

AIDS Drug Assistance Programs (ADAPs)

March 2000

What Are ADAPs?

AIDS Drug Assistance Programs (ADAPs) provide HIV/AIDS-related prescription drugs to low income, uninsured and underinsured individuals living with HIV/AIDS in the 50 states, the District of Columbia, Puerto Rico, Guam and the Virgin Islands. ADAPs 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 under Title II of the newly enacted Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. Federal funding for ADAPs is allocated by formula to states. ADAPs are not entitlement programs and annual federal, and in some cases state, appropriations determine how many clients and services ADAPs can provide.

Each state or territory administers its own ADAP, including the establishment of financial and clinical eligibility criteria and ADAP drug formularies. As a result, there is wide programmatic variation across states and in client access to ADAPs.

The introduction of combination therapy (the use of two, three, or even more antiretroviral drugs in combination) as the standard of care in late 1995 heralded a new era for state ADAPs. Combination therapy is expensive, estimated to cost \$10,000 - \$12,000 per person per year and many people with HIV are unable to afford the recommended therapy. As a result, ADAPs have been playing an increasingly important role in providing needed care to low income individuals with HIV:

- The FY 99 ADAP budget was **\$665.5 M**;
- In June 1999, ADAPs served **61,822¹** clients and spent **\$46.8 M**.

ADAP Eligibility

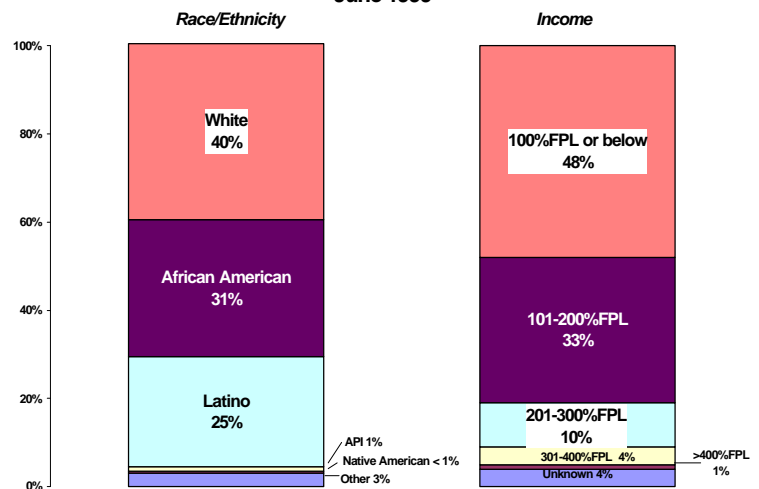
To be eligible for ADAPs, individuals must have limited or no access to drug coverage and must meet state-specific clinical and financial eligibility criteria. Most states require an individual to be HIV-positive to be clinically eligible for ADAPs (some have other clinical criteria such as low CD4 counts). Financial eligibility for ADAPs is quite variable, ranging from a low of 125% of the Federal Poverty Level (FPL) in Georgia and North Carolina, to a high of 500% of FPL in New York.

The ADAP Client Population

ADAPs serve clients who are primarily low income, uninsured, and represent a mix of racial and ethnic population groups. In June 1999:

- Most (80%) clients had incomes at or below 200% FPL; almost half had incomes below 100%FPL.
- Only a small percentage of clients were also covered by Medicaid or had some private insurance (7% respectively);
- Forty percent were white, almost one third (31%) were African American, and one quarter were Hispanic (25%). Asian/Pacific Islanders and American Indian/Native Alaskans comprised 1% or less of clients.
- Most (80%) were male, while one fifth (20%) were female. Almost all (99%) were above age 19.

Profile of ADAP Clients by Race/Ethnicity and Income, June 1999



ADAP Drug Formularies

The number of drugs covered by ADAPs also varies greatly across states, from fewer than 20 in some to more than 100 in others:

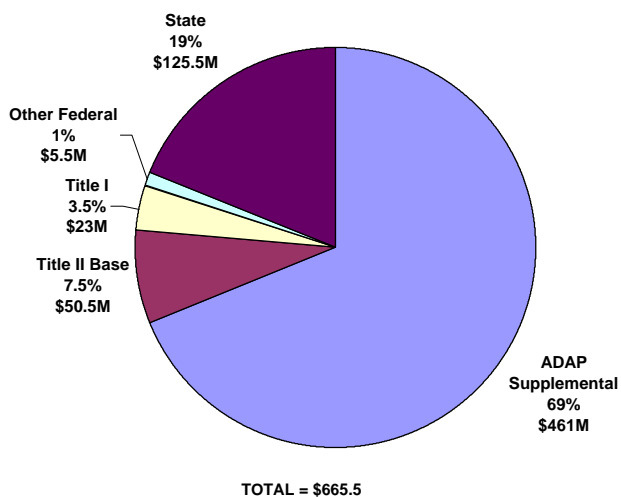
- Today, 45 ADAPs cover all approved antiretroviral treatments for HIV/AIDS, compared to only 2 ADAPs in mid-1997.
- However, only 23 ADAPs provide 10 or more of the 16 drugs that are strongly recommended by the US Public Health Service/Infectious Disease Society of America Guidelines for the Prevention of Opportunistic Infections in People with HIV.

Trends in Clients Served and Expenditures

Due to the new standard of care, ADAPs have experienced a tremendous growth in monthly expenditures and a large influx of new clients. Growth continues nationally today, although at slower rates.

- The number of clients served doubled between July 1996 and June 1999, from 27,472 to 54,981, including a 16% increase between June 1998 and June 1999 alone.²
- Monthly program expenditures more than tripled between July 1996 and June 1999, from \$13.3 million to \$43.1 million, including a 23% increase between June 1998 and June 1999.²
- Antiretroviral expenditures make up the bulk of ADAP program expenditures, accounting for 89% of program expenditures in June 1999, and increasing by 25% since June 1998.²

National ADAP Budget, FY 1999



Trends in the ADAP Budget

The overall national ADAP budget has more than tripled since FY 96, from \$207.5 million to 665.5 million in FY 99, including a 30% increase since last year.

- Federal ADAP supplemental funding increased from \$285.5 million in FY 98 to \$461 million in FY 99, and accounted for more than two thirds (69%) of the national ADAP budget in FY 99.
- The amount of funds states elect to devote to ADAPs from other federal Ryan White sources decreased.
- Some states contribute state general revenue support to ADAPs. State funding rose nationally by 5%, from \$119.4 million in FY 98 to \$125.5 million in FY 99. Fifteen states did not provide any state funding for their ADAPs and rely solely on federal funds to provide ADAP services.

ADAP Restrictions, Budget Shortfalls, and Unexpended Funds

Despite significant growth in the national ADAP budget, several states have had persistent access limitations, particularly those in the Southeast, a region of the country that has been increasingly impacted by HIV/AIDS, and in the western states. These states also tend to have less generous Medicaid programs and to provide no or limited state funding for their ADAPs. In June 1999:

- Twenty states reported one or more current or projected ADAP limitations, including 11 that capped enrollment to their ADAPs;
- Six ADAPs capped or restricted access to protease inhibitors or other antiretrovirals;
- Nine states expect to exhaust their ADAP budgets before the end of FY 1999, although 6 reported that they will have funds remaining in their budgets.

The Future of ADAPs

ADAPs, in addition to filling gaps in prescription drug access, often serve as a gateway into more comprehensive healthcare services including Ryan White-funded HIV care programs, Medicaid and private or high-risk pool insurance coverage. Given the rapidly changing standard of care that includes expensive prescription drug treatment, ADAPs will continue to play a critical role in the healthcare continuum for low-income, uninsured individuals living with HIV/AIDS.

Prepared by Arnie Doyle of the National Alliance of State and Territorial AIDS Directors (NASTAD) and Jennifer Kates of the Kaiser Family Foundation. Data from this report are part of the *National ADAP Monitoring Project*, a project of the Kaiser Family Foundation conducted by NASTAD and the AIDS Treatment Data Network. The full report can be accessed at www.aidsinfonyc.org/adap or www.kff.org. For additional copies of the full report, please contact our Publications Request Line at 1-800-656-4533 (ask for document #1582). Additional copies of this fact sheet are also available (ask for document #1584).

ENDNOTES

¹ The National ADAP Monitoring Project collects data based on a one-month snapshot each year. The Health Resources and Services Administration (HRSA), which administers the Ryan White CARE Act, estimates that ADAPs served a total of 110,000 unduplicated clients in FY 99 (HRSA, *The AIDS Epidemic and the Ryan White CARE Act*, Winter 2000).

² Comparisons over time include those states reporting comparable data in both periods.