

AIDS Drug Assistance Programs (ADAPs)

March 2001

What Are ADAPs?

AIDS Drug Assistance Programs (ADAPs) provide HIV/AIDS-related prescription drugs to 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; annual federal, and in some cases state, appropriations determine how many clients ADAPs can serve and the level of services they can provide. While Medicaid represents the largest source of public funding for care of persons with HIV/AIDS (\$4.1B in FY 2000), ADAPs are a critical source of prescription drugs for the low income and uninsured population living with HIV.

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 recommended therapy. As a result, ADAPs have been playing an increasingly important role in providing needed care to individuals with HIV with limited or no access to medication coverage:

- The FY 2000 ADAP budget was **\$724.5 M**;
- In June 2000, ADAPs served **69,407¹** clients and had drug expenditures of **\$58.5 M**.

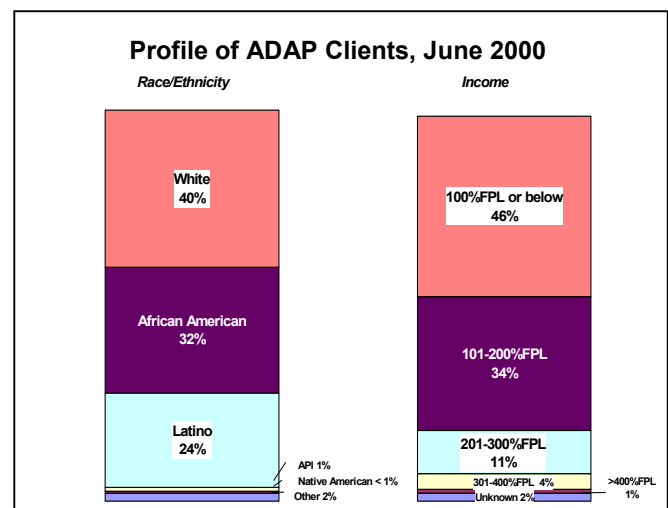
ADAP Eligibility

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. All states require an individual to be HIV-positive to be clinically eligible for ADAPs. A few have additional clinical criteria such as low CD4 counts/high viral loads. Financial eligibility for ADAPs is quite variable, ranging from a low of 125% of the Federal Poverty Level (FPL) in North Carolina to over 500% of FPL in New York.

The ADAP Client Population

ADAPs serve a racially and ethnically diverse mix of clients who are primarily low income and uninsured. In June 2000:

- Most (80%) clients had incomes at or below 200% FPL; almost half had incomes at or below 100% FPL.
- Only a small percentage of clients were also covered by Medicaid (7%) or had some private insurance (10%); about 8% were reported to have Medicare coverage.
- Forty percent were white, almost one third (32%) were African American, and about one quarter were Hispanic (24%). Asian/Pacific Islanders and American Indian/Native Alaskans comprised 1% or less of clients.
- Most (79%) were male and age 19 or older (98%). Women comprised one fifth of ADAP clients.



ADAP Drug Formularies

The number of drugs covered by ADAPs also varies greatly across states, from fewer than 20 in some states to more than 200 in others:

- Today, all but one of the state ADAPs reporting data cover all FDA-approved antiretroviral treatments for HIV/AIDS, compared to only 2 ADAPs in mid-1997.
- Thirty-one ADAPs (up from 23 at this time last year) now 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

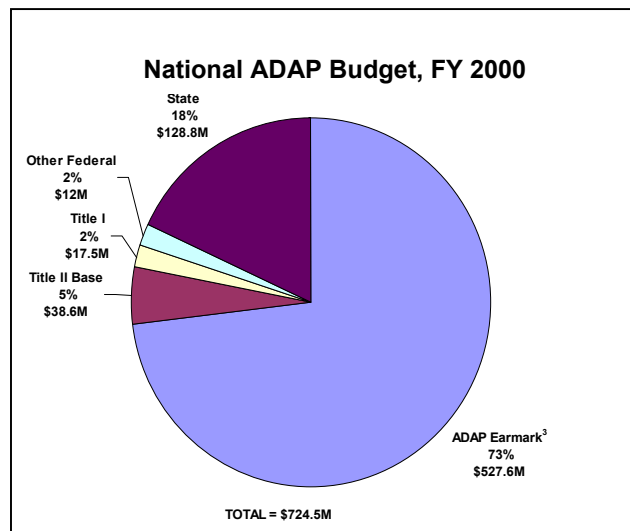
Due in part to the new standard of care, ADAPs have continued to experience a tremendous growth in monthly drug expenditures and a large influx of new clients. Growth continues nationally today, although at slower rates.

- The number of clients served more than doubled between July 1996 and June 2000, from 27,472 to 61,007, including a 12% increase between June 1999 and June 2000 alone.²
- Monthly drug expenditures increased by more than threefold between July 1996 and June 2000, from \$13.3 M to \$48.3 M, including a 23% increase between June 1999 and June 2000.²
- Antiretroviral expenditures make up the bulk of ADAP drug expenditures, accounting for 87% of expenditures in June 2000.

Trends in the ADAP Budget

The overall national ADAP budget has increased by almost fourfold since FY 1996, from \$188.5 M to \$724.5 M in FY 2000, including a 9% increase since last year.

- Federal ADAP earmark³ funding increased from \$460.6 M in FY 1999 to \$527.6 M in FY 2000, and accounted for almost three-quarters (73%) of the national ADAP budget in FY 2000.
- The amount of funds states elect to devote to ADAPs from other federal Ryan White sources continued to decrease.
- Some states contribute state general revenue support to ADAPs. State funding rose nationally by 3%, from \$126 M in FY 1999 to \$129 M in FY 2000. Fourteen 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

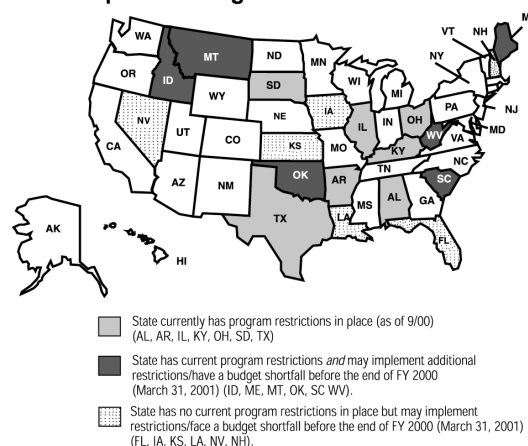
Despite significant growth in the national ADAP budget, several states face access limitations. In June 2000:

- Seventeen states reported one or more current and/or projected ADAP limitations, including 10

that reported capping enrollment to their ADAPs (9 reported capping enrollment as of September 2000; 1 projected an enrollment cap for early 2001);

- Five ADAPs capped or restricted access to protease inhibitors or other antiretrovirals;
- Ten states expect to exhaust their ADAP budgets before the end of FY 2000. Six reported that they expect to have funds remaining in their budgets.

States with Current or Planned Program Restrictions or Expected Budget Shortfalls in FY 2000



*Planned restrictions and expected shortfalls were reported by states at the time surveyed, between July and September 2000. States may or may not have implemented restrictions or experienced budget shortfalls.

The Future of ADAPs

ADAPs, in addition to filling gaps in prescription drug access, often serve as a gateway into more comprehensive health care services including other 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 health care continuum for uninsured and underinsured individuals living with HIV/AIDS.

Prepared by Arnold Doyle and Chris Aldridge of the National Alliance of State and Territorial AIDS Directors (NASTAD) and Jennifer Kates of the Kaiser Family Foundation. Data for this fact sheet are drawn from the *National ADAP Monitoring Project*, a project of the Kaiser Family Foundation conducted by NASTAD and the AIDS Treatment Data Network. Fifty-one of 54 jurisdictions with ADAPs reported data for the 2001 report. The full report can be accessed at www.kff.org.

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 approximately 125,800 unduplicated clients in FY 2000 (HRSA, HIV/AIDS Bureau website, Spring 2001).

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

³ The "ADAP earmark" refers to the federal dollars within Title II of the CARE Act specifically designated for ADAPs.