THE HENRY J. KAISER FAMILY FOUNDATION

HIV/AIDS

HIV/AIDS POLICY FACT SHEET

AIDS Drug Assistance Programs (ADAPs)

March 2006

What are ADAPs?[1]

AIDS Drug Assistance Programs (ADAPs) provide FDA approved HIV-related prescription drugs to low-income people with HIV/AIDS who have limited or no prescription drug coverage. They do so directly or by purchasing health insurance that includes medications. With more than 134,000 enrollees, ADAPs reach approximately one quarter of people with HIV/AIDS estimated to be receiving care nationally. In June 2005 alone, ADAPs provided medications to more than 96,000 clients and insurance coverage to thousands more.

ADAPs operate in 57 jurisdictions including all 50 states,[2] the District of Columbia, Puerto Rico, the U.S. Virgin Islands, three U.S. Pacific Territories (Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa) and one Associated Jurisdiction (the Republic of the Marshall Islands). They began serving clients in 1987, when Congress first appropriated funds to help states purchase AZT—the only approved antiretroviral drug at that time. In 1990, they were incorporated into Title II of the newly enacted Ryan White Comprehensive AIDS Resources Emergency (CARE) Act.

Since Fiscal Year (FY) 1996, Congress has specifically earmarked funding through Title II of the CARE Act for ADAPs, which is allocated by formula to states.[3] ADAPs may also receive funding from states and other sources, but such support is highly variable and largely dependent on local decisions and resources. ADAPs are not entitlement programs; annual federal appropriations and, where available, funding from other sources, determine how many clients ADAPs can serve and the level of services they can provide. Each state administers its own ADAP, including the establishment of eligibility criteria, drug formularies, and other program elements. No minimum formulary or client income eligibility level is required under current law. There is wide variation in access to ADAPs and in the range of drugs offered across the country.

Eligibility Criteria

As of June 2005, ADAP eligibility was as follows:

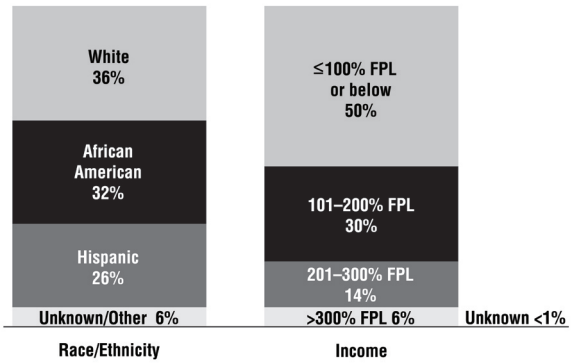
- All ADAPs require documentation of HIV status. Four used additional clinical criteria (e.g., specific CD4 counts or viral loads) generally or for access to particular drugs.
- Income eligibility ranged from a low of 100% of the Federal Poverty Level (FPL) in the Northern Mariana Islands to 500% FPL or more in 4 states – Maryland, Massachusetts, New Jersey, and Ohio (in 2005, the federal poverty level was $9,570 for a single person).

Clients

The number of clients served by ADAPs has grown over time, but at a decreasing rate and more slowly than drug spending. ADAP clients are predominantly low-income and uninsured. Most are people of color and male, and many have indicators of advanced HIV disease. In June 2005:

- ADAPs provided medications to 96,404 clients (thousands more had their insurance coverage paid for by ADAPs). Client utilization increased by 3% over June 2004.
- Almost two-thirds of ADAP clients (62%) were people of color. Most clients (80%) had incomes at or below 200% FPL.
- More than three quarters (79%) of ADAP clients were men; over half (54%) were between the ages of 25 and 44.
- A majority were uninsured (73%), with relatively small percentages reporting some other source of coverage (18% private; 13% Medicare; 10% Medicaid and 3% with both Medicare and Medicaid).
- About half (49%) had CD4 counts of 350 or less at time of enrollment.

Profile of ADAP Clients, June 2005



Drug Spending and Prescriptions

ADAP drug spending and prescriptions have grown over time. In June 2005:

- Drug spending reached $102.6 million, a 6% increase over June 2004, but a slower rate of growth than in prior periods. Per capita drug spending was $1,064.
- ADAPs filled 376,511 prescriptions.
- The average expenditure per prescription was $272. Antiretrovirals (ARVs) accounted for the bulk of drug expenditures (89%), and expenditures per prescription were much higher for ARVs than non-ARVs ($382 compared to $85).

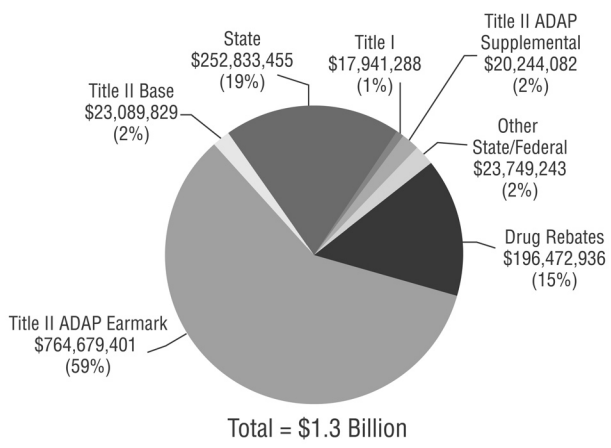
ADAP Budget

The budget has increased over time but at a slower rate:

- The national ADAP budget, from all sources, grew to $1.3 billion in FY 2005, an increase of 10% over FY 2004 (see figure). Since FY 1996, the budget has increased more than six-fold.
- The federal ADAP earmark[4] represents the largest share of the ADAP budget (59%), followed by state funding (19%). Drug rebates are now the third largest share of the budget (15%) and were the biggest driver of funding growth between FY 2004 and FY 2005.
- Within states, funding from sources other than the ADAP earmark was highly variable. In FY 2005, 4 ADAPs received only earmark funding; 39 received state general revenue support; 19 received Title II base funds; 12 received Title I funding; 20 received ADAP supplemental treatment grants; and 39 received drug rebates.

- Despite an increase in the national ADAP budget, 12 ADAPs experienced net decreases in their funding, largely due to decreases in the non-earmark components of their funding.

National ADAP Budget, by Source, FY 2005



Drug Formularies

ADAP formularies ranged from a low of 19 drugs in Guam to nearly 500 in New York, and open formularies[5] in 4 jurisdictions (Massachusetts, New Hampshire, New Jersey and the Northern Mariana Islands):

- While the majority of ADAPs (35) cover all FDA-approved antiretrovirals, 20 do not, including one state (South Dakota) that does not provide any protease inhibitors. 44 ADAPs cover Fuzeon, the one approved fusion inhibitor; 11 do not.
- 33 ADAPs cover more than 15 of the 29 drugs highly recommended ("A1") for the prevention and treatment of opportunistic infections (OIs)[6]; 3 of these ADAPs cover all 29. 22 ADAPs cover 15 or fewer of "A1" medications, including one (Louisiana) that does not cover any drugs other than antiretrovirals.
- 26 ADAPs cover drugs for the treatment of Hepatitis C; 24 cover Hepatitis A and B vaccines.

Waiting Lists and Other Cost Containment Measures

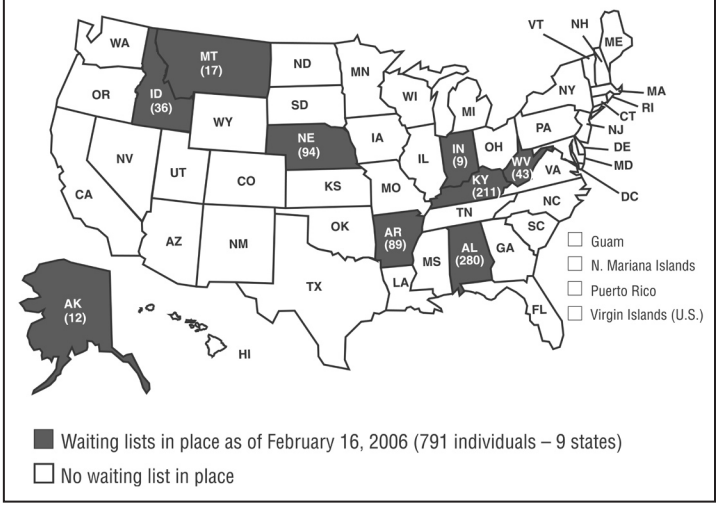
Due to budget shortfalls, some ADAPs have waiting lists and other cost containment measures in place. As of February 2006:

- 9 ADAPs had waiting lists totaling 791 individuals.
- 9 ADAPs, including one with a waiting list, had other cost containment measures as follows: reduced formularies (4); waiting list for Fuzeon (3); eligibility restrictions (2); per capita expenditure limits (2); and cost sharing (1).
- An additional 9 ADAPs anticipate instituting new cost containment measures in ADAP FY 2006.
- The President's ADAP Initiative (PAI), announced June 2004, provided $20 million in one-time funds targeted to individuals on ADAP waiting lists in 10 states. Clients were first enrolled in October 2004 and enrollment reached its maximum – 1,487 – in July 2005. The PAI is scheduled to end in March 2006; as of February 2006, 4 clients remained on the PAI.

Drug Purchasing Models and Insurance Coverage

- All but 3 ADAPs participate in the 340B program, enabling them to purchase drugs at or below the statutorily defined 340B ceiling price.
- 30 ADAPs purchase drugs directly from wholesalers; 24 purchase through a pharmacy network.
- 29 ADAPs report using ADAP federal earmark funding to pay insurance premiums, co-payments, and/or deductibles, providing coverage for 12,311 clients in June 2005. In 2005, ADAPs spent an estimated $75.4 million on insurance coverage.

ADAPs with Waiting Lists, February 2006
(791 Individuals in 9 States)



Coordination with the Medicare Drug Benefit (Part D)

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a new outpatient prescription drug benefit, Part D, to the Medicare program. An estimated 17,000 ADAP enrollees are also Medicare beneficiaries and ADAPs are required to ensure that they enroll in Part D by May 15, 2006. Most ADAPs have developed policies to coordinate with the new benefit: 32 will pay Part D co-payments; 22 will pay premiums; and 29 will pay for all medications on their ADAP formularies when clients reach the coverage gap (so called "doughnut hole"). These ADAP payments, however, will not count towards clients' True Out of Pocket Costs (TrOOP). It is not yet clear how Part D will impact ADAP clients and programs, including whether the new benefit will ease or exacerbate pressure on some ADAP budgets.

The Future of ADAPs

ADAPs continue to play a critical role in providing prescription medications to low-income people living with HIV/AIDS who have limited or no access elsewhere. In addition, ADAPs often serve as a bridge to other health care and support services. As the number of people living with HIV/AIDS has increased in the U.S., largely due to advances in HIV treatment, so too has the need for ADAPs. Because of resource constraints, however, several ADAPs have waiting lists or other cost containment measures in place that may affect client access. In addition, ADAP eligibility and drug formularies vary significantly across the country. The challenge for ADAPs in meeting growing demand with limited resources will likely continue for the foreseeable future and figure prominently in discussions about the third Reauthorization of the Ryan White CARE Act.

References

[1] All data in this fact sheet are from the *National ADAP Monitoring Project Report*, March 2006, which is based on an annual comprehensive survey of all ADAPs (53 of 57 responded) and supplemental data collection.
[2] The term "state" includes states, territories, and associated jurisdictions.
[3] Three percent of the ADAP earmark is set aside for the ADAP Supplemental Treatment Drug Grant, grants to states with severe need.
[4] Not including the ADAP Supplemental.
[5] Providing any FDA-approved HIV-related prescription drug. New Hampshire has some limitations to its open formulary.
[6] CDC, "Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus." *MMWR* 2002; 51(No. RR08):1-46; CDC, "Treating Opportunistic Infections Among HIV-Infected Adults and Adolescents." *MMWR* 2004; 53(No. RR15):1-112.

Additional copies of this publication (#1584-07) are available at www.kff.org. This fact sheet is part of the National ADAP Monitoring Project, an Initiative of the Kaiser Family Foundation and the National Alliance of State and Territorial AIDS Directors. It is based on data from the March 2006 National ADAP Monitoring Project report (#7464). The full report can be accessed at www.kff.org and www.NASTAD.org.