

AIDS Drug Assistance Programs (ADAPs)

April 2008

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 146,000 enrollees, ADAPs reach approximately 3 in 10 people with HIV/AIDS estimated to be receiving care nationally.² In June 2007 alone, ADAPs provided medications to about 102,000 clients and insurance coverage to thousands more.

ADAPs began serving clients in 1987, when Congress first appropriated funds to help states³ purchase the only approved antiretroviral (ARV) drug at that time, AZT. In 1990, they were incorporated into Part B of the newly enacted Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, now known as the Ryan White Program.^{4,5} Since Fiscal Year (FY) 1996, Congress has specifically earmarked funding for ADAPs through Part B of the Ryan White Program, which is allocated by formula to states.⁶ The most recent reauthorization of the Ryan White Program, in 2006, changed the way in which federal funding is distributed to states for ADAPs and led to new requirements, including a minimum formulary requirement.

In FY 2007, 58 jurisdictions received ADAP earmark funding, including all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, American Samoa, Federated States of Micronesia, Guam, Marshall Islands, and the Northern Mariana Islands.⁷ ADAPs may also receive state funding and contributions from other sources, including other parts of the Ryan White Program, 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 significant variation in ADAPs across the country.

Eligibility Criteria

ADAP clients must be HIV-positive, low-income, and under- or uninsured, but no income level is specified under current law. As of December 2007:

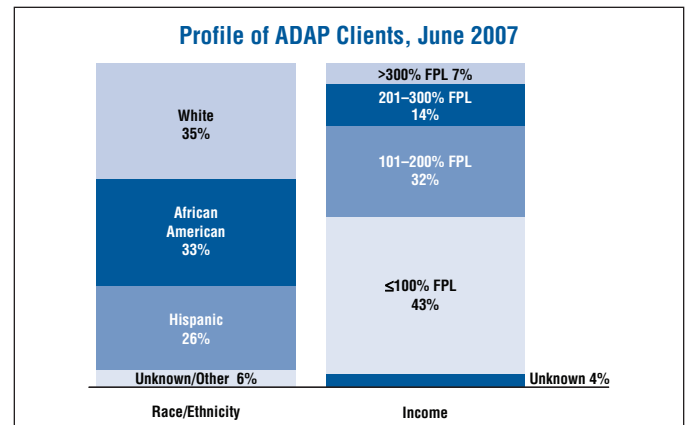
- All ADAPs require documentation of HIV status. Seven use additional clinical eligibility criteria (e.g., specific CD4 counts or viral load ranges) and 17 use clinical criteria for access to particular drugs.
- All ADAPs require clients to be residents in their state, and many require proof of residency.
- Financial eligibility ranges from 200% of the Federal Poverty Level (FPL) in 9 states to 500% FPL in 6 states (FPL was \$10,210 for a single person in 2007). Eighteen ADAPs also use asset limits to determine eligibility.

Clients

ADAP client enrollment and client utilization were at their highest levels in June 2007. Client demographics vary by state and region, but nationally have remained fairly constant over time. In June 2007:

- ADAPs provided medications to 101,987 clients across the country; thousands more were provided with insurance coverage.

- Most clients were people of color (63%) and most were male (77%).
- Most had incomes at or below 200% FPL (75% of clients), including more than four in ten (43%) with incomes at or below 100% FPL.
- A majority were uninsured (69%), with only small shares reporting some other source of coverage (15% private; 12% Medicare; 2% Medicaid; 2% with both Medicare and Medicaid).
- Over half (51%) had CD4 counts of 350 or below (at time of enrollment or recertification).
- The number of clients served has grown significantly over time (by 226% between 1996 and 2007), but at a decreasing rate in later periods (client utilization increased by 5% between June 2006 and June 2007).



Drug Expenditures and Prescriptions

ADAP drug expenditures and prescriptions have generally grown over time but at slower rates. In June 2007:

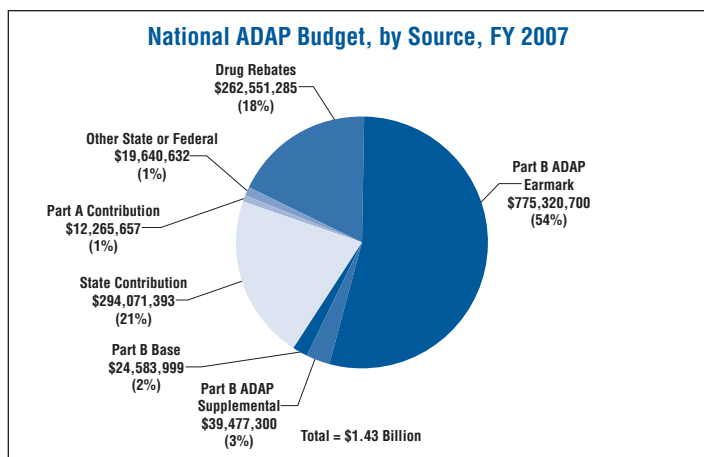
- Drug expenditures totaled \$100.1 million; ADAPs spent an additional \$8.8 million on insurance purchasing/maintenance.
- Per capita drug spending was \$982.
- ADAPs filled 344,600 prescriptions.
- The average expenditure per prescription was \$291. ARVs accounted for the bulk of drug expenditures (89%), and expenditures per prescription were more than 5 times higher for ARVs than non-ARVs.
- Drug spending has increased more than six-fold (525%) since 1996. Growth continues, but at slower rates, with drug spending increasing by 6% between June 2006 and June 2007.

ADAP Budget

ADAP funding levels and budget composition are highly variable from year to year, and influenced by a broad range of factors:

- The national ADAP budget totaled \$1.4 billion in FY 2007, an increase of 3% over FY 2006. Since FY 1996, the budget has increased more than seven-fold.
- The federal ADAP earmark⁸ is the largest component of the budget (54%), although funding distributed to ADAPs from the earmark decreased for the first time since it was created (decrease of 1%).

- State funding accounted for the second largest share (21%) of the budget, although it decreased by 4% between FY 2006 and FY 2007.
- Drug rebates accounted for the third largest component (18%), and were the largest driver of budget growth in FY 2007; rebates increased by 14% over FY 2006.
- While ADAP Supplemental Drug Treatment Grants accounted for only 3% of the overall ADAP budget, they grew more than four-fold between FY 2006 and FY 2007.
- In addition to all 58 ADAPs receiving earmark funding in FY 2007: 16 received ADAP supplemental funds; 21 received Part B base funds; 40 received state funds; 8 received Part A funds; and 42 received drug rebates.
- Despite an increase in the national ADAP budget, 18 ADAPs experienced net decreases in their budgets.



Drug Formularies

ADAP formularies (the list of drugs covered) vary significantly across the country. The most recent reauthorization of the Ryan White Program instituted the first-ever minimum formulary requirement for ADAPs and, effective July 1, 2007, ADAPs were required to cover at least one medication from within each approved ARV drug class. As of December 2007:

- All ADAPs were in compliance with the new minimum formulary requirement.⁹
- ADAP formularies ranged from a low of 28 drugs offered in Louisiana to about 460 in New York, and open formularies¹⁰ in four jurisdictions (Massachusetts, New Hampshire, New Jersey, and Oregon).
- The majority of ADAPs (29) covered every approved ARV in each ARV class and all ADAPs covered the one available multi-class combination product on their formulary although these drugs are not subject to the new requirement.
- 39 ADAPs covered 15 or more of the 29 "A1" drugs highly recommended ("A1") for the prevention and treatment of opportunistic infections (OIs).¹¹ Six of these ADAPs covered all 29. Thirteen ADAPs covered less than 15 "A1" drugs, including one (Louisiana) that did not cover any drugs other than ARVs.
- 22 ADAPs covered drugs for the treatment of hepatitis C; 28 covered hepatitis A and B vaccines.

Waiting Lists and Other Cost-Containment Measures

Some ADAPs have instituted waiting lists or other cost-containment measures at times when client demand exceeds available resources. In 2007, waiting lists were nearly eliminated and fewer ADAPs reported instituting new cost-containment measures in FY 2007. As of March 5, 2008:

- Only 1 ADAP had a waiting list (with 3 people).
- Three states had implemented and maintained new cost-containment measures (other than waiting lists) during ADAP FY 2007. Seven eliminated an existing measure.

Drug Purchasing Models and Insurance Coverage

- All ADAPs 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; 24 purchase drugs through a pharmacy network.
- 40 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 20,960 clients in June 2007. ADAPs spent \$8.8 million in June 2007 and \$74.5 million in FY 2007 on insurance coverage.

Medicare Part D

Since the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which added a new outpatient prescription drug benefit, Part D, to the Medicare program, ADAPs have been working to coordinate with Medicare drug plans. As the payer of last resort, ADAPs are required to ensure that any Medicare Part D-eligible client is enrolled in Part D or ensure that ADAP is not paying for any of their Part D covered expenses. ADAPs reported the following (as of May 2007): 28 ADAPs paid for Part D co-payments; 25 paid for deductibles; 20 paid for premiums; and 26 paid for medications on their ADAP formularies when clients reach the Part D coverage gap (or "doughnut hole").

Looking Ahead

ADAPs continue to play a critical role in providing prescription drugs 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 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. Looking ahead, it will be important to continue to track ADAP program capacity, as measured by waiting lists and other factors, and to assess whether the significant reductions in waiting lists and other program limitations are maintained. It will also be important to monitor several recent developments, including: the ongoing implications of the 2006 reauthorization of the Ryan White Program, which, while still being played out at the state level, offers both new opportunities and challenges for ADAPs; the continuing implementation of Medicare Part D; and state fiscal environments, given recent signals of a renewed state-level economic downturn, which could affect the amount of state resources, a key component of the ADAP budget, available to ADAPs.

References

- 1 All data in this fact sheet are from the *National ADAP Monitoring Project Annual Report*, April 2008.
- 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 Five percent of the ADAP earmark is set-aside for the ADAP Supplemental Drug Treatment Grant.
- 7 Palau was eligible to receive funding in FY 2007 but did not report any HIV/AIDS cases and therefore did not receive a funding award.
- 8 Not including the ADAP Supplemental Drug Treatment Grant set-aside.
- 9 ADAPs are required to add a new drug in a new class 90 days after it has been incorporated into the Department of Health and Human Services "Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents", which itself occurs sometime after FDA-approval.
- 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 (#1584-09) 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 April 2008 National ADAP Monitoring Project report (#7746). The full report can be accessed at www.kff.org and www.NASTAD.org.