

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

1. Louisiana must adopt the Medicaid expansion, pursuant to the ACA, extending eligibility to most individuals living under 133% of the federal poverty level in order to slow the transmission of HIV, improve health outcomes, and make treatment accessible to thousands of individuals who currently lack care;

2. Effectively defining the EHB, patient navigation, and outreach systems and opting into prevention and health home program resources will maximize the potential for the state to meet the care and service needs of individuals living with HIV; and

3. Louisiana must ensure that Ryan White and ADAP services are available where coverage gaps exist (eg, nonmedical case management, food and nutrition, childcare, treatment adherence counseling) or where cost sharing makes meaningful 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 ADAP who will be newly eligible for Medicaid in 2014, the following formula was used:

	Total #	ADAP clients served in 2010[14]
−	**est. #**	ADAP clients with incomes above 133% FPL[17,‡‡]
−	**est. #**	insured ADAP clients with incomes below 133% FPL[82,83]
−	**est. #**	ADAP clients who are uninsured undocumented immigrants with incomes below 133% FPL [84,§§]
=	**Total #**	ADAP clients served in fiscal year 2010 who will be newly eligible for Medicaid in 2014[***,†††]

In Louisiana, 3,557 individuals were served by ADAP in fiscal year 2010. Of those, it is estimated that 11.3% (402) ADAP clients have incomes above 133% FPL. Additionally, an estimated 19.5% (693) of individuals with incomes below 133% FPL are currently insured and approximately 1.5% of the state population were undocumented immigrants in 2008 (46 ADAP individuals). Thus, the calculation for Louisiana is:

	3,557	ADAP clients in fiscal year 2010
−	**401.94**	ADAP clients living above 133% FPL
−	**693.39**	insured ADAP clients living below 133% FPL
−	**45.82**	uninsured undocumented immigrants living below 133% FPL on ADAP
=	**2,416**	(68%) of ADAP clients served in fiscal year 2010 who will be newly eligible for Medicaid in 2014

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

State	# of ADAP Clients Newly Eligible for Medicaid	% of ADAP Clients Newly Eligible for Medicaid
Alabama	1,345	76%
Arkansas	299	53%
California	12,274	31%
DC	1,124	41%
Florida	7,321	51%
Georgia	3,075	52%
Illinois	4,374	68%
Kentucky	619	42%
Louisiana	2,416	68%
Maryland	1,394	22%
Massachusetts	1,400	21%
Mississippi	1,008	68%
New Jersey	2,101	29%
New York	4,233	20%
North Carolina	3,476	62%
Ohio	1,287	37%
Pennsylvania	1,334	22%
South Carolina	1,428	39%
Tennessee	2,505	60%
Texas	8,797	53%
Virginia	2,690	66%
Wisconsin	696	40%
United States	**62,971**	**29%**

Note: Data on the insurance status of ADAP clients in Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.[85] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages of insured clients exceed 100% for Maryland and Ohio.) The 2012 NASTAD Report is also missing data for Louisiana, but that data have been provided to us by the Louisiana Department of Health and Hospitals' STD/HIV program.

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

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

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

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

Private Insurance Subsidy Estimates

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

	Total #	ADAP clients served in fiscal year 2010[14]
–	**est. #**	ADAP clients living below 133% FPL or above 400% FPL[17]
–	**est. #**	insured ADAP clients living between 133-400% FPL[51,52]
–	**est. #**	uninsured undocumented ADAP clients living between 133-400% FPL[53]
=	**Total #**	ADAP clients served in fiscal year 2010 who will be newly eligible for subsidized private insurance in 2014[***,†††]

In Louisiana, 3,557 individuals were served by ADAP in fiscal year 2010. Of those, approximately 88.7% (3,155) were living below 133% or above 400% FPL. We estimate that 3.5% (125) of individuals with incomes between 133-400% FPL are currently insured. About 1.5% of the state's population were undocumented immigrants in 2008. Applying this percentage to the individuals enrolled in Louisiana's ADAP, we estimate that 6 Louisiana ADAP clients are uninsured and undocumented, living between 133-400% FPL. Thus, completing the calculation for Louisiana's ADAP yields:

	3,557	ADAP clients served in fiscal year 2010
–	**3,155.06**	ADAP clients with incomes below 133% FPL or above 400% FPL
–	**124.72**	insured ADAP clients with incomes between 133-400% FPL
–	**5.84**	estimated uninsured undocumented immigrants with incomes between 133-400% FPL
=	**271**	(8%) of ADAP clients served in fiscal year 2010 who will be newly eligible for subsidized private insurance in 2014

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

State	# of ADAP Clients Eligible for Insurance Subsidies	% of ADAP Clients Eligible for Insurance 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	271	8%
Maryland	1,726	28%
Massachusetts	932	14%
Mississippi	384	26%
New Jersey	1,879	26%
New York	4,502	21%
North Carolina	621	11%
Ohio	901	26%
Pennsylvania	1,567	26%
South Carolina	1,091	30%
Tennessee	1,531	37%
Texas	4,301	26%
Virginia	896	22%
Wisconsin	401	23%
United States	**32,758**	**15%**

Note: Data on the insurance status of ADAP clients in Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.[86] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages of insured clients exceed 100% for Maryland and Ohio). The 2012 NASTAD Report is also missing data for Louisiana, but those data have been provided to us by the Louisiana Department of Health and Hospitals' STD/HIV program.

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

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

METHODOLOGY FOR DISTRIBUTION OF INSURED ADAP CLIENTS BY INCOME

Estimating the proportion of insured ADAP clients falling into each income bracket required several steps:

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

   In Louisiana, for example, 50% of adults living below 133% FPL are insured; 70% of adults living between 133-400% FPL are insured; and 93% living above 400% FPL are insured;

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

   In Louisiana, we gave the figure 50% the baseline number 1. 70% is 1.40 times 50%, and 93% is 1.96 times 50%. Thus, in other words, an adult in Louisiana with income between 133-400% FPL is 1.40 times more likely to be insured than an adult with income below 133% FPL, while an adult with income above 400% FPL is 1.96 times more likely to be insured;

3. Next, we calculated the number of insured ADAP clients in each state, by referring to Tables 8 and 14 of the 2012 NASTAD National ADAP Monitoring Project Report.[87] Table 8 lists the total number of ADAP clients served in each state in 2010. Using this number, and applying to it the percentage of ADAP clients who are insured in each state (Table 14), we attempted to estimate the number of insured ADAP clients in each state.[‡‡‡]

   In Louisiana, we estimated that about 818 of the state's 3,557 ADAP clients served in 2010 were insured. The insurance rate for ADAP clients in that state stood at 23% in 2011;

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

   Because Table 13 is missing data for Louisiana, the Louisiana Department of Health and Hospitals was contacted directly. The STD/HIV program provided data that stated that in fiscal year 2011, 84% of ADAP clients had incomes below 100% FPL, 14% had incomes between 101-200% FPL, and 2% had incomes between 201-300% FPL. For the purposes of this calculation it was assumed that the people with incomes between 101-200% FPL were evenly distributed. Consequently, it is estimated that 4.7% of ADAP clients have incomes between 101-133% FPL, while 9.3% have incomes between 134-200% FPL.

   Thus, in Louisiana it is estimated that 88.7% of ADAP clients have incomes below 133% FPL, 11.3% are living between 133-400% FPL, and none are living above 400% FPL; and finally

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

   We relied on two formulas:

Formula 1:

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

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

Formula 2:

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

Thus, for Louisiana:

818
= (1 x 0.887 x *a*)
+ (1.40 x 0.113 x *a*)
+ (1.96 x 0.00 x *a*)

Solving for *a*,

$a = 781.72$

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

The estimated number of insured ADAP clients in Louisiana with,

Incomes below 133% FPL = 693
Incomes between 133-400% FPL = 125
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

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 and Territorial AIDS Directors (NASTAD), and information from that organization has been provided for income and insurance status of ADAP clients. NASTAD's data for fiscal years 2010 and 2011 and June 2011 were used (fiscal year 2010 was necessary for states that did not report data in 2011). Because ADAP data compiled by NASTAD are unduplicated (ie, patients are not double-counted by multiple providers), it is one of the most reliable sources of information about demographic information for people living with HIV. Data from June 2011 provide information on how many people living with HIV currently enrolled in ADAP live between 100-133% of the federal poverty level (FPL). Since the expansion of Medicaid eligibility to those living under 133% FPL is a new development, there is a relative dearth of data regarding the number of HIV+ individuals currently living between 100-133% FPL. NASTAD provides the only reliable source of these data to date. NASTAD's ADAP information was used for estimates regarding people living with HIV who are newly eligible for Medicaid in 2014 at the end of this report. Information available from state departments of health or the Health Resources and Services Administration (HRSA) has also been provided.

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

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

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

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

NOTES

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

- Data on the insurance status of ADAP clients in Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.[88] (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.
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 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).

REFERENCES

1. Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010).
2. The states assessed include: Alabama, Arkansas, California, District of Columbia, Florida, Georgia, Illinois, Kentucky, Louisiana, Maryland, Massachusetts, Mississippi, New Jersey, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, and Wisconsin.
3. State of Louisiana, Department of Health and Hospitals, Office of Public Health, 2010 STD/HIV Program Report 68, 124.
4. State of Louisiana, Department of Health and Hospitals, Office of Public Health, 2010 STD/HIV Program Report 67.
5. The Kaiser Family Foundation State Health Facts, Louisiana: Total Ryan White Program Funding, FY2010, http://www.statehealthfacts.org/profileind.jsp?rgn=20&cat=11&ind=534 (*last visited* October 30, 2012).
6. Health Resources and Services Administration (HRSA), US Department of Health & Human Services (DHHS), Louisiana: Client Characteristics, Ryan White HIV/AIDS Program – State Profiles, available at http://hab.hrsa.gov/stateprofiles (last visited October 30, 2012).
7. The Kaiser Family Foundation State Health Facts, Louisiana: Distribution of Ryan White Program Funding By Part, FY2010, available at http://www.statehealthfacts.org/profileind.jsp?ind=535&cat=11&rgn=20 (*last visited* October 30, 2012).
8. The Kaiser Family Foundation State Health Facts, Louisiana: Distribution of Ryan White Program Part B Funding By Component, FY2010, available at http://www.statehealthfacts.org/profileind.jsp?rgn=20&cat=11&ind=536 (last visited October 30, 2012).
9. State of Louisiana, Department of Health and Hospitals, Office of Public Health, Louisiana AIDS Drug Assistance Program (LA ADAP) Guidelines 1, *forthcoming, available at* http://new.dhh.louisiana.gov/index.cfm/page/1118.
10. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, 54 tbl.9, August 2012, available at http://www.nastad.org/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.
11. The Kaiser Family Foundation State Health Facts, Louisiana: Distribution of AIDS Drug Assistance Program (ADAP) Budget by Source, FY2011, *available at* http://www.statehealthfacts.org/profileind.jsp?rgn=20&cat=11&ind=545 (*last visited* October 30, 2012).
12. The Kaiser Family Foundation State Health Facts, Louisiana: AIDS Drug Assistance Program (ADAP) Expenditures, FY2010, *available at* http://www.statehealthfacts.org/profileind.jsp?rgn=20&cat=11&ind=668 (*last visited* October 30, 2012).
13. State of Louisiana, Department of Health and Hospitals, Office of Public Health, Louisiana AIDS Drug Assistance Program (LA ADAP) Guidelines 1, *forthcoming, available at* http://new.dhh.louisiana.gov/index.cfm/page/1118.
14. State of Louisiana, Department of Health and Hospitals, Office of Public Health, Louisiana AIDS Drug Assistance Program (LA ADAP) Guidelines 1, *forthcoming, available at* http://new.dhh.louisiana.gov/index.cfm/page/1118.
15. State of Louisiana, Department of Health and Hospitals, Office of Public Health, Louisiana AIDS Drug Assistance Program (LA ADAP) Guidelines 1, *forthcoming, available at* http://new.dhh.louisiana.gov/index.cfm/page/1118.
16. State of Louisiana, Department of Health and Hospitals, Office of Public Health, 2010 STD/HIV Program Report 59.
17. State of Louisiana, Department of Health and Hospitals, Office of Public Health, 2010 STD/HIV Program Report 59.
18. State of Louisiana, Department of Health and Hospitals, Office of Public Health, 2010 STD/HIV Program Report 59.
19. State of Louisiana, Department of Health and Hospitals, Office of Public Health, 2010 STD/HIV Program Report 59.
20. State of Louisiana, Department of Health and Hospitals, Office of Public Health, 2010 STD/HIV Program Report 59.
21. The Kaiser Family Foundation State Health Facts, AIDS Drug Assistance Program (ADAP) with Waiting Lists or Other Cost-Containment Strategies, as of September 2012, *available at* http://www.statehealthfacts.org/comparetable.jsp?typ=5&ind=552&cat=11&sub=204 (*last visited November 5, 2012*).
22. State of Louisiana, Department of Health and Hospitals, Office of Public Health, 2010 STD/HIV Program Report 59.
23. Affordable Care Act, tit. II, § 2001(a)(1), 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).
24. Affordable Care Act, tit. I § 1331(e), 42 U.S.C. § 18051(e).
25. Affordable Care Act, tit. I, § 1331(a)(1-2), 42 U.S.C. § 18051(a)(1-2).
26. Affordable Care Act, tit. I, § 1331(a)(2)(A)(ii), 42 U.S.C. § 18051(a)(2)(A)(ii).
27. Affordable Care Act, tit. I, § 1331(d)(3), 42 U.S.C. § 18051(d)(3).
28. Affordable Care Act, tit. I, § 1321(b)-(c), 42 U.S.C. § 18041(b)-(c) (2010).
29. Affordable Care Act, tit. I, § 1311(b)(1), 42 U.S.C. § 18031(b)(1) (2010).
30. Affordable Care Act, tit. I, § 1401(a), 26 U.S.C. § 36(B) (2010).
31. Affordable Care Act, tit. I, § 1302(a), 42 U.S.C. § 18022(a).
32. Affordable Care Act, tit. I, § 1302(b), 42 U.S.C. § 18022(b).
33. 45 C.F.R. pts. 144, 147, 150, et al. (proposed Nov. 26, 2012).
34. Letter from Cindy Mann, director, Centers for Medicare & Medicaid Services, to State Medicaid Director (November 20, 2012).
35. Social Security Act, 42 U.S.C. §1927 (2010).
36. Health Resources and Services Administration (HRSA), US Department of Health & Human Services (DHHS), Louisiana: Client Characteristics, Ryan White HIV/AIDS Program – State Profiles, *available at* http://hab.hrsa.gov/stateprofiles (*last visited* October 30, 2012).
37. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, 53 tbl. 8, August 2012, available at http://www.nastad.org/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.
38. E-mail from Kira Radtke, STD/HIV Program Services Manager, to Center for Health Law Policy and Innovation at Harvard Law School (November 8, 2012) (on file with author).
39. Health Resources and Services Administration (HRSA), US Department of Health & Human Services (DHHS), Louisiana: Client Characteristics, Ryan White HIV/AIDS Program – State Profiles, *available at* http://hab.hrsa.gov/stateprofiles (*last visited* October 30, 2012).
40. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, tbl.7, March 2011, *available at* http://www.nastad.org/Docs/highlight/2011429_Module%20One%20-%20National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20March%202011.pdf.
41. Health Resources and Services Administration (HRSA), US Department of Health & Human Services (DHHS), Louisiana: AIDS Drug Assistance Program, Ryan White HIV/AIDS Program – State Profiles, *available at* http://hab.hrsa.gov/stateprofiles (*last visited* October 30, 2012).
42. Health Resources and Services Administration (HRSA), US Department of Health & Human Services (DHHS), Louisiana: Client Characteristics, Ryan White HIV/AIDS Program – State Profiles, *available at* http://hab.hrsa.gov/stateprofiles (*last visited* October 30, 2012).
43. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, tbl.11, March 2011, available at http://www.nastad.org/Docs/highlight/2011429_Module%20One%20-%20National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20March%202011.pdf.
44. E-mail from Kira Radtke, STD/HIV Program Services Manager, to Center for Health Law Policy and Innovation at Harvard Law School (Nov. 8, 2012) (on file with author).
45. E-mail from Kira Radtke, STD/HIV Program Services Manager, to Center for Health Law Policy and Innovation at Harvard Law School (Nov. 8, 2012) (on file with author).
46. State of Louisiana, Department of Health and Hospitals, Office of Public Health, State of Louisiana Statewide Coordinated Statement of Need and HIV Comprehensive Plan (2009) 47–49.
47. State of Louisiana, Department of Health and Hospitals, What is Bayou Health?, *available at* http://new.dhh.louisiana.gov/index.cfm/page/32/n/71 (*last visited* November 12, 2012).
48. State of Louisiana, Department of Health and Hospitals, Bayou Health Implementation, *available at* http://new.dhh.louisiana.gov/index.cfm/page/34/n/73 (*last visited* November 24, 2012).

49. Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services (DHHS), Louisiana: Services Utilization, Ryan White HIV/AIDS Program – State Profiles, *available at* http://hab.hrsa.gov/stateprofiles (*last visited* October 31, 2012).

50. Amerigroup, Amerigroup Member Handbook, *available at* https://www.myamerigroup.com/English/Member%20Handbooks/LA/LALA_CAID_MHB_ENG.pdf; Community Health Solutions of Louisiana, Member Handbook, *available at* http://www.louisiana.chsamerica.com/documents/CHS-LA%20Member%20Handbook_v5_12-28-11.pdf; LaCare Louisiana, Member Handbook, available at http://www.lacarelouisiana.com/pdf/member/handbook/english.pdf; Louisiana Healthcare Connections, Benefits Grid, available at http://www.louisianahealthconnect.com/for-members/benefit-information/benefits-grid (*last visited November 14, 2012*); UnitedHealthcare, UnitedHealthcare Community Plan Member Handbook, available at http://www.uhccommunityplan.com/assets/LA-UHCCommunityPlan-Member-Handbook.pdf.

51. GroupCare PPO, BlueCross BlueShield of Louisiana, Healthcare.gov, *available at* http://finder.healthcare.gov/sbiz/get_benefits?audience=sbiz&effective_day=01&effective_month=12&effective_year=2012&employeeNum=5&issuer_ids=97176&nojs=n&plan_id=97176LA003&situation=need&sliders=false&state=LA&utf8=%E2%9C%93&x=34&y=17&zip=70112 (*last visited* November 5, 2012).

52. Chart adapted from NASTAD. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, 66, tbl. 28, August 2012, *available at* http://www.nastad.org/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.

53. State of Louisiana, Department of Health and Hospitals, Office of Public Health, Louisiana AIDS Drug Assistance Program (LA ADAP) Guidelines 6, *forthcoming, available at* http://new.dhh.louisiana.gov/index.cfm/page/1118.

54. Call with Louisiana Medicaid Pharmacy Department, October 31, 2012.

55. State of Louisiana, Department of Health and Hospitals, Prior Authorization PDL Implementation Schedule, *available at* http://www.lamedicaid.com/provweb1/forms/rxpa/PDL_NPDL_11_1.pdf (last updated June 12, 2012).

56. BlueCross and BlueShield of Louisiana Prescription Drug Coverage Guide, *available at* http://www.bcbsla.com/Docs/2012_3Tier_Formulary.pdf (*last visited* October 31, 2012).

57. State of Louisiana, Department of Health and Hospitals, Office of Public Health, Louisiana AIDS Drug Assistance Program (LA ADAP) Guidelines 6, *forthcoming, available at* http://new.dhh.louisiana.gov/index.cfm/page/1118.

58. State of Louisiana, Department of Health and Hospitals, Office of Public Health, Louisiana AIDS Drug Assistance Program (LA ADAP) Guidelines 6, *forthcoming, available at* http://new.dhh.louisiana.gov/index.cfm/page/1118.

59. E-mail from Kira Radtke, STD/HIV Program Services Manager, to Center for Health Law Policy and Innovation at Harvard Law School (November 8, 2012) (on file with author).

60. E-mail from Kira Radtke, STD/HIV Program Services Manager, to Center for Health Law Policy and Innovation at Harvard Law School (November 8, 2012) (on file with author).

61. State of Louisiana, Department of Health and Hospitals, Medicaid Pharmacy Benefits Management, *available at* http://new.dhh.louisiana.gov/index.cfm/page/240 (*last visited* October 31, 2012).

62. State of Louisiana, Department of Health and Hospitals, Medicaid Pharmacy Benefits Management, *available at* http://new.dhh.louisiana.gov/index.cfm/page/240 (*last visited* October 31, 2012).

63. State of Louisiana, Department of Health and Hospitals, Prior Authorization PDL Implementation Schedule, *available at* http://www.lamedicaid.com/provweb1/forms/rxpa/PDL_NPDL_11_1.pdf (last updated June 12, 2012).

64. State of Louisiana, Department of Health and Hospitals, Bureau of Health Services Financing, Letter to Medicaid Providers re: PDL #11-01, *available at* http://www.lamedicaid.com/provweb1/forms/RxPA/Medicaid_Provider_11_1.pdf (issued June 20, 2012).

65. State of Louisiana, Department of Health and Hospitals, Pharmacy Services, *available at* http://new.dhh.louisiana.gov/index.cfm/page/358 (*last visited* November 5, 2012).

66. State of Louisiana, Department of Health and Hospitals, Pharmacy Services, *available at* http://new.dhh.louisiana.gov/index.cfm/page/358 (*last visited* November 5, 2012).

67. State of Louisiana, Department of Health and Hospitals, Pharmacy Services, *available at* http://new.dhh.louisiana.gov/index.cfm/page/358 (*last visited* November 5, 2012).

68. State of Louisiana, Department of Health and Hospitals, Pharmacy Services, *available at* http://new.dhh.louisiana.gov/index.cfm/page/358 (*last visited* November 5, 2012).

69. Pharmacy Benefit Changes, LaCare, *available at* http://www.lacarelouisiana.com/pharmacy/benefits/pharmacy-benefit-changes.aspx (*last visited* November 12, 2012).

70. Pharmacy Benefit Changes, LaCare, *available at* http://www.lacarelouisiana.com/pharmacy/benefits/pharmacy-benefit-changes.aspx (*last visited* November 12, 2012).

71. Pharmacy Benefit Changes, LaCare, *available at* http://www.lacarelouisiana.com/pharmacy/benefits/pharmacy-benefit-changes.aspx (*last visited* November 12, 2012).

72. Pharmacy Benefit Changes, LaCare, *available at* http://www.lacarelouisiana.com/pharmacy/benefits/pharmacy-benefit-changes.aspx (*last visited* November 12, 2012).

73. BlueCross BlueShield of Louisiana, Specialty Pharmacy Program Drug List, *available at* http://www.bcbsla.com/Docs/SpecialtyPharmacyDrugList.pdf (*last visited* October 31, 2012).

74. How the Health Care Law is Making a Difference for the People of Louisiana, Healthcare.gov, *available at* http://www.healthcare.gov/law/resources/la.html (*last visited* October 31, 2012).

75. Health Resources and Services Administration, US Department of Health & Human Services, Health Center Planning Grant Awards, available at http://www.hrsa.gov/about/news/2011tables/1108healthcenterplanning.html (*last visited* October 31, 2012).

76. Louisiana Health Center Fact Sheet, National Association of Community Health Centers, *available at* http://www.nachc.com/client/documents/research/LA11.pdf (*last visited* October 31, 2012).

77. NCHCMC Sites, National Center for HIV Care in Minority Communities, *available at* http://www.nchcmc.org/sites/ (*last visited* September 17, 2012).

78. Community Health Center FAQ, NO/AIDS Task Force, *available at* http://www.noaidstaskforce.org/community-health-center-faq (*last visited* October 31, 2012).

79. How to Access Services – Your initial visit and what to expect, NO/AIDS Task Force, *available at* http://www.noaidstaskforce.org/enrollment (*last visited* October 31, 2012).

80. Letter from Cindy Mann, Director, Centers for Medicare & Medicaid Services, to State Medicaid Director (November 26, 2012).

81. 45 C.F.R. pts. 144, 147, 150, et al. (proposed November 26, 2012).

82. The Kaiser Family Foundation State Health Facts, Health Insurance Coverage of Adults (19-64) With Incomes Under 139% of the Federal Poverty Level (FPL), states (2009-2010), US (2010), http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=3&rgn=45&ind=779&sub=177 (*last visited* October 12, 2012).

83. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, August 2012, 58-59, tbls.13-14, *available at* http://www.nastad.org/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.

84. The number of undocumented immigrants on ADAP in each state in fiscal year 2008 was extrapolated from Pew Research Center, A Portrait of Unauthorized Immigrants in the United States, *available at* http://pewhispanic.org/files/reports/107.pdf (*last visited* October 8, 2012). This number, divided by the overall population of the state in 2008 (estimated at http://www.census.gov/popest/intercensal/state/state2010.html), provides the percentage of undocumented immigrants in the state. This percentage is then applied to the number of individuals enrolled in ADAP, and adjusted by the appropriate Kaiser Family Foundation and NASTAD percentages, to estimate how many ADAP beneficiaries will not be newly eligible for private insurance subsidies as a result of their immigration status. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, 58, tbl.13, August 2012, *available at* http://www.nastad.org/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.

85. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, 39, tbl.11, May 2011, *available at* http://www.nastad.org/Docs/highlight/2011429_Module%20One%20-%20National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20March%202011.pdf.

86. National Alliance of State & Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, 56, tbl.11, August 2012, *available at* http://www.nastad.org/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf.

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

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

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