ADAP INSURANCE ASSISTANCE PROGRAMS IN THE SOUTH

Duke University School of Law
Health Justice Clinic &
Southern AIDS Strategy Initiative (SASI)

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Introduction

The AIDS Drug Assistance Program (ADAP), funded by the Ryan White Care Act, provides low-income, HIV positive individuals with essential medications for the treatment of HIV, and HIV-related conditions and illnesses. Under Title XXVI of the Public Health Services Act and the Health Resources and Services Administration (HRSA) policy, states may use Ryan White funds to pay health insurance costs for ADAP eligible clients.

This report surveyed the different ways that 11 ADAP programs in Southern States—Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Texas, and Virginia—are using Ryan White funds to help pay for health insurance, including (1) the types of insurance costs for which the states are providing aid, (2) the types of insurance for which assistance is provided, and (3) eligibility requirements. The information was gathered through interviews with the state officials and community organizers responsible for the programs and for distributing aid, as well as the National ADAP Monitoring Project 2016 Annual Report published by the National Association of State and Territorial AIDS Directors.

Terminology

**Premiums**: monthly payments made to the insurance company for the cost of health care; must be paid regardless of whether a client uses health services.

**Drug Copayment**: set fee that the client pays when he or she purchases a prescription drug.

**Drug Coinsurance**: percentage of the total cost of the medication that the client must pay when he or she receives a prescription.

**Deductible**: the out-of-pocket costs a client must pay before the health insurance company will pay for the client’s care.

**Medical Copayment**: fee that the client must pay when he or she receives medical care.

**Medical Coinsurance**: percentage of the total cost of the visit that the client must pay when receiving medical care.

Insurance Costs for Which ADAP Programs are Providing Aid

In the eleven Southern states reviewed, eight ADAP programs are using Ryan White funds to pay for insurance premiums. Ten programs are paying for drug copayments or drug co-insurance costs. Eight programs are paying for drug deductibles. Three programs are paying for medical copayments or medical cost sharing.

Types of Insurance for Which Assistance is Provided

Seven ADAP programs are providing assistance for Qualified Health Plans in the Affordable Care Act (ACA) marketplace. Four programs are providing assistance for employer-sponsored plans. Five programs are providing assistance for COBRA plans. All eleven ADAPs assist with Medicare Part D.

Eligibility Requirements

Eligibility requirements vary by state. Income limits range from 200% of the Federal Poverty Level (FPL) to 550%, FPL depending on state and program.

Reported Problems and Benefits

ADAP programs reported that they experienced very few problems with their insurance assistance programs. Anecdotally, many programs are finding that paying insurance costs is more cost effective and beneficial to their clients’ health than directly providing HIV medications. A University of Virginia study found higher rates of viral suppression in Virginia ADAP clients enrolled in QHPs (84.6%) than those in the direct purchase program (78.6%).
Table 1. Benefits Provided by Insurance Assistance Program (Not Including Benefits for Medicare Part D Recipients)

<table>
<thead>
<tr>
<th>State</th>
<th>Premiums</th>
<th>Drug Co-payments/Drug Cost-sharing</th>
<th>Deductibles</th>
<th>Medical Co-payments/Cost-sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Arkansas</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Florida</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Georgia</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Louisiana</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Mississippi</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>North Carolina</td>
<td>No*</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>South Carolina</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Tennessee</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Texas</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Virginia</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

*Legislation passed in July 2016 authorized premium assistance, which will be implemented in 2017

**States Paying Insurance Premiums**

**Expanded Medicaid**
States Paying Insurance Copayments and/or Drug Cost-sharing

States Paying Drug Deductibles

States Paying Medical Copayments/Cost-sharing

Expanded Medicaid
Table 2. Types of Insurance for which Benefits Are Provided (Not Including Medicare Part D)

<table>
<thead>
<tr>
<th>State</th>
<th>ACA Marketplace Plans</th>
<th>Employer-Sponsored Plans</th>
<th>COBRA plans</th>
<th>Other (e.g. privately purchased)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes (standard Blue Cross Plan)</td>
</tr>
<tr>
<td>Arkansas</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Florida</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Georgia</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Louisiana</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes (private; spouses’ plan)</td>
</tr>
<tr>
<td>Mississippi</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>North Carolina</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>South Carolina</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>Tennessee</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Texas</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Virginia</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

States Providing Benefits for ACA Marketplace Plans

- Expanded Medicaid
States Providing Benefits for Employer-Sponsored Plans
- Expanded Medicaid

States Providing Benefits for COBRA Plans
- Expanded Medicaid

States Providing Benefits for Other Types of Insurance Plans
- Expanded Medicaid
Table 3. Eligibility Requirements and Coverage (Not Including Medicare Part D eligibility requirements)

<table>
<thead>
<tr>
<th>State</th>
<th>Income Limits</th>
<th>Covers Medicaid Gap?</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>300% FPL</td>
<td>Yes</td>
<td>N/A</td>
</tr>
<tr>
<td>Arkansas</td>
<td>N/A</td>
<td>N/A (expanded Medicaid)</td>
<td>N/A</td>
</tr>
<tr>
<td>Florida</td>
<td>249% FPL for ACA plans; 400% FPL other</td>
<td>Yes, but only for those in non-ACA plans.</td>
<td>Clients must complete an insurance screening prior to enrollment.</td>
</tr>
<tr>
<td>Georgia</td>
<td>300% FPL</td>
<td>Yes</td>
<td>Client must have cash assets less than or equal to $4,500 ($5,500 if married).</td>
</tr>
<tr>
<td>Louisiana</td>
<td>400% FPL</td>
<td>N/A (expanded Medicaid)</td>
<td>Client must fill out application for or currently be enrolled in an insurance plan.</td>
</tr>
<tr>
<td>Mississippi</td>
<td>300% FPL</td>
<td>Yes</td>
<td>Client must be enrolled in ACA marketplace plan.</td>
</tr>
<tr>
<td>North Carolina</td>
<td>300% FPL</td>
<td>Yes</td>
<td>Client must be enrolled in ACA marketplace plan</td>
</tr>
<tr>
<td>South Carolina</td>
<td>550% FPL</td>
<td>Yes</td>
<td>Client must make commitment to take medication as prescribed by physician</td>
</tr>
<tr>
<td>Tennessee</td>
<td>300% FPL</td>
<td>Yes</td>
<td>N/A</td>
</tr>
<tr>
<td>Texas</td>
<td>200% FPL</td>
<td>Yes</td>
<td>Client must be enrolled in insurance plan covering specific medications.</td>
</tr>
<tr>
<td>Virginia</td>
<td>400% FPL</td>
<td>Yes</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Graph 1. Income Eligibility (as % of Federal Poverty Level)
Alabama assists ADAP clients with insurance costs through a novel program in which it contracts with Blue Cross Blue Shield Alabama to provide all qualifying clients with a specified insurance plan. As of June 30, 2016, the Insurance Assistance Program was serving 1,557 clients.

**History of Alabama’s Health Insurance Assistance Program**

Prior to the Affordable Care Act, Alabama assisted clients only with Medicare Part D plans. Alabama ADAP began its Insurance Assistance Program in January 2015.

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### Program Summary

<table>
<thead>
<tr>
<th>Eligibility Requirements</th>
<th>Program Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income at or below 300% of the Federal Poverty Level</td>
<td>Insurance premiums</td>
</tr>
<tr>
<td></td>
<td>Drug copayments</td>
</tr>
<tr>
<td></td>
<td>Deductibles for drugs</td>
</tr>
<tr>
<td></td>
<td>Medical co-payments (for in-network-outpatient office visits).</td>
</tr>
</tbody>
</table>

**Insurance Eligible for Wrap Around**

- Blue Cross Blue Shield Plan purchased directly by Alabama ADAP Program
- Medicare Part D

**Serves People in Medicaid Coverage Gap?**

Yes

**Drugs Covered by the Program**

- Any drug covered by clients’ Blue Cross Blue Shield insurance plan
Program Logistics

How does a client apply to Alabama’s Insurance Assistance Program?

Clients first must apply to Alabama ADAP with help of a caseworker at their medical provider’s office. Applications are currently on paper, though an electronic application system is being developed. The medical provider submits the application to the central ADAP office for processing. The ADAP application is then used to determine eligibility for the Insurance Assistance Program.

How are benefits provided?

When clients fill a prescription, they provide the pharmacy with a secondary insurance card along with their regular, Blue Cross Blue Shield insurance card. Any remaining cost sharing is then paid through a fiscal agent of the program.

Alabama pays premiums directly through a contract with Blue Cross Blue Shield.

Does the program limit eligible plans? If so, how were these limitations decided?

One insurance plan was chosen for all clients. Currently, this is a Blue Cross Blue Shield platinum plan. This plan was chosen because of its cost-effectiveness for premiums, deductibles, and co-pays.

How did Alabama determine the cost neutrality of the Insurance Assistance Program?

The program’s cost-neutrality calculations and determinations were made within the state ADAP office. All costs associated with the particular insurance plan were considered, including premiums, deductibles, and copays. This was then compared across plans via the same series of calculations. The predicted costs have so far proved to be about 93% accurate. Drug rebates are included in cost neutrality calculations. Overall, actual costs of the program have been less than direct purchase of drugs. 2015 was the first year of the program, and, as of the time data was collected for this report, final costs for the year had not been determined.

Has the program addressed tax reconciliation?

No. Alabama purchases plans directly from Blue Cross Blue Shield, with no tax subsidies involved, so tax reconciliation is not an issue.

Has the program affected the state’s ADAP budget or client health outcomes?

Cost savings from the program have allowed Alabama to increase the income level limits for ADAP from 250% to 300% FPL. Analysis of data has shown higher levels of viral suppression among AIAP clients (92%) compared to full pay ADAP clients (84%).
Arkansas

Overview
Arkansas expanded Medicaid in 2014. Because of this expansion, Arkansas ADAP does not provide health insurance assistance for its ADAP clients. Two Community Based Organizations (“CBOs”) in the state receive Ryan White Part B funding and may use this funding to assist ADAP clients with insurance copayments and deductibles.

Arkansas ADAP provides insurance assistance for clients on Medicare Part D. As of June 2015, the program was providing assistance for 128 clients. 

History of Arkansas's Health Insurance Assistance Program
Prior to the Affordable Care Act, Alabama assisted clients only with Medicare Part D plans. It had no other insurance assistance program.

Program Summary

<table>
<thead>
<tr>
<th>Eligibility Requirements</th>
<th>Program Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualifies for Medicare Part D</td>
<td>Drug copayments</td>
</tr>
<tr>
<td></td>
<td>Drug deductibles</td>
</tr>
</tbody>
</table>

**Insurance Eligible for Wrap Around**

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<table>
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<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Medicare Part D</td>
</tr>
</tbody>
</table>

**Serves People in Medicaid Coverage Gap?**

N/A (Medicaid has been expanded in Arkansas)

**Drugs Covered by the Program**

N/A
Overview

In June 2015, Florida ADAP’s Premium Plus Insurance Program served 3,260 clients, including clients enrolled in Medicare Part D.

History of Florida’s Health Insurance Assistance Program

Before the Affordable Care Act’s enactment, Florida ADAP had a health insurance assistance program called the AIDS Insurance Continuation Program. This program provided deductible and copay assistance for some HIV symptomatic or AIDS diagnosed clients. The program assisted with costs of employer-sponsored insurance, including COBRA continuation. The program evolved into the Premium Plus Insurance Program, which began in 2014.

Program Summary

<table>
<thead>
<tr>
<th>Eligibility Requirements</th>
<th>Program Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income at or below 249% of the Federal Poverty Level for ACA plans; up to 400% of the Federal Poverty Level for other plans</td>
<td>Insurance premiums</td>
</tr>
<tr>
<td>Complete Insurance Screening</td>
<td>Drug copayments</td>
</tr>
<tr>
<td></td>
<td>Deductibles for drugs</td>
</tr>
</tbody>
</table>

Insurance Eligible for Wrap Around

- Select ACA marketplace plans
- Select employer-sponsored insurance
- Select COBRA plans
- Medicare Part D

Serves People in Medicaid Coverage Gap?

Yes (for non-ACA marketplace plans)

Drugs Covered by the Program

- Any drug on the Florida ADAP formulary that is also covered by client’s primary insurance plan
How does a client apply to Florida’s Insurance Assistance Program?

Interested clients must visit their county health department and complete a Florida ADAP Core Eligibility Screening. Once this screening is complete, they may be considered for placement into one or more ADAP program. Florida ADAP staff examine and accept applications for the Premium Plus Insurance Program and complete the enrollment process.

Florida ADAP is currently working on creating a web-based application, which should be available at the end of 2016. Although clients cannot yet enroll online from home, all applications are on a centralized electronic database, accessible by each county's health department.

How are benefits provided?

Florida ADAP contracts with Broward Regional Health Planning Council ("BRHPC") to pay clients’ premiums throughout the state. Clients submit invoices for premiums to Florida ADAP, which sends the invoice to BRHPC. BRHPC pays the premiums and invoices Florida ADAP for all premiums paid and associated administrative costs.

Florida ADAP uses a Pharmacy Benefits Manager, CVS Caremark, to pay drug copays. CVS Caremark sends clients a secondary insurance card that they present to CVS when they receive their medications. CVS then invoices Florida ADAP for any costs that the clients’ primary insurance does not cover.

Does the program limit eligible plans? If so, how were these limitations decided?

All plans must be cost-effective and cover at least one medication in each HIV drug class. Florida ADAP provides clients who wish to enroll in a marketplace plan with a list of plans that meet these requirements. For clients with employer-sponsored insurance plans and COBRA, Florida ADAP reviews the plan first and determines if the plan would be cost effective before agreeing to provide assistance.

How did Florida determine the cost neutrality of the Insurance Assistance Program?

Florida ADAP employs an on-staff actuary to determine the financial feasibility of the Premium Plus Insurance Program. Pharmaceutical rebates were taken into account when determining cost neutrality for 2015, but program staff stated that providing assistance for the 2015-2016 federal marketplace plans still would be cost-effective or nearly cost-effective even without rebates.

Has the program addressed tax reconciliation?

Yes. Clients with federal marketplace plans are required to accept their tax credits at the time of enrollment, reducing the monthly premium cost. Clients must notify Florida ADAP and the federal marketplace of any changes in income or household composition that would affect the subsidy or tax credit.

Has the program affected the state’s ADAP budget or client health outcomes?

The Premium Plus Insurance Program appears to be beneficial to Florida’s ADAP budget. The program has only been in place for a short time, so its impact, both financially and otherwise, is still unclear.

The program has started to monitor viral loads and CD4 counts of clients and has found that those with insurance tend to have better health outcomes than those clients who are uninsured.
Overview

As of January 31, 2016, Georgia ADAP was serving 6,000 clients. Seventy-six percent of these clients were receiving medications only. Georgia ADAP’s Health Insurance Continuation Program (HICP) was serving 486 clients, including clients receiving assistance enrolled in Medicare Part D.

History of Georgia’s Health Insurance Assistance Program

HICP went into effect in 1998. The program has continued to evolve to meet client needs.

Program Summary

Eligibility Requirements

- Income at or below 300% of the Federal Poverty Level
- Cash assets equal to or less than $4,500; if married, cash assets equal to or less than $5,500
- 18 years or older

Program Benefits

- Insurance premiums (maximum monthly premium of $1,100; may include spouse and dependent children on a family health insurance plan, as well as dental and vision; average premium payment is $474/month)
- Drug copayments (drug copayments count towards out-of-pocket costs)

Insurance Eligible for Wrap Around

- ACA marketplace plans
- Medicare Part D
- Private Insurance (not linked to ACA marketplace plans)

Serves People in Medicaid Coverage Gap?

Yes

Drugs Covered by the Program

- Drugs listed on the ADAP 70+ medication formulary
How does a client apply to Georgia’s Health Insurance Continuation Program?

Clients enroll in-person through a District Part B Health Department Enrollment site or other approved agencies. There are 27 enrollments sites within 18 health districts and 4 approved sites in Metro Atlanta. Clients receive application assistance from case managers at the enrollment sites.

The application is entirely electronic. On receiving an application, ADAP/HICP staff verify eligibility, the premium amount, type of coverage, and extent of medication coverage under the plan.

How are benefits provided?

Georgia ADAP pays premiums directly to the insurance companies.

Georgia ADAP uses a pharmacy benefits manager, Data RX, to pay drug copayments. Data RX sends clients a secondary insurance card that they present to the pharmacy when they receive their medications. Data RX then invoices Georgia ADAP for any costs that the client’s primary insurance does not cover.

Does the program limit eligible plans? If so, how were these limitations decided?

The Health Insurance Continuation Program does not provide assistance for plans without comprehensive coverage. Determinations on which plans would be covered by the program were made on the basis of their cost-effectiveness.

How did Georgia determine the cost neutrality of Georgia’s Health Insurance Continuation Program?

Georgia used the template created by NASTAD to determine cost effectiveness of the program.

Has the program addressed tax reconciliation?

Not yet. Georgia is working on the issue and has not yet decided how to handle it.

Has the program affected the state’s ADAP budget or client health outcomes?

The payment of health insurance premiums is more cost effective than directly providing medications.

Clients on HICP are able to access their providers, continue primary health care, and improve their quality of life. The state has no data yet, but anecdotally, clients in HICP are able to access a wider array of services.
In June 2015, Louisiana ADAP’s Health Insurance Program (“HIP”) served 3,426 clients, including clients enrolled in Medicare Part D.

### History of Louisiana’s Health Insurance Assistance Program

Prior to the Affordable Care Act, Louisiana established several insurance assistance programs. Louisiana wrapped around Medicare Part D (“HAP”) and the Federal Pre-existing Condition Insurance Program (“PCIP”). The state also provided premium assistance for people living outside Baton Rouge and New Orleans. People living in these two cities received Ryan White Part A assistance with premiums. Louisiana began HIP in 2013.

### Program Summary

<table>
<thead>
<tr>
<th>Eligibility Requirements</th>
<th>Program Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Income at or below 400% of the Federal Poverty Level</td>
<td>• Insurance premiums</td>
</tr>
<tr>
<td>• Application for or currently enrolled in insurance plan</td>
<td>• Drug copayments</td>
</tr>
<tr>
<td>• Medical cost-sharing (except for in-patient hospital stays)</td>
<td>• Deductibles for drugs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Insurance Eligible for Wrap Around</th>
<th>Serves People in Medicaid Coverage Gap?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Non-ACA/Private insurance plans</td>
<td>N/A (expanding Medicaid)</td>
</tr>
<tr>
<td>• ACA marketplace plans</td>
<td></td>
</tr>
<tr>
<td>• Employer-sponsored insurance plans</td>
<td>Drugs Covered by the Program</td>
</tr>
<tr>
<td>• COBRA</td>
<td>• All drugs covered by the client’s insurance plan</td>
</tr>
<tr>
<td>• Spouse’s insurance plan (requires itemized cost from insurer for individual client)</td>
<td></td>
</tr>
<tr>
<td>• Medicare Part D</td>
<td></td>
</tr>
</tbody>
</table>
How does a client apply to Louisiana’s Health Insurance Program?

Interested clients must complete a general application that is available online. They then submit the application to the Health Insurance Program office. Typically, clients rely on case managers or social workers to help them fill out the application.

How are benefits provided?

Louisiana ADAP pays premiums and medical copayments through HIV/AIDS Alliance for Region Two, Inc. ("HAART, Inc."). To pay a medical copayment, HAART, Inc. requires a bill from the provider and an explanation of benefits from the client.

Louisiana ADAP uses a pharmacy benefits manager, Ramsell, to pay drug deductibles and copayments. Ramsell sends clients a secondary insurance card that they present to the pharmacy when they receive their medications. Ramsell then invoices Louisiana ADAP for any costs that the clients’ primary insurance does not cover.

Does the program limit eligible plans? If so, how were these limitations decided?

There are a few limitations on plans. The state prefers that clients avoid enrolling in bronze plans because the out of pocket costs are high.

How did Louisiana determine the cost neutrality of the Health Insurance Program?

Unknown.

Has the program addressed tax reconciliation?

Yes. Louisiana is encouraging clients to promptly notify the federal marketplace of changes in income so subsidies may be adjusted.

Has the program affected the state’s ADAP budget or client health outcomes?

Clients have greater access to specialized care. Before HIP, many clients relied on the state’s public hospital system. They would usually have to wait months for specialty referrals. Under HIP, Clients can better access specialized, private care. They also have a wider selection of health care providers throughout the state.
Overview

Mississippi ADAP serves approximately 2,000 clients per year. About 1,400 clients are on the direct-purchase program. Others are enrolled in the state’s ACA assistance program.

History of Mississippi’s ADAP Medication Assistance Program

Prior to the Affordable Care Act, Mississippi ADAP provided assistance for clients enrolled in Medicare Part D only. There was no assistance with other health insurances plans.

Program Summary

<table>
<thead>
<tr>
<th>Eligibility Requirements</th>
<th>Program Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Income at or below 300% of the Federal Poverty Level</td>
<td></td>
</tr>
<tr>
<td>• Must fill prescriptions through state MSDH pharmacy</td>
<td>• Drug copayments waived</td>
</tr>
<tr>
<td>• ACA marketplace plans (silver plans only)</td>
<td>• Drug deductibles waived</td>
</tr>
<tr>
<td>• Medicare Part D</td>
<td></td>
</tr>
</tbody>
</table>

Insurance Eligible for Wrap Around

• ACA marketplace plans (silver plans only)
• Medicare Part D

Serves People in Medicaid Coverage Gap?

No

Drugs Covered by the Program

• Only drugs listed on the ADAP formulary. The formulary includes a few non-HIV medications.
How does a client apply to Mississippi’s Insurance Assistance Program?

For the ADAP medication assistance program, clients apply with a paper application. Case managers and social workers throughout the state provide assistance to clients. Completed applications are sent to the Mississippi State Department of Health.

How are benefits provided?

Mississippi ADAP directly purchases medications and sends clients their prescriptions by mail. Through the state’s pharmacy benefits manager, the state pharmacy is reimbursed by insurance companies for costs of the client’s medications. The state pharmacy has its own pharmacy benefits manager, both of which are run by state employees. MSDH Pharmacy serves as the ADAP pharmacy benefits manager. It processes all adjudications and reimbursements for medications.

Does the program limit eligible plans? If so, how were these limitations decided?

Mississippi ADAP provides assistance only for silver plans on the federal marketplace because the state has found that most other plans offered are not cost effective.

How did Mississippi determine the cost neutrality of the Insurance Assistance Program?

The state health department compared the average cost of providing insurance assistance, in addition to subsidizing Part C providers in the state, to the costs of providing drugs. Pharmaceutical rebates were included in the calculations. The state health department found that providing direct medication purchase was a cost-neutral alternative and had some benefits to the ADAP program internally.

Has the program addressed tax reconciliation?

No. The state does not provide assistance for premiums, so tax reconciliation is not an issue.

Has the program affected the state’s ADAP budget or client health outcomes?

Initial reports indicate that insurance assistance is benefitting the Mississippi ADAP budget.

Mississippi hopes to provide assistance for other insurance plans in the future. Providing assistance for premiums for silver federal marketplace plans would require doubling the state’s ADAP budget. According to the state’s calculations, the only affordable way to provide premium assistance would be to negotiate as a group with a larger insurer, similar to what Alabama is doing with Blue Cross Blue Shield. They believe that this is not feasible with the plans currently being offered in the state.
North Carolina

Overview

As of September 25, 2015, North Carolina ADAP’s Insurance Copayment Assistance Program (“ICAP”) was serving 160 clients.

History of North Carolina’s Health Insurance Assistance Program

Before the Affordable Care Act, North Carolina ADAP provided assistance for clients enrolled in Medicare Part D though its SPAP program. In 2013, it offered a pilot program to assist with PCIP insurance, under which it covered all insurance costs. The Insurance Copayment Assistance Program began in February 2015. On July 14, 2016 the state’s updated budget was approved and signed, authorizing ADAP to provide premium assistance to clients. "As of yet, no premium assistance program has been implemented in the state."

Program Summary

<table>
<thead>
<tr>
<th>Eligibility Requirements</th>
<th>Program Benefits</th>
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<tbody>
<tr>
<td>Income at or below 300% of the Federal Poverty Level</td>
<td>Drug copayments</td>
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<tr>
<td>Enrolled in ACA marketplace plan</td>
<td>Deductibles for drugs</td>
</tr>
<tr>
<td>At least one prescription on ADAP’s formulary</td>
<td>Premiums will start being covered in 2017</td>
</tr>
</tbody>
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<table>
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<tr>
<th>Insurance Eligible for Wrap Around</th>
<th>Serves People in Medicaid Coverage Gap?</th>
</tr>
</thead>
<tbody>
<tr>
<td>All ACA marketplace plans (ICAP)</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicare Part D (SPAP)</td>
<td></td>
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</tbody>
</table>

Drugs Covered by the Program

- All drugs covered by the client’s insurance plan
Program Logistics

How does a client apply to North Carolina’s Insurance Copayment Assistance Program?

To enroll in ICAP, case managers assisting clients send paper applications and proof of insurance to the ADAP office. ICAP applications are identical to the general ADAP application.

How are benefits provided?

North Carolina ADAP uses a pharmacy benefits manager, Ramsell, to pay drug copayments. Ramsell sends clients a secondary insurance card that they present to the pharmacy when they receive their medications. Ramsell then invoices North Carolina ADAP for any costs that the clients’ primary insurance does not cover.

Does the program limit eligible plans? If so, how were these limitations decided?

ICAP insurance plans must allow for prescriptions to be filled at a pharmacy that contracts with Ramsell, currently Walgreens, CVS (Specialty & Retail pharmacies), Josefs, OptumRX Specialty Pharmacy, Accredo Specialty Pharmacy, Rx Clinic Pharmacy, ECU Family Practice Pharmacy, Main Street Pharmacy, or Aetna Specialty Pharmacy (for Coventry clients).

How did North Carolina determine the cost neutrality of the Insurance Copayment Assistance Program?

North Carolina ADAP used an actuarial firm, Mercer, to assess ICAP’s cost-neutrality. Drug rebates have not been included in the cost-neutrality calculation. Because the program is so new, however, exact calculations of cost savings are unavailable.

Has the program addressed tax reconciliation?

No. The state does not provide assistance for premiums, so tax reconciliation is not an issue.

Has the program affected the state’s ADAP budget or client health outcomes?

Based on the current numbers, ICAP is estimated to save North Carolina ADAP about 50% of the costs that direct purchase would incur. Viral suppression rates are higher for clients participating in the ICAP (89.80%) and SPAP (93.39%) programs have higher levels of viral suppression than those in standard ADAP (83.04%)
Overview

The South Carolina ADAP provides medication assistance via the following services: (1) Direct Dispensing to provide medications via mail-order through a contracted pharmacy; (2) Insurance Assistance to reimburse costs for private insurance premiums, copayments, and deductibles; and (3) Medicare Assistance to provide support for Medicare Part D copayment and deductible costs. As of June 2015, South Carolina ADAP's Insurance Assistance Program served 2,264 clients, including those enrolled in Medicare Part D.

History of South Carolina’s Health Insurance Assistance Program

South Carolina ADAP has been providing insurance assistance for more than 12 years through reimbursement to Ryan White service providers. South Carolina ADAP also provides assistance with medication copays and deductibles for clients enrolled in Medicare Part D.

Program Summary

Eligibility Requirements
- Resident of and live in South Carolina
- Income at or below 550% of the Federal Poverty Level
- Must make commitment to take medication as prescribed by physician
- Enrolled in an insurance plan with adequate coverage for medications

Program Benefits
- Insurance premiums (ADAP enrollees only)
- Drug copayments
- Drug deductibles

Insurance Eligible for Wrap Around
- COBRA plans
- Private insurance, including ACA Marketplace plans
- Medicare Part D

Serves People in Medicaid Coverage Gap?
- Yes, including formulary limitations

Drugs Covered by the Program
- All medications on the ADAP formulary
How does a client apply to South Carolina’s Insurance Assistance Program?

A client must fill out a paper application that is available on the South Carolina Department of Health and Environmental Control (SCDHEC) website. The client must return the completed application to the Insurance Assistance Program (IAP). All clients who are eligible for IAP are required to enroll, rather than remain in the Direct Dispensing tier of the program. Clients are advised to seek the assistance of their case manager, nurse, or doctor to determine if they are eligible for ADAP assistance.

How are benefits provided?

ADAP-eligible clients sign up for insurance through several paths: Clients sign up for Marketplace insurance during open enrollment, with assistance from a variety of sources, including a navigator, Federally-qualified Health Center (FQHC), a Ryan White service provider or other health benefit enrollment service. Clients with employer-sponsored insurance sign up during their annual open enrollment period.

For premium assistance, IAP applicants must have a Ryan White or other ADAP-contracted provider pay the insurance premium and bill ADAP for reimbursement. Clients may contact ADAP for a referral to a provider in their service area for premium reimbursement support.

Each client may choose from a list of ADAP-contracted pharmacies that will work with the health insurance plan to receive copay and deductible assistance with their medications. Clients may use any pharmacy that is willing to contract with the South Carolina DHEC. Medications on the IAP formulary will then be provided at no cost to the client.

Does the program limit eligible plans? If so, how were these limitations decided?

South Carolina ADAP is required to support health insurance coverage that is more cost-effective than the direct dispensing. As such, SC ADAP assesses which ACA plans meet this requirement via a Coverage Review process. During the insurance plan selection process, the client and enroller must review the plan’s compatibility with the client’s HIV-centered coverage needs.

How did South Carolina determine the cost neutrality of the Insurance Assistance Program?

During the IAP application review, each client’s ADAP enrollment model is reviewed for cost-efficiency through the Insurance Enrollment Specialist. Drug rebates and coverage for medical care, labs, and other health conditions are considered when determining cost neutrality.

Has the program addressed tax reconciliation?

Applicants who sign up for ACA Marketplace plans are required to accept the up-front tax credit. Since the 2013 start of ACA expansion in South Carolina, very few enrollees have reported tax reconciliation issues to ADAP. In the few instances of tax reconciliation issues reported, the client is referred to a Ryan White Part B service provider for ACA wraparound/reconciliation solutions.

Has the program affected the state’s ADAP budget or client health outcomes?

Cost-savings derived from health insurance coverage and drug rebates have expanded ADAP’s ability to provide services to more HIV-positive residents of the state who are in need of medication assistance.
As of June 2015, Tennessee ADAP’s Insurance Assistance Program (“IAP”) was serving 3,226 clients, including clients enrolled in Medicare Part D.

**Overview**

**History of Tennessee’s Health Insurance Assistance Program**

Tennessee IAP began in the early 2000s, before the enactment of the Affordable Care Act. The program’s design has not changed much since its inception.

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<tr>
<td></td>
<td>Drug copayments (capped at $1,500/month, $18,000/year; some individual exceptions)</td>
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<tr>
<td></td>
<td>Drug Deductibles</td>
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<td>Medical cost-sharing (for care related to HIV)</td>
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<td></td>
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<tr>
<td>COBRA plans</td>
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<tr>
<td>Medicare Part D</td>
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<tr>
<td>Yes</td>
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</table>

**Drugs Covered by the Program**

- All drugs covered by the client’s insurance plan.
How does a client apply to Tennessee’s Insurance Assistance Program?

To enroll in IAP, a client must visit either a medical or non-medical case manager. The case manager then sends an electronic application through a state database for approval by the HIV/STD Program of the Tennessee Department of Health. The HIV/STD Program approves over 90% of clients’ applications within 24 hours of submission. The office sends a daily list of eligible clients to insurance and medication vendors.

How are benefits provided?

The Insurance Assistance Program contracts with Nashville CARES, an AIDS Services Organization, to pay program benefits. Nashville CARES pays premiums directly to insurance companies, usually several months before the due date.

To pay medical copayments, Nashville CARES sends the client a packet with an “emergency financial plan.” This packet contains a secondary insurance card that the client can use to pay deductibles and copays related to his or her HIV.

For drug copayments, Nashville CARES, acting as a pharmacy benefits manager, sends clients a secondary insurance card that they present to the pharmacy when they receive their medications. Nashville CARES then invoices Tennessee ADAP for any costs that the clients’ primary insurance does not cover.

Does the program limit eligible plans? If so, how were these limitations decided?

No. IAP does not require that clients enroll in particular plans.

How did Tennessee determine the cost neutrality of the Insurance Assistance Program?

The HIV/STD Program calculates IAP’s cost-neutrality. Drug rebates are not counted when determining cost neutrality.

Has the program addressed tax reconciliation?

Clients sign a form agreeing to return any refunds that they are given due to the ACA. Thus far the state has had a good track record with clients returning these refunds. It is the program’s expectation that clients will return any refunds to the IAP program.

Has the program affected the state’s ADAP budget or client health outcomes?

It costs about $5,000 to directly provide a client with medications, whereas it costs about $3,000 to provide a client with insurance.

Tennessee officials are starting to analyze the health benefits provided by IAP. It is clear that clients have access to a greater array of medical services because of IAP.

Nashville CARES has instituted a peer benefits management system to help keep clients enrolled in their insurance plans. Peers make direct phone contact with any person who is new to the Insurance Assistance Program to check for problems related to enrollment. If Nashville CARES does not receive a bill for services or medications, the program contacts the client to see if the client is caring for his or her health needs.
Texas

Overview
As of June 2015, Texas ADAP was providing 1,930 clients with insurance assistance, including clients enrolled in Medicare Part D (SPAP). The state ADAP’s health insurance assistance pilot program, the Texas Insurance Assistance Program (“TIAP”), served 300 clients as of August 30, 2015.

History of Texas’s Health Insurance Assistance Program
Texas did not have a general health insurance assistance program before the Affordable Care Act. Texas ADAP, however, provided assistance for clients enrolled in Medicare Part D. TIAP began in July 2013.

Program Summary

Eligibility Requirements

- Income at or below 200% of the Federal Poverty Level
- Insurance plan covering medications

Program Benefits

- Insurance premiums (for COBRA plans)
- Drug copayments
- Drug cost-sharing

Insurance Eligible for Wrap Around

- Employer sponsored insurance
- COBRA plans
- Medicare Part D

Serves People in Medicaid Coverage Gap?
No

Drugs Covered by the Program

- ADAP formulary drugs if on COBRA plan
- All plan drugs if on Medicare Part D
How does a client apply to Texas's Insurance Assistance Program?

To enroll in TIAP, clients send paper applications and proof of insurance to the Texas Department of Health, HIV Medication Program Office. As the program is in its initial stages, public awareness of the program is limited. Most eligible clients have been identified through word-of-mouth.

How are benefits provided?

Texas ADAP uses a pharmacy benefits manager, Ramsell, to pay drug copayments. Ramsell sends clients a secondary insurance card that they present to the pharmacy when they receive their medications. Ramsell then invoices Texas ADAP for any costs that the clients’ primary insurance does not cover.

Does the program limit eligible plans? If so, how were these limitations decided?

TIAP currently serves only clients who have employer-sponsored insurance or COBRA. The HIV Medication Programs Office is currently analyzing the possibility of adding ACA plans to the list of insurance plans covered by TIAP.

How did Texas determine the cost neutrality of the Insurance Assistance Program?

Because TIAP is a pilot program, the HIV Medication Programs Office is still calculating its cost neutrality.

Has the program addressed tax reconciliation?

No. The state does not provide assistance for premiums for ACA marketplace plans, and so tax reconciliation is not an issue.

Has the program affected the state’s ADAP budget or client health outcomes?

Because TIAP is a pilot program, the HIV Medication Programs Office has not yet determined the program’s effects on the Texas ADAP budget or on client health outcomes.
Virginia ADAP has two health insurance assistance programs, the Health Insurance Marketplace Program ("HIMAP") and the Insurance Continuation Assistance Program ("ICAP"). HIMAP provides assistance to clients enrolled in an ACA marketplace plan, while ICAP assists clients who are enrolled in other types of insurance. HIMAP served 3,174 clients as of October 20, 2015, while ICAP served 542 clients.

**Overview**

Virginia did not have a general health insurance assistance program before the Affordable Care Act. Virginia ADAP did provide assistance for clients enrolled in Medicare Part D. It also used ADAP funds to cover clients in the Federal Preexisting Condition Insurance Program (PCIP). HIMAP and ICAP began in 2013, and clients were enrolled in ACA marketplace plans starting in 2014.

**History of Virginia’s Health Insurance Assistance Program**

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How does a client apply to Virginia’s Health Insurance Marketplace Program?

To enroll in HIMAP, interested clients first apply to the ADAP program using a paper application. Virginia ADAP program then enrolls the client in HIMAP if they are eligible.

How are benefits provided?

To pay a client’s premiums, Virginia ADAP provides certified application counselors with checklists to calculate the payment amount. HIMAP clients are required to send any premium bills to the HIV Care Services offices. The premiums are paid through Mercer, a contractor. Beginning in 2015, Virginia made advance payments on premiums. Most of the insurance companies serving Virginia allow for a three-month advance payment.

Virginia ADAP uses a pharmacy benefits manager, Ramsell, to pay drug cost sharing and deductibles. Ramsell sends clients a secondary insurance card that they present to the pharmacy when they receive their medications. Ramsell then invoices Virginia ADAP for any costs that the clients’ primary insurance does not cover.

Does the program limit eligible plans? If so, how were these limitations decided?

Initially, Virginia assisted only with bronze and silver marketplace plans, but currently covers all metal level plans.

How did Virginia determine the cost neutrality of the Health Insurance Marketplace Program?

Virginia had an in-house data analyst determine the cost-neutrality of HIMAP. Pharmaceutical company rebates were included in these calculations.

Has the program addressed tax reconciliation?

Yes. Virginia ADAP requires clients to send their tax returns to the HIV Care Services Office. State officials are then able to pursue a tax refund or help a client pay any remaining tax payments.

Has the program affected the state’s ADAP budget or client health outcomes?

Projections for the impact to the overall state ADAP budget are unknown, though pharmaceutical rebates on their own are projected to save the program between $8 and $18 million annually. This has allowed the ADAP program to avoid having a waitlist.

Virginia has not yet evaluated its HIMAP and ICAP programs. Researchers at the University of Virginia, however, conducted a study in conjunction with the State ADAP program and found that insured clients had better health outcomes than uninsured clients. Specifically, the study found higher rates of viral suppression in Virginia ADAP clients enrolled in QHPs (85.5%) than those in the direct purchase program (78.7%). Additionally, there has been increased contact between clients and the ADAP program because of these insurance programs. Clients are required to provide up-to-date contact and demographic information.
Citations

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3 Telephone Interview with Harold Clayton, ADAP Program Director, Arkansas (Oct. 26, 2015).
5 Telephone Interview with Paul Mekeel, Division of Disease Control and Health Protection, Florida ADAP (Oct. 19, 2015); Cynthia Albert, Director of Client Services, BASIC NWFL, Inc. (Nov. 30, 2015); Email from Paul Mekeel, Division of Disease Control and Health Protection, Florida ADAP (Nov. 30, 2015, May 16, 2016).
6 Telephone Interview with Pat O’Neal, ADAP Director, and Employees, Georgia ADAP (Feb. 22, 2016); email communication with Pat O’Neal (May 17, 2016).
7 Telephone Interview with Lucy Cordts, Director of Client Services, NO/AIDS Task Force, A Division of CrescentCare (Dec. 3, 2015).
8 Telephone Interview with Dr. James Stewart, Bureau Director, Prevention and Treatment, Mississippi State Department of Health (Feb. 16, 2016).
13 Telephone Interview with Tonya King, Director of Ryan White Part B Program, HIV/STD Program, Tennessee Department of Health (Oct. 8, 2015).
14 Telephone Interview with Rachel Sanor, Manager, Texas HIV Medication Program, Texas Department of State Health Services (Oct. 23, 2015).
15 Telephone Interview with Carrie Rhodes, ADAP Coordinator, HIV Care Services, VA Department of Health (Oct. 6, 2015); email communication with Carrie Rhodes (May 16, 2016).