THE HENRY J. KAISER FAMILY FOUNDATION

HIV/AIDS

HIV/AIDS POLICY FACT SHEET

AIDS Drug Assistance Programs (ADAPs)

April 2007

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 nearly 142,000 enrollees, ADAPs reach approximately one quarter of people with HIV/AIDS estimated to be receiving care in the United States.[2] In June 2006 alone, ADAPs provided medications to more than 96,000 clients and insurance coverage to thousands more.

ADAPs began serving clients in 1987, when Congress first appropriated funds to help states[3] purchase the only approved antiretroviral (ARV) drug at that time, AZT. In 1990, they were incorporated into Title II of the newly enacted Ryan White Comprehensive AIDS Resources Emergency (CARE) Act (now called "Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006" or the "Ryan White Program").[4,5]

Since Fiscal Year (FY) 1996, Congress has specifically earmarked funding through Title II (now called Part B) of Ryan White for ADAPs, which is allocated by formula to states.[6] In FY 2006, 54 jurisdictions received earmark funding, including all states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam.[7] ADAPs may also receive state funding and contributions from other sources, but this 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 operates its own ADAP, including determining eligibility criteria and other program elements, resulting in wide variation in ADAPs across the country. No client income eligibility level is required under current law, although clients must be HIV positive, low-income, and under- or uninsured. Until the recent reauthorization of Ryan White, no minimum formulary was required. Reauthorization added a new minimum formulary requirement, effective July 1, 2007, requiring ADAPs to cover at least one medication from within each antiretroviral drug class (there are currently four classes).

Eligibility Criteria

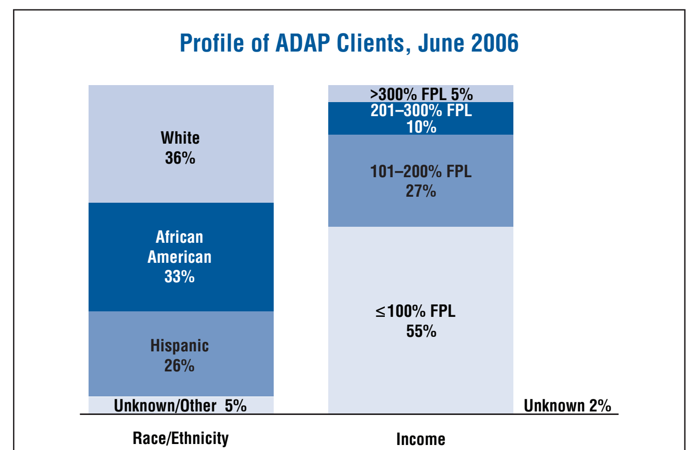
As of June 2006:

- All ADAPs require documentation of HIV status. Seven use additional clinical criteria (e.g., specific CD4 counts or viral load ranges) generally; 13 use clinical criteria for access to particular drugs.
- All ADAPs require clients to be residents in their state, and some require proof of residency.
- Financial eligibility ranges from a low of 125% of the Federal Poverty Level (FPL) in North Carolina[8] to 500% FPL or more in 4 states—Maryland, Massachusetts, New Jersey, and Ohio (in 2006, FPL was $9,800 annually for a single person). Some ADAPs also have asset limits.

Clients

The number of clients served by ADAPs has grown over time, but at a decreasing rate. ADAP clients are predominantly low-income and uninsured, and many have indicators of advanced HIV disease. Most ADAP clients are people of color (61%), male (78%), and between the ages of 25 and 44 (54%). In June 2006:

- ADAPs provided medications to 96,121 clients across the country; thousands more were provided with insurance coverage.
- Most had incomes at or below 200% FPL (82%), including over half (55%) with incomes at or below 100% FPL.
- A majority were uninsured (71%), with only small shares reporting some other source of coverage (17% private; 12% Medicare; 6% Medicaid; 3% with both Medicare and Medicaid).
- Over half (54%) had CD4 counts of 350 or below (at time of enrollment or recertification).



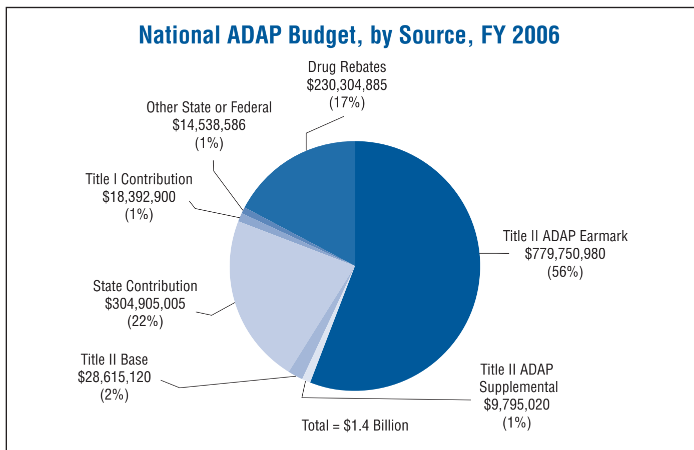
Drug Expenditures and Prescriptions

ADAP drug expenditures and prescriptions have generally grown over time but at slower rates. In June 2006:

- Drug expenditures totaled $95.3 million; ADAPs spent an additional $5.4 million on insurance purchasing/maintenance.
- Per capita drug spending was $991.
- ADAPs filled 344,904 prescriptions.
- The average expenditure per prescription was $276. ARVs accounted for the bulk of drug expenditures (89%), and expenditures per prescription were about 5 times higher for ARVs than non-ARVs.

ADAP Budget

- The national ADAP budget grew to $1.4 billion in FY 2006, an increase of 7% over FY 2005. Since FY 1996, the budget has increased more than six-fold.
- The federal ADAP earmark[9] is the largest component of the budget (56%), followed by state funding (22%). State funding was the largest driver of budget growth in FY 2006, increasing 21% over FY 2005. Drug rebates were the third largest component of the budget.
- Within states, funding from sources other than the earmark was highly variable. In FY 2006, 2 ADAPs received only earmark funding; 20 received ADAP supplemental treatment grants; 21 received Title II base funds; 40 received state general revenue support; 12 received Title I (now called Part A) funding; and 39 received drug rebates.
- Despite an increase in the national ADAP budget, 20 ADAPs experienced net decreases in their budgets, largely due to decreases in the non-earmark components of their funding.



Drug Formularies

ADAP formularies ranged from a low of 19 drugs in Guam to nearly 500 in New York, and open formularies[10] in three jurisdictions (Massachusetts, New Hampshire, and New Jersey):

- While the majority of ADAPs (35) cover all antiretrovirals, 19 do not, including one (South Dakota) that does not provide any protease inhibitors; 48 ADAPs offer Fuzeon, the one approved fusion inhibitor, and 6 do not.
- 37 ADAPs cover 15 or more of the 29 "A1" drugs highly recommended for the prevention and treatment of opportunistic infections (OIs).[11] Only 4 of these ADAPs cover all 29. Seventeen ADAPs cover less than 15 "A1" drugs, including one (Louisiana) that does not cover any drugs other than ARVs.
- 25 ADAPs cover drugs for the treatment of hepatitis C; and 21 cover hepatitis A and B vaccines.

Waiting Lists and Other Cost-Containment Measures

Due to budget shortfalls, some ADAPs have instituted waiting lists and other cost-containment measures.

- As of March 2007, 4 ADAPs had waiting lists, totaling 571 people with HIV who could not gain access to medications through their state's ADAP, despite meeting eligibility criteria.
- Many states have other cost-containment measures in place, including formulary limits, drug-specific enrollment caps, client cost-sharing, and prior authorization for drugs. A few states implemented new measures over the past fiscal year: 3 further restricted eligibility; 2 reduced formularies; and 1 introduced client cost-sharing. An additional 3 ADAPs anticipate the need to implement additional cost-containment measures during ADAP FY 2007.

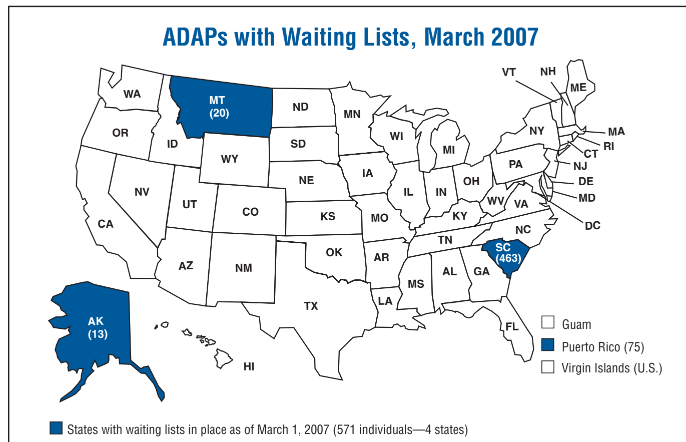
Drug Purchasing Models and Insurance Coverage

- All ADAPs but one participate in the 340B program, enabling them to purchase drugs at or below the statutorily defined 340B ceiling price.
- 29 ADAPs purchase drugs directly from wholesalers; 25 purchase drugs through a pharmacy network.
- 31 ADAPs use ADAP earmark funding to purchase health insurance and/or pay insurance premiums, co-payments, and/or deductibles for people with HIV/AIDS, paying for coverage for 13,744 clients in June 2006. In FY 2006, ADAPs spent $83.5 million on insurance coverage.

Medicare 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. As the payer of last resort, ADAPs were required by HRSA to ensure that all Medicare Part D-eligible clients enrolled in a Medicare prescription drug plan (or to ensure that the ADAP was not paying for any Medicare covered prescription drug expenses) by May 15, 2006. ADAPs are permitted to coordinate with Medicare drug plans and most have developed policies to do so: 33 ADAPs pay Part D co-payments; 23 pay premiums; and 25 pay for medications on their ADAP formularies when clients reach the coverage gap (so called "doughnut hole").

Due to the one-time shift of eligible clients to Part D plans and/or transition from paying for medications directly to paying cost-sharing only in May 2006, ADAP client utilization was stable in June 2006 compared to June 2005, and drug expenditures decreased. This impact is not expected to continue as either more clients are able to be served by ADAPs or some need to return to ADAP when they reach the Medicare coverage gap. Still, some ADAPs report that Part D has enabled them to serve more clients including one state that was able to eliminate its waiting list.



The Future of ADAPs

ADAPs will 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 need for ADAPs. Because of resource constraints, however, some ADAPs have waiting lists in place, or use other cost-containment measures that may affect client access. There is also significant variation in access to ADAPs across the country. Moving forward, it will be important to monitor the evolving relationship between Medicare Part D and ADAPs, as well as the changes brought about by the most recent reauthorization of the Ryan White Program, particularly its new minimum ADAP formulary requirement. Each of these developments is likely to offer both new opportunities and challenges to ADAPs and their clients.

References

1 All data in this fact sheet are from the *National ADAP Monitoring Project Annual Report,* April 2007.
2 Based on KFF analysis of data from CDC and UNAIDS.
3 The term "state" includes both states and territories.
4 Pub. L. 101-381; Pub. L. 104-146, SEC. 2616. [300ff-26].
5 HRSA, HIV/AIDS Bureau.
6 Until the most recent reauthorization of Ryan White, 3% of the ADAP earmark was set-aside for the ADAP Supplemental Treatment Drug Grant. As of FY 2007, this amount will increase to 5%.
7 Three previously funded territories/associated jurisdictions were determined by HRSA not to be eligible for ADAP funding in FY 2006. As of FY 2007, all will again be eligible, as specified in the 2006 Ryan White Reauthorization.
8 Following the survey period, North Carolina raised its income eligibility level to 200% FPL.
9 Not including the ADAP Supplemental Treatment Drug Grant set-aside.
10 Providing any FDA-approved HIV-related prescription drug.
11 See http://aidsinfo.nih.gov/Guidelines/Default.aspx?MenuItem=Guidelines for current guidelines.

Additional copies of this publication (#1584-08) 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 (#7619). The full report can be accessed at www.kff.org and www.NASTAD.org.