National ADAP Monitoring Project
Annual Report

MARCH 2006

NASTAD™
NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS

THE HENRY J. KAISER FAMILY FOUNDATION

Acknowledgements

The Henry J. Kaiser Family Foundation (KFF) and The National Alliance of State and Territorial AIDS Directors (NASTAD) would like to thank the state ADAP and AIDS program managers and staff for their time and effort in completing the National ADAP Survey which serves as the foundation for this report, and for providing ongoing updates to inform the National ADAP Monitoring Project. The authors would also like to thank Ardine Hockaday of the Kaiser Family Foundation for graphic design and layout and Lanny Cross for expert consultation.

The National ADAP Monitoring Project is one component of NASTAD's National ADAP Monitoring and Technical Assistance Program which provides ongoing technical assistance to all state and territorial ADAPs. The program also serves as a resource center, providing timely information on the status of ADAPs, particularly those experiencing resource constraints or other challenges, to national coalitions and organizations, policy makers, and state and federal government agencies. NASTAD also receives support for the National ADAP Monitoring and Technical Assistance Program from the following companies: Boehringer Ingelheim Pharmaceuticals, Gilead Sciences, GlaxoSmithKline, Pfizer, Roche, and Tibotec Therapeutics. NASTAD also has a Training and Technical Assistance Cooperative Agreement with the Health Resources and Services Administration (HRSA), to provide technical assistance to ADAPs.

National ADAP Monitoring Project
Annual Report

MARCH 2006

Prepared by

JENNIFER KATES
The Henry J. Kaiser Family Foundation

MURRAY PENNER
National Alliance of State and Territorial AIDS Directors

BETH CRUTSINGER-PERRY
National Alliance of State and Territorial AIDS Directors

ALICIA L. CARBAUGH
The Henry J. Kaiser Family Foundation

NATANE SINGLETON
National Alliance of State and Territorial AIDS Directors

NASTAD™
NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS

THE HENRY J. KAISER FAMILY FOUNDATION

TABLE OF CONTENTS

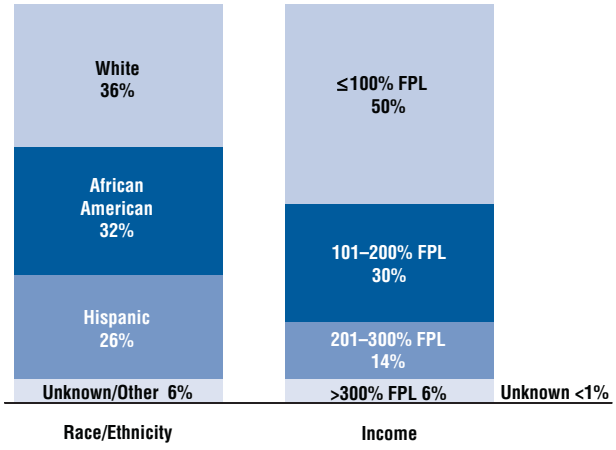
Appendices

Summary & Highlights

The National ADAP Monitoring Project Annual Report is based on a comprehensive survey of all state and territorial AIDS Drug Assistance Programs (ADAPs). The ADAP Monitoring Project is a more than 10-year effort of the National Alliance of State and Territorial AIDS Directors (NASTAD) and the Kaiser Family Foundation. It documents new developments and challenges facing ADAPs each year, assesses key trends over time, and provides the latest available data on the status of these programs. The current report is being released on the cusp of two significant markers in the HIV/AIDS epidemic—the 25th year of the first case of AIDS in the United States and the 10th year since the advent of highly active antiretroviral therapy (HAART). Data in this report are primarily from FY 2005 and June 2005; more recent data are provided in select areas. Key highlights are as follows:

- ADAPs are the **nation's prescription drug safety-net for people with HIV/AIDS, serving primarily low-income, uninsured, people of color who have limited or no access to needed medications**. ADAPs act as the payer of last resort, the "net" which catches people as they fall through the cracks in the larger U.S. health care system. With more than 134,000 enrollees, and 96,404 clients served in June 2005 alone, ADAP reaches approximately one-quarter of all people with HIV/AIDS in care. Almost two-thirds of clients are people of color, half have incomes at or below 100% of the Federal Poverty Level (FPL was $9,570 for a family of one in 2005), and almost three quarters are uninsured.

Profile of ADAP Clients, June 2005



Notes: American Samoa, the Marshall Islands, New Mexico, and Rhode Island not included in race/ethnicity and income data; in addition, the District of Columbia, Idaho, Louisiana, the Northern Mariana Islands, and Puerto Rico were not included in income data. The Federal Poverty Level (FPL) was $9,570 for a single person in 2005. Percentages may not total 100% due to rounding.

ADAP SNAPSHOT

- Number of ADAPs: 57
- Total ADAP Budget, FY 2005: $1.3 billion
- Federal ADAP Earmark, FY 2005: $765 million
- Clients Served, June 2005: 96,404
- ADAP Drug Spending, June 2005: $102.6 million

- However, the capacity of the ADAP safety-net varies significantly by state and, ultimately, **what one gets depends on where one lives**. ADAP income eligibility ranges from a low of 100% FPL in one state to greater than 500% FPL in four. Formulary coverage also varies from just a few medications in some states, including one that does not cover any protease inhibitors, to open formularies in other states.
- The **need for HIV-related medications continues to outstrip their availability**, as evidenced by ADAP waiting lists and other cost containment measures including limited formularies and restrictive income eligibility criteria. As of February 2006, nine states had waiting lists in place, representing close to 800 people and several others had limited access in other ways. The "fixes" introduced thus far, while alleviating unmet need for some, have generally been time-limited; focused on one-time snapshots of the problem; and/or emergency measures undertaken by select states (e.g., The President's ADAP Initiative; supplemental state general revenue support). This is symptomatic of the fact that ADAPs are discretionary grant programs, not entitlements, and therefore dependent on annual federal appropriations and funding from states and other sources where available.
- Consequently, as currently configured with budget limitations, **ADAPs will continue to have to make difficult trade-off decisions between serving more people with less services or serving less people with more services**.
- **Waiting lists and other cost containment measures, may, therefore, be semi-permanent features of ADAPs**, amidst a growing population of people with HIV/AIDS in need of medications and rising drug costs. Indeed, waiting lists have been documented throughout the course of the National ADAP Monitoring Project

and have been present in some states for months if not years. Nationally, at least several hundred people with HIV/AIDS are waiting to obtain medications from ADAPs at any given point in time.

- **ADAPs are spending virtually all of their budgets on direct client services—medications and insurance coverage.** The national ADAP budget from all sources reached $1.3 billion in FY 2005, almost all of which supported direct client services. ADAPs have diversified their funding base to meet increasing client need over time, as key components of the budget have slowed in growth (e.g., the Title II earmark) or decreased/fluctuated over time (e.g., contributions from the Title II base). Twelve states experienced an overall decrease in their budgets while 43 had increases. ADAPs are increasingly relying on state general revenue support (39 states provided such support in FY 2005) and manufacturers' drug rebates (39 states). Once the smallest component of the national ADAP budget, drug rebates now represent the third largest share and, for the first time, were the largest driver of budget growth over the last fiscal period.

- **Drug rebates, however, require careful consideration as a major funding source for ADAPs**. Drug rebates fluctuate regularly and are not necessarily stable or predictable. Although never intended to fund these programs, some rebates are mandated by law and others are voluntary on the part of drug manufacturers. States must actively track and pursue rebates to receive them. Despite these factors, drug rebates represent an important example of collaboration with industry, in ways that have expanded access to medications over time.

- Two recent events—**Hurricane Katrina** and **Medicare Part D** implementation—provide critical insight into the role of ADAPs and offer lessons, and questions, for the future:

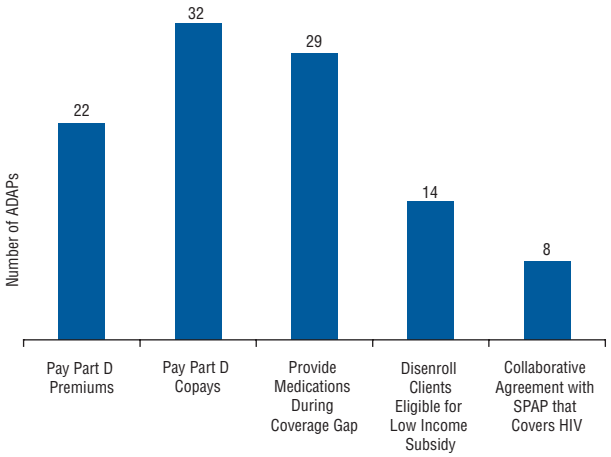
  – Hurricane Katrina threw into stark relief many of the structural challenges faced by all ADAPs but also their ability to serve as a life-line to those in need. An estimated 21,000 people with HIV/AIDS lived in the Hurricane affected counties prior to Katrina, many of whom evacuated. While those states most directly affected—Louisiana, Mississippi, and Texas—quickly jumped into action by reaching out to evacuees with HIV, they also faced such challenges as: how to account for varying eligibility criteria and formularies across states as displaced individuals relocated; the difficulty in transferring funds to follow people; and questions about the relative responsibilities of the federal and state governments in meeting client needs when they cross state lines.

  – Implementation of the new Medicare Part D drug benefit has also required quick action by ADAPs on a state-by-state basis in response to a new and evolving policy framework that is both complex and untested. For the estimated 17,000 ADAP enrollees who are also Medicare beneficiaries, most states have developed policies to coordinate with the new benefit and help transition clients between programs. How the new benefit unfolds over time for ADAPs and their clients, however, remains to be seen, and, as with other aspects of the AIDS Drug Assistance Program, will likely vary significantly by state. Key questions include:

    - How will clients fare in states where ADAPs are not able to pay for Part D co-pays or premiums, or to provide them with medications when they find themselves in the Part D coverage gap (the so called "doughnut hole") before they reach the new benefit's catastrophic coverage level?

    - What are the financial implications for ADAPs that do cover Part D drug co-pays and premiums and other expenses given that these, by law, cannot count towards Part D True Out of Pocket Costs (TrOOP)? Will Part D ease or exacerbate the budget pressure for some ADAPs?

ADAP Policies Related to Medicare Part D, as of November 2005



- Finally, what does all this mean for the current policy context? The Administration and Congress are actively considering the **third Reauthorization of the Ryan White CARE Act**, with a heavy focus on ADAPs. The Administration has released principles for Reauthorization and the President called for swift reauthorization in his State of the Union address; his FY 2007 budget request to Congress emphasized the need to eliminate ADAP waiting lists. A Congressional bill to reauthorize the CARE Act has already been introduced and others are in development.

The National ADAP Monitoring Report offers critical and timely data to this discussion, underscoring the increasingly important role played by ADAPs in serving people with HIV/AIDS throughout the U.S. as well as the many challenges these programs face. In particular, the report sheds important light on who ADAP clients are; the relationship between ADAP client utilization, drug spending, and funding; current capacity limitations; and key elements of program and access variation across the country.

Hurricane Katrina

Hurricane Katrina hit the Gulf Coast on August 29, 2005. More than 21,000 people with HIV/AIDS were estimated to be living in the disaster-affected counties of Alabama, Louisiana and Mississippi prior to Hurricane Katrina, and many were undoubtedly among those forced to take refuge elsewhere. As of the end of September 2005, ADAP and other CARE Act grantees in 27 States and the District of Columbia had already reported treating more than 1,500 evacuees with HIV/AIDS. NASTAD estimates that more than 420 Louisiana ADAP clients alone sought assistance in other states, primarily Texas, as a result of their evacuation.

Hurricane Katrina threw into stark relief many of the challenges already faced by ADAPs and their clients, particularly concerning differential access across the country and the lack of transferability of federal ADAP funding, provided via formula, across state lines. As such, it offers important lessons for Ryan White CARE Act Reauthorization. The disaster also demonstrated how ADAPs can quickly and innovatively adapt to emergency and changing circumstances to serve people with HIV in need.

Soon after the Hurricane hit, ADAPs in affected states quickly responded to identify displaced individuals with HIV/AIDS and facilitate their access to medications. The Louisiana ADAP staff, themselves forced to evacuate to Baton Rouge and beyond, immediately organized to try to locate their clients throughout the state and elsewhere. The Texas ADAP prepared to serve evacuees from New Orleans and other affected areas, and without guiding legislation, policies, or funding guarantees in place, decided to accept any evacuee with HIV into its ADAP. To facilitate this process, the Texas ADAP created a streamlined one-page application form and enrollment process. Nearly all ADAPs followed suit, rushing to accept evacuees into their programs despite program variations and even capacity challenges across states—for example, Alabama's ADAP had a large waiting list in place but accepted HIV positive evacuees from other states to avoid any potential interruption in their antiretroviral therapy.

HRSA worked with ADAPs to the extent possible within the constraints of the Ryan White CARE Act legislation, which does not allow for the transfer of federal funds across states to follow those who evacuated. Instead, states were encouraged by HRSA to waive their normal eligibility process and requirements for Ryan White CARE Act services as permissible under current state policy, even if client medical records were missing. To date, no supplemental federal funding has been provided to ADAPs serving evacuees with HIV, but HRSA has asked states to track the number of patients treated, their home location, services provided, and associated costs as the agency continues to work with the Department of Health and Human Services to assess additional funding options.

Finally, some pharmaceutical companies that manufacture antiretroviral medications agreed to partner with ADAPs on an emergency basis and provide in-kind replacement of medications dispensed to evacuees for the first 30–90 days following the disaster (the value of these contributions is estimated to be $150,000–$200,000). ◗

Sources:

KFF, *Fact Sheet: Assessing the Number of People with HIV/AIDS in Areas Affected by Hurricane Katrina*, September 2005; HRSA, Hurricane Relief and Recovery, Update October 3, 2005. Available at: www.hrsa.gov/katrina/updatehrsa1003.htm; KFF, *Report on The Experience of Hurricane Evacuees*, forthcoming 2006; KFF, *From the States: Beth Scalco, Louisiana AIDS Director.* Interview by Jackie Judd, 9/22/2005: www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=1522; Texas HIV Medication Program (THMP), News & Updates: www.tdh.state.tx.us/hivstd/meds/NEWS.htm.=

INTRODUCTION

This report of the National ADAP Monitoring Project, a more than ten-year initiative of the Kaiser Family Foundation and the National Alliance of State and Territorial AIDS Directors (NASTAD), provides the latest data on ADAPs across the country. It is based on a comprehensive survey of all 57 ADAPs; 53 responded (see Methodology). In addition to the main survey, supplemental data collection was conducted to provide more recent data in select areas. All data are from FY 2005 and June 2005, unless otherwise noted. Detailed findings are provided below, followed by accompanying charts and appendices. State-level data are provided in the appendices and on the Kaiser Family Foundation's State Health Facts website: www.statehealthfacts.org/hiv.

BACKGROUND AND OVERVIEW OF ADAPS

The AIDS Drug Assistance Program (ADAP) of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act[1] has become a critical source of prescription drugs for low-income people with HIV/AIDS in the United States who have limited or no prescription drug coverage. Reaching about one quarter of people with HIV/AIDS estimated to be receiving care nationally,[2] ADAPs provided medications to more than 96,000 clients and insurance coverage to thousands more in the month of June 2005 alone. ADAPs operate in 57 jurisdictions, including all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, three U.S. Pacific Territories (American Samoa, Guam and the Commonwealth of the Northern Mariana Islands) and one Associated Jurisdiction (the Republic of the Marshall Islands). In addition to helping to fill gaps in prescription drug coverage, ADAPs serve as a bridge between a broader array of healthcare and supportive services funded by Ryan White, Medicaid, Medicare, and private insurance. As the number of people living with HIV/AIDS in the U.S. has increased, largely due to advances in HIV treatment, and drug prices have continued to rise, the importance of ADAPs has grown over time. Today, there are more than one million people estimated to be living with HIV/AIDS in the United States.[3]

As stated in the Ryan White CARE Act, the purpose of ADAPs is to:

> …provide therapeutics to treat HIV disease or prevent the serious deterioration of health arising from HIV disease in eligible individuals, including measures for the prevention and treatment of opportunistic infections.[4]

ADAPs meet this purpose through two main activities: by providing FDA-approved HIV-related prescription drugs to people with HIV/AIDS and by paying for health insurance that includes HIV treatments. Eligible individuals are low-income individuals with HIV/AIDS who have limited or no prescription drug coverage. ADAPs began serving clients in 1987, when Congress first appropriated funds ($30 million over two years[5]) to help states purchase AZT, the only FDA-approved antiretroviral drug at that time. In 1990, these federally-funded, state administered "AZT Assistance Programs" were incorporated into the newly created Ryan White CARE Act under Title II (grants to states) and became known as "AIDS Drug Assistance Programs." The CARE Act has become the nation's third largest source of federal funding for HIV/AIDS care, after Medicaid and Medicare.[6]

Key Dates in the History of ADAPs

1987: First antiretroviral, (AZT an NRTI), approved by the FDA; Federal government provides grants to states to help them purchase AZT, marking beginning of federally-funded, state administered "AZT Assistance Programs."

1990: ADAPs incorporated into Title II of the newly created Ryan White CARE Act.

1995: First Reauthorization of CARE Act; first protease inhibitor approved by FDA, and the highly active antiretroviral therapy (HAART) era begins.

1996: Federal ADAP earmark created; first non-nucleoside reverse transcriptase inhibitor (NNRTI) approved by FDA.

2000: Second Reauthorization of CARE Act, changes for ADAPs include: allowance of insurance purchasing and maintenance, flexibility to provide other limited services (e.g., adherence support and outreach), and creation of ADAP supplemental grants.

2003: NASTAD's ADAP Crisis Task Force formed to negotiate with pharmaceutical companies on pricing of antiretroviral medications; first fusion inhibitor approved by FDA.

2004: President's ADAP Initiative (PAI) announced, allocating $20 million in one-time funding outside of the ADAP system to reduce ADAP waiting lists in ten states.

2005: CARE Act expired on September 30. CARE Act programs continue operating under current law while Congress considers the third Reauthorization. ◗

Since FY 1996, Congress has specifically earmarked funding for ADAPs within Title II of the CARE Act, which is allocated by formula to states.[7,8] The ADAP earmark has become the largest component of the overall ADAP budget. ADAPs may also receive funding from other sources, including state general revenue support,[9] funding from other parts of the CARE Act, and manufacturers' drug rebates, but these funding sources are highly variable and largely dependent on state and local policy decisions, differing ADAP program management strategies, and resource availability. The Health Resources and Services Administration (HRSA) of the Department of Health and Human Services is the federal agency that administers the CARE Act. Each state operates its own ADAP, and is given broad authority by the CARE Act to design its program, including determining client eligibility criteria, formularies, and other key program elements. Other than the broad stipulation above about the purpose of ADAPs, no minimum formulary is required under current law. Additionally, there is no client income eligibility level required, although clients must be HIV-positive, low-income, and under- or uninsured.

Allocation of Federal Funding to ADAPs & State Match Requirements

Each year, Congress specifically earmarks federal funding for ADAPs within the Ryan White CARE Act. The formula used to allocate federal earmark funding to states is based on their proportion of the nation's estimated living AIDS cases. Estimated living AIDS cases are determined by the Centers for Disease Control and Prevention (CDC) and provided to the Health Resources and Services Administration (HRSA). To determine estimated living AIDS cases, CDC applies annual survival weights to the most recent 10 years of reported AIDS cases.* A jurisdiction's proportion of estimated living AIDS cases is applied to the earmark to determine the award amount. In FY 2005, 57 jurisdictions received federal ADAP earmark funding.

States with one percent or more of reported AIDS cases during the most recent two-year period must match (with non-federal contributions) their Ryan White Title II award, which includes the ADAP earmark, according to an escalated matching rate (based on the number of years in which the state has met the one percent threshold). States are not required, however, to use all or even part of the state match for ADAP and the match may consist of in-kind or dollar contributions from the state.

The CARE Act Amendments of 2000 included a new Supplemental Treatment Drug Grant Program, which awards grants to states with "severe need." Three percent of federal ADAP earmark funding appropriated by Congress is set aside for ADAP supplemental awards. Award amounts are based on an eligible jurisdiction's proportion of estimated living AIDS cases among those states eligible for and applying to receive a supplemental grant. This proportion is applied to the number of dollars available under the supplemental grant to determine the award amount.

While a three percent set aside of the ADAP earmark is the basis for ADAP supplemental grants, the "hold harmless" clause in the ADAP supplemental grant legislation may require that adjustments be made in ADAP earmark awards so that each overall state Title II award is at least equal to the previous year. If this is required, those funds are taken from the three percent set aside for the ADAP supplemental before awards are made to states. In most recent years, the total ADAP supplemental amount distributed has been less than three percent due to this provision within the ADAP supplemental grant legislation.

States applying for supplemental grants must provide matching dollars in an amount equal to $1 for each $4 of federal funds provided in the grant, and the match must be put toward ADAP (in-kind contributions from the state such as office space, personnel, and other relevant expenses are allowable contributions to meet this required match). To be eligible for supplemental awards, states must have met one of the following criteria as of January 1, 2000:

- Financial eligibility at or below 200% of the Federal Poverty Level (FPL);
- Medical eligibility criteria in place (e.g., specific CD4 T-cell count or viral load);
- Limited formulary compositions for antiretrovirals; and/or
- Less than 10 medications on formulary to treat opportunistic infections.

In FY 2005, of the 27 ADAPs eligible for Supplemental Award funding, 20 applied; the other eligible jurisdictions did not apply either because they could not meet the state match requirement or did not require supplemental funding.

It is important to note that the ADAP fiscal year differs from the federal and state fiscal year periods. The ADAP fiscal year begins on April 1 and ends on March 31; the federal fiscal year begins on October 1 and ends on September 30; for most states, the state fiscal year begins on July 1 and ends on June 30. For example, the ADAP FY 2005 began on April 1, 2005 and will end on March 31, 2006. The Federal FY 2006 began on October 1, 2005 and will end on September 30, 2006. The State FY 2006, in most states, began July 1, 2005 and will end on June 30, 2006. ◗

*CDC, "AIDS cases by state and metropolitan area, provided for the Ryan White CARE Act", *HIV/AIDS Surveillance Supplemental Report* 2005. 11(No. 1). Available at: www.cdc.gov/hiv/STATS/HASRSuppVol11No1.pdf.

Like all Ryan White CARE Act programs, ADAPs serve as "payer of last resort;" that is, they provide prescription medications to, or pay for health insurance for, people with HIV/AIDS when no other funding source is available to do so. Demand for ADAPs depends on the size of the prescription drug "gap" that ADAPs must fill in their jurisdiction—larger gaps, such as in states that have less generous Medicaid programs, may strain ADAP resources further. But ADAPs are discretionary grant programs, not entitlements,[10] and their funding may not correspond to the number of people who need prescription drugs or to the costs of medications. Therefore, annual federal appropriations, and where provided, state funding and contributions from other sources, determine how many clients ADAPs can serve and the level of services they can provide. For the last several years, ADAPs have been the only part of the CARE Act to receive federal budget increases and these increases have helped ADAPs serve more clients.[6,11] Nonetheless, given that ADAPs are an integral component of the larger Ryan White system, it is unclear how level funding in other areas of the CARE Act may affect client access to ADAPs.

DETAILED FINDINGS

CLIENTS, DRUG EXPENDITURES, AND PRESCRIPTIONS

ADAP Clients

- In June 2005, 134,128 clients were enrolled in ADAPs nationwide, a slight increase over last year's enrollment (see Chart 2 and Appendix 1). More clients are typically enrolled in ADAPs than seek services in a given month, reflecting changing clinical needs, different prescription lengths, and fluctuation in the availability of other resources to pay for medications, with some individuals cycling on and off ADAP throughout a year. In June 2005, 72% of those enrolled received ADAP services.
- ADAPs provided medications to 96,404 clients across the country in June 2005, a three percent increase over the prior period (see Chart 3).
  - While most states experienced increases in clients served (33 ADAPs) between June 2004 and June 2005, 15 had decreases (see Appendix I).
  - In addition to providing medications, ADAPs also paid for insurance coverage (premiums, co-pays, and/or deductibles) for 12,311 clients (some of whom may have also received medications) (see Appendix XV).
- ADAP clients are predominantly low-income and uninsured. Most are people of color, and male, and many have indicators of advanced HIV disease (see Charts 5–9 and Appendices IV–VII). In June 2005:
  - African Americans and Hispanics represented 58% (32% and 26%, respectively) of clients. Asian/Pacific Islanders, and Alaskan Native/American Indians combined represented approximately two percent of the total ADAP population. White non-Hispanics comprised 36% of ADAP clients.
  - More than three-quarters (79%) of ADAP clients were men and the majority (54%) were between the ages of 25 and 44.
  - Eight in ten (80%) were at or below 200% of the Federal Poverty Level (FPL), including half (50%) at or below 100% FPL. In 2005, the FPL was $9,570 (slightly higher in Alaska and Hawaii) for a family of one.
  - A majority of ADAP clients (73%) were uninsured, with few reporting any other source of insurance coverage—18% private, 13% Medicare, and/or 10% Medicaid; three percent were dual beneficiaries of both Medicaid and Medicare.
  - Half of ADAP clients (49%) had CD4 counts of 350 or below at time of enrollment, an indication of advanced HIV disease.

ADAP Drug Expenditures and Prescriptions

- ADAP drug expenditures were $102,595,753 in June 2005, a six percent increase over the prior period (see Chart 10).
  - If annualized, this represents approximately $1.2 billion, or most (95%) of the FY 2005 national ADAP budget. When funds used by ADAPs for insurance purchasing/maintenance are included ($75.4 million in FY 2005) and all cost recovery accounted for, estimated annual ADAP spending for direct client services (medications and insurance coverage) would total almost the entire ADAP budget from all sources.
  - Thirty-two ADAPs had increases in their monthly drug expenditures; 17 had decreases (see Appendix I).
- ADAPs filled a total of 376,511 prescriptions in June 2005 (see Chart 13 and Appendix III). This represented a less than one percent increase over the prior period.
- Per capita drug expenditures were $1,064 in June 2005, an increase of four percent over last year ($1,024 in June 2004) (see Chart 12). This represents an estimated $12,768 in annual drug costs per client. Per capita expenditures in June 2005 ranged from a low of $240 in Ohio to $1,930 in Maine (see Chart 1).

- Most ADAP drug spending is for FDA-approved antiretrovirals[12] (89% in June 2005). While this is in part due to their high utilization, it is also related to their costs, as they represent a greater share of expenditures than prescriptions filled (63%). The 29 "A1" drugs highly recommended for the prevention and treatment of HIV-related opportunistic infections[13,14] accounted for three percent of expenditures and nine percent of prescriptions (see Chart 13 and Appendices II and III).
- The average expenditure per prescription was $272. It was significantly higher for ARVs ($382) than non-ARVs ($85). Among ARV drug classes, fusion inhibitors represented the highest expenditure per prescription ($1,412), followed by protease inhibitors ($430), nucleoside reverse transcriptase inhibitors ($372) and non-nucleoside reverse transcriptase inhibitors ($303). "A1" OI drugs were $84 per prescription filled in June 2005 (see Chart 14).

Trends in Client Utilization and Drug Expenditures

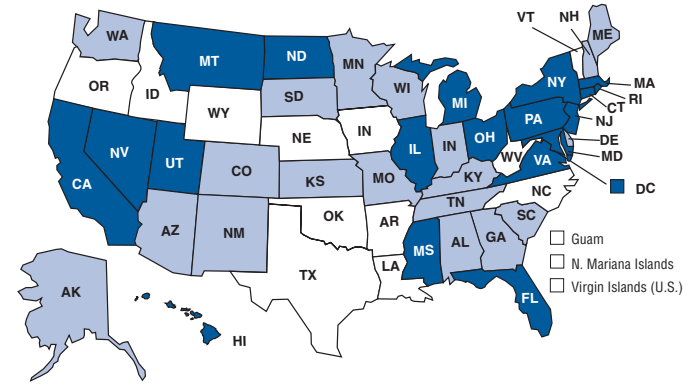
- Client utilization has grown significantly since 1996 (202% among the 47 ADAPs reporting data in both periods), but growth has slowed considerably in recent years and has never been as high as the rate of increase in drug expenditures. Between 2004 and 2005, client utilization increased by three percent (see Chart 4).
- Drug spending by ADAPs has increased more than six-fold (508%) since 1996, more than twice the rate of client growth (in the same 47 states reporting data on clients). It too has continued to increase but at slower rates; between June 2004 and June 2005, drug spending grew by six percent (see Chart 11).

ELIGIBILITY CRITERIA AND FORMULARIES

ADAP Eligibility Criteria

- All ADAPs require that individuals document their HIV status. Four reported additional clinical eligibility criteria (e.g., specific CD4 or viral load ranges), one more state than last year (see Chart 1).
- ADAP income eligibility ranges from a low of 100% FPL in the Northern Mariana Islands to 500% FPL or more in four states: Maryland, Massachusetts, New Jersey, and Ohio. Overall, 20 states set income eligibility at greater than 300% FPL; 19 are between 201% and 300% FPL; and 15 are at or below 200% FPL (see Chart 15).

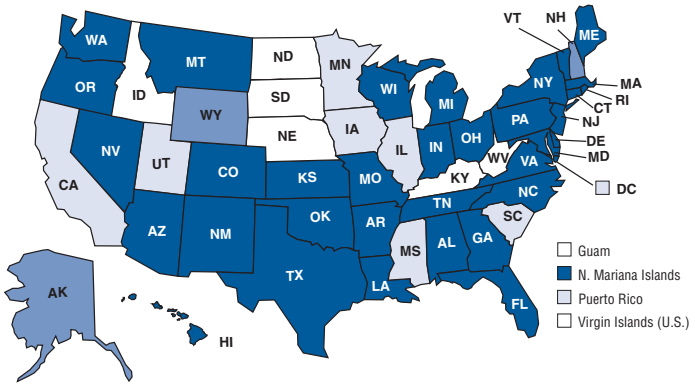
ADAP Income Eligibility by State, as of September 2005



Income eligibility greater than 300% FPL (20 ADAPs)
Income eligibility between 201% FPL and 300% FPL (19 ADAPs)
Income eligibility at 200% FPL or below (15 ADAPs)

Notes: The 2005 Federal Poverty Level (FPL) was $9,570 (slightly higher in Alaska and Hawaii) for a household of one. 54 ADAPs reported income eligibility criteria. American Samoa, the Marshall Islands, and Puerto Rico are not included.

ADAP Formulary Coverage of Approved Antiretroviral Drugs by State, as of September 2005



Covers all approved ARVs in all four drug classes, NRTIs, NNRTIs, PIs, and Fusion Inhibitor (35 ADAPs)
Covers all approved NRTIs, NNRTIs, PIs, but not approved Fusion Inhibitor (3 ADAPs)
Covers approved Fusion Inhibitor but not all approved NRTIs, NNRTIs, and PIs (9 ADAPs)
Does not cover approved Fusion Inhibitor or all approved drugs in other classes (8 ADAPs)

Notes: 55 ADAPs reported formulary data for ARV drugs. American Samoa and the Marshall Islands are not included.

ADAP Formularies

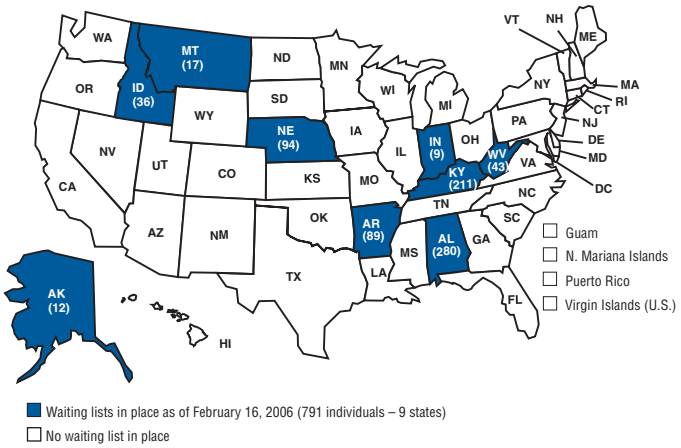
- ADAP formularies vary significantly across the country, ranging from 19 drugs covered in Guam to nearly 500 in New York and open formularies[15] in four jurisdictions—Massachusetts, New Hampshire,[16] New Jersey, and the Northern Mariana Islands (see Chart 1).
- While the majority of ADAPs (35) cover all 25 FDA-approved antiretrovirals on their formularies, 20 ADAPs do not, including one that does not provide any protease inhibitors (South Dakota). Forty-four ADAPs cover Fuzeon, the only approved fusion inhibitor for people with HIV/AIDS (see Charts 1, 16).
- Coverage of medications to prevent and treat opportunistic infections and other HIV-related conditions is also highly variable across the country (see Charts 1, 17):
  - Thirty-three ADAPs cover more than 15 of the 29 drugs highly recommended ("A1") for the prevention and treatment of opportunistic infections, including three that cover all 29 (Massachusetts, New Jersey, and the Northern Mariana Islands). Twenty-two ADAPs cover 15 or fewer of these medications, including one that does not include any medications for OIs or other HIV-related conditions on its formulary, and only covers antiretrovirals (Louisiana). It is important to note that ADAPs may cover slightly fewer than the full set of highly recommended OI medications because they cover equivalent medications, also highly recommended, on their formularies or have other state-level programs that can provide these medications.
  - Twenty-six ADAPs cover treatments for hepatitis C (HCV), a major co-morbidity for people with HIV, that is also considered to be an opportunistic infection[14,17] (see Chart 18).
  - Twenty-four ADAPs cover Hepatitis A and B vaccines, which are recommended for those at high risk for HIV and living with HIV[18] (see Chart 18).

WAITING LISTS AND OTHER COST CONTAINMENT MEASURES

Waiting Lists

- In February 2006, nine ADAPs had waiting lists in place, totaling 791 people. Waiting lists have been in place in some states for several months, if not years, and the size of waiting lists within and across states has fluctuated significantly over time (see Charts 19–21). Based on bi-monthly surveys conducted between July 2002 and February 2006 (26 surveys overall) (see Appendix VIII):

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



Notes: 55 ADAPs reported waiting list data. American Samoa and the Marshall Islands are not included.

  - Eighteen states reported having a waiting list in place at some point over the period, including one (Alabama) that had a waiting list throughout.
  - The fewest number of states reporting a waiting list in any given period was six; the most was 11.
  - Twelve ADAPs had waiting lists in 10 or more of the survey periods.
  - The number of people on waiting lists ranged from a low of 435 to a high of 1,629 (the average was 804). The highest number of individuals on any one state's waiting list was 891 (North Carolina); the lowest was one (Alaska, Idaho, Montana, and West Virginia). North Carolina also had the highest average number of people on its waiting list over the period (337), followed by Alabama (200). The lowest average was four in Guam and in Wyoming, respectively.

President's ADAP Initiative

- The President's ADAP Initiative (PAI), announced June 2004, provided $20 million in one-time funds targeted to individuals on ADAP waiting lists in ten states (AK, AL, CO, ID, IA, KY, MT, NC, SD, and WV). Clients were first enrolled in October 2004, and the number of clients receiving medications through the PAI increased significantly through July 2005, when it reached its maximum of 1,487. It has since declined as states were required to transition PAI clients into their "traditional" ADAPs by the end of December 2005. Still, as of February 2006, four clients remained on the PAI who could not be absorbed into their state's ADAP

ADAP WAITING LISTS

Since the beginning of the AIDS Drug Assistance Program, many ADAPs have had to make difficult trade-off decisions between client access and services. In some cases, states have capped program enrollment until more resources become available. When enrollment is capped, the next individual eligible for ADAP who seeks services cannot get them through the ADAP. States that have enrollment caps have often turned to waiting lists in order to facilitate client access when the program can accommodate them. In February 2006, nine ADAPs had waiting lists, with a total of 791 individuals.

When an individual is on a waiting list, they may not have access to HIV-related medications. Or, they may have access through other mechanisms, but these are often unstable. Some individuals on waiting lists can get medications through other state pharmacy assistance programs, if their state has these programs, or through pharmaceutical manufacturer patient assistance programs (PAPs). PAPs, however, require people to apply often, sometimes as frequently as every month, and separate applications must be sent to the manufacturer of each medication needed. For someone on a multiple drug regimen, this process can be quite cumbersome and may not provide the full range of drugs necessary for optimal clinical outcomes.

To date, no state has eliminated current clients from its ADAP when faced with the need to implement a waiting list for new applicants. Nevertheless, states with waiting lists are faced with many challenges, such as: how to monitor those on waiting lists; how to help those on waiting lists access prescription drugs through other programs, if available; whether criteria should be developed to bring people off waiting lists into services or whether new clients should be accommodated on a first come, first serve basis; and what kinds of future decisions could be made to reduce or eliminate the need for waiting lists, while least compromising access for all clients?

In recognition of the challenges waiting lists pose to ADAPs, in June 2004, President Bush announced the one-time availability of $20 million for HIV-related drug therapies, targeted at 10 states with waiting lists at that time (see box on "President's ADAP Initiative"). This Initiative has served to alleviate the size of waiting lists in some states while in effect.

It is important to note that waiting lists are but one measure of unmet need for ADAP services. Some people who need ADAP services may not be counted on a waiting list. And, the level of services provided by ADAPs and the number of clients they serve vary across the country, so those receiving ADAP services in a state with a limited formulary may have unmet needs compared to others receiving services in a state with a more expansive formulary. ◗

ADAP COST CONTAINMENT MEASURES AND OTHER STRATEGIES FOR MANAGING COSTS

State ADAPs use a variety of strategies to contain costs. Some of these strategies may affect client access and services, whereas others may lead to a more efficient use of funding enabling ADAPs to serve more people. Occasionally states must implement cost containment measures (such as waiting lists) multiple times over the course of a year, depending on their fiscal situation and client demand. Cost containment measures used by ADAPs have included:

- Instituting waiting lists;
- Lowering financial eligibility criteria;
- Limiting and/or reducing ADAP formularies;
- Limiting access to one or more drugs, including instituting waiting lists for access to a particular drug;
- Instituting monthly or annual limits on per capita expenditures;
- Using drug purchasing strategies (discount programs, rebates, purchasing alliances and coalitions);
- Using ADAP dollars to pay for insurance coverage (premiums, co-payments, deductibles) instead of medications directly;
- Seeking cost recovery through drug rebates and third party billing; and
- Using non-ADAP Ryan White CARE Act and other funds (e.g., Title II Base, state funding) for ADAPs. ◗

PRESIDENT'S ADAP INITIATIVE (PAI)

On June 23, 2004, President Bush announced the one-time, immediate availability of $20 million to provide medications to individuals on ADAP waiting lists in 10 states with waiting lists as of June 21, 2004: Alabama, Alaska, Colorado, Idaho, Iowa, Kentucky, Montana, North Carolina, South Dakota, and West Virginia. Funding for 1,738 treatment slots (reflecting the number of individuals on waiting lists at that time) was made available through a reallocation of Department of Health and Human Services (DHHS) non-AIDS funding. It was provided to a pharmacy benefits manager (PBM) to directly serve individuals within the 10 states, rather than through the state-based ADAP system. Individuals were only allowed to obtain medications through the PAI that were included on their state's ADAP formulary as of June 21, 2004.

The Health Resources and Services Administration (HRSA), which coordinates the PAI, contracted with Bioscrip, Inc. (formerly Chronimed) to directly purchase and distribute medications to individuals on waiting lists in the 10 states. Eligible clients first began receiving medications in October 2004; by July 2005, the number of clients being served through the PAI reached its maximum of 1,487. The PAI initially expired on September 30, 2005; however, Bioscrip received a no-cost extension to continue serving PAI clients as long as funding remained available. Following a request by HRSA in September 2005, participating states began transitioning clients onto their ADAPs or into pharmaceutical patient assistance programs (PAPs) where available; by February 2006, only four individuals remained in the program. The PAI was scheduled to end in March 2006, as funding for the initiative was not renewed.

(see Chart 22 and Appendix IX). In addition, over the course of the Initiative, other states that were not originally eligible for the PAI have instituted waiting lists, and new individuals who were not eligible for the PAI have been added to ADAP waiting lists.

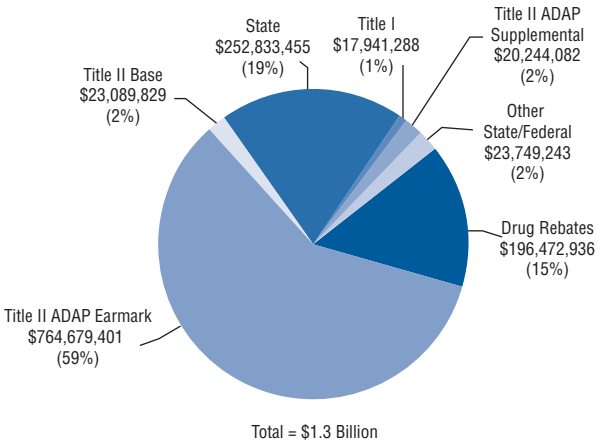
Other Cost Containment Measures

- In addition to waiting lists, some ADAPs have instituted other measures to contain costs (see Charts 23 and 24). As of February 2006, nine ADAPs had such measures in place including:
  - Four that had reduced the number of drugs on their formularies;
  - Three with waiting lists for Fuzeon, the only approved Fusion Inhibitor;
  - Two that further restricted eligibility to the program;
  - Two limiting annual per client expenditures;
  - One that has begun requiring clients to pay cost sharing (co-payments) in order to participate in the program;
  - One of these nine states also has a waiting list in place. Five of these states are in the U.S. South.
  - An additional nine ADAPs anticipate having to newly institute cost containment measures during ADAP FY 2006 (April 1, 2006–March 31, 2007).

ADAP BUDGET

- The national ADAP budget reached $1.3 billion in FY 2005, an increase of 10 percent over FY 2004. Since FY 1996, the budget has increased more than six-fold (see Charts 25, 29).
- The ADAP earmark represented the largest share of the ADAP budget (59%),[19] followed by state general revenue support (19%), and drug rebates (15%). Other sources of funding each represented two percent or less of the budget (see Chart 25).
- By definition, all eligible jurisdictions (57) receive federal ADAP earmark funding based on a formula, but not all ADAPs receive funding from other sources, which are often dependent on individual state and local planning, policy, and/or legislative decisions, as well as resource availability. In FY 2005, four ADAPs

National ADAP Budget, by Source, FY 2005



Notes: 53 ADAPs reported all National ADAP Budget data. National ADAP Budget includes FY 2005 federal Title II ADAP earmark and Title II ADAP supplemental only for American Samoa, the Marshall Islands, New Mexico, and Rhode Island.

received only ADAP earmark funding (see Chart 26). The breakdown of other sources of funding across the country was as follows (see Appendix X):

- – Title II ADAP Supplemental Treatment Grants: 20 ADAPs received funding, 37 did not;
- – Title II Base Funds: 19 ADAPs received funding, 34 did not;
- – Title I EMA Funds: 12 ADAPs received funding, 41 did not;
- – State General Revenue Support: 39 ADAPs received funding, 14 did not;
- – Other State/Federal Funds: 13 received funding, 40 did not;
- – Drug Rebates: 39 ADAPs received funding, 14 did not.

- Additionally, despite a 10 percent increase in the national ADAP budget across all ADAPs between FY 2004 and FY 2005, some ADAPs had decreases either in their overall budget or for specific funding streams (see Chart 27):
  - – Overall Budget: 43 ADAPs had increases or level funding, 12 had decreases;
  - – Title II ADAP Earmark: 54 ADAPs had increases; 3 had decreases;
  - – Title II ADAP Supplemental Treatment Grants: 3 ADAPs had increases; 17 had decreases;
  - – Title II Base Funds: 10 ADAPs had increases or level funding; 10 had decreases;
  - – Title I EMA Funds: 9 ADAPs had increases or level funding, 4 had decreases;
  - – State General Revenue Support: 32 ADAPs had increases or level funding, 12 had decreases;
  - – Drug Rebates: 31 ADAPs had increases or level funding, 12 had decreases.
- The composition of the budget has shifted significantly since the introduction of the federal ADAP earmark in FY 1996 (see Chart 28):
  - – The ADAP earmark has risen from one quarter (26%) of the budget in FY 1996, the year it began, to its current share of 59%.
  - – State general revenue support decreased from 25% in FY 1996 to 19% in FY 2005 as a share of the overall budget, but has increased significantly in amount and has been the second largest source of funding over the entire period. Such state support is, for the most part, dependent on individual state decisions and budgets.
  - – Drug rebates rose from six percent to 15% of the budget. The rise of drug rebates as a source of revenue is an important development that is in part due to the need for states to seek additional funding as client demand continues, and to the growing sophistication of states and the ADAP Crisis Task Force in working to obtain rebates. Some drug rebates are dependent on negotiations by individual states or state coalitions, most of which include the ADAP Crisis Task Force, and rebate increases are in part a function of rising drug prices (since rebates are based on a percentage of drug price).
  - – Title II base funding and funding from Title I EMAs each represent much smaller proportions of the budget today than they did in FY 1996, and were also the only two funding sources in the national ADAP budget that were less in FY 2005 than in FY 1996.
- Although the ADAP earmark continues to increase, its growth has slowed over time and it is no longer the largest driver of national ADAP budget growth. Rebates were the largest driver of budget growth between FY 2004 and FY 2005, as measured by dollar increase,

ADAP CRISIS TASK FORCE

The ADAP Crisis Task Force was formed by a group of state AIDS Directors and ADAP Coordinators in December 2002 to address resource constraints within ADAPs. NASTAD serves as the convening organization for the Task Force, which originally consisted of 10 representatives of the largest ADAP programs. Beginning in March 2003, the Task Force met with the eight companies that manufacture antiretroviral (ARV) drugs. The goal of the meetings was to obtain multi-year concessions on HIV/AIDS drug prices, to be provided to all ADAPs across the country. Agreements were reached with all eight manufacturers to provide supplemental rebates and discounts (in addition to mandated 340B rebates and discounts—see chart 25), price freezes, and free products to all ADAPs nationwide. The Task Force estimated savings of $65 million for ADAPs in 2003. During 2004, the Task Force expanded its negotiations to include companies that manufacture high-cost non-ARV drugs. Additional agreements were obtained during 2004 and 2005 and previous agreements were extended and/or enhanced. The Task Force estimated savings of approximately $90 million for ADAPs in 2004 and $145 million in 2005.

The Task Force also coordinates its efforts with the Fair Pricing Coalition (a coalition of organizations and individuals working with pharmaceutical companies regarding pricing of ARV drugs for all payers) and other community partners. Current members of the Task Force include representatives from ADAPs in California, Florida, Ohio, New Jersey, New York, North Carolina, Texas, and Utah. ◗

followed by state funding and then the earmark.

  - The ADAP earmark increased by $36.7 million, or five percent, over FY 2004 (see Chart 30).
  - State funding increased by $26.2 million, or 12%, over FY 2004 (see Chart 33).
  - Drug rebates increased by $50.3 million, or 34%, reaching their highest level to date (see Chart 34).
  - After declining for several years in a row, Title II base funds allocated by states to ADAPs rose slightly over FY 2004, to $23.1 million (see Chart 31).
  - Contributions from Title I jurisdictions have fluctuated over time, and decreased by $3.1 million between FY 2004 and 2005 (see Chart 32)

- State contributions to ADAPs ranged from 0%, in the 12 states that did not provide any state support, to 50% of the ADAP budget in one state; Title II base funding ranged from 0% to 40%; Title I funding ranged from 0% to 47%%; ADAP supplemental funding ranged from 0% to 9%; and drug rebates ranged from 0% to 39% (see Appendix X).

- Cost recovery, reimbursement from other entities for medications purchased through the ADAP (other than drug rebates), represented $26.9 million in FY 2005 (see Chart 35). [Note—this category is not included in the National ADAP Budget].

DRUG PURCHASING MODELS AND INSURANCE COVERAGE

Drug Purchasing Models

- The federal 340B program enables ADAPs to purchase drugs at or below the statutorily defined 340B ceiling price.[20] All but three ADAPs participate (see Chart 36 and Appendix XIV).

  - ADAPs may purchase drugs either directly from wholesalers or through retail pharmacy networks and then apply to drug manufacturers for rebates. As of June 2005, 30 ADAPs reported purchasing directly; 24 reported purchasing through a pharmacy network and then seeking rebates.
  - Direct purchase ADAPs can choose to participate in the HRSA Prime Vendor Program,[20] which was created to negotiate pharmaceutical pricing below the 340B price. Seven of the 30 ADAPs that purchase directly participate in the Prime Vendor Program. One antiretroviral is currently on the prime vendor list.
  - While the prime vendor is only available to ADAPs that purchase directly, the ADAP Crisis Task Force has worked with all ADAPs (direct purchasers and pharmacy network ADAPs) to achieve below 340B pricing for all antiretrovirals.

Insurance Purchasing/Maintenance Programs

- The Ryan White CARE Act allows states to use ADAP earmark dollars to purchase health insurance and pay insurance premiums, co-payments, and/or deductibles for individuals eligible for ADAP, provided the insurance has comparable formulary benefits to that of the ADAP.[21,22] States are increasingly using ADAP funds for this purpose. Most ADAPs (29, up from 26 last year) reported doing so in 2005, representing $75.4 million, or nearly double the amount spent in FY 2004. In June 2005, 12,311 ADAP clients were served by such arrangements, significantly higher than in June 2004 (see Charts 37–38 and Appendix XV).

- These strategies appear to be cost effective—in June 2005, spending on insurance represented an estimated $513 per capita, about half of per capita drug expenditures in that month ($1,064). In addition to ADAPs, other CARE Act (Title I, Title II base) or state programs may also purchase and maintain insurance coverage for eligible individuals.

Coordination with 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 effective January 1, 2006. An estimated 17,000 ADAP enrollees are Medicare eligible (13% of ADAP clients in June 2005 were Medicare beneficiaries). A subset of these clients is dually eligible for Medicare and Medicaid (see Appendix VI).

- As the payer of last resort, ADAPs are required by HRSA to ensure that all Medicare Part D eligible clients enroll in a Medicare prescription drug plan (2006 enrollment is to be completed by May 15, 2006). ADAPs are permitted to coordinate with Medicare prescription drug plans and, in accordance with state policy, pay for drug plan premiums, deductibles, coinsurance, and co-payments.[23] However, the MMA prohibits ADAP funds (whether federal or state) from being applied toward a beneficiary's True Out of Pocket Costs (TrOOP). This means that ADAP enrollees must incur these costs themselves (costs incurred by a State Pharmacy Assistance Program on their behalf and co-pays waived by a pharmacy will count towards TrOOP) when in the coverage gap before they are eligible to receive catastrophic coverage under their Medicare drug plan.[24] To meet these federal requirements and maintain appropriate medication coverage for their clients, most ADAPs have developed policies to coordinate with the Part D benefit (see Chart 39 and Appendix XVI). As of November 2005:

- Thirty-two ADAPs report that they will pay Part D co-payments for their Part D eligible ADAP clients (these payments will not count toward TrOOP);
- Twenty-two will pay Part D premiums (these payments will not count toward TrOOP);
- Twenty-nine will pay for all medications on their ADAP formularies when their Part D clients reach the coverage gap or "doughnut hole" (these payments will not count toward TrOOP);
- Fourteen ADAPs will disenroll clients if determined to be eligible for the Low Income Subsidy (LIS) available under Medicare Part D (some states are requiring clients to apply for the LIS to see if they are eligible);
- Eight ADAPs have collaborative agreements with their State Pharmacy Assistance Programs (SPAPs) to provide ADAP Medicare eligible clients with medications.

CONCLUSION

This report documents the ongoing role of ADAPs in providing medications to low-income individuals living with HIV/AIDS in the United States. It also offers insight into the ways in which ADAPs adapt to policy and other changes over time, as well as the challenges they face. Looking forward, perhaps the most significant change that stands to affect ADAPs is the Reauthorization of the Ryan White CARE Act. Some of the critical questions concerning ADAPs in Reauthorization include:

- What is the best way to address waiting lists? Are time-limited and/or geographically targeted efforts enough to alleviate unmet need? Should such efforts be channeled through the existing ADAP structure or parallel to it, as the PAI has done? Should HRSA have the authority to use un-obligated CARE Act funds for ADAPs with waiting lists? Does a heavy focus on ADAP waiting lists run the risk of missing other ways in which access varies across the country, such as limited formularies and restrictive income eligibility criteria?
- Should funding from other parts of the CARE Act be "tapped" for ADAPs? What would that mean for the larger CARE Act-supported infrastructure and system? If ADAPs represent one "leg" in the Ryan White program chair, will shoring up the ADAP leg more so than others cause an imbalance that could affect the very clients who need to find their way to ADAP? Conversely, will trimming other legs of the chair (e.g., Title I, Title II) also affect clients' abilities to access ADAP? Or does bolstering access to medications through ADAP ultimately produce the largest benefit to clients?
- Should the ADAP Supplemental Treatment Grant Program (which channels three percent of ADAP earmark funding to areas with severe need and requires a state match to receive such funds) be changed or strengthened to meet the ongoing problem of ADAP waiting lists and other program limitations? Can this be done without harming programs that may not face the same fiscal challenges? Should states with severe need continue to be required to provide a state match to receive supplemental funding or does this hinder their ability to access these funds?
- Should a standard drug formulary be mandated, at least for FDA-approved antiretroviral therapy and highly recommended medications for the prevention and treatment of opportunistic infections? Would such a standard set a floor that would be difficult for some states to meet without limiting their programs in other ways? Could a standard be designed to enable ADAPs to quickly add newly approved treatments even if they are more expensive?
- Are there better ways to help ADAPs assess whether or not they are getting the best prices for medications? Should other parts of the CARE Act that currently purchase medications for clients be required to coordinate purchasing with ADAPs?
- How can the lessons learned from the experience of Hurricane Katrina inform Reauthorization?

Beyond Reauthorization, ADAPs will continue to assess and adapt to Medicare Part D implementation. As medication providers, they represent an important nexus between the new benefit and a group of beneficiaries who face particularly complex and multiple prescription drug needs and as such offer a unique perspective on this new and important national policy. ADAPs will also continue to adapt to other system changes, particularly changes in Medicaid and in their state's fiscal condition.

In addition to ongoing tracking of ADAP client utilization, drug spending, budgets, and program characteristics over time, the National ADAP Monitoring Project will continue to monitor these issues and questions as they unfold.

Methodology

Since 1996, the National ADAP Monitoring Project, an initiative of the Kaiser Family Foundation (KFF) and the National Alliance of State and Territorial AIDS Directors (NASTAD), has surveyed all jurisdictions receiving federal ADAP earmark funding through the Ryan White CARE Act. In FY 2005, 57 jurisdictions received earmark funding and all 57 received the ADAP survey; 53 responded. American Samoa, The Marshall Islands, New Mexico, and Rhode Island did not respond; these jurisdictions represent less than one percent of estimated living AIDS cases.*

NASTAD distributes the survey to states on an annual basis. The survey requests data and other program information for a one month period (June), the fiscal year, and for other periods as specified. After the survey is sent out, NASTAD conducts extensive follow-up to ensure completion by as many ADAPs as possible. Due to differences in data collection and availability across ADAPs, some are not able to respond to all survey questions. Where trend data are presented, only states that provided data in relevant periods are included. In some cases, ADAPs have provided revised program data from prior years and these revised data are incorporated where possible. Therefore, data from prior year reports may not be comparable for assessing trends.

Data used in this report are from June 2005 and FY 2005, unless otherwise noted. For example, NASTAD collects supplemental data on key issues, such as waiting lists, cost containment measures and Medicare Part D progress as part of its bi-monthly "ADAP Watch" survey. Every effort has been made to ensure that the annual report represents the current status of ADAPs as reported by survey respondents; however, some information may have changed between data collection and this report's release. Data issues specific to a particular jurisdiction are provided on relevant charts and tables. ◗

*CDC, "AIDS cases by state and metropolitan area, provided for the Ryan White CARE Act," *HIV/AIDS Surveillance Supplemental Report* 2005. 11(No. 1). Available at: www.cdc.gov/hiv/STATS/HASRSuppVol11No1.pdf.

REFERENCES

[1] Public Law No. 101-381.

[2] According to CDC, there were an estimated 1,039,000–1,185,000 people living with HIV/AIDS in the United States as of the end of 2003 (See, Glynn MK, Rhodes P, "Estimated HIV Prevalence in the United States at the End of 2003," 2005 National HIV Prevention Conference, June 2005). The CDC also estimates that approximately half of those living with HIV/AIDS, or 550,000, are in the care system (See, Fleming P, et al. Abstract #11, Oral Abstract Session 5, 9th Conference on Retroviruses and Opportunistic Infections 2002). ADAP client enrollment of 134,000 represents approximately 24% of the estimated number of people living with HIV/AIDS who are receiving care.

[3] Glynn MK, Rhodes P, "Estimated HIV Prevalence in the United States at the End of 2003," 2005 National HIV Prevention Conference, June 2005.

[4] Pub. L. 101-381; Pub. L. 104-146, SEC. 2616. [300ff-26]

[5] HRSA, HIV/AIDS Bureau, Personal Communication, March 15, 2005.

[6] Kaiser Family Foundation, *Fact Sheet: U.S. Federal Funding for HIV/AIDS: The FY 2007 Budget Request*, February 2006.

[7] The term "state" is used in this report to include states, territories and associated jurisdictions.

[8] Three percent of the ADAP earmark is set aside for the ADAP Supplemental Treatment Drug Grant, grants to states with severe need. See box on "Allocation of Federal Funding to ADAPs & State Match Requirements."

[9] Some of these funds must be provided to ADAPs, due to state matching fund requirements. See box on "Allocation of Federal Funding to ADAPs & State Match Requirements."

[10] Funding for entitlement programs, such as Medicaid and Medicare, generally changes (increases or decreases) based on the number of eligibles who enroll in these programs and the costs of providing them care.

[11] HRSA, HIV/AIDS Bureau, CARE Act Funding History. Available at: ftp://ftp.hrsa.gov/hab/fundinghis04.xls.

[12] FDA, "Drugs Used in the Treatment of HIV Infection," October 2005. Available at: www.fda.gov/oashi/aids/virals.html.

[13] CDC, "Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus." *MMWR* 2002; 51(No. RR08):1–46.

[14] CDC, "Treating Opportunistic Infections Among HIV-Infected Adults and Adolescents." *MMWR* 2004; 53(No. RR15):1-112.

[15] Providing any FDA-approved HIV-related prescription drug.

[16] New Hampshire has some restrictions to its open formulary.

[17] CDC, Frequently Asked Questions and Answers About Coinfection with HIV and Hepatitis C Virus. Available at www.cdc.gov/hiv/pubs/faq/HIV-HCV_Coinfection.pdf.

[18] CDC, "Sexually Transmitted Diseases Treatment Guidelines, 2002", *MMWR*, Vol. 51, No. RR-6, May 2002.

[19] Not including the ADAP supplemental, a three percent set aside of the total amount earmarked for ADAPs by Congress.

[20] HRSA, Pharmacy Services Support Center, "What is the 340B Program?" Available at: http://pssc.aphanet.org/about/whatisthe340b.htm.

[21] HRSA, HIV/AIDS Bureau, Policy Notice 99-01, "The Use of the Ryan White CARE Act Title II ADAP Funds to Purchase Health Insurance."

[22] HRSA, HIV/AIDS Bureau, DSS Program Policy Guidance No. 2, "Allowable Uses of Funds for Discretely Defined Categories of Services," Formerly Policy No. 97-02, First Issued: February 1, 1997, June 1, 2000.

[23] CMS, "Tip Sheet: People with Medicare and HIV/AIDS", August 2005. Available at: www.cms.hhs.gov/partnerships/downloads/AIDS.pdf.

[24] HRSA, HIV/AIDS Bureau, "Medicare Prescription Drug Benefit and CARE Act Grantees." Available at: www.hrsa.gov/medicare/HIV/about.htm.

FDA-APPROVED ANTIRETROVIRAL MEDICATIONS

GENERIC NAME	BRAND NAME
NRTIs	
abacavir	Ziagen
abacavir, zidovudine, and lamivudine	Trizivir
abacavir/ lamivudine	Epzicom
didanosine, ddI, dideoxyinosine	Videx
FTC, emtricitabine	Emtriva
lamivudine and zidovudine	Combivir
lamivudine, 3TC	Epivir
stavudine, d4T	Zerit
tenofovir disoproxil fumarate	Viread
tenofovir disoproxil/emtricitabine	Truvada
zalcitabine, ddC, dideoxycytidine	Hivid
zidovudine, AZT, azidothymidine, ZDV	Retrovir
NNRTIs	
delavirdine, DLV	Rescriptor
efavirenz	Sustiva
nevirapine, BI-RG-587	Viramune
Protease Inhibitors	
amprenavir	Agenerase
atazanavir sulfate	Reyataz
fosamprenavir Calcium	Lexiva
indinavir, IDV, MK-639	Crixivan
lopinavir and ritonavir	Kaletra
nelfinavir mesylate, NFV	Viracept
ritonavir, ABT-538	Norvir
saquinavir	Fortovase*
saquinavir mesylate, SQV	Invirase
tipranavir	Aptivus
Fusion Inhibitors	
enfuvirtide, T-20	Fuzeon

Sources: DHHS, "Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents—October 2005": http://aidsinfo.nih.gov/Guidelines/GuidelineDetail.aspx?MenuItem=Guidelines&Search=Off&GuidelineID=7&ClassID=1; FDA, "Drugs Used in the Treatment of HIV Infection" www.fda.gov/oashi/aids/virals.html. *Discontinued on February 5, 2006: see www.rocheusa.com/newsroom/current/2006/pr2006020601.html

"A1" MEDICATIONS FOR THE PREVENTION & TREATMENT OF OPPORTUNISTIC INFECTIONS (HIGHLY RECOMMENDED)

GENERIC NAME	BRAND NAME	PREVENTION	TREATMENT
acyclovir	Zovirax	X	X
amphotericin B	Fungizone	X	X
azithromycin	Zithromax	X	
cidofovir	Vistide	X	X
clarithromycin	Biaxin	X	X
clindamycin			X
famciclovir	Famvir	X	X
fluconazole	Diflucan	X	X
flucytosine			X
fomivirsen	Vitravene	X	X
foscarnet	Foscavir	X	X
ganciclovir	Cytovene	X	X
Isoniazid (INH)	Lanizid, Nydrazid		X
itraconazole	Sporonox	X	X
leucovorin calcium	Wellcovorin	X	X
peginterferon alfa-2a	PEG-Intron		X
pentamidine	Nebupent		X
pentavalent antimony	—		X
prednisone	Deltasone, Liquid Pred, Metocorten, Orasone, Panasol, Prednicen-M, Sterapred		X
probenecid	—	X	
pyrazinamide (PZA)	—		X
pyrimethamine	Daraprim, Fansidar	X	X
ribavirin	Virazole, Rebetol, Copegus		X
rifabutin	Mycobutin		X
rifampin (RIF)	Rifadin, Rimactane		X
sulfadiazine (oral generic)	Microsulfon	X	X
trimethoprim- sulfamethoxazole (TMP/SMX)	Bactrim, Septra	X	X
valacyclovir	Valtrex		X
valganciclovir	Valcyte		X

*"A" = "should always be offered"; "1" = "evidence from at least one properly randomized, controlled trial"

Sources: 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.

Charts

Chart 1
Key ADAP Highlights

State	Financial Eligibility as % of FPL	Medical Eligibility (CD4=CD4 Cell Count, VL=Viral Load)	Total Number of Drugs on Formulary	Nucleoside Reverse Transcriptase Inhibitors (12 Drugs Approved)	Protease Inhibitors Covered (9 Drugs Approved)*	Non-nucleosides Covered (3 Drugs Approved)	Fusion Inhibitors Covered (1 Drug Approved)	"A1" OI Medications (29 PHS Recommended Drugs)	Other Medications Covered	Total FY 2005 Est. Budget (Federal/State Sources)	State Contribution	State $ Contribution as % of Total Budget	ADAP Clients Served In June 2005	June 2005 Per Capita Drug Expend.	Cost-Containment Measures in Place as of February 2006
Alabama	250%		38	12	9	3	1	8	5	$13,305,055	$2,999,632	23%	915	$1,091	Waiting list; waiting list for Fuzeon
Alaska	300%		72	12	9	3	0	22	26	$517,035	$0	0%	37	$1,019	Waiting list
American Samoa	NR	NR	NR	NR	NR	NR	NR	NR	NR	$2,360	NR	NR	NR	NR	
Arizona	300%		91	12	9	3	1	14	52	$10,326,619	$1,000,000	10%	918	$939	
Arkansas	200% (300%)	CD4<350 or VL>55,000	53	12	9	3	1	14	14	$3,393,643	$0	0%	272	$1,252	Waiting list
California	<400%; 400% - $50,000 - sliding		153	12	8 (9)	3	1	27	102	$264,291,174	$84,961,250	32%	18,275	$1,190	
Colorado	300%		48	12	9	3	1	18	5	$11,425,978	$4,413,606	39%	1,045	$869	
Connecticut	400%		191	12	9	3	1	21	145	$18,401,556	$1,776,352	10%	1,205	$1,185	
Delaware	300%; 301% - 500% - sliding		238	12	9	3	1	23	190	$3,379,523	$40	0%	249	$585	
District of Columbia	400%		78	12	8 (9)	3	1	17	37	$14,648,361	$0	0%	726	$1,015	
Florida	350%		71	12	9	3	1	11	36	$99,702,484	$9,000,000	9%	8,682	$695	
Georgia	300%	CD4≤350 or, if CD4>350, VL≥55,000	56	12	9	3	1	18	13	$43,205,839	$11,305,339	26%	4,162	$902	
Guam	< 200%; ≥ 200% - sliding		19	5	4	2	0	8	0	$101,695	$0	0%	5	$1,677	
Hawaii	400%		95	12	9	3	1(0)	22	48	$2,668,577	$440,535	17%	211	$986	
Idaho	200%		41	11	7(8)	3	0	16	4	$1,284,073	$177,500	14%	76	$1,418	Waiting list
Illinois	400%		86	12	8(9)	3	1	20	45	$37,926,143	$10,100,000	27%	3,459	$1,032	
Indiana	300%		97	12	9	3	1	13	60	$7,242,843	$0	0%	62	$1,185	Waiting list
Iowa	200%		35	11(12)	8(9)	3	1	9	3	$2,029,657	$375,000	18%	161	$664	
Kansas	300%		54	12	9	3	1	12	17	$3,259,977	$400,000	12%	315	$1,553	
Kentucky	300%		48	11(12)	7(9)	3	0	13	14	$5,559,691	$180,000	3%	401	$1,092	Waiting list
Louisiana	200%		26	12	9	3	1	0	1	$17,442,981	$0	0%	1,704	$561	Waiting list for Fuzeon
Maine	300%		39	12	9	3	1	9	5	$1,062,831	$60,000	6%	43	$1,930	
Marshall Islands	NR	NR	NR	NR	NR	NR	NR	NR	NR	$2,360	NR	NR	NR	NR	
Maryland	500%		114	12	9	3	1	26	63	$45,289,205	$0	0%	2,301	$1,173	
Massachusetts	522% plus $3,100 per dependent (<$50,000 net annual income)		open formulary	12	9	3	1	29	open formulary	$21,604,898	$4,216,175	20%	2,368	$248	
Michigan	450%		194	12	9	3	1	23	146	$15,364,472	$0	0%	1,337	$1,189	
Minnesota	300%		130	12	8	3	1	20	87	$6,080,294	$1,150,000	19%	726	$489	
Mississippi	400%		52	12	9	2	1	15	13	$6,495,703	$700,000	11%	772	$899	
Missouri	300%		238	12	9	3	1	18	195	$13,799,516	$2,096,000	15%	1,200	$1,025	Reduced formulary; income eligibility restrictions
Montana	330%		144	12	9	3	1	19	100	$468,112	$9,000	2%	49	$828	Waiting list

Data in parentheses are from the prior report, if states made changes since that time. The 2005 Federal Poverty Level (FPL) was $9,570 (slightly higher in Alaska and Hawaii) for a household of one. **NR** indicates not reported.
*Aptivus (tipranavir) was approved in June 2005; therefore, several states added it to their formularies after October 1, 2005, the date of the survey. Given the discontinuation of Fortovase (saquinavir soft-gel), the survey counts Fortovase and Invirase (saquinavir hard-gel) as one drug for the purpose of tabulating the number of protease inhibitors covered on an ADAP's formulary.
**New Hampshire will only reimburse for non-ARV treatments if a patient is currently receiving ARV therapy.

(continued on next page)

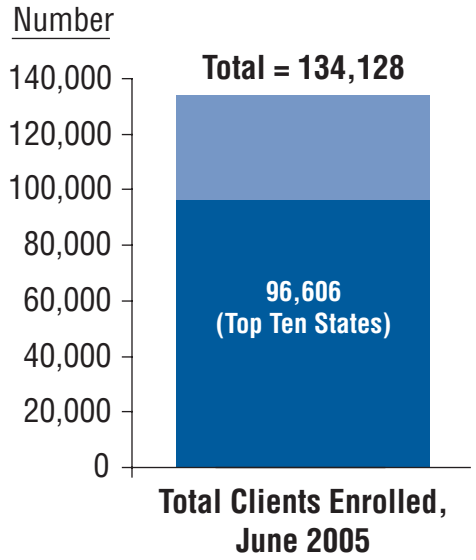
(continued from previous page)

Chart 1
Key ADAP Highlights

State	Financial Eligibility as % of FPL	Medical Eligibility (CD4=CD4 Cell Count, VL=Viral Load)	Total Number of Drugs on Formulary	Nucleoside Reverse Transcriptase Inhibitors (12 Drugs Approved)	Protease Inhibitors Covered (9 Drugs Approved)*	Non-nucleosides Covered (3 Drugs Approved)	Fusion Inhibitors Covered (1 Drug Approved)	"A1" OI Medications (29 PHS Recommended Drugs)	Other Medications Covered	Total FY 2005 Est. Budget (Federal/State Sources)	State Contribution	State $ Contribution as % of Total Budget	ADAP Clients Served In June 2005	June 2005 Per Capita Drug Expend.	Cost-Containment Measures in Place as of February 2006
Nebraska	200%		104	12	8(9)	3	0	15	66	$1,474,557	$150,000	10%	265	$533	Waiting list
Nevada	400%		69	12	9	3	1	13	31	$6,996,445	$1,565,704	22%	704	$885	
New Hampshire	300%	At least one: CD4<350, or currently on ARV therapy, or currently has a designated OI	open formulary,** Hep C drugs and Fuzeon excluded (open formulary)	12	9	3	0(1)	27	open formulary, Hep C drugs and Fuzeon excluded	$2,718,924	$180,000	7%	137	$1,050	Reduced formulary; medical eligibility restrictions
New Jersey	500%		open formulary	12	9	3	1	29	open formulary	$64,592,155	$9,000,000	14%	3,964	$1,437	
New Mexico	300%		69	12	9	3	1(0)	18	26	$2,293,895	NR	NR	NR	NR	
New York	460%		480	12	9	3	1	27	428	$237,916,843	$37,350,000	16%	12,686	$1,556	
North Carolina	125%		59	12	9	3	1	16	18	$30,408,944	$12,120,856	40%	1,887	$1,511	
North Dakota	400%		94	12	7(8)	3	0	19	53	$259,493	$0	0%	33	$674	
N. Mariana Islands	100%		open formulary	12	9	3	1	29	open formulary	$4,720	$0	0%	6	$505	
Ohio	500% (<$46,550 gross annual income)		86	12	9	3	1	15	46	$16,214,008	$338,787	2%	1,371	$240	
Oklahoma	200%		53	12	9	3	1	18	10	$5,474,149	$884,032	16%	611	$770	Annual per capita expenditure limit
Oregon	200%		63	12	9	3	1	22	16	$7,357,790	$977,678	13%	1,028	$265	
Pennsylvania	<$30,000 gross annual income		76	12	9	3	1	22	29	$42,485,124	$13,448,000	32%	3,186	$1,465	
Puerto Rico	NR (200%)	NR	124	12	8(9)	3	1	23	77	$31,716,607	$1,199,828	4%	3,750	$1,304	
Rhode Island	400%		67	12	9	3	1	15	27	$2,109,545	NR	NR	NR	NR	
South Carolina	300%, 300% - 550% - sliding (300%)		54	11	8(9)	3	1	14	17	$15,087,564	$500,000	3%	1,793	$753	
South Dakota	300%		44	12	0	3	0	12	17	$471,692	$0	0%	59	$503	Annual per capita expenditure limit
Tennessee	300%		91	12	9	3	1	19	47	$17,612,899	$0	0%	346	$521	Reduced formulary
Texas	200%		41	12	9	3	1	11	5	$95,072,995	$30,509,949	32%	8,802	$816	Waiting list for Fuzeon
Utah	400%		37	10	9	3	1	11	3	$2,602,257	$180,000	7%	225	$845	Reduced formulary; cost sharing
Vermont	200%		92	12	9	3	1	18	49	$622,594	$0	0%	136	$305	
Virgin Islands (U.S.)	200%		38	10	8	3	0	9	8	$709,945	$0	0%	57	$827	
Virginia	300%/333% in Northern VA	CD4≤500 for NRTIs, PIs, and NNRTIs (None)	68	12	9	3	1	23	20	$19,844,417	$2,612,200	13%	1,781	$1,125	
Washington	300%		179	12	9	3	1	21	133	$16,441,895	$5,587,602	34%	1,194	$644	
West Virginia	250%		33	12	8(9)	3	0	6	4	$2,165,992	$36,890	2%	183	$1,001	Waiting list
Wisconsin	300%		69	12	9	3	1	21	23	$5,334,712	$464,000	9%	477	$999	
Wyoming	200%		80	12(11)	9	3	0	17	39	$737,418	$367,500	50%	47	$1,321	

Data in parentheses are from the prior report, if states made changes since that time. The 2005 Federal Poverty Level (FPL) was $9,570 (slightly higher in Alaska and Hawaii) for a household of one. **NR** indicates not reported.
*Aptivus (tipranavir) was approved in June 2005; therefore, several states added it to their formularies after October 1, 2005, the date of the survey. Given the discontinuation of Fortovase (saquinavir soft-gel), the survey counts Fortovase and Invirase (saquinavir hard-gel) as one drug for the purpose of tabulating the number of protease inhibitors covered on an ADAP's formulary.
**New Hampshire will only reimburse for non-ARV treatments if a patient is currently receiving ARV therapy.

Chart 2
ADAP Clients Enrolled and Top Ten States, by Clients Enrolled, June 2005



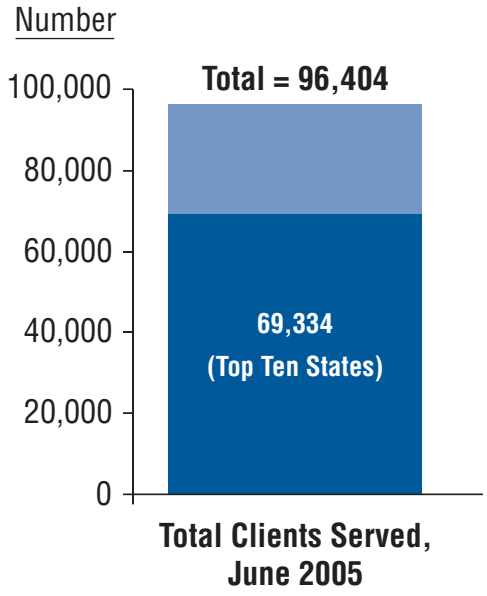
State	Clients Enrolled, June 2005
California	23,264
New York	16,404
Texas	13,365
Florida	13,062
Georgia	7,877
Pennsylvania	5,625
New Jersey	5,355
Illinois	4,811
Puerto Rico	3,750
Maryland	3,093
Total	**96,606**

Notes: 53 ADAPs reported data on enrolled clients. American Samoa, the Marshall Islands, New Mexico, and Rhode Island are not included.

In June 2005, there were 134,128 clients enrolled in ADAPs across the country. Enrollment varies by state and is concentrated in certain areas—ten states accounted for 72% of enrollment. In general, these states represent those with the highest estimated numbers of people living with AIDS, and the concentration of clients within these states largely reflects the allocation of CARE Act funding based on estimated living AIDS cases.

In any given month, more clients are typically enrolled in ADAPs than seek services. This is because clients may seek ADAP services at different times of the year, depending on their clinical needs, length of prescriptions, availability of other resources for obtaining prescription drugs, and other factors. Some individuals cycle on and off ADAPs throughout the year, particularly those with Medicaid coverage who may face limits in their coverage in some states and/or are in the spend down process. In June 2005, nearly three-fourths (72%) of those enrolled in ADAPs received services (see Chart 3 and Appendix I).

Chart 3
ADAP Clients Served and Top Ten States, by Clients Served, June 2005



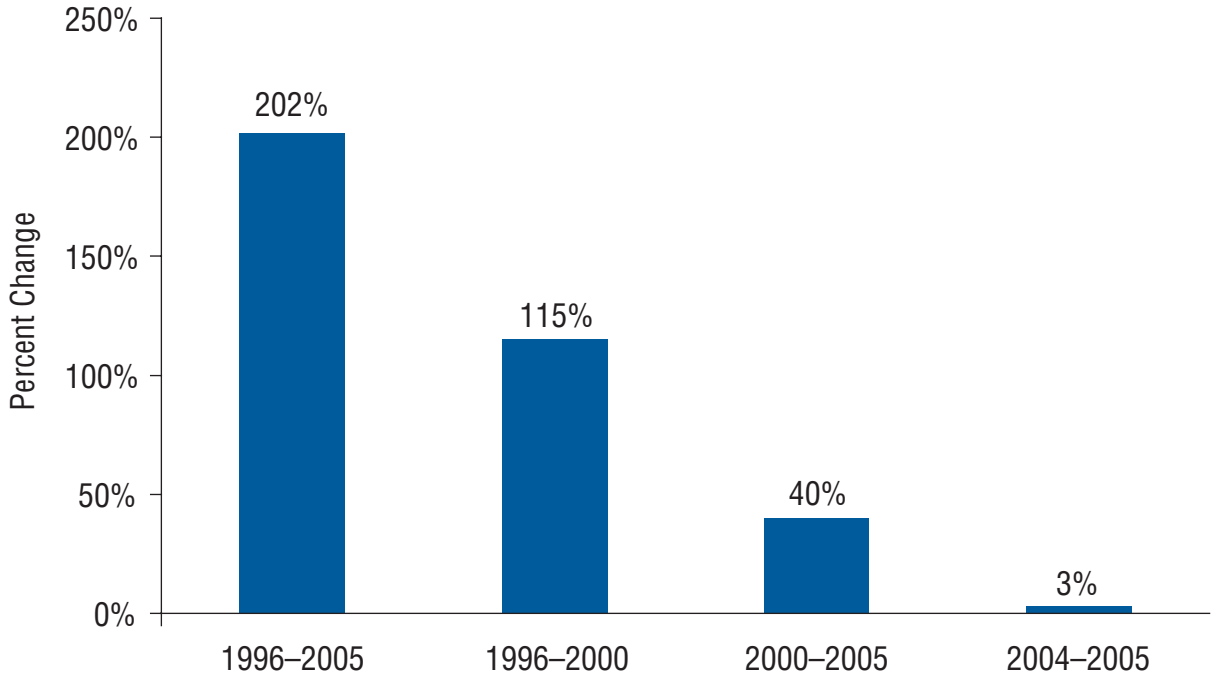
State	Clients Served, June 2005
California	18,275
New York	12,686
Texas	8,802
Florida	8,682
Georgia	4,162
New Jersey	3,964
Puerto Rico	3,750
Illinois	3,459
Pennsylvania	3,186
Massachusetts	2,368
Total	**69,334**

Notes: 53 ADAPs reported data on clients served. American Samoa, the Marshall Islands, New Mexico, and Rhode Island are not included.

ADAPs provided medications to 96,404 clients across the country in June 2005. Ten states accounted for 72% of all clients served in June 2005, with four states accounting for half (50%) of clients served. The number of clients served varies considerably by state, ranging from five in Guam to more than 18,000 in California. Between June 2004 and June 2005, client utilization increased by three percent, a smaller increase than in prior years. Client utilization increased at a slower rate than drug expenditures over the same period. Thirty-three ADAPs experienced an increase in the number of clients served between June 2004 and June 2005 (see Appendix I).

In addition to providing medications, ADAPs also paid for insurance coverage (premiums, co-pays and/or deductibles) for 12,311 clients in June 2005 (see Chart 37 and Appendix XV), some of whom may have also received medications through ADAP.

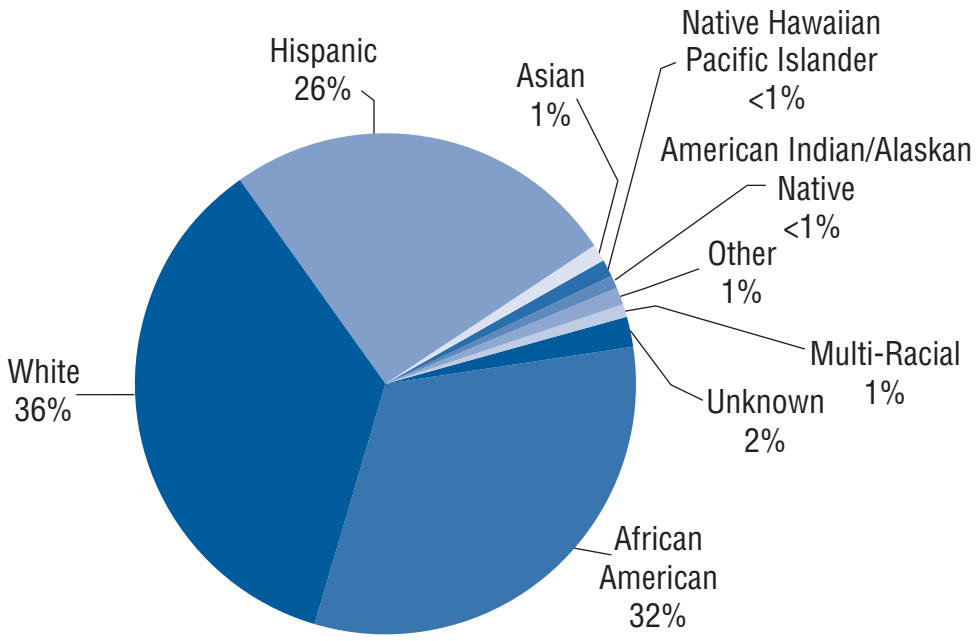
Chart 4
Trends in ADAP Client Utilization, 1996–2005



Note: 1996–2005 percent change based on 47 ADAPs reporting in both periods; 1996–2000 and 2000–2005 percent change based on 49 ADAPs reporting in both periods, respectively; 2004–2005 percent change based on 50 ADAPs reporting in both periods.

The number of clients served by ADAPs increased significantly between 1996 and 2005 (202% among the 47 ADAPs that reported data in both periods), but the rate of growth has slowed over time. Between 2004 and 2005, client utilization increased by three percent (among the 50 ADAPs reporting in both periods). Growth in the number of clients may reflect several factors including: increases in the number of people living with HIV/AIDS; increasing client demand due to the availability of more effective therapies; ADAP client outreach efforts; limits in the availability of other non-ADAP prescription drug services; and increases in funding available to ADAPs, enabling them to serve more people over time (see Chart 29 for trends in the National ADAP Budget over time).

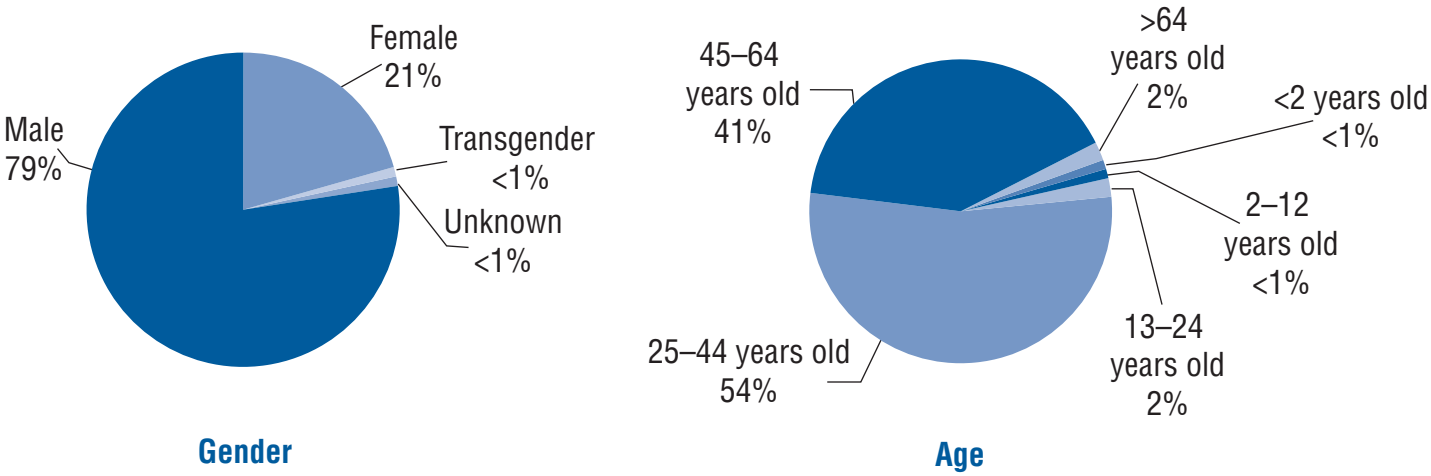
Chart 5
ADAP Clients Served, by Race/Ethnicity, June 2005



Notes: 53 ADAPs reported race/ethnicity data. American Samoa, the Marshall Islands, New Mexico, and Rhode Island are not included. Percentages may not total 100% due to rounding.

African Americans and Hispanics represented 58% (32% and 26%, respectively) of clients served in June 2005. White non-Hispanics comprised 36%. Asians, Native Hawaiians/Pacific Islanders, and American Indians/Alaskan Natives combined represented approximately two percent of the total ADAP population served. The race/ethnicity breakdown of ADAP clients varies by state (see Appendix IV). ADAP client demographics have remained fairly constant over the course of the National ADAP Monitoring Project, despite changes in the epidemic within the U.S. Limited national data are available, however, to assess whether or not ADAPs are serving clients by race/ethnicity in proportion to their need.

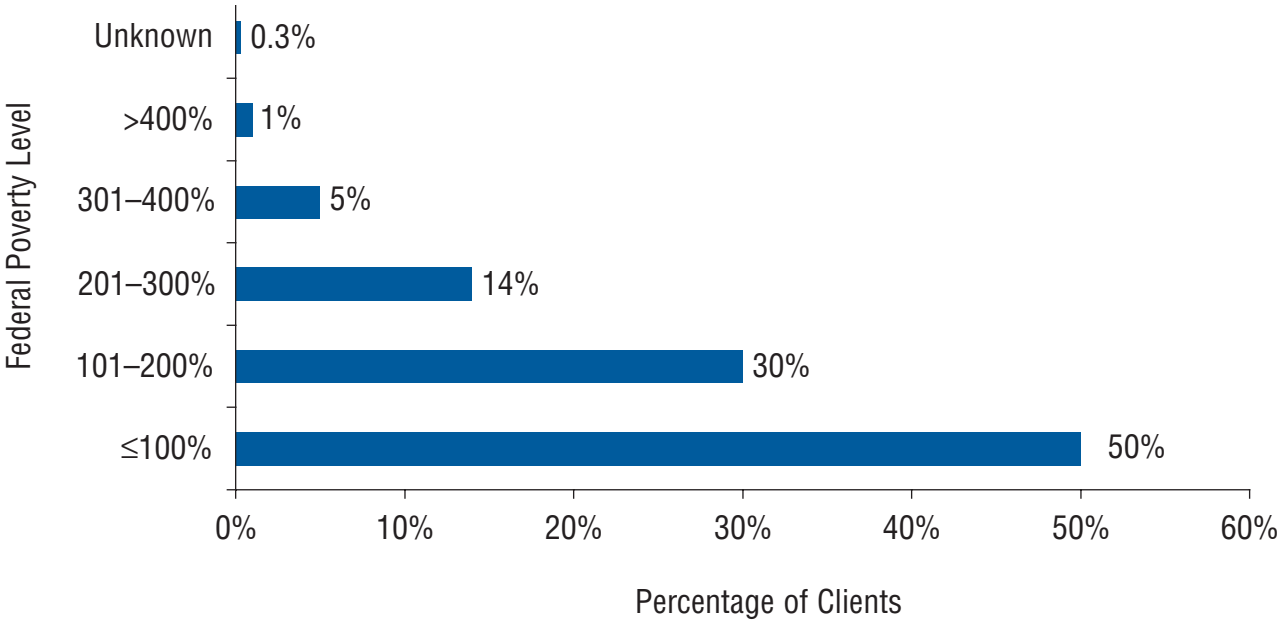
Chart 6
ADAP Clients Served, by Gender and by Age, June 2005



Notes: 53 ADAPs reported gender and age data. American Samoa, the Marshall Islands, New Mexico, and Rhode Island are not included. Percentages may not total 100% due to rounding.

More than three-quarters (79%) of ADAP clients served in June 2005 were male; approximately one-fifth were female (21%). Less than one percent of clients served in June 2005 self-identified as transgender (some ADAPs have just begun to collect data on those identifying as transgender and this client population may therefore be underreported). The majority of ADAP clients served are between the ages of 25 and 44 years (54%), followed by those between the ages of 45 and 64 (41%). The gender and age breakdown of ADAP clients varies by state (see Appendix V).

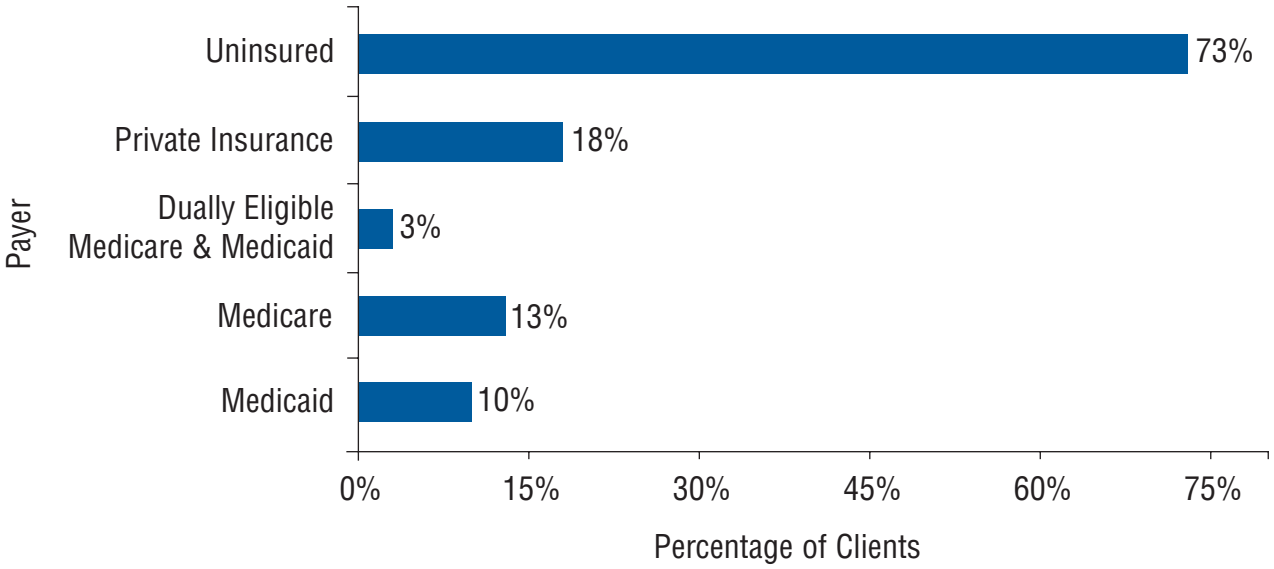
Chart 7
ADAP Clients Served, by Income Level, June 2005



Notes: 48 ADAPs reported income data. American Samoa, the District of Columbia, Idaho, Louisiana, the Marshall Islands, New Mexico, N. Mariana Islands, Puerto Rico, and Rhode Island are not included. Percentages may not total 100% due to rounding.

Most ADAP clients are low-income—eight in ten (80%) served in June 2005 were at or below 200% of the federal poverty level (FPL), including half (50%) at or below 100% FPL (in 2005, the FPL was $9,570—slightly higher in Alaska and Hawaii—for a family of one). These figures are consistent with data reported in previous periods (see Appendix VI).

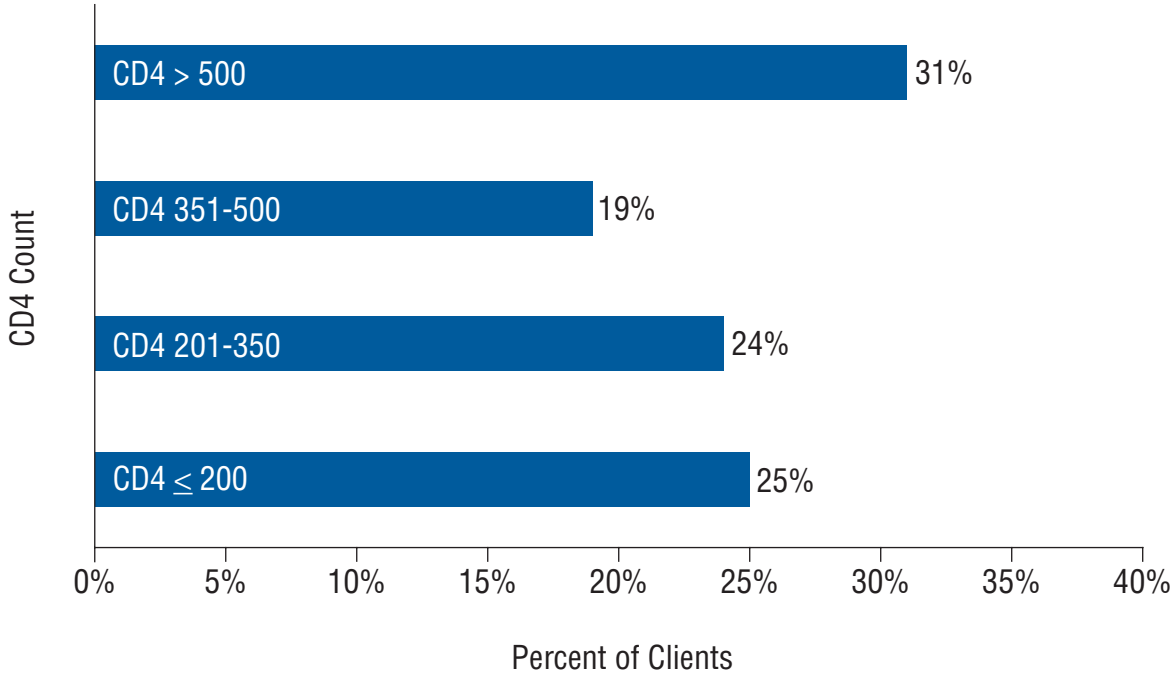
Chart 8
ADAP Clients Served, by Insurance Coverage, June 2005



Notes: 48 ADAPs reported data on insurance coverage. American Samoa, Guam, Louisiana, Maine, the Marshall Islands, New Mexico, Puerto Rico, Rhode Island, and Tennessee are not included. Insurance categories are not mutually exclusive. The overall percentage of clients insured in each category is calculated separately for each based on reported data.

The majority of ADAP clients (73%) lack any form of private or public insurance. In June 2005, 18% had private insurance, compared to 15% in June 2004; 13% were covered by Medicare (9% in 2004); and 10% by Medicaid (7% in 2004). ADAP clients dually eligible for both Medicaid and Medicare represented three percent of clients served, among the 31 ADAPs that were able to report these data. Insurance coverage of ADAP clients varies by state (see Appendix VI).

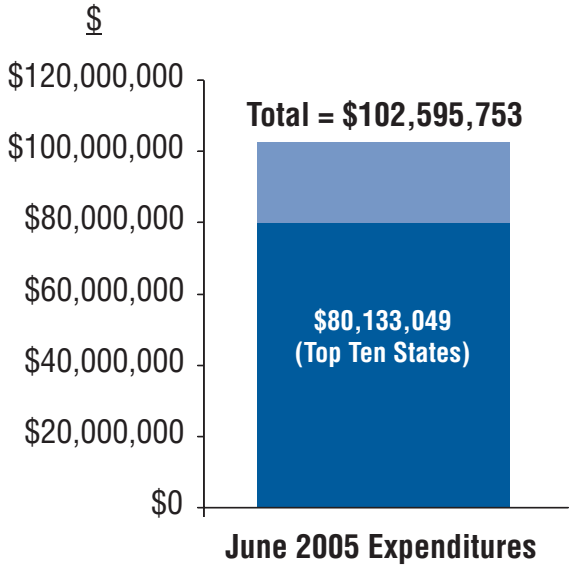
Chart 9
ADAP Clients by CD4 Count, Enrolled During 12-Month Period, June 2005



Notes: 34 ADAPs reported CD4 count data. Percentages do not total 100% due to rounding.

Approximately half (49%) of ADAP clients had a CD4 count of 350 or less, including 25% with CD4 counts at or below 200, suggesting that a significant number continue to enroll well into disease progression. Thirty-one percent of clients had CD4 counts above 500, the same percentage as in the previous year's report. CD4 count information, an important marker of health status of people with HIV/AIDS, was available from 34 ADAPs, representing 86% of ADAP clients served in June 2005, and included data on CD4 count at time of client enrollment in ADAP for clients enrolled over a 12-month period (see Appendix VII). Higher CD4 counts may represent successful treatment or early intervention efforts. It is important to note that a number of states require annual re-enrollment for ADAP clients. As a result, these figures do not necessarily represent new clients.

Chart 10
ADAP Drug Expenditures and Top 10 States, by Expenditures, June 2005

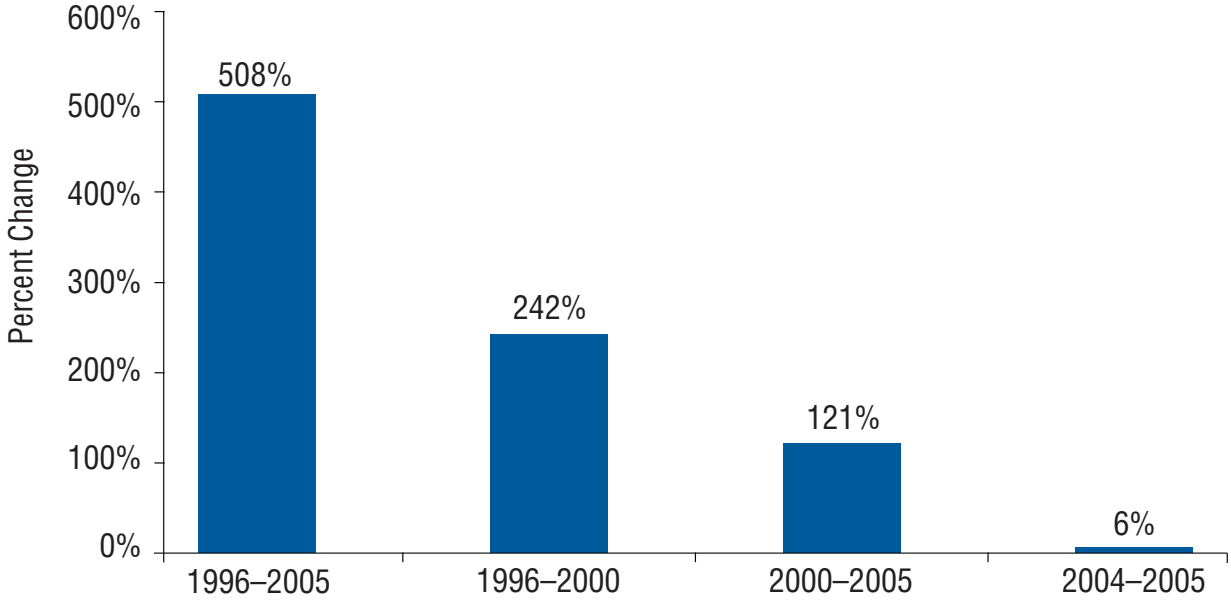


State	Drug Expenditures, June 2005
California	$21,744,727
New York	$19,743,999
Texas	$7,179,803
Florida	$6,034,910
New Jersey	$5,696,256
Puerto Rico	$4,888,766
Pennsylvania	$4,668,522
Georgia	$3,754,677
Illinois	$3,570,547
North Carolina	$2,850,842
Total	**$80,133,049**

Notes: 53 ADAPs reported drug expenditures data. American Samoa, the Marshall Islands, New Mexico, and Rhode Island are not included.

ADAP monthly drug expenditures totaled $102,595,753 in June 2005. As with clients served, 10 states accounted for more than three-fourths (78%) of all drug spending; four states accounted for 53%. These 10 states are primarily the same set that served the majority of ADAP clients. Drug expenditures in June 2005 ranged from $3,031 in the Commonwealth of Northern Mariana Islands to $21.7 million in California. Drug expenditures increased by six percent between June 2004 and June 2005, slower than in prior periods but a higher rate of increase than clients served over the same period. Thirty-two ADAPs had increases in drug expenditures between the two periods (eight fewer than the previous year) (see Appendix I). In addition to drug expenditures, 26 ADAPS spent $75.4 million on insurance purchasing/maintenance for ADAP clients in 2005 (see Chart 37 and Appendix XV).

Chart 11
Trends in ADAP Drug Expenditures, 1996–2005

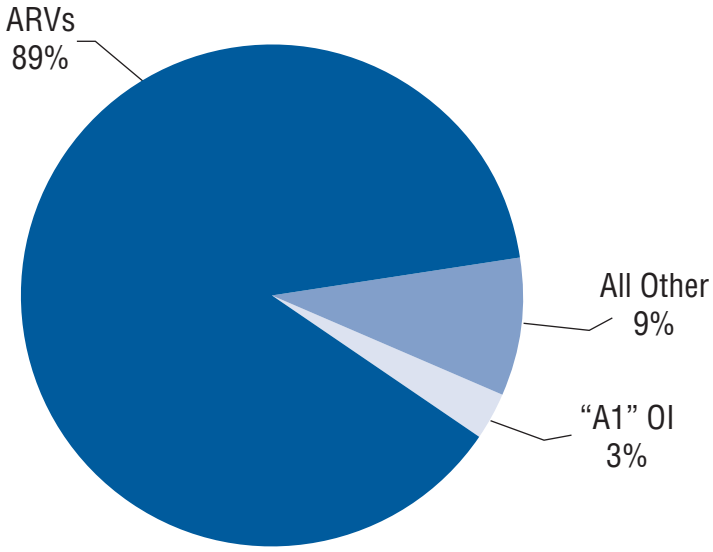


Note: 1996–2005 percent change based on 47 ADAPs reporting in both periods; 1996–2000 and 2000–2005 percent change based on 49 ADAPs reporting in both periods, respectively; 2004–2005 percent change based on 50 ADAPs reporting in both periods.

Monthly ADAP drug expenditures have increased significantly since 1996 and at a faster rate than client growth. Between 1996 and 2005, drug expenditures grew by 508%, more than twice the rate of client growth over this same period (among the 47 ADAPs reporting in both periods).

As with clients, the rate of growth in drug expenditures has slowed. Between 2004 and 2005, drug spending increased by six percent (among the 50 ADAPs reporting in both periods).

Chart 12
Per Capita Drug Expenditures, June 2005



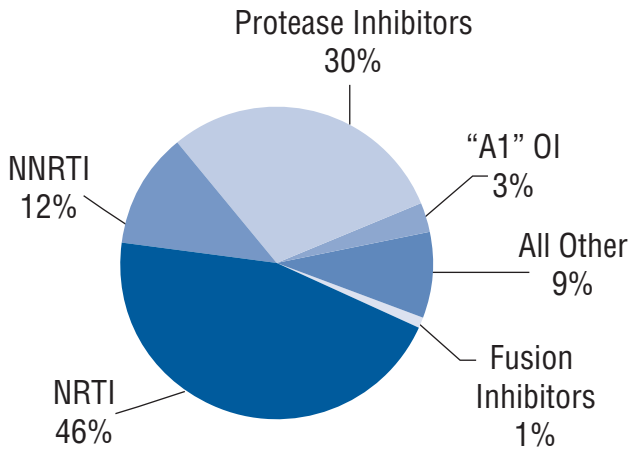
Total Per Capita Spending = $1,064

Notes: 53 ADAPs reported data to determine June 2005 per capita drug spending. American Samoa, the Marshall Islands, New Mexico, and Rhode Island are not included. Percentages may not total 100% due to rounding.

ADAPs spent an average of $1,064 on prescription drugs per client served in June 2005, a four percent increase over June 2004 per capita spending of $1,024. Antiretroviral (ARV) drugs accounted for most (89%) of per capita drug expenditures in June 2005. Per capita spending varies significantly by state, ranging from a low of $240 in Ohio to a high of $1,930 in Maine (see Chart 1). These variations are likely the result of differing ADAP formularies, purchasing mechanisms, and/or prices paid by ADAPs across the country.

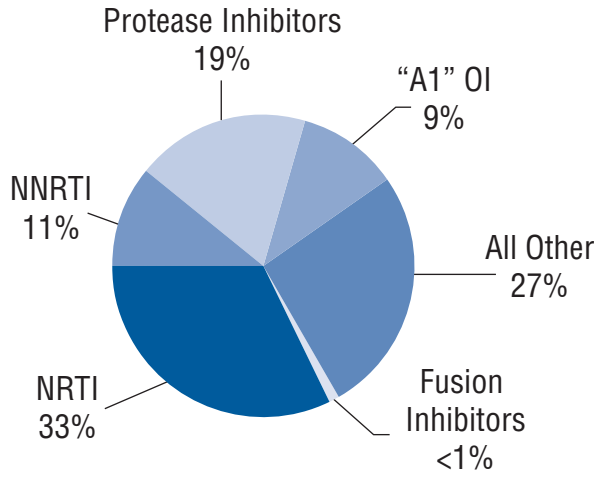
Chart 13

ADAP Drug Expenditures, by Drug Class, June 2005



Total = $102.6 Million

ADAP Prescriptions Filled, by Drug Class, June 2005



Total = 376,511 Prescriptions

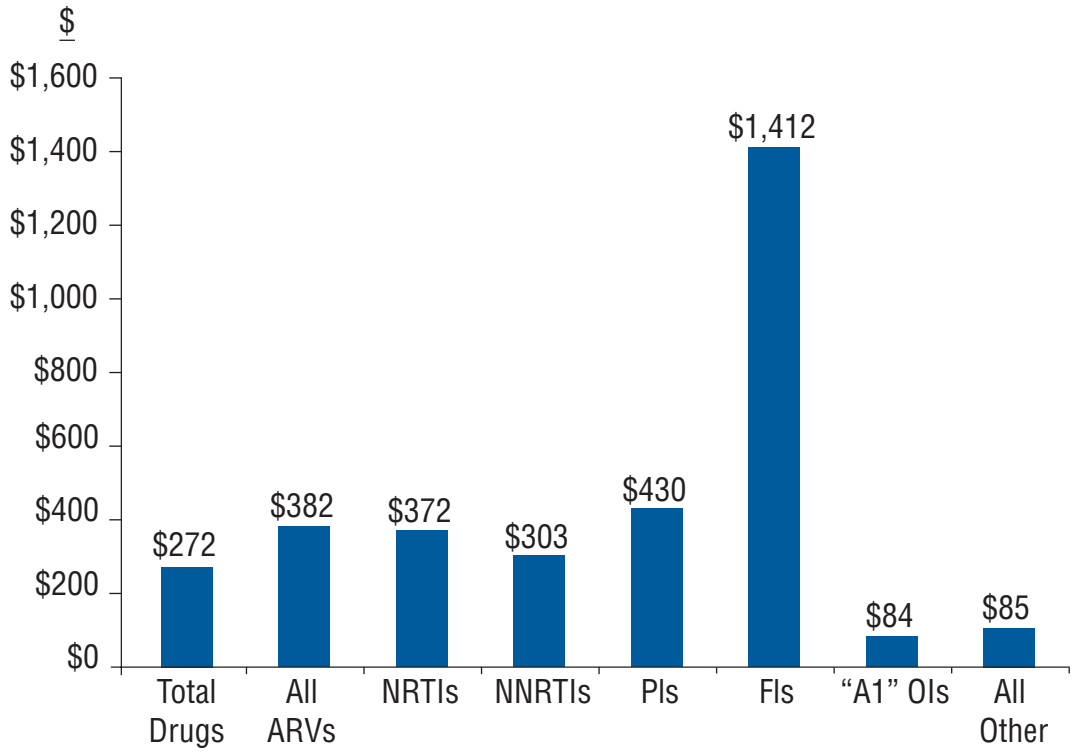
Notes: 53 ADAPs reported data on drug expenditures. American Samoa, the Marshall Islands, New Mexico, and Rhode Island are not included. Minnesota drug expenditures estimated only. 52 ADAPs reported data on prescriptions filled. American Samoa, the Marshall Islands, New Mexico, Rhode Island, and Tennessee are not included. Percentages may not total 100% due to rounding.

Antiretrovirals continue to account for the bulk of ADAP drug expenditures (89% in June 2005). Nucleoside reverse transcriptase inhibitors (NRTIs) accounted for nearly half (46%) of June 2005 expenditures; followed by protease inhibitors (PIs) at 30%; and non-nucleoside reverse transcriptase inhibitors (NNRTIs) at 12%. Fusion inhibitors (FIs) accounted for one percent of drug expenditures. The 29 "A1" OI drugs (those highly recommended for the prevention and treatment of opportunistic infections*) accounted for three percent of total drug spending. All other drugs accounted for nine percent. The distribution of expenditures by drug class varies across the states, likely reflecting differing formularies, drug prices, and prescribing decisions (see Appendix II).

ADAPs filled a total of 376,511 prescriptions in June 2005. As with expenditures by class, ARVs represented the majority of all prescriptions filled (63%); ARVs represented a smaller proportion of prescriptions filled than of drug expenditures, reflecting their relatively higher price compared to non-ARV medications. Nucleoside reverse transcriptase inhibitors accounted for one third (33%) of June 2005 prescriptions filled; followed by PIs at 19%, and NNRTIs at 11%. Fusion inhibitors accounted for less than one percent of prescriptions filled in June 2005. Prescriptions for "A1" OI drugs accounted for nine percent. All other drugs accounted for 27%. The distribution of prescriptions by class varies by state (see Appendix III).

* See: Centers for Disease Control and Prevention. "Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus." *MMWR* 2002; 51(No. RR08):1-46; Centers for Disease Control and Prevention. "Treating Opportunistic Infections Among HIV-Infected Adults and Adolescents." *MMWR* 2004; 53(No. RR15):1-112.

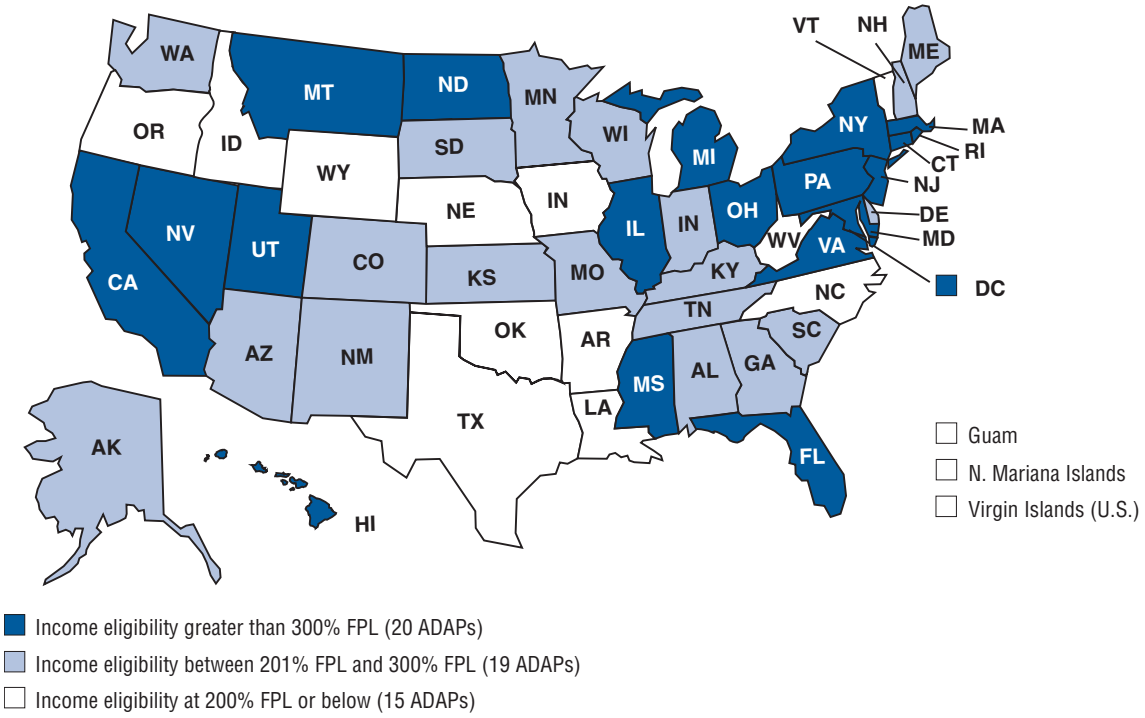
Chart 14
ADAP Expenditures Per Prescription, by Drug Class, June 2005



Notes: 52 ADAPs reported data to determine ADAP expenditures per perscription. American Samoa, the Marshall Islands, New Mexico, Rhode Island, and Tennessee are not included.

The average expenditure per prescription, across all ADAPs and for all medications, was $272 in June 2005. Expenditure per prescription was significantly higher for ARVs ($382) compared to non-ARVs ($85). Some ARV drug classes accounted for higher per prescription expenditures than others, with fusion inhibitors topping the list at $1,412—more than three times that of PIs ($430), NRTIs ($372), and NNRTIs ($303). "A1" OI drugs were $84 per prescription filled in June 2005.

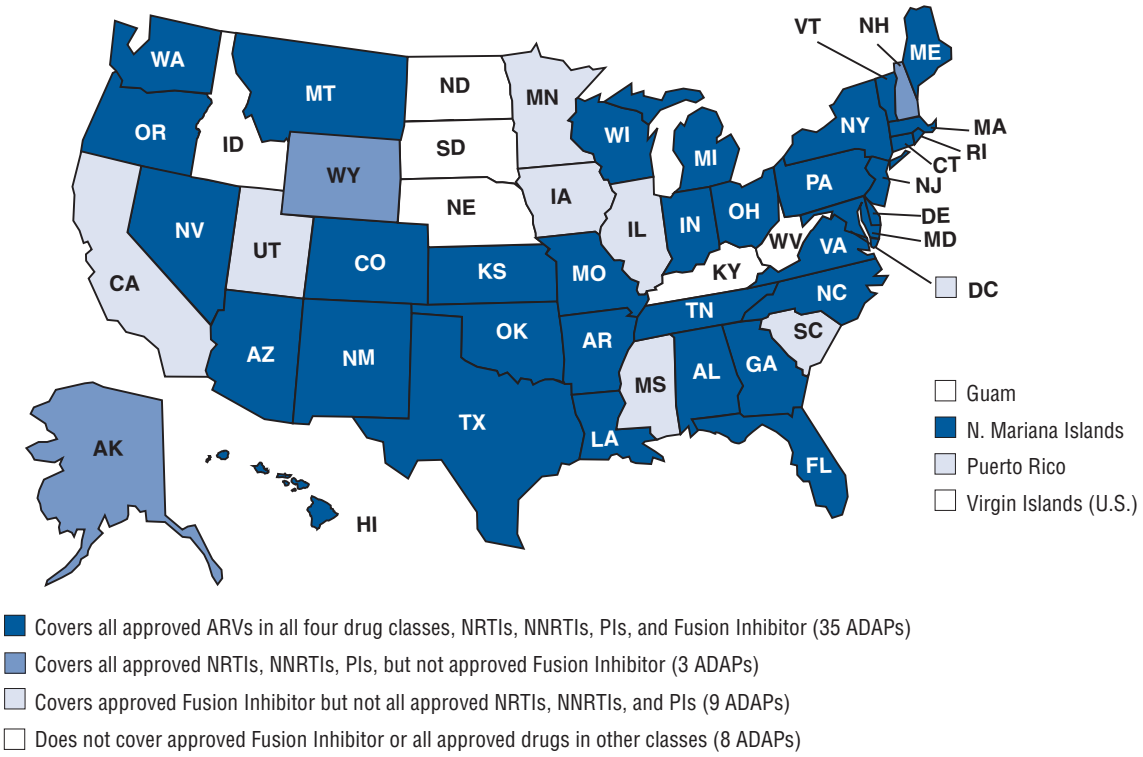
Chart 15
ADAP Income Eligibility by State, as of September 2005



Notes: The 2005 Federal Poverty Level (FPL) was $9,570 (slightly higher in Alaska and Hawaii) for a household of one. 54 ADAPs reported income eligibility criteria. American Samoa, the Marshall Islands, and Puerto Rico are not included.

ADAP income eligibility is determined at the state level—there is no minimum ADAP income eligibility threshold set by the federal government, although clients are required to be low-income and must have limited or no insurance coverage for prescription medications. ADAP income eligibility decisions reflect budget conditions within the state and the size of the population living with HIV/AIDS needing services. As a result of these factors, income eligibility levels for ADAPs vary widely across the country, ranging from a low of 100% FPL in the Northern Mariana Islands to 500% FPL or more in four states: Maryland, Massachusetts, New Jersey, and Ohio. Income eligibility was greater than 300% FPL in 20 states; between 201%–300% FPL in 19 states; and at or below 200% FPL in 15 states (see Chart 1).

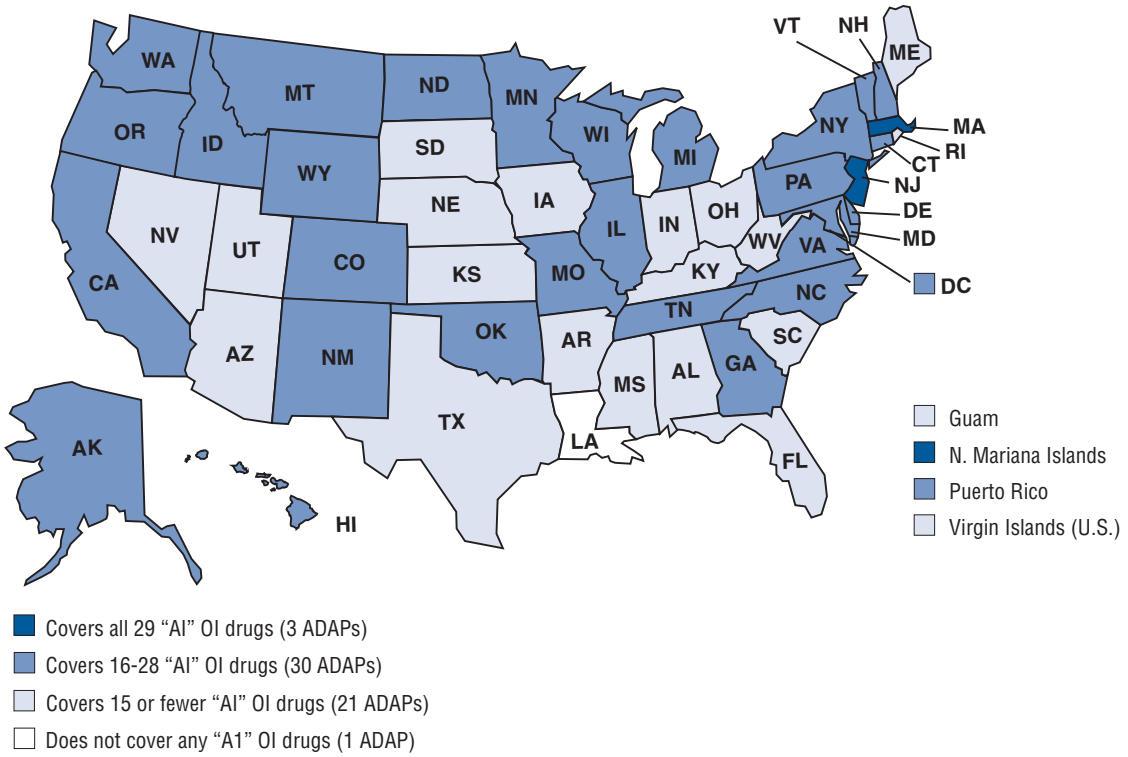
Chart 16
ADAP Formulary Coverage of Approved Antiretroviral Drugs by State, as of September 2005



Notes: 55 ADAPs reported formulary data for ARV drugs. American Samoa and the Marshall Islands are not included. The protease inhibitor Aptivus (tipranavir) was approved in June 2005; therefore several states added it to their formularies after September 2005.

ADAP formularies (the list of drugs available) vary significantly across the country—there are no minimum standards for which and how many drugs are included in ADAP formularies although federal law requires that states use ADAP funds "to provide therapeutics to treat HIV disease or prevent the serious deterioration of health arising from HIV disease in eligible individuals, including measures for the prevention and treatment of opportunistic infections." Formularies range from 19 drugs covered in Guam to nearly 500 drugs in New York, with open formularies in a small number of ADAPs. The majority of ADAPs (35) cover the full complement of FDA-approved ARVs on their formularies; 20 do not. All ADAPs covered most if not all of the approved NRTIs, NNRTIs, and PIs with the exception of South Dakota which did not provide any PIs. Forty-four ADAPs covered Fuzeon, the only approved fusion inhibitor, up from 42 in last year's report (see Chart 1).

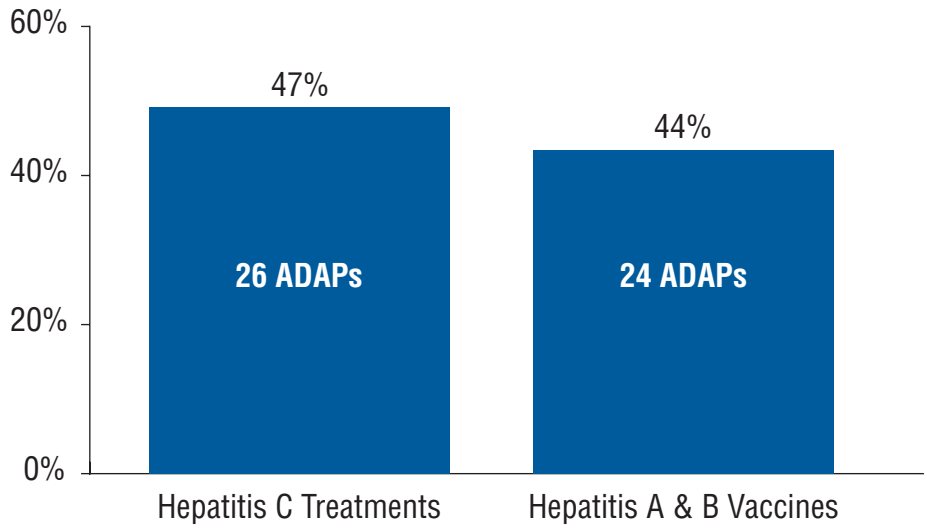
Chart 17
ADAP Formulary Coverage of Drugs Recommended ("A1") for Prevention and Treatment of Opportunistic Infections (OIs) by State, as of September 2005



Notes: 55 ADAPs reported formulary data for "A1" OI drugs. American Samoa and the Marshall Islands are not included.

As with formulary coverage of antiretrovirals, coverage of medications to prevent or treat opportunistic infections and other HIV-related conditions is also highly variable across the country. Thirty-three ADAPs cover more than 15 of the 29 drugs highly recommended ("A1") for the prevention and treatment of opportunistic infections, including three that cover all 29 (Massachusetts, New Jersey, and the Northern Mariana Islands). Twenty-one ADAPs cover 15 or fewer of these medications. One state, Louisiana, did not cover any "A1" OI drugs (see Chart 1). It is important to note that ADAPs may cover less than the full set of recommended drugs because they cover equivalent medications, also highly recommended, on their formularies, or these medications are available from other sources.

Chart 18
ADAP Formulary Coverage of Hepatitis C Treatments and Hepatitis A & B Vaccines, as of September 2005



Notes: 26 of 55 ADAPs report coverage for HCV treatment: Arizona, California, Colorado, Connecticut, Delaware, the District of Columbia, Illinois, Maryland, Massachusetts, Michigan, Mississippi, New Jersey, New York, N. Mariana Islands, Ohio, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Vermont, Virginia, Washington, West Virginia, and Wisconsin. American Samoa and the Marshall Islands did not report data and are not included. 24 of 55 ADAPs report hepatitis A and B vaccine coverage: Alaska, Arizona, California, Connecticut, Delaware, Florida, Kentucky, Massachusetts, Michigan, Mississippi, Missouri, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Pennsylvania, South Dakota, Vermont, Virginia, Washington, Wisconsin, and Wyoming. American Samoa and the Marshall Islands did not report data and are not included.

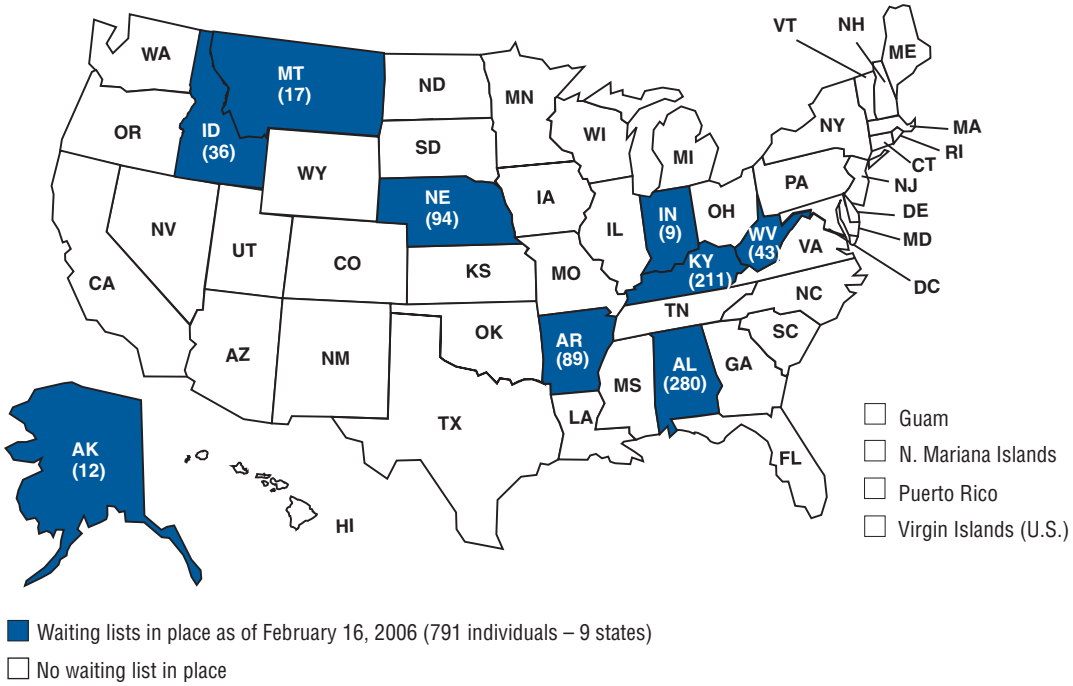
Hepatitis A, B, and C infections are important considerations for people with HIV/AIDS, and ADAPs have begun to play an increasing role in the provision of treatment and vaccines for all three.

Hepatitis C (HCV) is considered to be an opportunistic infection among those with HIV, due to the relatively high co-infection rate of HIV and HCV.* In September 2005, 26 ADAPs covered treatment for HCV on their ADAP formularies, up from 20 in 2004. In early 2005, the ADAP Crisis Task Force negotiated an agreement with a pharmaceutical company to provide free full-course HCV treatments for up to 1,500 clients in all ADAP programs. Some states take advantage of this program and thus do not include hepatitis C drugs on their ADAP formularies. Currently, no national funding infrastructure exists to provide treatment to those infected with HCV, and state and local resources for such treatment vary greatly. Without HCV treatment programs, much of the burden has fallen on ADAPs and other CARE Act programs.

Hepatitis A and B vaccines are recommended for those at high risk for HIV and people living with HIV. In September 2005, 24 ADAPs reported covering hepatitis A and B vaccines on their formularies.

*See: Centers for Disease Control and Prevention, Frequently Asked Questions and Answers About Coinfection with HIV and Hepatitis C Virus. Available at http://www.cdc.gov/hiv/pubs/faq/HIV-HCV_Coinfection.pdf (accessed February 9, 2006); Centers for Disease Control and Prevention. "Treating Opportunistic Infections Among HIV-Infected Adults and Adolescents." *MMWR* 2004; 53(No. RR15):1-112.

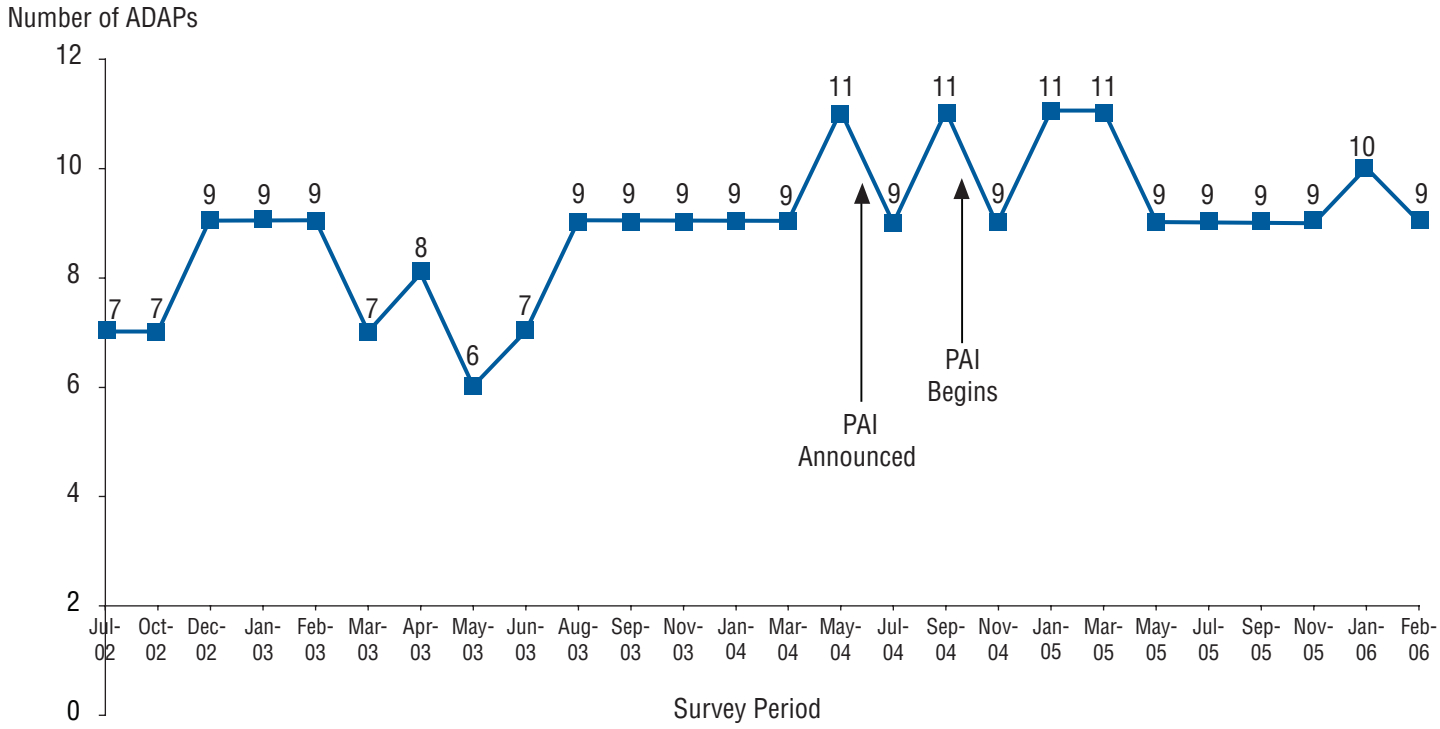
Chart 19
ADAPs with Waiting Lists, February 2006
(791 Individuals in 9 States)



Notes: 55 ADAPs reported waiting list data. American Samoa and the Marshall Islands are not included.

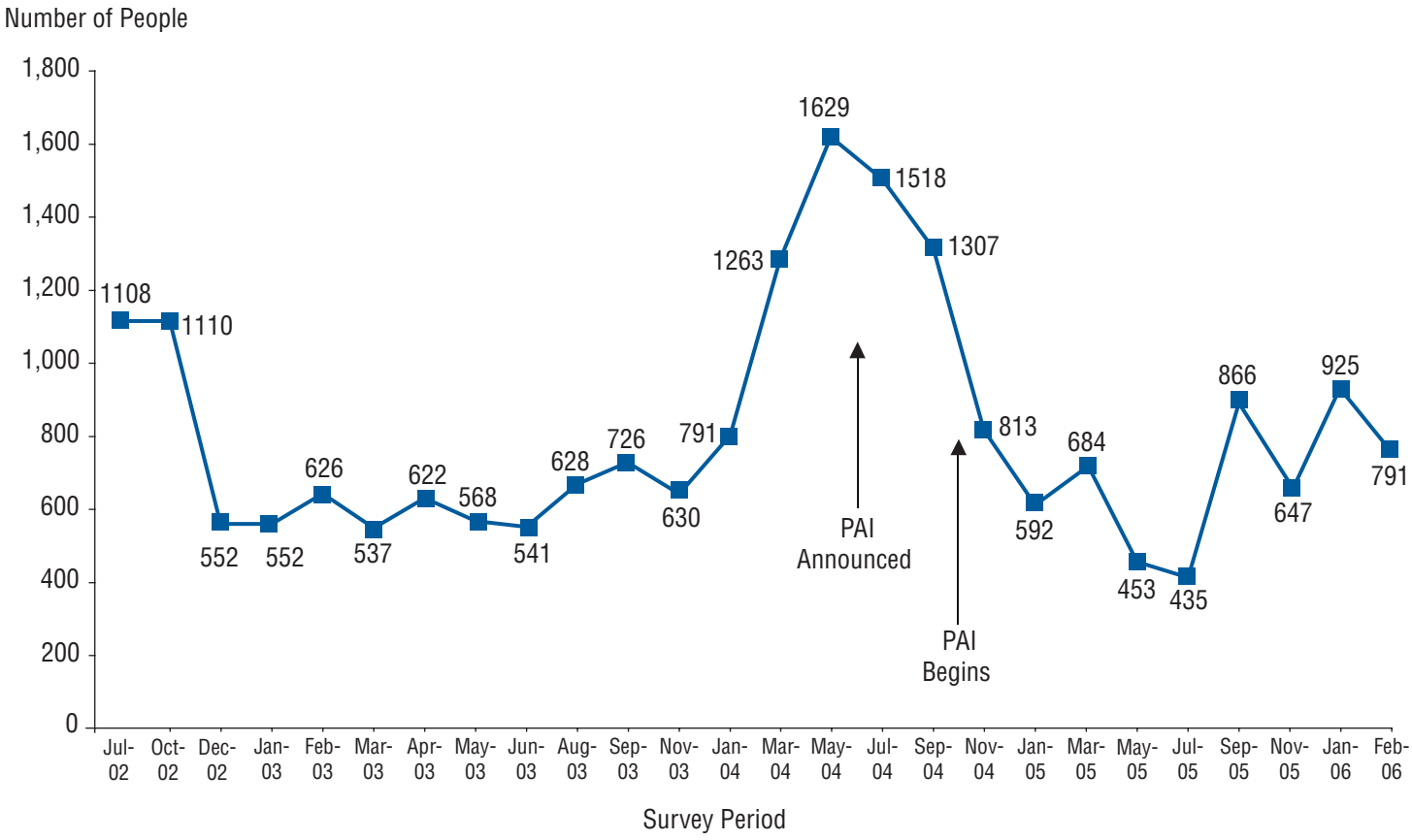
As of February 2006, nine states had waiting lists in place, totaling 791 individuals with HIV who could not gain access to medications through their state's ADAP, despite meeting its eligibility criteria. Seven of these nine states have had waiting lists in place for the previous twelve months, and several for much longer (see Appendix VIII). Four of the nine states are in the U.S. South. In addition to waiting lists, the most visible representation of unmet need for ADAP services, ADAPs have also sought other ways to limit expenditures and some may already have quite limited formularies, very low income eligibility requirements, and/or have instituted further restrictions in these and other areas, even if they do not have an active waiting list in place (see Charts 1, 15, 16, 17 and 23).

Chart 20
Number of States with ADAP Waiting Lists by Survey Period, July 2002–February 2006



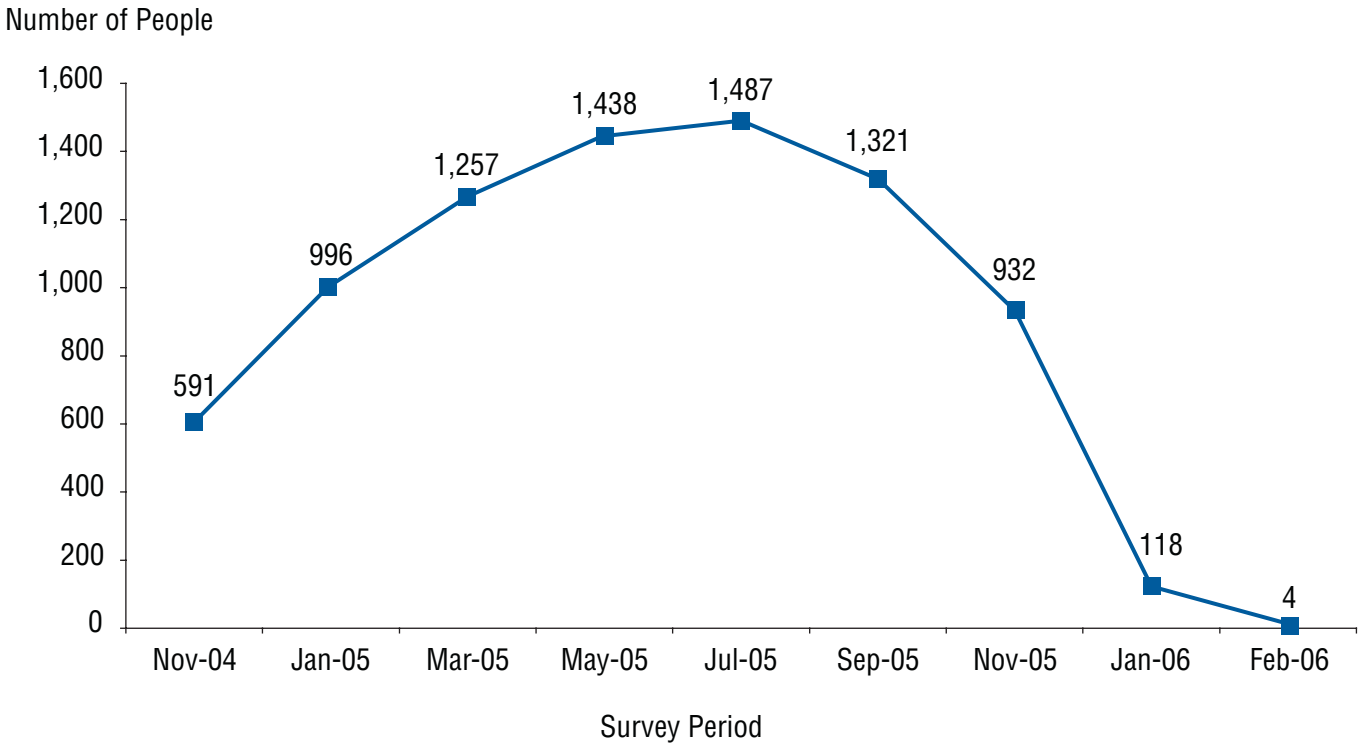
In February 2006, nine ADAPs had waiting lists (totaling 791 people). Data from bi-monthly surveys conducted between July 2002 and February 2006 (26 surveys overall) indicate that 18 different states reported having a waiting list in at least one survey period, ranging from a low of six states in one period to a high of 11 in another. Twelve ADAPs had waiting lists in 10 or more of the survey periods (see Appendix VIII).

Chart 21
Number of People on ADAP Waiting Lists by Survey Period, July 2002–February 2006



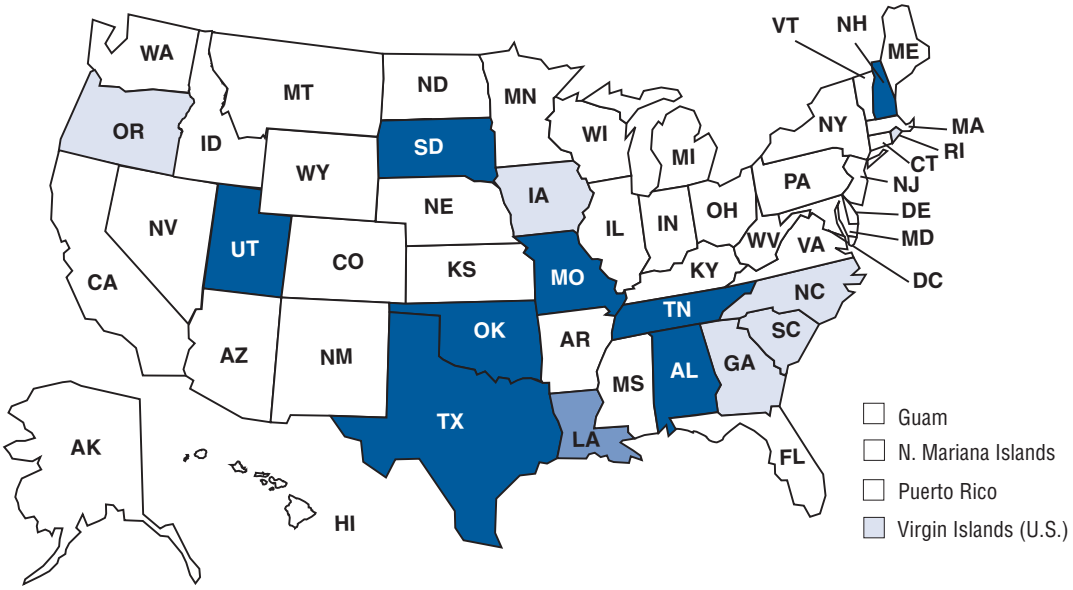
In February 2006, 791 people with HIV/AIDS were on ADAP waiting lists across the country. Waiting lists have been in place in some states for several months, if not years, and there is significant fluctuation in the size of waiting lists within and across states over time. Data from bi-monthly surveys conducted between July 2002 and February 2006 (26 surveys overall), indicate that the number of people on waiting lists ranged from a low of 435 to a high of 1,629, with an average of 804. The highest number of individuals on any one state's waiting list was 891 (North Carolina); the lowest was one (Alaska, Idaho, Montana, and West Virginia). North Carolina had the highest average number of people on its waiting list over the period (337), followed by Alabama (200). The lowest average was four each in Guam and Wyoming (see Appendix VIII).

Chart 22
Number of People on President's ADAP Initiative (PAI) by Survey Period, November 2004–February 2006



The President's ADAP Initiative (PAI), announced in June 2004, provided $20 million in one-time funds targeted to individuals on ADAP waiting lists in 10 states (AK, AL, CO, ID, IA, KY, MT, NC, SD, and WV) (see description on page 10). The first clients were enrolled in the PAI in October 2004. By November 2004, 591 individuals were enrolled, with new enrollees added to the initiative through July 2005. The number of clients receiving medications through the PAI increased significantly through July 2005, when it reached its maximum of 1,487. States were instructed by HRSA's HIV/AIDS Bureau to begin transitioning these PAI clients into their "traditional" ADAPs in September 2005 and to have all clients removed from the PAI by the end of December 2005. Some states were able to absorb the PAI clients into their ADAPs without reinstating them on waiting lists (through increased state funding and/or other methods); however not all were able to do so. Four individuals remained on the program in February 2006 (see Appendix IX). The PAI was scheduled to end in March 2006.

Chart 23
ADAPs with Current or Planned Cost-Containment Measures (other than waiting lists), February 2006



Cost-containment measures in place (8 states), as of February 16, 2006

Current cost-containment measures in place and anticipate the need to implement additional measures in FY 2006 (1 state), as of February 16, 2006

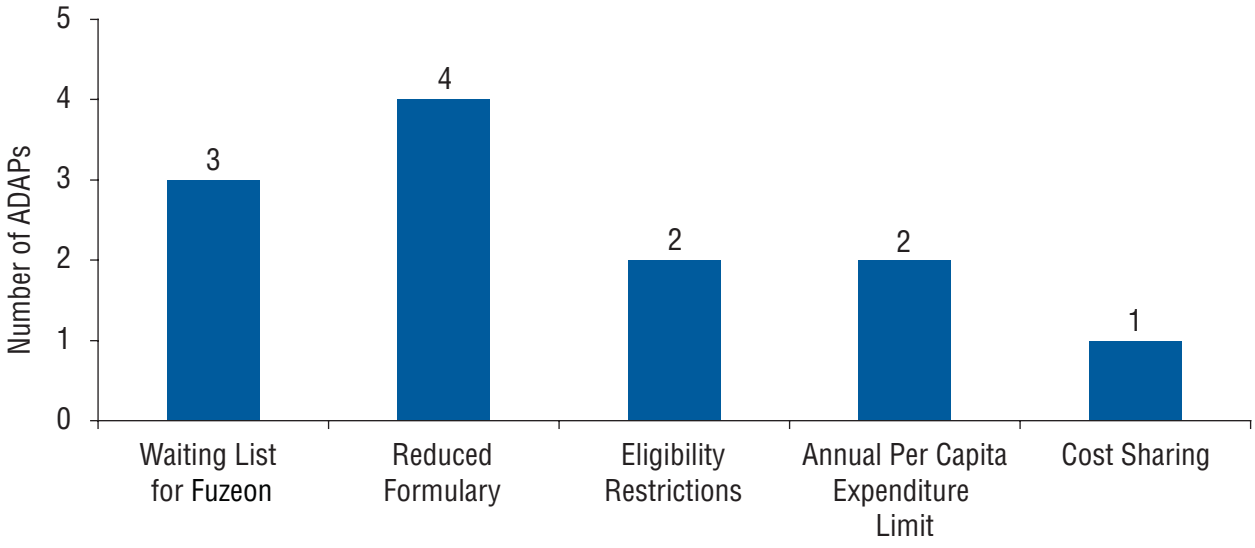
No cost-containment measures in place but anticipate the need to institute cost-containment measures in FY 2006 (9 states), as of February 16, 2006 (Two states did not wish to be named)

No cost-containment measures in place or anticipated

Notes: 55 ADAPs reported data on cost-containment measures. American Samoa and the Marshall Islands are not included. The ADAP fiscal year runs from April 1 through March 31.

As of February 2006, nine ADAPs had cost-containment measures in place, other than waiting lists, including one that anticipates having to institute an additional measure by the end of the ADAP fiscal year 2006 (see Chart 1). One of these states also reported having a client waiting list in place. Five of these states are in the U.S. South. An additional nine ADAPs anticipate having to newly institute cost-containment measures in ADAP FY 2006.

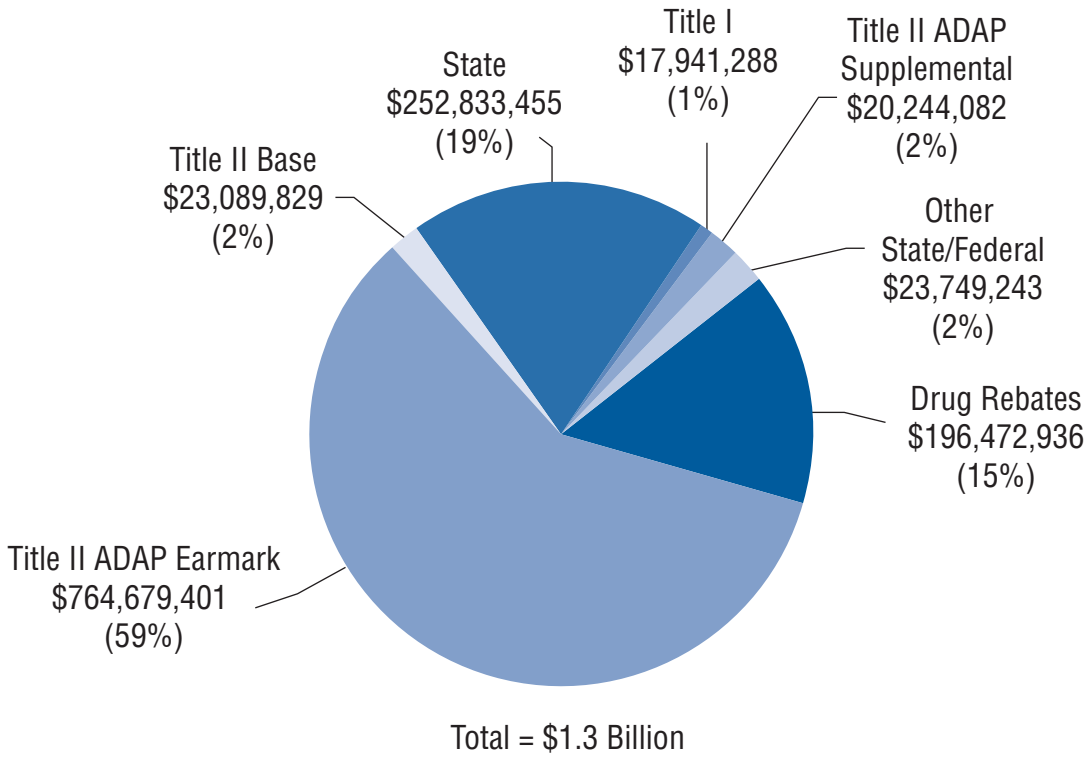
Chart 24
Number of ADAPs with Cost-Containment Measures (other than waiting lists), February 2006



Notes: 55 ADAPs reported data on cost-containment measures. American Samoa and the Marshall Islands are not included. Nine ADAPs reported having cost-containment measures in place—three have two measures each.

As of February 2006, among the states that reported having a current cost-containment measure in place other than a client waiting list: four had reduced the number of drugs on their formularies; three had waiting lists for access to Fuzeon, the only approved Fusion Inhibitor; two further restricted eligibility to the program; and two reported limiting annual per-client expenditures. One state has begun requiring ADAP clients to pay cost sharing (co-payments) in order to participate in the program (see Chart 1).

Chart 25
National ADAP Budget, by Source, FY 2005



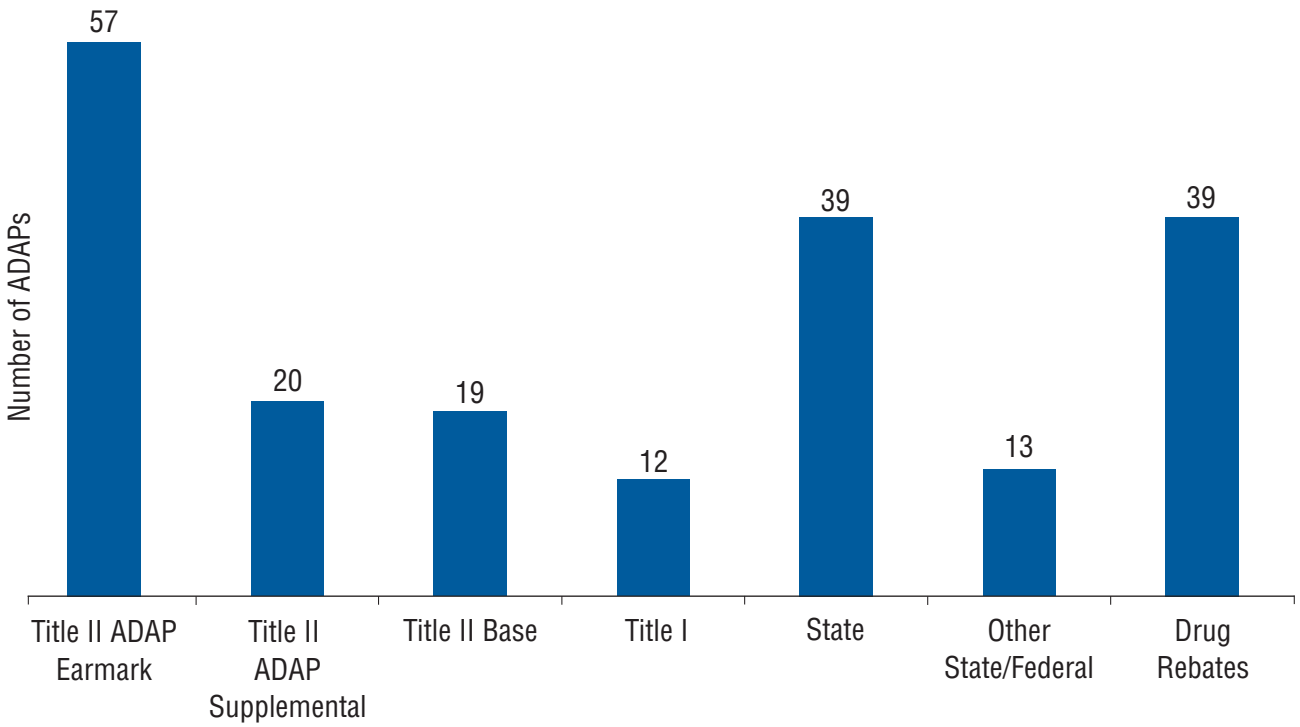
Notes: 53 ADAPs reported all National ADAP Budget data. National ADAP Budget includes FY 2005 federal Title II ADAP earmark and Title II ADAP supplemental only for American Samoa, the Marshall Islands, New Mexico, and Rhode Island.

In FY 2005, the National ADAP Budget totaled $1.3 billion, up from $1.19 billion in FY 2004 (a 10% increase). The Title II ADAP earmark represented the largest share of the ADAP budget, accounting for $764.7 million, or 59%, of total ADAP funding in FY 2005, a slightly smaller share than last year (61%). State funding followed at $252.8 million, or 19% (the same share as last year). Title II base funding, other State and Federal funding, and Title II ADAP supplemental grants each represented approximately two percent or less of the total ADAP budget. Title I EMA funding decreased as a share of the budget in FY 2005 to one percent compared with two percent in FY 2004 (see Appendix X).

Drug rebates account for a growing share of the ADAP budget over time, reaching $196.5 million or 15% of the budget in FY 2005. Rebates are an increasingly important source of revenue for ADAPs and were the biggest driver of the total budget increase between FY 2004 and FY 2005. (Note: ADAP Monitoring Reports prior to March 2005 did not include drug rebates as part of the national budget; the current and all prior year budgets have been adjusted to include drug rebates for comparison purposes).

FY 2005 budgets range from $2,360 in American Samoa and the Marshall Islands to approximately $264 million in California.

Chart 26
Number of ADAPs, by Budget Source, FY 2005

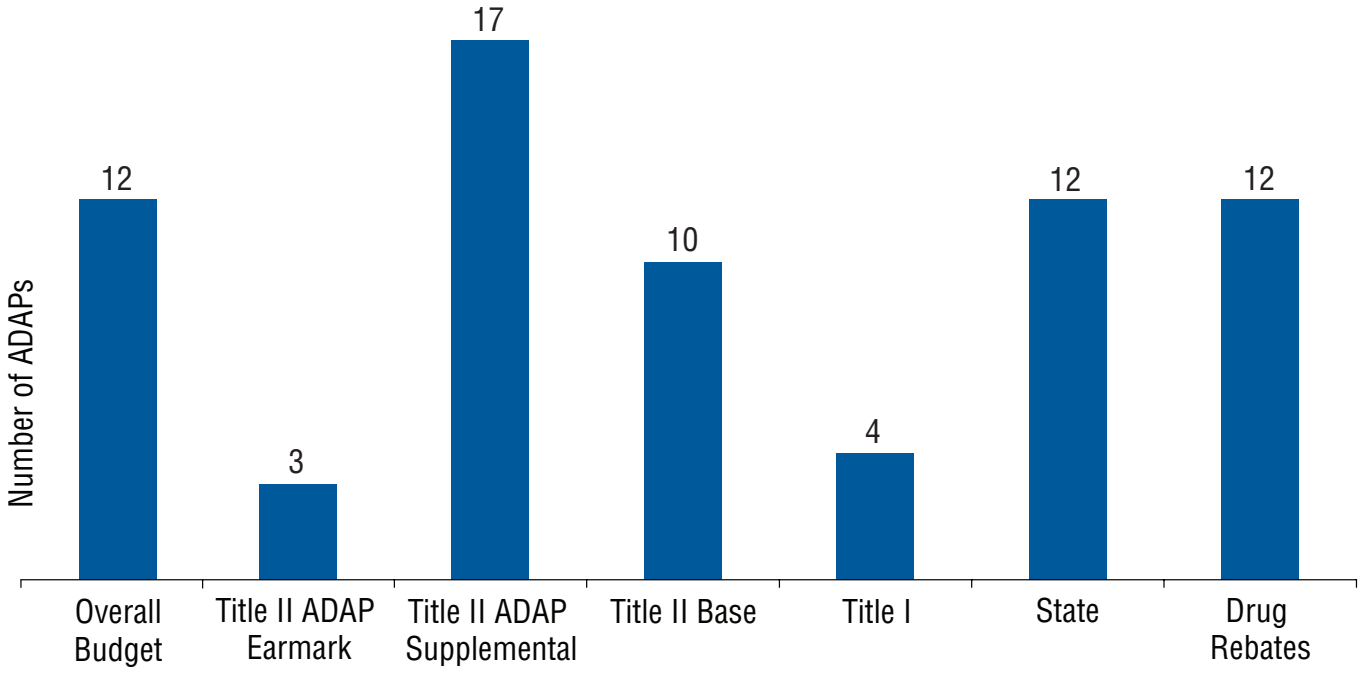


Notes: 53 ADAPs reported all National ADAP Budget data. American Samoa, the Marshall Islands, New Mexico, and Rhode Island only included above in Title II ADAP Earmark and Title II ADAP Supplemental. Data for other categories not reported for those jurisdictions.

By definition, all eligible jurisdictions (57) receive federal ADAP earmark funding based on a formula, but not all ADAPs receive funding from other sources, which are often dependent on individual state and local planning, policy, and/or legislative decisions, as well as resource availability. In FY 2005, four ADAPs received only ADAP earmark funding. The breakdown of other sources of funding across the country was as follows (among the 53 ADAPs reporting data):

- Title II ADAP Supplemental Treatment Grants: 20 ADAPs received funding, 37 did not;
- Title II Base Funds: 19 ADAPs received funding, 34 did not;
- Title I EMA Funds: 12 ADAPs received funding, 41 did not;
- State General Revenue Support: 39 ADAPs received funding, 14 did not;
- Other State/Federal Funds: 13 received funding, 40 did not;
- Drug Rebates: 39 ADAPs received funding, 14 did not.

Chart 27
Number of ADAPs with Funding Decreases, by Budget Source, FY 2004–FY 2005

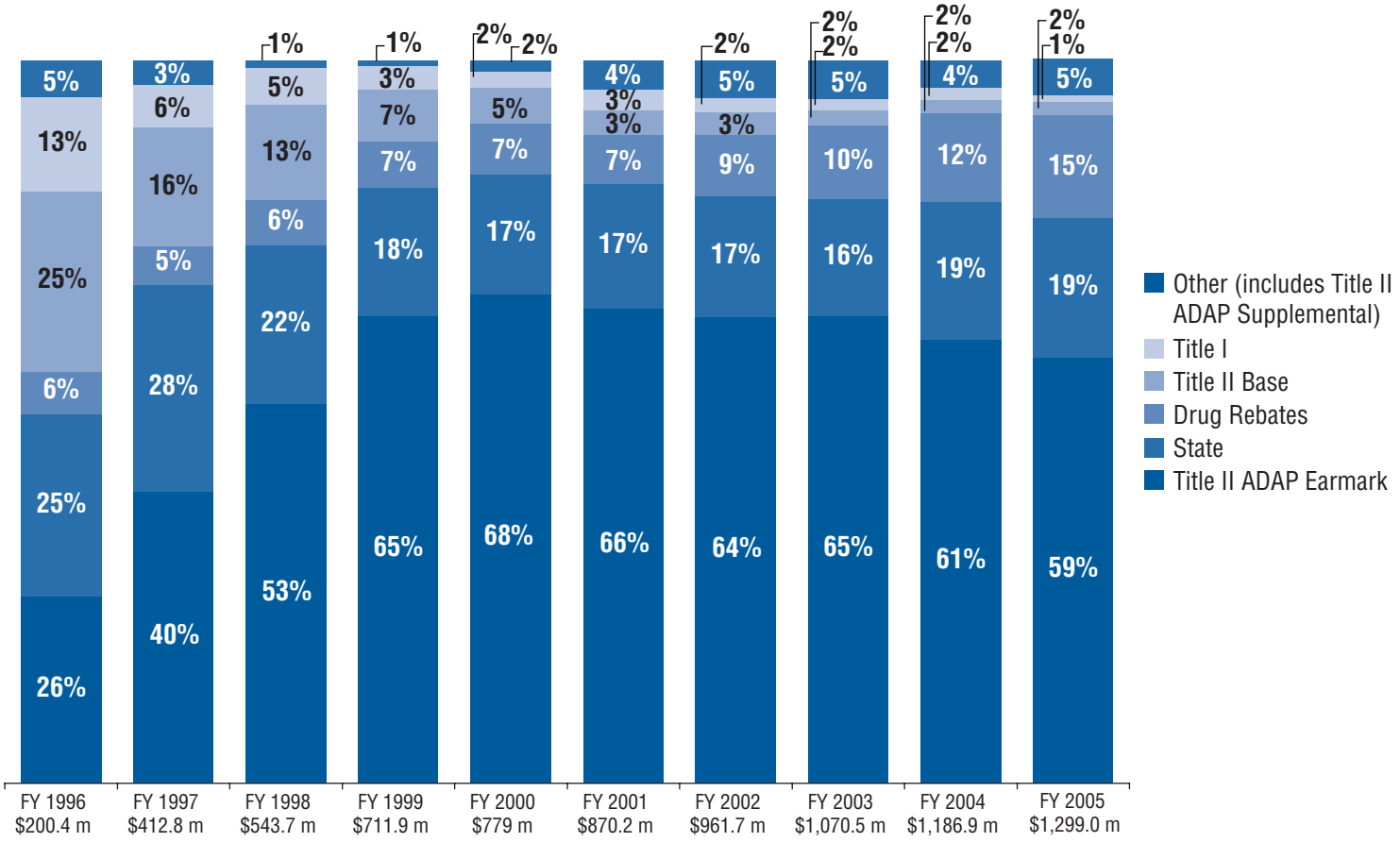


Notes: 53 ADAPs reported all National ADAP Budget data. American Samoa, the Marshall Islands, New Mexico, and Rhode Island included only in Title II ADAP Earmark and Title II ADAP Supplemental.

Despite a ten percent increase in the National ADAP Budget across all ADAPs between FY 2004 and FY 2005, some ADAPs had decreases either in their overall budget or for specific funding streams as follows:

- Overall Budget: 43 ADAPs had increases or level funding, 12 had decreases;
- Title II ADAP Earmark: 54 ADAPs had increases; three had decreases;
- Title II ADAP Supplemental Treatment Grants: 3 ADAPs had increases; 17 had decreases;
- Title II Base Funds: 10 ADAPs had increases or level funding; 10 had decreases;
- Title I EMA Funds: nine ADAPs had increases or level funding, four had decreases;
- State General Revenue Support: 32 ADAPs had increases or level funding, 12 had decreases;
- Drug Rebates: 31 ADAPs had increases or level funding, 12 had decreases.

Chart 28
National ADAP Budget, by Source, FY 1996–FY 2005

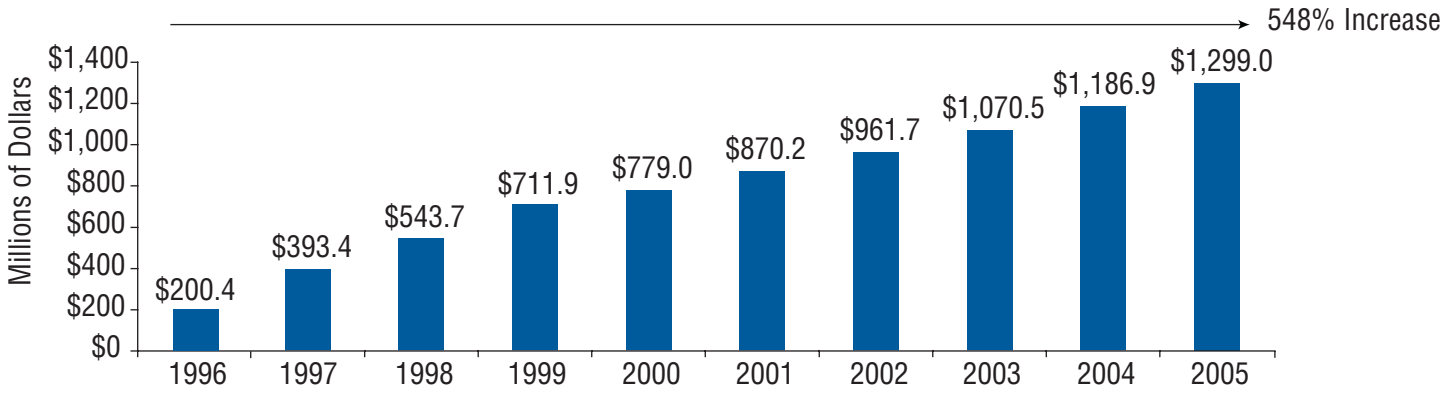


The composition of the national ADAP budget has changed since FY 1996, the year in which the Title II ADAP earmark began. The earmark has grown significantly as a proportion of the budget, rising from 26% of the budget in FY 1996 to 59% in FY 2005. State funding has declined as a proportion of the national ADAP budget (25% in FY 1996 and 19% in FY 2005), but has increased significantly in amount and has been the second largest source of ADAP revenue over the entire period. Manufacturers' drug rebates have risen from six percent in FY 1996 to 15% in FY 2005, and are now the third largest source of revenue for ADAPs.

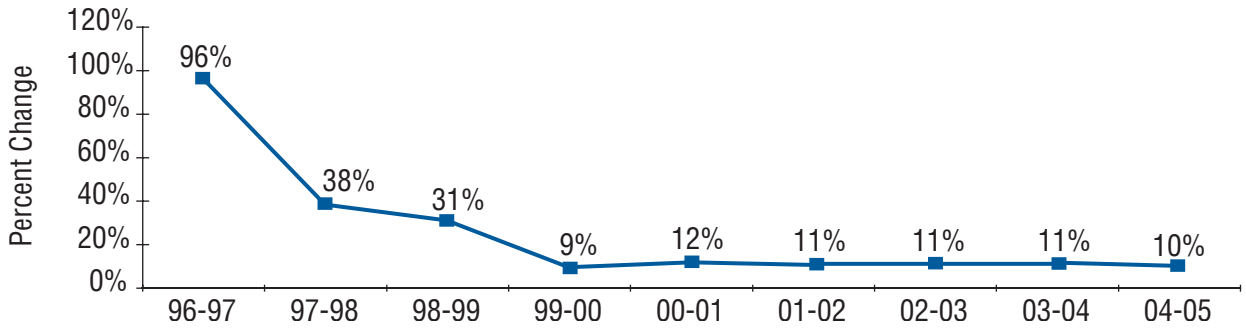
Title II base funding as a proportion of the total ADAP budget has declined markedly, from 25% in FY 1996 to two percent in FY 2005. Title I EMA funding has also decreased significantly over time as a share of the budget (13% in FY 1996 to 1% in FY 2005). Title II base and Title I EMA contributions are the only two funding sources in the national ADAP budget that were less in amount in FY 2005 than in FY 1996 (see Appendix X).

Chart 29

The National ADAP Budget, FY 1996–2005



The National ADAP Budget, Rate of Growth, FY 1996–2005

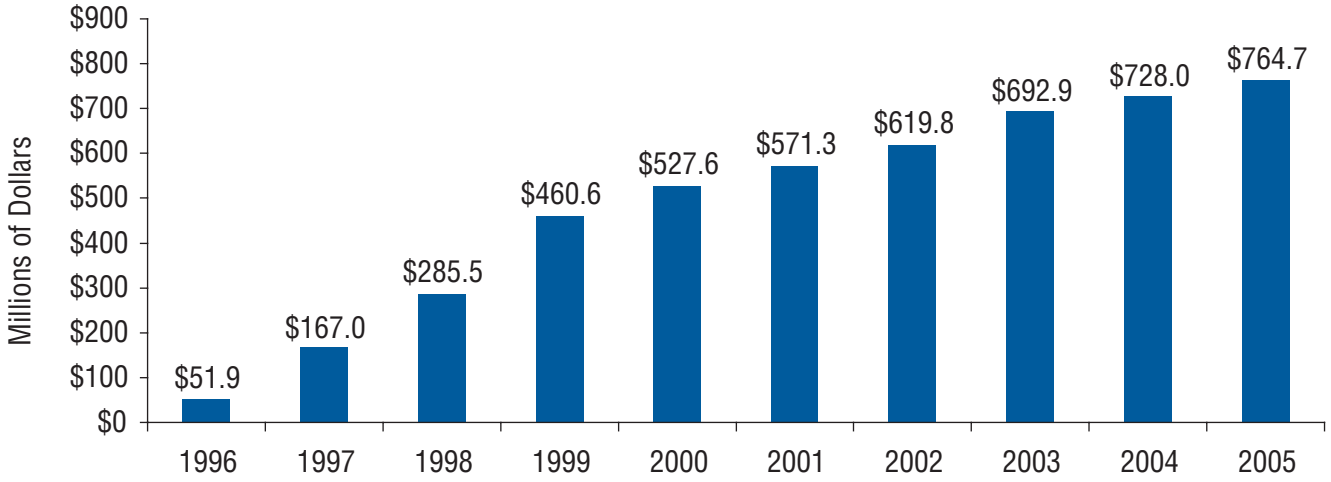


Notes: 53 ADAPs reported National ADAP Budget data. American Samoa, the Marshall Islands, New Mexico, and Rhode Island included in Title II ADAP Earmark and Title II ADAP Supplemental categories only. Percentages on the *National ADAP Budget Rate of Growth* graph represent changes between the two years indicated, not aggregate changes since FY 1996.

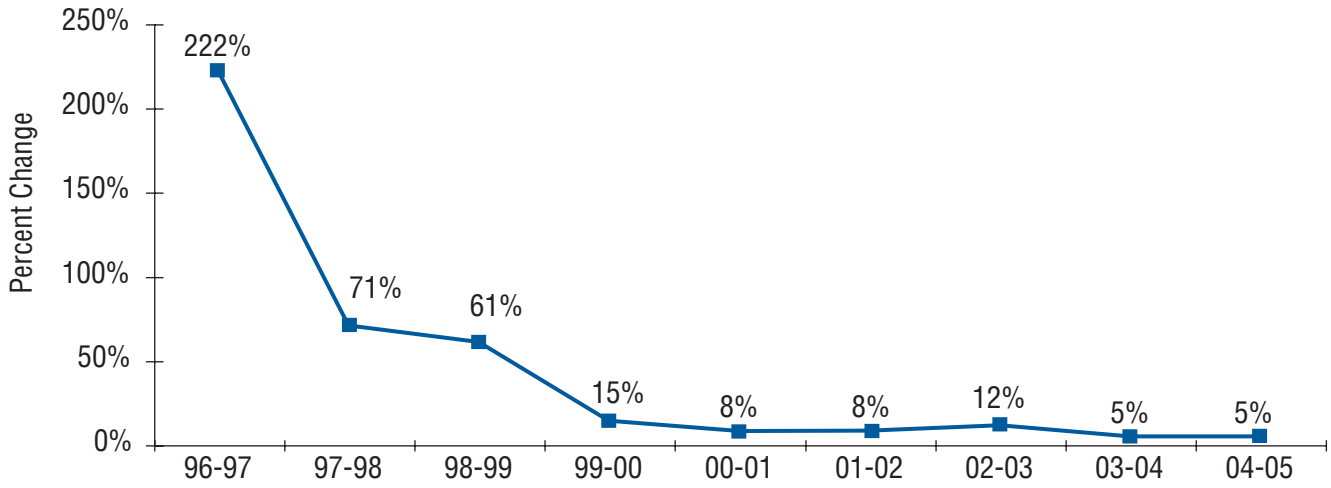
The national ADAP budget grew to $1.3 billion in FY 2005, a $113 million or ten percent increase over the prior year (see Appendix XI). Since FY 1996, the first year of the National ADAP Monitoring Project and the year in which highly active antiretroviral therapy (HAART) emerged as the new standard of care, the national budget has increased by more than six-fold (a 548% increase). The budget has grown each year since 1996, but generally at slower rates since an initial growth spurt between 1996 and 1997; since 1999, the annual rate of increase has ranged between nine and twelve percent.

Chart 30

Title II ADAP Earmark, FY 1996–2005



Title II ADAP Earmark, Rate of Growth, FY 1996–2005

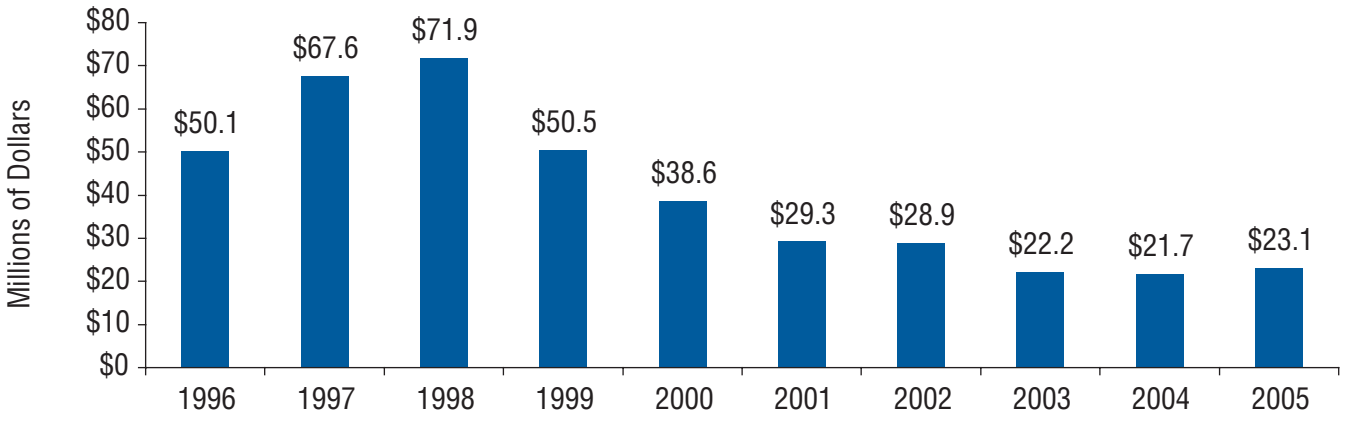


Notes: Includes data from all 57 ADAPs. Percentages on the *ADAP Earmark Rate of Growth* graph represent changes between the two years indicated, not aggregate changes since FY 1996. ADAP Earmark does not include ADAP Supplemental Funds set-aside from FY 2001–FY 2005.

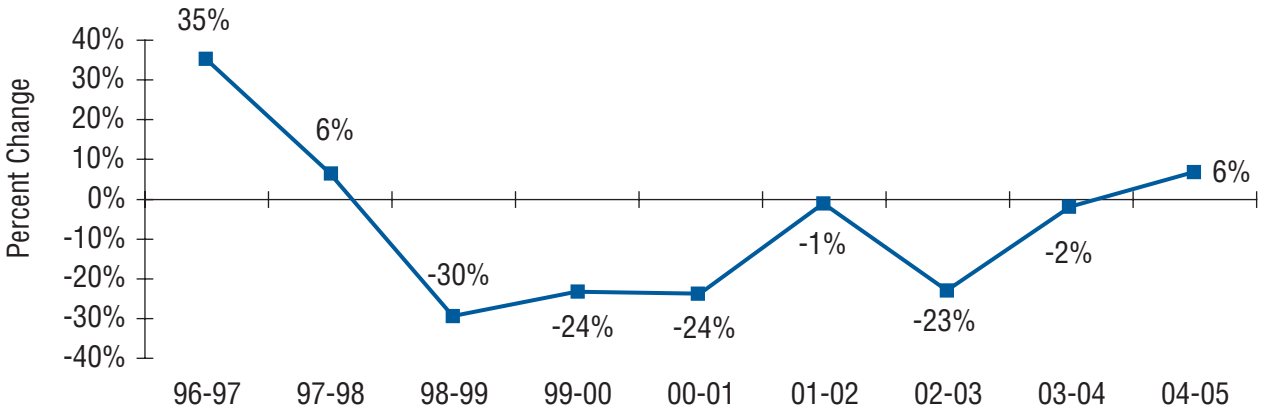
The Title II ADAP earmark represents funding appropriated each year by Congress under Title II of the CARE Act that is specifically designated for ADAPs. The earmark—the largest component of the national ADAP budget—grew by $36.7 million (5%) between FY 2004 and 2005, to $764.7 million, the second year at its smallest increase since it began (see Appendices X and XII). Note: ADAP supplemental awards are counted separately in this report. (see page 5 for description).

Chart 31

Title II Base Funding, FY 1996–2005



Title II Base Funding, Rate of Growth, FY 1996–2005

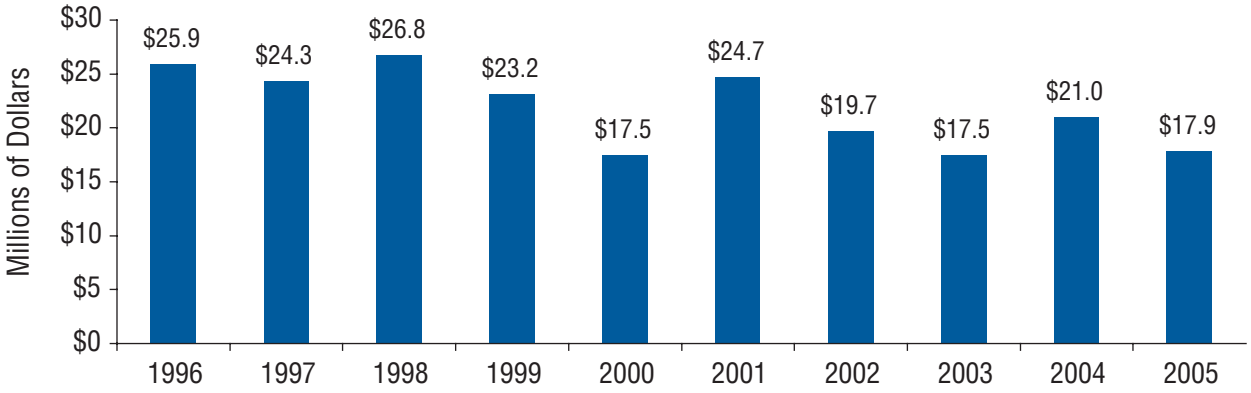


Notes: 53 ADAPs reported Title II Base Funding data. American Samoa, the Marshall Islands, New Mexico, and Rhode Island are not included. Percentages on the *Title II Base Funding Rate of Growth* graph represent changes between the two years indicated, not aggregate changes since FY 1996.

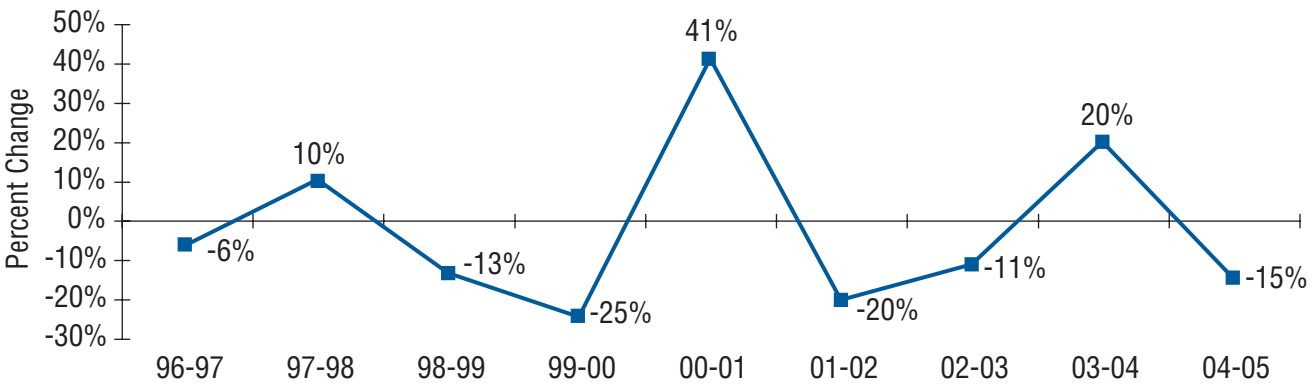
States receive CARE Act Title II base funds (funds through Title II other than those earmarked for ADAP) based on a formula and they are not required to allocate these funds to ADAPs, although historically many states have found this necessary to fill the gap of the ADAP earmark awards and need (see page 5 for description). Title II base funds allocated by states to ADAPs declined each year between FY 1999 and FY 2004. In FY 2005, Title II base funds rose slightly over FY 2004 to $23.1 million. In FY 2005, 19 states allocated Title II base funds to their ADAPs, down from 20 in FY 2004 (see Appendices X and XII). As noted in previous reports, declines in Title II base funding provided to ADAPs may be related to a state's overall Title II base award amount or its decision to fund other services allowable under Title II base funds, including primary care, mental health care, substance abuse treatment, and supportive services to maintain clients on HAART and improve their drug adherence. In addition, states have greater flexibility to spend Title II base funding in other ways (due to changes made during prior reauthorizations of the CARE Act) and may also use these funds for cost-effective insurance purchasing and continuation programs.

Chart 32

Title I EMA Funding, FY 1996–2005



Title I EMA Funding, Rate of Growth, FY 1996–2005

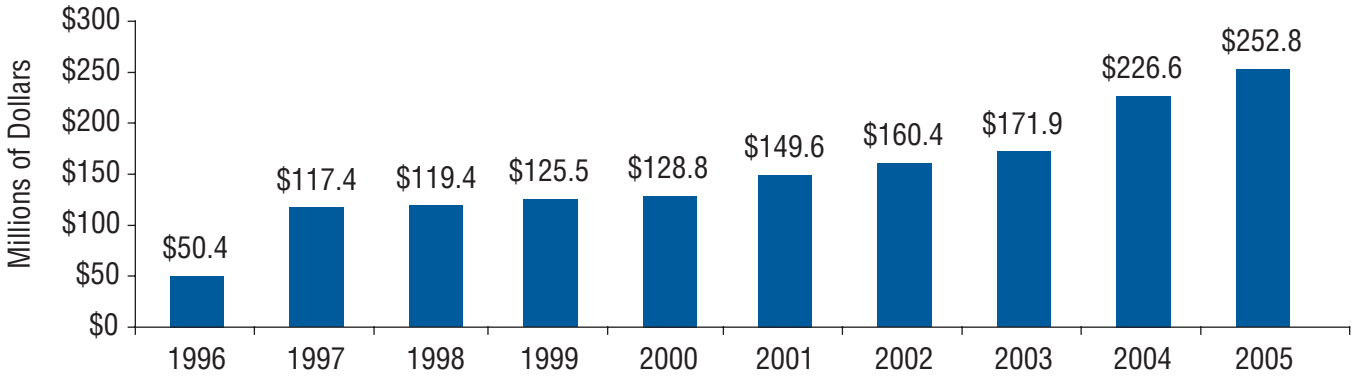


Notes: 53 ADAPs reported Title I funding data. American Samoa, the Marshall Islands, New Mexico, and Rhode Island did not report data, although they do not have Title I areas within their borders. Percentages on the *Title I EMA Funding Rate of Growth* graph represent changes between the two years indicated, not aggregate changes since FY 1996.

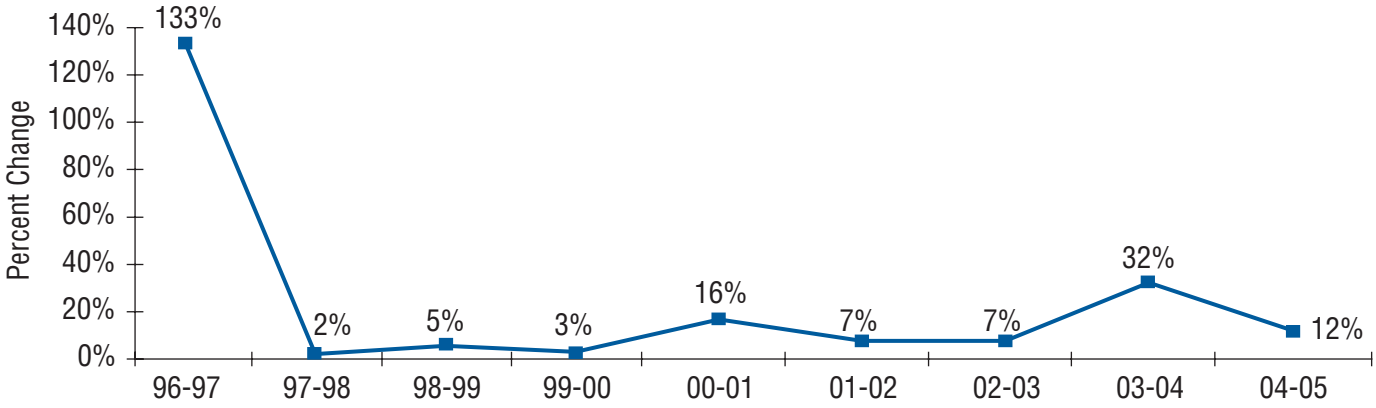
While states make decisions regarding allocation of state general revenue funds (other than matching requirements for ADAP supplemental funding) and Title II base funds to ADAPs, local Ryan White HIV Services Planning Councils make allocation decisions regarding Title I funds. In FY 2005, 12 Title I Eligible Metropolitan Areas (EMAs) contributed a total of $17.9 million to their states' ADAPs to purchase medications for clients living within the Title I EMA. FY 2005 ADAP contributions from Title I EMAs decreased by $3 million, or 15%, from FY 2004. These voluntary Title I contributions to ADAP represented one percent of the national ADAP budget, a slight decrease over last year (2% in FY 2004) (see Appendices X and XII).

Chart 33

State Funding, FY 1996–2005



State Funding, Rate of Growth, FY 1996–2005

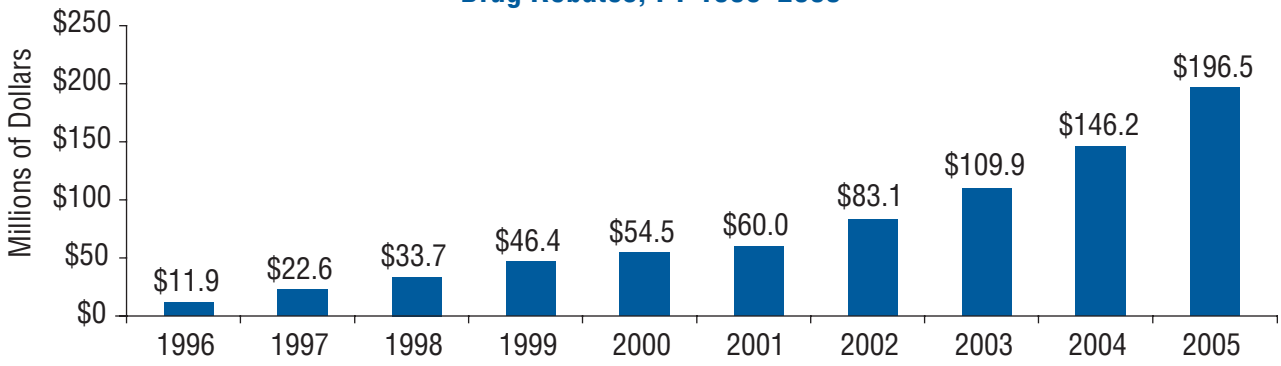


Notes: 53 ADAPs reported state funding data. American Samoa, the Marshall Islands, New Mexico, and Rhode Island are not included. Percentages on the *State Funding Rate of Growth* graph represent changes between the two years indicated, not aggregate changes since FY 1996.

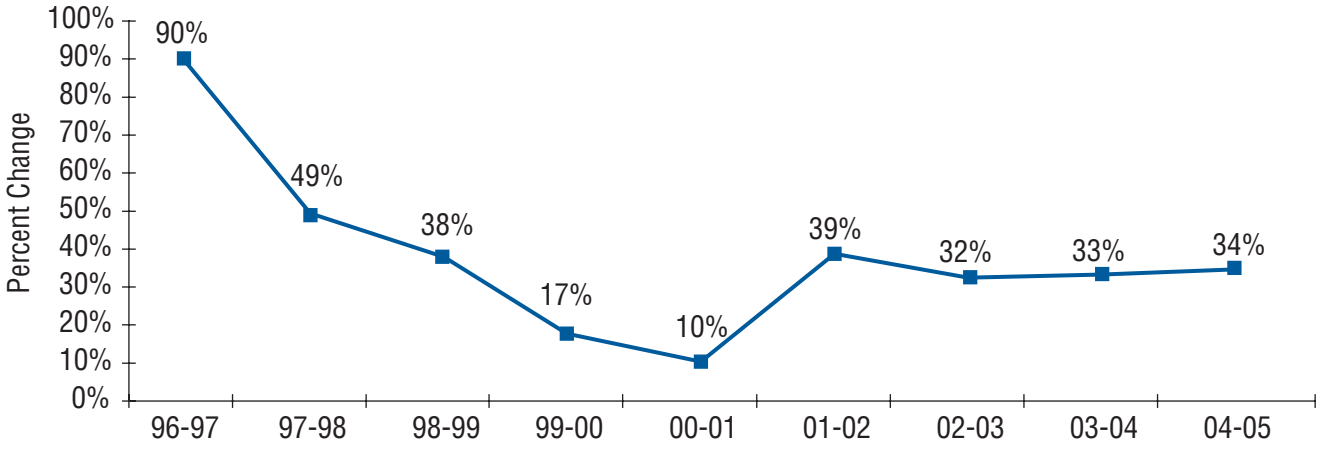
State general revenue funding for ADAPs reached $252.8 million in FY 2005, an increase of $26.2 million or 12% over FY 2004. State funding for ADAPs is the second largest component (19%) of the ADAP budget. Thirty-nine states contributed general revenue funds to ADAP in FY 2005, compared to 40 in FY 2004 (see Appendices X and XII). State funding for ADAPs varies significantly across the country, ranging from 0% of their overall budget in those states that do not contribute to a high of 50% (Wyoming) in FY 2005 (see Chart 1 and Appendix X). Some states are required to match a portion of their federal ADAP funding (see page 5 for description).

Chart 34

Drug Rebates, FY 1996–2005



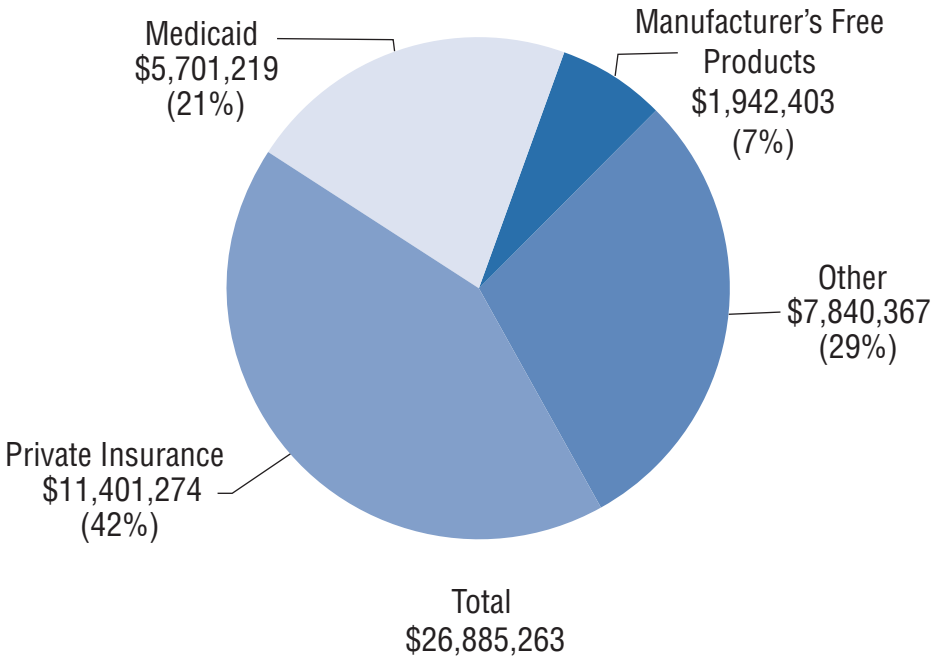
Drug Rebates, Rate of Growth, FY 1996–2005



Notes: 53 ADAPs reported drug rebate data. American Samoa, the Marshall Islands, New Mexico, and Rhode Island are not included. Percentages on the *Drug Rebates Rate of Growth* graph represent changes between the two years indicated, not aggregate changes since FY 1996.

Manufacturers' drug rebates totaled $196.5 million in FY 2005, an increase of $50.3 million, or 34%, over FY 2004. Funding from rebates is now the third largest component of the ADAP budget (15%), after the federal earmark and state funding (see Appendices X and XII). This was the first year in which rebates experienced the largest increase of any component of the budget. Drug rebates may be voluntary (such as those negotiated with manufacturers and the ADAP Crisis Task Force—see page 11 for description), mandated by state law, or mandated and available to ADAPs as 340B entities. The mandated 340B discounts for ADAPs are realized by direct purchase states at the time medications are purchased and are not reflected in estimated rebates (see Chart 36 and Appendix XIV).

Chart 35
Cost Recovery and Other Cost Saving Mechanisms (Excluding Drug Rebates), FY 2005

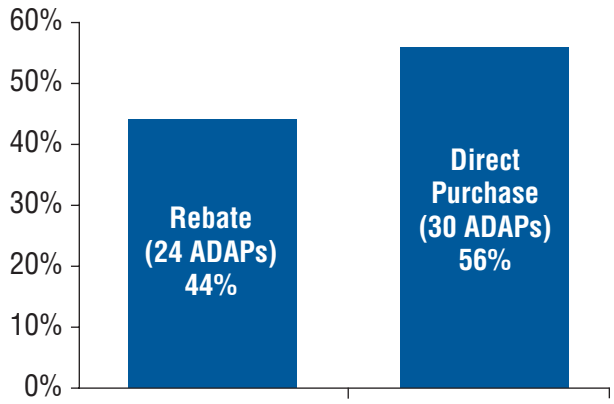


Notes: 18 ADAPs reported data from cost recovery or other cost savings mechanisms. Manufacturers' drug rebates are not included here. Cost recovery and other cost saving mechanisms are not included in the National ADAP Budget. Percentages may not total 100% due to rounding.

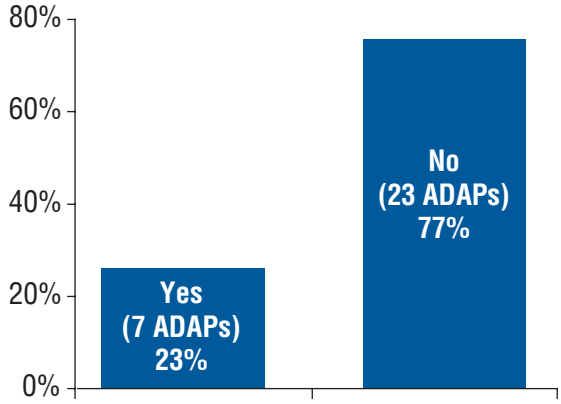
Cost recovery represents reimbursement to ADAPs from other entities for medications purchased through the ADAP. Cost recovery from sources other than rebates represented $26.9 million to ADAPs in FY 2005. Private insurance recovery, in which an ADAP receives reimbursement from insurance providers for medications purchased for their clients, represents the primary recovery source. However, it decreased significantly as a proportion of total cost recovery compared to FY 2004 ($11.4 million, or 42% in FY 2005 vs. 69% in FY 2004). Insurance recovery from Medicaid represents $5.7 million, or 21% of ADAP cost recovery. Other recovery ($7.8 million, or 29%) includes income received from sources such as other state public assistance programs, cost sharing, and state carryover from previous state fiscal years. These contributions made up a much larger proportion of total cost recovery compared to FY 2004 (29% in FY 2005 vs. 16% in FY 2004) (see Appendix XIII).

Chart 36

ADAP Drug Purchasing Mechanisms, FY 2005



Direct Purchase ADAPs Participating in HRSA Prime Vendor Program, FY 2005



Notes: 54 ADAPs reported drug purchasing mechanism data. American Samoa, the Marshall Islands, and Rhode Island did not report data.

The Section 340B Drug Discount Program, authorized under the Veterans' Health Care Act of 1992, allows certain U.S. Public Health Service covered entities, including ADAPs, to access at least the same drug price discounts as Medicaid. Participation in the 340B program is not mandatory but is strongly encouraged by HRSA, and all but three ADAPs participate (51 of the 54 jurisdictions reporting data; the District of Columbia, Guam, and the Northern Mariana Islands do not participate). States that participate in the 340B program may purchase drugs either directly from wholesalers or through retail pharmacies and then apply to drug manufacturers for rebates. As of June 2005, 30 ADAPs reported using a direct purchase option and 24 reported purchasing through a pharmacy network and then seeking rebates (see Appendix XIV).

Direct purchase ADAPs may choose to enroll and purchase drugs with negotiated supplemental discounts via the HRSA Prime Vendor Program. The "prime vendor" is an entity that negotiates with manufacturers on behalf of a group of purchasers, in this case 340B covered entities, to achieve sub-340B prices. The prime vendor negotiates up-front price discounts only, and as a result, only direct purchase covered entities can participate in this program. Because the group has larger purchasing power than any one entity, the prime vendor can theoretically achieve greater discounts. Seven of the 30 direct purchase ADAPs reported being enrolled in the HRSA Prime Vendor Program in June 2005 (see Appendix XIV). As of March 2006, only one antiretroviral HIV drug, Epzicom, was included on the list of drugs with negotiated supplemental discounts through the prime vendor. While the prime vendor is only available to ADAPs that purchase directly, the ADAP Crisis Task Force has worked with all ADAPs (direct purchasers and pharmacy network ADAPs) to achieve below 340B pricing for all antiretrovirals.

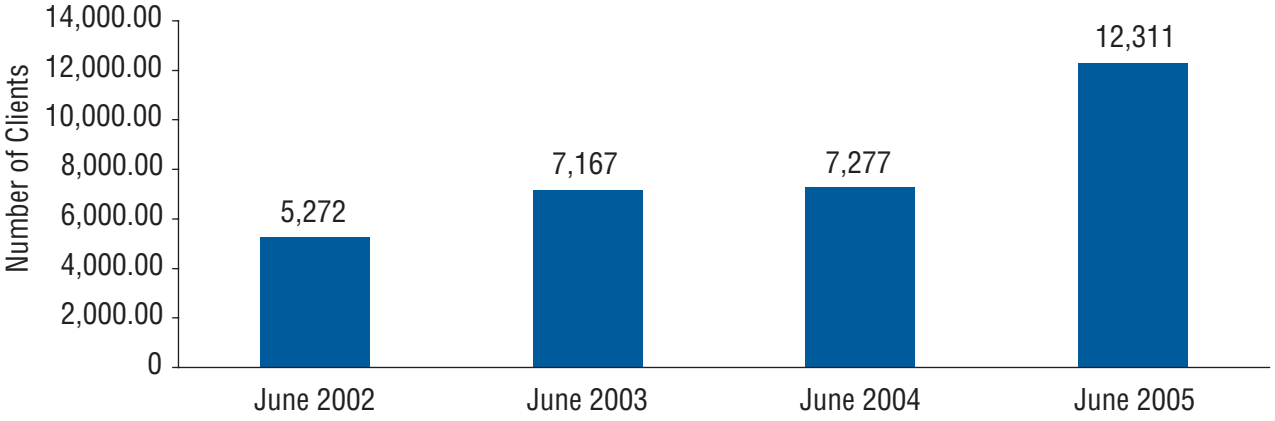
For ADAPs that choose not to participate in the 340B program, HRSA requires that they show that they are receiving 340B or better prices/rebates on formulary drugs through other means. The District of Columbia purchases drugs through the Department of Defense, allowing it to access the Federal Ceiling Price, a lower price only available to certain federal purchasers. The Northern Mariana Islands ADAP purchases drugs through the Veterans Affairs (VA) pharmacy prime vendor program.

States have other options for achieving lower drug prices. For example, several states that participate in the 340B program also have state laws or their own negotiation processes that result in prices lower than 340B ceiling prices. In addition, the ADAP Crisis Task Force has been successful in negotiating prices lower than 340B ceiling prices for all states; the Task Force estimates that these negotiations led to an additional $145 million in supplemental rebates and discounts in FY 2005 (see page 11 for description).

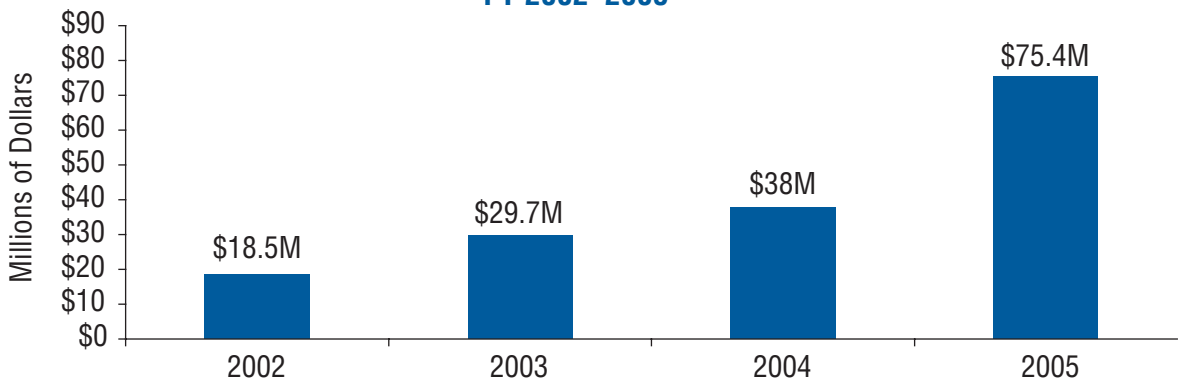
For more information on ADAP drug purchasing mechanisms, see NASTAD/KFF/ATDN, *AIDS Drug Assistance Programs—Getting the Best Price?*, April 2002. Available at: http://www.kff.org/hivaids/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14159.

Chart 37

Clients Served in Insurance Purchasing/Maintenance Programs, 2002–2005 (June)



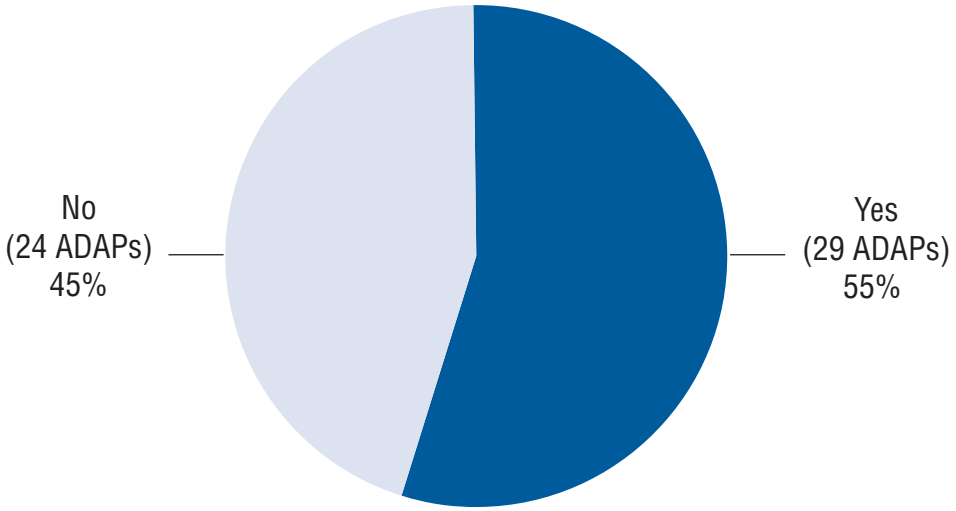
Estimated ADAP Spending on Insurance Purchasing/Maintenance Programs, FY 2002–2005



Notes: 29 ADAPs reported insurance purchasing/maintenance program data. Includes purchasing health insurance and paying insurance premiums, co-payments, and/or deductibles.

The Ryan White CARE Act allows states to use ADAP earmark dollars to purchase health insurance and/or pay insurance premiums, co-payments and/or deductibles for individuals eligible for ADAP, provided the insurance has comparable or improved formulary benefits to that of the state ADAP. Twenty-nine states (up from 26 states in FY 2004) reported using ADAP funds for this purpose, representing $75.4 million. This is nearly double the amount spent in FY 2004 (see Appendix XV). In June 2005, an estimated 12,311 ADAP clients were served by these ADAPs under such arrangements, approximately 5,000 more clients than in June 2004 (some of these clients may have also received medications through ADAP). Insurance purchasing and maintenance strategies appear to be cost effective—in June 2005, spending on insurance represented an estimated $513 per capita, significantly less than per capita drug expenditures in that month ($1,064).

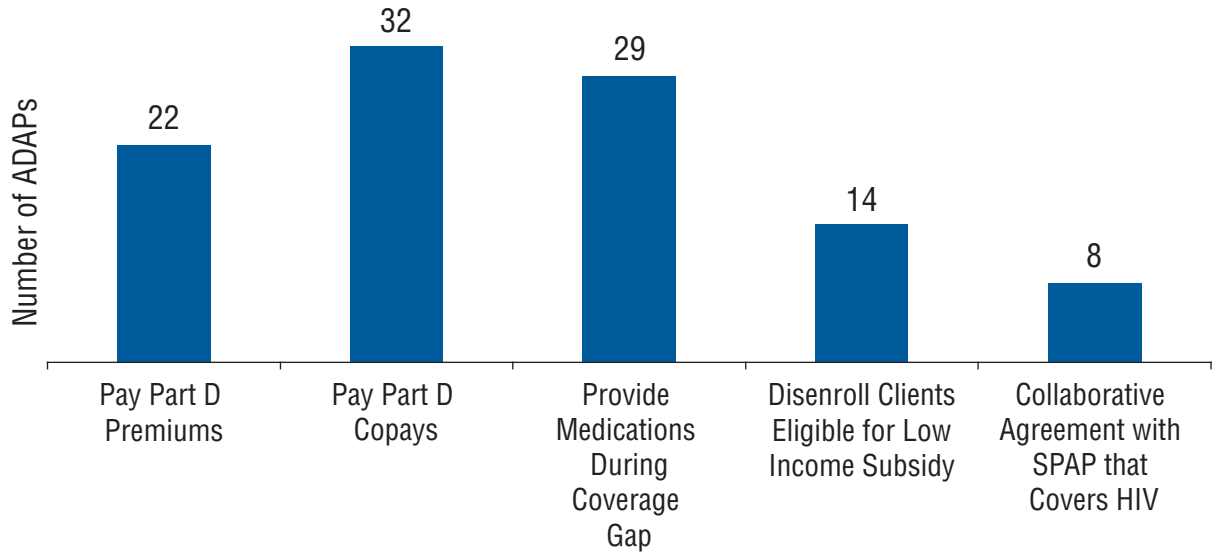
Chart 38
ADAP Coverage of Insurance Premiums, Co-Payments, and/or Deductibles, June 2005



Notes: 53 ADAPs reported whether or not they utilized ADAP funds to purchase/maintain insurance. American Samoa, the Marshall Islands, New Mexico, and Rhode Island did not report and are not included.

A majority of ADAPs (29) report using ADAP earmark funds to purchase health insurance and/or pay insurance premiums, co-payments and/or deductibles for individuals eligible for ADAP (see Chart 37 and Appendix XV).

Chart 39
ADAP Policies Related to Medicare Part D, as of November 2005



The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a new outpatient prescription drug benefit, Part D, to the Medicare program effective January 1, 2006. An estimated 13% of ADAP clients are Medicare eligible (representing more than 12,000 clients who used services in June 2005, and more than 17,000 of all enrolled clients). A subset of these clients is dually eligible for Medicare and Medicaid.

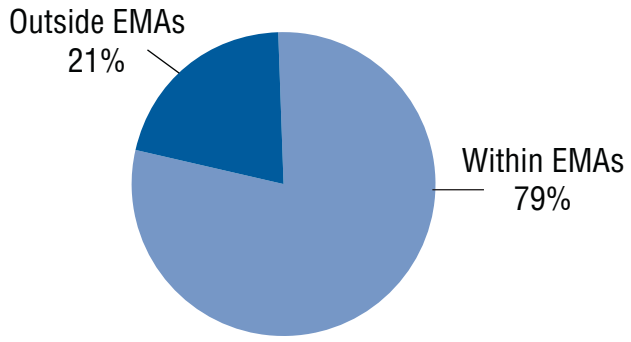
ADAPs are required by HRSA to ensure that all Medicare Part D eligible clients enroll in a Medicare prescription drug plan. ADAPs are permitted to coordinate with Medicare prescription drug plans and pay for drug plan premiums, deductibles, coinsurance, and co-payments. However, the MMA does not allow ADAP funds (either federal or state) to be applied to True Out of Pocket Costs (TrOOP), the costs clients must incur before reaching catastrophic coverage thresholds under Part D. To meet these federal requirements and maintain appropriate medication coverage for their clients, most ADAPs have developed policies to coordinate with the Part D benefit.

Thirty-two ADAPs will pay Part D co-payments for their Part D eligible ADAP clients; 22 will pay Part D premiums; 29 will pay for all medications on their ADAP formularies when their Part D clients reach the coverage gap (so called “doughnut hole”); 14 ADAPs plan to disenroll clients from their ADAPs if determined to be eligible for the Low Income Subsidy available under Medicare Part D; and eight ADAPs have collaborative agreements with their State Pharmacy Assistance Programs (SPAPs) to provide ADAP Medicare eligible clients with medications (see Appendix XVI). Some ADAPs, while not paying for wrap-around services, will continue to provide drugs on their formulary to Medicare eligible clients who are not eligible for the Low Income Subsidy.

It should be noted that these policies are current as of November 2005 and ADAPs may change their coordination plans as the benefit is implemented.

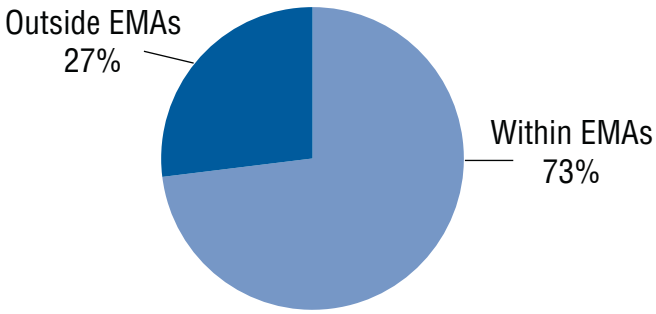
Chart 40

ADAP Clients Served in June 2005 Who Reside within Title I EMAs, in 29 States with EMAs (or portions of EMAs)



Note: EMA clients in North Carolina, Puerto Rico, and Wisconsin are not included, nor are clients in any states without EMAs.

ADAP Clients Served in June 2005 Who Reside within Title I EMAs, All States



Note: American Samoa, the Marshall Islands, New Mexico, North Carolina, Puerto Rico, Rhode Island, and Wisconsin are not included.

Title I of the CARE Act provides funding for health care and supportive services to Eligible Metropolitan Areas (EMAs) that report at least 2,000 AIDS cases during the previous five years and have a population of at least 500,000. There are a total of 51Title I EMAs in 29 states across the country; five have only a portion of an EMA in their state, with the Title I grantee located in an adjacent state. In June 2005, 26 states with Title I EMAs reported that 79% of their ADAP clients resided within a Title I jurisdiction. Seventy-three percent of *all* ADAP clients served in June 2005 resided within a Title I. These concentrations reflect the epidemic's continued impact in urban, highly populated areas of the country as well as the ADAP earmark funding allocation to states based on estimated living AIDS cases (see Appendix XVII).

Appendices

Appendix I

Total Clients Enrolled/Served, Expenditures and Prescriptions Filled in June 2004 and June 2005

Appendix I
Total Clients Enrolled/Served, Expenditures and Prescriptions Filled in June 2004 and June 2005

State	June 2004 Clients Enrolled	June 2005 Clients Enrolled	% Change	June 2004 Clients Served	June 2005 Clients Served	% Change	June 2004 Prescription Expenditures	June 2005 Prescription Expenditures	% Change	June 2004 Prescriptions Filled	June 2005 Prescriptions Filled	% Change
Alabama	1,330	1,100	-17%	1,220	915	-25%	$1,100,169	$998,331	-9%	4,328	3,898	-10%
Alaska	38	37	-3%	35	37	6%	$33,241	$37,717	13%	85	94	11%
American Samoa	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Arizona	952	998	5%	845	918	9%	$786,422	$862,225	10%	3,193	3,625	14%
Arkansas	413	313	-24%	376	272	-28%	$385,806	$340,433	-12%	1,467	916	-38%
California	25,013	23,264	-7%	18,263	18,275	0%	$21,158,096	$21,744,727	3%	80,991	74,454	-8%
Colorado	815	1,464	80%	667	1,045	57%	$556,710	$908,411	63%	1,974	3,301	67%
Connecticut	1,524	1,594	5%	1,112	1,205	8%	$1,285,997	$1,428,122	11%	5,108	5,367	5%
Delaware	399	339	-15%	226	249	10%	$189,634	$145,746	-23%	1,011	898	-11%
District of Columbia	3,312	1,202	-64%	809	726	-10%	$826,434	$737,223	-11%	3,346	2,723	-19%
Florida	11,947	13,062	9%	9,558	8,682	-9%	$6,822,400	$6,034,910	-12%	31,252	24,000	-23%
Georgia	5,798	7,877	36%	3,820	4,162	9%	$3,343,888	$3,754,677	12%	14,098	14,783	5%
Guam	NR	7	—	NR	5	—	NR	$8,383	—	NR	13	—
Hawaii	259	251	-3%	223	211	-5%	$215,909	$208,132	-4%	946	829	-12%
Idaho	109	89	-18%	100	76	-24%	$132,732	$107,765	-19%	263	200	-24%
Illinois	4,836	4,811	-1%	3,234	3,459	7%	$3,055,902	$3,570,547	17%	10,772	11,757	9%
Indiana	28	79	182%	13	62	377%	$17,818	$73,463	312%	57	216	279%
Iowa	302	312	3%	203	161	-21%	$143,811	$106,889	-26%	691	535	-23%
Kansas	535	426	-20%	535	315	-41%	$407,281	$489,310	20%	798	1,148	44%
Kentucky	661	581	-12%	555	401	-28%	$481,538	$438,077	-9%	1,972	1,334	-32%
Louisiana	2,347	1,704	-27%	1,654	1,704	3%	$1,154,466	$955,331	-17%	4,135	4,609	11%
Maine	118	70	-41%	42	43	2%	$63,794	$83,003	30%	NR	194	—
Marshall Islands	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Maryland	2,697	3,093	15%	1,989	2,301	16%	$2,390,384	$2,699,826	13%	7,923	8,457	7%
Massachusetts	3,436	2,685	-22%	2,291	2,368	3%	$1,185,327	$587,041	-50%	12,278	9,945	-19%
Michigan	1,400	1,734	24%	1,075	1,337	24%	$1,146,876	$1,589,245	39%	5,278	6,240	18%
Minnesota	998	1,258	26%	597	726	22%	$241,503	$354,759	47%	1,940	322	-83%
Mississippi	1,011	1,238	22%	769	772	0%	$711,348	$693,982	-2%	2,512	2,427	-3%
Missouri	2,403	1,795	-25%	1,402	1,200	-14%	$1,151,982	$1,230,555	7%	5,221	5,374	3%
Montana	68	56	-18%	53	49	-8%	$40,611	$40,590	0%	163	175	7%
Nebraska	415	446	7%	181	265	46%	$127,052	$141,245	11%	635	476	-25%
Nevada	725	836	15%	614	704	15%	$519,849	$622,725	20%	1,996	2,141	7%
New Hampshire	327	375	15%	183	137	-25%	$204,913	$143,902	-30%	324	689	113%
New Jersey	5,366	5,355	0%	4,705	3,964	-16%	$5,964,042	$5,696,256	-4%	22,955	22,963	0%
New Mexico	568	NR	—	327	NR	—	$332,800	NR	—	1,270	NR	—
New York	15,976	16,404	3%	12,484	12,686	2%	$18,756,730	$19,743,999	5%	61,822	60,667	-2%
North Carolina	2,575	2,547	-1%	1,843	1,887	2%	$2,281,607	$2,850,842	25%	6,610	7,264	10%
North Dakota	30	45	50%	19	33	74%	$14,410	$22,232	54%	49	93	90%

NR indicates data not reported.

Comparison Totals are based on only those states that reported data in both fiscal years.

(continued on next page)

(continued from previous page)

Appendix I
Total Clients Enrolled/Served, Expenditures and Prescriptions Filled in June 2004 and June 2005

State	June 2004 Clients Enrolled	June 2005 Clients Enrolled	% Change	June 2004 Clients Served	June 2005 Clients Served	% Change	June 2004 Prescription Expenditures	June 2005 Prescription Expenditures	% Change	June 2004 Prescriptions Filled	June 2005 Prescriptions Filled	% Change
N. Mariana Islands	NR	6	—	NR	6	—	NR	$3,031	—	NR	397	—
Ohio	1,671	1,554	-7%	1,271	1,371	8%	$774,009	$328,962	-57%	5,258	5,387	2%
Oklahoma	627	755	20%	533	611	15%	$390,537	$470,647	21%	1,511	1,827	21%
Oregon	741	1,041	40%	656	1,028	57%	$246,367	$272,172	10%	2,307	4,287	86%
Pennsylvania	5,589	5,625	1%	2,971	3,186	7%	$4,011,302	$4,668,522	16%	13,019	18,593	43%
Puerto Rico	3,336	3,750	12%	3,154	3,750	19%	$2,703,933	$4,888,766	81%	15,462	19,711	27%
Rhode Island	642	NR	—	315	NR	—	$254,455	NR	—	1,201	NR	—
South Carolina	2,126	2,527	19%	1,531	1,793	17%	$1,117,558	$1,350,045	21%	4,627	4,729	2%
South Dakota	83	114	37%	40	59	48%	$33,028	$29,653	-10%	103	111	8%
Tennessee	843	583	-31%	474	346	-27%	$363,351	$180,418	-50%	326	NR	—
Texas	12,226	13,365	9%	8,060	8,802	9%	$6,461,692	$7,179,803	11%	23,057	23,798	3%
Utah	286	289	1%	170	225	32%	$116,136	$190,168	64%	547	1,092	100%
Vermont	168	176	5%	99	136	37%	$41,063	$41,446	1%	302	379	25%
Virgin Islands (U.S.)	NR	121	—	NR	57	—	NR	$47,117	—	NR	171	—
Virginia	2,721	2,816	3%	1,812	1,781	-2%	$1,989,845	$2,003,407	1%	6,314	6,034	-4%
Washington	2,455	2,734	11%	926	1,194	29%	$665,866	$769,278	16%	4,051	5,023	24%
West Virginia	322	299	-7%	151	183	21%	$172,749	$183,236	6%	438	398	-9%
Wisconsin	923	855	-7%	357	477	34%	$257,528	$476,363	85%	1,151	1,912	66%
Wyoming	82	71	-13%	35	47	34%	$49,801	$62,098	25%	134	189	41%
Total	**133,572**	**134,128**		**94,577**	**96,404**		**$96,880,703**	**$102,595,753**		**377,271**	**376,165**	
Comparison Total	***132,362***	***133,994***	***1%***	***93,935***	***96,336***	***3%***	***$96,293,448***	***$102,537,222***	***6%***	***374,800***	***375,584***	***0%***

NR indicates data not reported.

Comparison Totals are based on only those states that reported data in both fiscal years.

Appendix II

ADAP Drug Expenditures, by Class, June 2005

Appendix II
ADAP Drug Expenditures, by Class, June 2005

State	June 2005 Total Expenses	June 2005 NRTI Expenses	NRTI % of Total Expenses	June 2005 NNRTI Expenses	NNRTI % of Total Expenses	June 2005 PI Expenses	PI % of Total Expenses	June 2005 Fusion Inhibitor Expenses	Fusion Inhibitor % of Total Expenses	June 2005 "A1" OI Expenses	"A1" OI % of Total Expenses	June 2005 All Other Rx Expenses	All Other Rx % of Total Expenses
Alabama	$998,331	$485,392	49%	$148,285	15%	$312,881	31%	$12,118	1%	$39,655	4%	$0	0%
Alaska	$37,717	$23,327	62%	$5,742	15%	$7,668	20%	$0	0%	$555	1%	$425	1%
American Samoa	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Arizona	$862,225	$435,784	51%	$89,557	10%	$266,068	31%	$18,495	2%	$13,229	2%	$39,092	5%
Arkansas	$340,433	$24,044	7%	$30,176	9%	$68,688	20%	$2,860	0.8%	$5,047	1%	$209,618	62%
California	$21,744,727	$10,133,352	47%	$2,396,935	11%	$6,519,042	30%	$74,017	0.3%	$778,992	4%	$1,842,389	8%
Colorado	$908,411	$491,854	54%	$126,690	14%	$254,181	28%	$12,685	1%	$23,001	3%	$0	0%
Connecticut	$1,428,122	$533,379	37%	$154,522	11%	$394,822	28%	$19,437	1%	$46,055	3%	$279,907	20%
Delaware	$145,746	$68,169	47%	$9,060	6%	$40,806	28%	$463	0.3%	$3,671	3%	$23,577	16%
District of Columbia	$737,223	$376,083	51%	$73,949	10%	$213,825	29%	$5,439	0.7%	$45,966	6%	$21,961	3%
Florida	$6,034,910	$3,339,531	55%	$747,159	12%	$1,599,111	26%	$73,332	1%	$106,378	2%	$169,398	3%
Georgia	$3,754,677	$1,624,795	43%	$434,992	12%	$1,207,627	32%	$7,037	0.2%	$95,023	3%	$385,203	10%
Guam	$8,383	$3,364	40%	$949	11%	$2,706	32%	$0	0%	$1,364	16%	$0	0%
Hawaii	$208,132	$108,297	52%	$27,449	13%	$56,454	27%	$0	0%	$8,685	4%	$7,247	3%
Idaho	$107,765	$59,527	55%	$13,767	13%	$34,378	32%	$0	0%	$93	0%	$0	0%
Illinois	$3,570,547	$1,817,899	51%	$585,904	16%	$949,201	27%	$74,301	2%	$60,284	2%	$82,959	2%
Indiana	$73,463	$39,531	54%	$11,901	16%	$18,039	25%	$0	0%	$589	1%	$3,402	5%
Iowa	$106,889	$58,121	54%	$13,540	13%	$33,759	32%	$0	0%	$1,366	1%	$103	0%
Kansas	$489,310	$240,141	49%	$61,304	13%	$166,928	34%	$3,421	0.7%	$1,263	0%	$16,253	3%
Kentucky	$438,077	$226,160	52%	$51,622	12%	$144,997	33%	$0	0%	$12,259	3%	$3,039	1%
Louisiana	$955,331	$497,777	52%	$127,440	13%	$305,773	32%	$24,342	3%	$0	0%	$0	0%
Maine	$83,003	$44,769	54%	$10,802	13%	$23,726	29%	$0	0%	$354	0%	$3,352	4%
Marshall Islands	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Maryland	$2,699,826	$1,301,478	48%	$280,801	10%	$919,168	34%	$24,943	0.9%	$55,830	2%	$117,606	4%
Massachusetts	$587,041	$252,990	43%	$90,227	15%	$73,743	13%	$3,158	0.5%	$14,452	2%	$152,471	26%
Michigan	$1,589,245	$672,757	42%	$184,258	12%	$431,667	27%	$42,579	3%	$49,911	3%	$208,072	13%
Minnesota	$354,759	$234,141	66%	$0	0%	$81,595	23%	$0	0%	$35,476	10%	$3,548	1%
Mississippi	$693,982	$352,346	51%	$116,901	17%	$162,588	23%	$15,814	2%	$27,331	4%	$19,002	3%
Missouri	$1,230,555	$559,517	45%	$157,992	13%	$364,923	30%	$17,775	1%	$25,823	2%	$104,525	8%
Montana	$40,590	$22,306	55%	$9,096	22%	$7,395	18%	$0	0%	$5	0%	$1,789	4%
Nebraska	$141,245	$72,305	51%	$16,258	12%	$49,560	35%	$0	0%	$2,013	1%	$1,110	1%
Nevada	$622,725	$318,403	51%	$72,742	12%	$202,892	33%	$12,520	2%	$6,440	1%	$9,728	2%
New Hampshire	$143,902	$53,502	37%	$18,708	13%	$33,107	23%	$0	0%	$36,610	25%	$1,975	1%
New Jersey	$5,696,256	$2,473,551	43%	$583,920	10%	$1,388,216	24%	$69,908	1%	$129,212	2%	$1,051,449	18%

NR indicates data not reported.

(continued on next page)

(continued from previous page)

Appendix II
ADAP Drug Expenditures, by Class, June 2005

State	June 2005 Total Expenses	June 2005 NRTI Expenses	NRTI % of Total Expenses	June 2005 NNRTI Expenses	NNRTI % of Total Expenses	June 2005 PI Expenses	PI % of Total Expenses	June 2005 Fusion Inhibitor Expenses	Fusion Inhibitor % of Total Expenses	June 2005 "A1" OI Expenses	"A1" OI % of Total Expenses	June 2005 All Other Rx Expenses	All Other Rx % of Total Expenses
New Mexico	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
New York	$19,743,999	$8,869,887	45%	$2,126,633	11%	$5,525,741	28%	$279,485	1%	$545,060	3%	$2,397,193	12%
North Carolina	$2,850,842	$1,480,295	52%	$366,772	13%	$856,050	30%	$22,227	0.8%	$53,230	2%	$72,268	3%
North Dakota	$22,232	$11,121	50%	$4,460	20%	$5,983	27%	$0	0%	$231	1%	$438	2%
N. Mariana Islands	$3,031	$1,079	36%	$372	12%	$404	13%	$0	0%	$1,176	39%	$0	0%
Ohio	$328,962	$132,920	40%	$107,773	33%	$88,243	27%	$0	0%	$0	0%	$26	0%
Oklahoma	$470,647	$243,962	52%	$65,947	14%	$126,683	27%	$1,171	0.2%	$20,729	4%	$12,155	3%
Oregon	$272,172	$42,452	16%	$38,805	14%	$34,741	13%	$5,230	2%	$8,222	3%	$142,722	52%
Pennsylvania	$4,668,522	$1,588,350	34%	$795,702	17%	$1,148,461	25%	$99,334	2%	$112,011	2%	$924,664	20%
Puerto Rico	$4,888,766	$1,148,976	24%	$301,283	6%	$2,918,306	60%	$158,600	3%	$305,281	6%	$56,321	1%
Rhode Island	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
South Carolina	$1,350,045	$521,981	39%	$184,901	14%	$314,669	23%	$84,172	6%	$34,883	3%	$209,438	16%
South Dakota	$29,653	$16,905	57%	$11,103	37%	$0	0%	$0	0%	$1,645	6%	$0	0%
Tennessee	$180,418	$94,991	53%	$58,566	32%	$7,452	4%	$14,092	8%	$3,402	2%	$1,914	1%
Texas	$7,179,803	$3,931,889	55%	$833,014	12%	$2,182,774	30%	$52,781	0.7%	$147,314	2%	$32,030	0%
Utah	$190,168	$87,678	46%	$27,460	14%	$59,570	31%	$0	0%	$4,026	2%	$11,435	6%
Vermont	$41,446	$19,249	46%	$6,961	17%	$11,195	27%	$931	2%	$304	1%	$2,806	7%
Virgin Islands (U.S.)	$47,117	$24,666	52%	$6,523	14%	$13,855	29%	$0	0%	$2,073	4%	$0	0%
Virginia	$2,003,407	$991,749	50%	$305,422	15%	$564,190	28%	$18,516	0.9%	$65,054	3%	$58,476	3%
Washington	$769,278	$360,951	47%	$105,449	14%	$209,770	27%	$17,503	2%	$13,273	2%	$62,331	8%
West Virginia	$183,236	$98,629	54%	$20,061	11%	$61,884	34%	$0	0%	$2,373	1%	$290	0%
Wisconsin	$476,363	$244,610	51%	$61,740	13%	$131,833	28%	$1,973	0.4%	$31,568	7%	$4,637	1%
Wyoming	$62,098	$31,325	50%	$8,785	14%	$18,237	29%	$0	0%	$978	2%	$2,773	4%
Total	**$102,595,753**	**$46,888,253**	**46%**	**$12,090,382**	**12%**	**$30,615,577**	**30%**	**$1,270,661**	**1%**	**$2,979,764**	**3%**	**$8,751,116**	**9%**

NR indicates data not reported.

Appendix III

ADAP Prescriptions Filled, by Class, June 2005

Appendix III
ADAP Prescriptions Filled, by Class, June 2005

State	June 2005 Total Rx	June 2005 NRTI Rx	NRTI % of Total Rx	June 2005 NNRTI Rx	NNRTI % of Total Rx	June 2005 Fusion Inhibitor Rx	Fusion Inhibitor % of Total Rx	June 2005 PI Rx	PI % of Total Rx	June 2005 "A1" OI Rx	"A1" OI % of Total Rx	June 2005 All Other Rx	All Other % of Total Rx
Alabama	3,898	1,731	44%	497	13%	11	0.3%	964	25%	695	18%	0	0%
Alaska	94	52	55%	14	15%	0	0%	13	14%	10	11%	5	5%
American Samoa	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Arizona	3,625	1,416	39%	393	11%	15	0.4%	842	23%	408	11%	551	15%
Arkansas	916	393	43%	123	13%	2	0.2%	203	22%	149	16%	46	5%
California	74,454	24,179	32%	7,295	10%	76	0%	13,472	18%	8,318	11%	21,114	28%
Colorado	3,301	1,459	44%	545	17%	11	0%	789	24%	497	15%	0	0%
Connecticut	5,367	1,348	25%	454	8%	10	0.2%	828	15%	476	9%	2,251	42%
Delaware	898	230	26%	45	5%	2	0.2%	166	18%	90	10%	365	41%
District of Columbia	2,723	1,053	39%	286	11%	3	0.1%	599	22%	320	12%	462	17%
Florida	24,000	9,854	41%	3,208	13%	67	0.3%	5,804	24%	2,924	12%	2,143	9%
Georgia	14,783	5,094	34%	1,779	12%	6	0%	3,563	24%	2,356	16%	1,985	13%
Guam	13	8	62%	2	15%	0	0%	3	23%	0	0%	0	0%
Hawaii	829	323	39%	99	12%	0	0%	137	17%	80	10%	190	23%
Idaho	200	116	58%	34	17%	0	0%	47	24%	3	2%	0	0%
Illinois	11,757	5,384	46%	1,950	17%	56	0.5%	2,530	22%	743	6%	1,094	9%
Indiana	216	71	33%	28	13%	0	0%	30	14%	16	7%	71	33%
Iowa	535	258	48%	82	15%	0	0%	139	26%	47	9%	9	2%
Kansas	1,148	521	45%	143	12%	3	0.3%	260	23%	68	6%	153	13%
Kentucky	1,334	591	44%	167	13%	0	0%	307	23%	154	12%	115	9%
Louisiana	4,609	2,474	54%	758	16%	21	0.5%	1,356	29%	0	0%	0	0%
Maine	194	93	48%	25	13%	0	0%	36	19%	10	5%	30	15%
Marshall Islands	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Maryland	8,457	3,101	37%	830	10%	20	0.2%	2,050	24%	857	10%	1,599	19%
Massachusetts	9,945	2,135	21%	840	8%	12	0.1%	725	7%	523	5%	5,710	57%
Michigan	6,240	1,626	26%	571	9%	27	0.4%	918	15%	502	8%	2,596	42%
Minnesota	322	200	62%	0	0%	0	0%	48	15%	34	11%	40	12%
Mississippi	2,427	923	38%	413	17%	11	0.5%	362	15%	442	18%	276	11%
Missouri	5,374	1,488	28%	501	9%	14	0.3%	768	14%	362	7%	2,241	42%
Montana	175	73	42%	32	18%	0	0%	26	15%	10	6%	34	19%
Nebraska	476	187	39%	61	13%	0	0%	112	24%	27	6%	89	19%
Nevada	2,141	939	44%	282	13%	9	0%	558	26%	181	8%	172	8%
New Hampshire	689	155	22%	63	9%	0	0%	73	11%	170	25%	228	33%

NR indicates data not reported.

(continued on next page)

(continued from previous page)

Appendix III
ADAP Prescriptions Filled, by Class, June 2005

State	June 2005 Total Rx	June 2005 NRTI Rx	NRTI % of Total Rx	June 2005 NNRTI Rx	NNRTI % of Total Rx	June 2005 Fusion Inhibitor Rx	Fusion Inhibitor % of Total Rx	June 2005 PI Rx	PI % of Total Rx	June 2005 "A1" OI Rx	"A1" OI % of Total Rx	June 2005 All Other Rx	All Other % of Total Rx
New Jersey	22,963	7,862	34%	1,546	7%	40	0.2%	2,403	10%	1,500	7%	9,612	42%
New Mexico	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
New York	60,667	16,823	28%	5,047	8%	145	0.2%	8,830	15%	4,349	7%	25,473	42%
North Carolina	7,264	3,236	45%	961	13%	18	0.2%	1,648	23%	712	10%	689	9%
North Dakota	93	33	35%	14	15%	0	0%	15	16%	9	10%	22	24%
N. Mariana Islands	397	120	30%	30	8%	0	0%	120	30%	127	32%	0	0%
Ohio	5,387	2,211	41%	705	13%	12	0.2%	710	13%	429	8%	1,320	25%
Oklahoma	1,827	749	41%	267	15%	1	0%	381	21%	322	18%	107	6%
Oregon	4,287	451	11%	302	7%	31	1%	379	9%	220	5%	2,904	68%
Pennsylvania	18,593	3,481	19%	2,147	12%	55	0.3%	2,108	11%	1,039	6%	9,763	53%
Puerto Rico	19,711	3,334	17%	1,144	6%	124	1%	7,040	36%	2,263	11%	5,806	29%
Rhode Island	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
South Carolina	4,729	1,586	34%	750	16%	13	0.3%	931	20%	539	11%	910	19%
South Dakota	111	56	50%	36	32%	0	0%	0	0%	19	17%	0	0%
Tennessee	346	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Texas	23,798	12,656	53%	3,454	15%	46	0.2%	5,919	25%	1,498	6%	225	1%
Utah	1,092	363	33%	143	13%	0	0%	189	17%	119	11%	278	25%
Vermont	379	136	36%	47	12%	3	1%	55	15%	30	8%	108	28%
Virgin Islands (U.S.)	171	85	50%	21	12%	0	0%	36	21%	29	17%	0	0%
Virginia	6,034	2,542	42%	866	14%	16	0.3%	1,315	22%	1,048	17%	247	4%
Washington	5,023	1,612	32%	565	11%	17	0.3%	784	16%	260	5%	1,785	36%
West Virginia	398	211	53%	51	13%	0	0%	101	25%	30	8%	5	1%
Wisconsin	1,912	836	44%	266	14%	3	0.2%	414	22%	251	13%	142	7%
Wyoming	189	67	35%	20	11%	0	0%	22	12%	24	13%	56	30%
Total	**376,511**	**125,925**	**33%**	**39,902**	**11%**	**900**	**0.2%**	**71,128**	**19%**	**35,289**	**9%**	**103,021**	**27%**

NR indicates data not reported.

Appendix IV

Race/Ethnicity of ADAP Clients Served, June 2005

Appendix IV
Race/Ethnicity of ADAP Clients Served, June 2005

State	June 2005 Clients	African American	White/ Non-Hispanic	Hispanic	Asian	Native Hawaiian/ Pacific Islander	American Indian/ Alaskan Native	Multi-Racial	Other	Unknown
Alabama	915	65%	23%	12%	0%	0%	0%	0%	0%	0%
Alaska	37	8%	73%	16%	3%	0%	0%	0%	0%	0%
American Samoa	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Arizona	918	6%	59%	33%	1%	0%	1%	0%	0%	0%
Arkansas	272	32%	63%	3%	1%	0.3%	0%	0%	0%	1%
California	18,275	12%	43%	39%	3%	0.1%	0.3%	2%	0%	2%
Colorado	1,045	13%	59%	24%	0%	0%	0%	0.1%	4%	0%
Connecticut	1,205	36%	40%	23%	0.6%	0.1%	0.3%	0%	0%	0%
Delaware	249	60%	33%	1%	0%	0%	1%	2%	2%	2%
District of Columbia	726	80%	9%	8%	0.1%	0%	1%	0%	0%	2%
Florida	8,682	35%	26%	28%	0.4%	0.1%	1%	0.1%	10%	0.1%
Georgia	4,162	63%	29%	4%	0.3%	0%	0%	1%	0%	3%
Guam	5	0%	0%	0%	0%	100%	0%	0%	0%	0%
Hawaii	211	3%	53%	9%	15%	18%	1%	1%	0%	0%
Idaho	76	1%	80%	15%	0%	0%	4%	0%	0%	0%
Illinois	3,459	40%	34%	24%	1%	0%	0%	0%	0.2%	1%
Indiana	62	13%	65%	18%	5%	0%	0%	0%	0%	0%
Iowa	161	14%	70%	14%	2%	0%	0%	0%	0%	0%
Kansas	315	22%	65%	13%	0%	0%	0.2%	0%	0%	0%
Kentucky	401	26%	69%	5%	0%	0%	0%	0%	0%	0%
Louisiana	1,704	60%	36%	3%	0%	0%	0%	0%	0%	0%
Maine	43	5%	90%	5%	0%	0%	0%	0%	0%	0%
Marshall Islands	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Maryland	2,301	65%	19%	5%	1%	0.2%	0.2%	0.1%	8%	2%
Massachusetts	2,368	26%	47%	21%	2%	0%	1%	1%	3%	0%
Michigan	1,337	39%	52%	6%	1%	0%	1%	0%	0%	1%
Minnesota	726	24%	55%	13%	2%	0.3%	1%	0.3%	0%	5%
Mississippi	772	73%	25%	0%	1%	0%	0.1%	0.4%	0%	0%
Missouri	1,200	40%	57%	1%	0.3%	0.3%	0.4%	0.1%	0%	1%
Montana	49	2%	88%	0%	0%	0%	10%	0%	0%	0%
Nebraska	265	20%	58%	19%	1%	1%	1%	0%	0%	0%
Nevada	704	19%	54%	22%	3%	0%	1%	0%	0%	1%
New Hampshire	137	11%	69%	15%	0%	0%	1%	0%	4%	0%
New Jersey	3,964	49%	23%	25%	1%	0.1%	0%	0%	0%	2%
New Mexico	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
New York	12,686	35%	30%	28%	2%	0.1%	0.4%	0%	0%	4%
North Carolina	1,887	54%	34%	10%	0.2%	0.1%	1%	0%	1%	0%
North Dakota	33	18%	73%	0%	0%	0%	9%	0%	0%	0%
N. Mariana Islands	6	0%	0%	0%	0%	100%	0%	0%	0%	0%
Ohio	1,371	29%	62%	5%	1%	0%	1%	0.1%	2%	0%
Oklahoma	611	16%	71%	6%	1%	0%	7%	0%	0%	0%
Oregon	1,028	6%	73%	15%	1%	0%	1%	3%	0%	0%
Pennsylvania	3,186	40%	43%	9%	1%	0%	0.3%	0%	1%	7%
Puerto Rico	3,750	0%	0%	100%	0%	0%	0%	0%	0%	0%
Rhode Island	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
South Carolina	1,793	67%	26%	3%	0.4%	0%	0.1%	3%	0%	0.1%
South Dakota	59	20%	67%	3%	2%	0%	8%	0%	0%	0%
Tennessee	346	52%	45%	0%	0%	0%	0%	0%	3%	0%
Texas	8,802	28%	35%	34%	1%	0%	0.2%	0%	0.2%	1%
Utah	225	9%	57%	27%	1%	0%	1%	2%	0%	5%
Vermont	136	7%	86%	4%	1%	0%	1%	2%	0%	0%
Virgin Islands (U.S.)	57	65%	10%	25%	0%	0%	0%	0%	0%	0%
Virginia	1,781	53%	33%	7%	1%	0%	1%	0%	0.2%	6%
Washington	1,194	12%	55%	16%	1%	1%	2%	4%	1%	8%
West Virginia	183	13%	85%	0%	2%	0%	0%	0%	0%	0%
Wisconsin	477	26%	66%	5%	1%	0%	2%	0%	0%	0%
Wyoming	47	7%	71%	12%	1%	0%	2%	6%	0%	0%
Total	**96,404**	**32%**	**36%**	**26%**	**1%**	**0.1%**	**0.4%**	**1%**	**1%**	**2%**

NR indicates data not reported. Percentages may not total 100% due to rounding.

Appendix V

Gender and Age of ADAP Clients Served, June 2005

Appendix V
Gender and Age of ADAP Clients Served, June 2005

State	June 2005 Clients	Gender				Age						
		Male	Female	Trans-gender	Unknown	<2 Years Old	2–12 Years Old	13–24 Years Old	25–44 Years Old	45–64 Years Old	>64 Years Old	Age Unknown
Alabama	915	74%	26%	0%	0%	0%	0%	12%	61%	28%	0%	0%
Alaska	37	70%	30%	0%	0%	0%	0%	3%	57%	40%	0%	0%
American Samoa	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Arizona	918	88%	12%	0%	0%	0%	0%	1%	56%	39%	4%	0%
Arkansas	272	78%	21%	0.4%	0%	0%	0%	0%	66%	32%	2%	0%
California	18,275	91%	9%	0.4%	0%	0%	0%	1%	56%	40%	3%	0%
Colorado	1,045	87%	12%	0.6%	0%	0%	0%	2%	57%	39%	1%	0%
Connecticut	1,205	72%	28%	0%	0%	0%	0.3%	1%	45%	50%	3%	0%
Delaware	249	70%	29%	0%	1%	0%	0%	4%	48%	46%	2%	0%
District of Columbia	726	80%	20%	0%	0%	0%	0%	2%	51%	44%	3%	0%
Florida	8,682	72%	27%	0.3%	0%	0%	0%	2%	54%	41%	3%	0%
Georgia	4,162	76%	24%	0.1%	0.1%	0%	0%	2%	56%	40%	2%	0%
Guam	5	80%	20%	0%	0%	0%	0%	20%	40%	40%	0%	0%
Hawaii	211	93%	7%	0%	0%	0%	0%	0%	43%	53%	4%	0%
Idaho	76	84%	16%	0%	0%	0%	0%	3%	47%	46%	4%	0%
Illinois	3,459	83%	16%	0%	0.1%	0%	0%	2%	57%	37%	3%	0%
Indiana	62	74%	26%	0%	0%	0%	0%	6%	69%	6%	18%	0%
Iowa	161	81%	19%	0%	0%	0%	1%	1%	56%	40%	2%	0%
Kansas	315	82%	17%	1%	0%	0%	1%	1%	57%	40%	1%	0%
Kentucky	401	84%	16%	0%	0%	0%	0%	0%	52%	46%	2%	0%
Louisiana	1,704	77%	23%	0%	0%	1%	0%	2%	52%	42%	3%	0%
Maine	43	83%	17%	0%	0%	0%	0%	1%	39%	56%	4%	0%
Marshall Islands	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Maryland	2,301	64%	36%	0%	0%	0%	0.2%	2%	54%	41%	3%	0%
Massachusetts	2,368	69%	31%	0%	0%	0%	1%	1%	50%	47%	2%	0%
Michigan	1,337	85%	15%	0.2%	0%	0%	0%	2%	56%	39%	2%	0%
Minnesota	726	80%	20%	0%	0%	0%	0%	2%	61%	35%	1%	0%
Mississippi	772	70%	30%	0%	0%	0%	0.1%	3%	59%	36%	2%	0%
Missouri	1,200	83%	17%	0%	0%	0%	0%	2%	64%	33%	1%	0%
Montana	49	78%	22%	0%	0%	0%	0%	4%	45%	47%	4%	0%
Nebraska	265	82%	18%	0%	0%	1%	0%	1%	63%	33%	2%	0%
Nevada	704	82%	17%	1%	0%	1%	1%	4%	61%	32%	1%	0%
New Hampshire	137	70%	28%	0%	2%	0%	0%	1%	56%	39%	2%	2%
New Jersey	3,964	66%	34%	0%	0%	0%	1%	2%	51%	45%	1%	0%
New Mexico	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
New York	12,686	75%	25%	0.1%	0%	0%	0%	2%	52%	43%	3%	0%
North Carolina	1,887	74%	26%	0%	0%	0%	0%	2%	54%	42%	2%	0%
North Dakota	33	78%	22%	0%	0%	0%	0%	4%	64%	32%	0%	0%
N. Mariana Islands	6	50%	50%	0%	0%	0%	0%	40%	60%	0%	0%	0%
Ohio	1,371	83%	17%	0.1%	0%	0%	1%	2%	57%	38%	2%	0%
Oklahoma	611	85%	15%	0%	0%	0%	0%	3%	65%	31%	1%	0%
Oregon	1,028	88%	12%	0.2%	0%	0%	0.2%	2%	57%	39%	2%	0%
Pennsylvania	3,186	79%	21%	0%	0.1%	0%	0%	1%	50%	45%	3%	0%
Puerto Rico	3,750	67%	33%	0%	0%	0%	2%	3%	47%	45%	4%	0%
Rhode Island	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
South Carolina	1,793	70%	30%	0.1%	0%	0%	0.1%	3%	57%	38%	2%	0%
South Dakota	59	71%	29%	0%	0%	0%	0%	3%	51%	45%	1%	0%
Tennessee	346	82%	17%	1%	0%	0%	0%	7%	71%	20%	1%	1%
Texas	8,802	81%	19%	0%	0%	0%	0.1%	2%	56%	39%	2%	0%
Utah	225	88%	12%	0%	0%	0%	1%	4%	66%	29%	1%	0%
Vermont	136	86%	14%	0%	0%	0%	0%	0%	48%	50%	2%	0%
Virgin Islands (U.S.)	57	55%	45%	0%	0%	2%	0%	13%	45%	35%	5%	0%
Virginia	1,781	71%	29%	0.1%	0%	0%	0%	2%	54%	41%	3%	0%
Washington	1,194	87%	13%	0%	0%	0%	0%	1%	58%	39%	2%	0%
West Virginia	183	84%	16%	0%	0%	0%	0%	0.02%	67%	33%	0%	0%
Wisconsin	477	84%	16%	0%	0%	0%	0%	3%	62%	32%	2%	0%
Wyoming	47	72%	28%	0%	0%	0%	0%	4%	35%	58%	3%	0%
TOTAL	**96,404**	**79%**	**21%**	**0.1%**	**0.02%**	**0.04%**	**0.2%**	**2%**	**54%**	**41%**	**2%**	**0.1%**

NR indicates data not reported. Percentages may not total 100% due to rounding.

Appendix VI

Income Level and Insurance Status of ADAP Clients Served, June 2005

Appendix VI
Income Level and Insurance Status of ADAP Clients Served, June 2005

State	June 2005 Clients	Income Level						Insurance Status*				
		≤100% FPL	101–200% FPL	201–300% FPL	301–400% FPL	>400% FPL	Unknown	Medicaid	Medicare	Dually Eligible	Private Insurance	Uninsured
Alabama	915	65%	25%	10%	0%	0%	0%	2%	5%	2%	1%	90%
Alaska	37	49%	35%	16%	0%	0%	0%	0%	8%	0%	14%	65%
American Samoa	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Arizona	918	25%	52%	23%	0%	0%	0%	0%	44%	0%	NR	NR
Arkansas	272	43%	48%	8%	1%	1%	0%	10%	28%	9%	1%	44%
California	18,275	57%	23%	12%	6%	1%	0.3%	12%	NR	0%	21%	65%
Colorado	1,045	70%	24%	6%	0%	0%	0%	0%	39%	NR	NR	NR
Connecticut	1,205	27%	47%	20%	6%	0%	0%	40%	10%	10%	57%	42%
Delaware	249	33%	37%	16%	9%	5%	1%	7%	8%	2%	39%	42%
District of Columbia	726	NR	NR	NR	NR	NR	NR	30%	8%	38%	NR	91%
Florida	8,682	56%	33%	10%	1%	0%	0%	1%	6%	NR	NR	NR
Georgia	4,162	43%	42%	12%	2%	1%	0%	0%	15%	0%	0%	85%
Guam	5	31%	69%	0%	0%	0%	0%	NR	NR	NR	NR	NR
Hawaii	211	32%	54%	12%	2%	0%	0%	2%	43%	NR	12%	27%
Idaho	76	NR	NR	NR	NR	NR	NR	0%	33%	0%	2%	NR
Illinois	3,459	32%	36%	20%	9%	3%	0%	24%	19%	NR	2%	98%
Indiana	62	52%	34%	15%	0%	0%	0%	0%	32%	NR	0%	100%
Iowa	161	57%	43%	0%	0%	0%	0%	19%	4%	NR	16%	61%
Kansas	315	84%	15%	1%	0%	0%	0%	54%	21%	15%	5%	56%
Kentucky	401	47%	44%	9%	0%	0%	0%	0%	58%	NR	12%	34%
Louisiana	1,704	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Maine	43	0%	0%	0%	0%	0%	100%	NR	NR	NR	NR	NR
Marshall Islands	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Maryland	2,301	17%	43%	25%	12%	4%	0%	0%	13%	0%	20%	77%
Massachusetts	2,368	43%	23%	16%	10%	8%	0%	34%	0%	NR	60%	6%
Michigan	1,337	28%	45%	16%	8%	2%	1%	17%	19%	10%	26%	45%
Minnesota	726	37%	44%	19%	0%	0%	0%	17%	19%	11%	NR	NR
Mississippi	772	70%	21%	8%	1%	0%	0%	0%	10%	0%	0%	90%
Missouri	1,200	45%	33%	16%	0%	0%	6%	20%	5%	NR	24%	55%
Montana	49	43%	41%	16%	0%	0%	0%	0%	15%	NR	8%	77%
Nebraska	265	35%	65%	0%	0%	0%	0%	0%	14%	0%	17%	69%
Nevada	704	9%	44%	39%	8%	0%	0%	0%	18%	10%	11%	89%
New Hampshire	137	34%	41%	16%	0%	0%	8%	7%	28%	6%	31%	37%
New Jersey	3,964	44%	25%	17%	9%	4%	0%	0%	5%	0%	25%	75%
New Mexico	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
New York	12,686	39%	32%	16%	10%	3%	0%	13%	14%	0%	10%	90%
North Carolina	1,887	95%	5%	0%	0%	0%	0%	0%	NR	NR	0%	NR
North Dakota	33	40%	36%	9%	13%	0%	2%	NR	21%	NR	55%	30%
N. Mariana Islands	6	NR	NR	NR	NR	NR	NR	50%	NR	NR	NR	40%
Ohio	1,371	59%	25%	10%	4%	2%	0%	0%	NR	NR	27%	73%
Oklahoma	611	45%	42%	11%	2%	0%	0%	1%	16%	1%	16%	66%
Oregon	1,028	45%	42%	13%	1%	0%	0%	0%	42%	1%	92%	8%
Pennsylvania	3,186	42%	34%	20%	4%	0%	0%	NR	3%	NR	11%	84%
Puerto Rico	3,750	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Rhode Island	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
South Carolina	1,793	49%	36%	12%	2%	0%	0%	NR	NR	NR	21%	79%
South Dakota	59	60%	28%	12%	0%	0%	0%	20%	19%	3%	29%	29%
Tennessee	346	68%	13%	7%	2%	5%	5%	NR	NR	NR	NR	NR
Texas	8,802	65%	20%	15%	0%	0%	0%	15%	17%	9%	1%	99%
Utah	225	47%	27%	21%	5%	0%	0%	0%	1%	0%	20%	67%
Vermont	136	76%	24%	0%	0%	0%	0%	32%	28%	18%	20%	19%
Virgin Islands (U.S.)	57	40%	30%	25%	5%	0%	0%	5%	5%	0%	10%	80%
Virginia	1,781	64%	23%	8%	1%	1%	3%	8%	5%	1%	6%	17%
Washington	1,194	40%	31%	23%	6%	0%	0%	0%	17%	0%	51%	32%
West Virginia	183	37%	48%	15%	0%	0%	0%	74%	NR	NR	4%	NR
Wisconsin	477	41%	29%	28%	0%	0%	1%	2%	4%	1%	42%	48%
Wyoming	47	51%	49%	0%	0%	0%	0%	23%	30%	13%	8%	91%
TOTAL	**96,404**	**50%**	**30%**	**14%**	**5%**	**1%**	**0.3%**	**10%**	**13%**	**3%**	**18%**	**73%**
Comparison Total	***90,142***							***85,544***	***67,041***	***64,459***	***78,453***	***77,039***

NR indicates data not reported. Percentages may not total 100% due to rounding.

Comparison Total is used to calculate overall percentage (using only states that reported data).

*Some states reported estimates only.

Appendix VII

ADAP Clients by CD4 Count, Enrolled During 12-Month Period, June 2005

Appendix VII
ADAP Clients by CD4 Count, Enrolled During 12-Month Period, June 2005

State	Number of Clients Enrolled With CD4 Count Data Reported (12-Month Period)	% with CD4 ≤ 200	% with CD4 between 201–350	% with CD4 between 351–500	% with CD4 >500
Arkansas	173	21%	28%	14%	38%
California	26,985	24%	21%	22%	34%
Delaware	136	29%	25%	10%	35%
Florida	13,167	23%	21%	19%	37%
Guam	5	20%	60%	0%	20%
Hawaii	37	19%	30%	22%	30%
Illinois	3,419	45%	7%	13%	36%
Indiana	114	27%	24%	23%	26%
Iowa	312	23%	28%	18%	30%
Kansas	984	20%	39%	30%	11%
Kentucky	97	40%	21%	19%	21%
Maryland	2,978	30%	15%	26%	28%
Massachusetts	4,442	22%	21%	21%	36%
Michigan	2,140	28%	22%	19%	31%
Minnesota	347	29%	38%	33%	0%
Mississippi	453	26%	55%	15%	4%
Montana	12	67%	8%	0%	25%
Nevada	1,121	36%	17%	16%	32%
New Hampshire	45	36%	27%	18%	20%
New Jersey	6,937	27%	20%	19%	34%
New York	2,651	38%	22%	17%	22%
North Carolina	3,355	20%	22%	21%	37%
North Dakota	9	0%	56%	22%	22%
Ohio	2,797	31%	21%	18%	30%
Oklahoma	695	24%	20%	22%	35%
Oregon	790	20%	26%	26%	28%
Puerto Rico	3,587	0%	100%	0%	0%
South Dakota	6	33%	17%	33%	17%
Tennessee	696	32%	22%	18%	28%
Texas	2,699	48%	26%	13%	13%
Utah	89	43%	28%	13%	16%
Virginia	1,050	30%	25%	26%	20%
West Virginia	62	19%	50%	23%	8%
Wisconsin	839	19%	23%	22%	37%
TOTAL	**83,229**	**25%**	**24%**	**19%**	**31%**

Appendix VIII

Number of People on ADAP Waiting Lists, by Survey Period and State, July 2002–February 2006

Appendix VIII
Number of People on ADAP Waiting Lists, by Survey Period and State, July 2002–February 2006

State	Jul-02	Oct-02	Dec-02	Jan-03	Feb-03	Mar-03	Apr-03	May-03	Jun-03	Aug-03	Sept-03	Nov-03	Jan-04	Mar-04	May-04	Jul-04	Sept-04	Nov-04	Jan-05	Mar-05	May-05	Jul-05	Sept-05	Nov-05	Jan-06	Feb-06	# of Survey Periods w/ Waiting List	Avg. # of People on Waiting List
Alabama	250	175	175	175	175	175	104	104	90	89	107	141	247	304	395	353	393	244	126	133	180	143	168	196	285	280	26	200
Alaska										1			4	9	7	8	12	4	5	1			8	8	12	12	15	7
American Samoa																												
Arizona																												
Arkansas															3		11	31	30	43	59	55	78	73	89	89	11	51
California																												
Colorado									12	28	80	130	190	292	310												7	149
Connecticut																												
Delaware																												
District of Columbia																												
Florida																												
Georgia																												
Guam			4	4	4	4	4																				5	4
Hawaii																		7									1	7
Idaho													3	5	13	24	34		1	5	13	18	26	33	40	36	13	19
Illinois																												
Indiana	30	34	34	34	34	34				47	48	47													9	9	11	33
Iowa															6	31	46	12	39	47	55						7	34
Kansas																												
Kentucky	50	62	121	121	121	121	141	141	130	135	165	140	140	123	113	138	191		27	72	80	125	192	217	258	211	25	133
Louisiana																												
Maine																												
Marshall Islands																												
Maryland																												
Massachusetts																												
Michigan																												
Minnesota																												
Mississippi																												
Missouri																												
Montana	2	2	8	8	8						4	1	4	4	8	10	14		6	5	4	6	15	12	17	17	20	8
N. Mariana Islands																												
Nebraska			8	8	15	15	29	29	30	36	30	30						15	27	46	61	85	85	92	89	94	19	43
Nevada																												
New Hampshire																												
New Jersey																												
New Mexico																												
New York																												
North Carolina	715	776	150	150	217		50					96	126	449	716	891	524	493	325	325		2	293	13	83		19	337
North Dakota																												
Ohio																												
Oklahoma																												
Oregon	18	18	9	9	9	145	236	236	220	228	228	24															12	115
Palau																												
Pennsylvania																												
Puerto Rico																												
Rhode Island																												
South Carolina																												
South Dakota	43	43	43	43	43	43	49	49	49	52	50		49	43	23	28	36										16	43
Tennessee																												
Texas																												
Virgin Islands (U.S.)																												
Utah																	11										1	11
Vermont																												
Virginia																												
Washington																												
West Virginia							9	9	10	12	14	21	28	34	35	35	35	5	1	1	1	1	1	3	43	43	20	17
Wisconsin																												
Wyoming																		2	5	6							3	4
Total # People on Waiting Lists	**1108**	**1110**	**552**	**552**	**626**	**537**	**622**	**568**	**541**	**628**	**726**	**630**	**791**	**1263**	**1629**	**1518**	**1307**	**813**	**592**	**684**	**453**	**435**	**866**	**647**	**925**	**791**		**804**
Total # of States with Waiting Lists	**7**	**7**	**9**	**9**	**9**	**7**	**8**	**6**	**7**	**9**	**9**	**9**	**9**	**9**	**11**	**9**	**11**	**9**	**11**	**11**	**9**	**9**	**9**	**9**	**10**	**9**	**18**	

Note: States in bold eligible for PAI. See Appendix IX.

Appendix IX

Number of People on President's ADAP Initiative (PAI), by Survey Period and State, November 2004–February 2006

Appendix IX
Number of People on President's ADAP Initiative (PAI), by Survey Period and State, November 2004–February 2006

State	Nov-04	Jan-05	Mar-05	May-05	Jul-05	Sep-05	Nov-05	Jan-06	Feb-06
Alabama	182	357	392	385	389	366	273	103	0
Alaska	9	14	14	14	11	11	11	0	0
Colorado*	0	0	0	0	0	0	0	0	0
Idaho	36	41	41	41	39	30	30	15	4
Iowa	28	31	31	33	0	0	0	0	0
Kentucky	187	197	197	180	180	68	48	0	0
Montana	18	21	21	20	20	11	14	0	0
North Carolina	100	293	519	723	803	792	516	0	0
South Dakota*	0	0	0	0	0	0	0	0	0
West Virginia	31	42	42	42	45	43	40	0	0
Total	**591**	**996**	**1,257**	**1,438**	**1,487**	**1,321**	**932**	**118**	**4**

*Were able to eliminate waiting list prior to start of PAI using state funds.

Appendix X

ADAP Budget, by Source, FY 2005

Appendix X
ADAP Budget, by Source, FY 2005

State	Title II ADAP Earmark	% of Total Budget	Title II ADAP Supplemental	% of Total Budget	Title II Base	% of Total Budget	State	% of Total Budget	Title I	% of Total Budget	Other State or Federal	% of Total Budget	Drug Rebates	% of Total Budget	Total Federal/State
Alabama	$8,474,550	64%	$804,633	6%	$1,026,240	8%	$2,999,632	23%	$0	0%	$0	0%	$0	0%	$13,305,055
Alaska	$505,035	98%	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%	$12,000	2%	$517,035
American Samoa	$2,360	100%	$0	0%	NR	NR	NR	NR	$0	0%	NR	NR	NR	NR	$2,360
Arizona	$9,326,619	90%	$0	0%	$0	0%	$1,000,000	10%	$0	0%	$0	0%	$0	0%	$10,326,619
Arkansas	$3,393,643	100%	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%	$3,393,643
California	$90,028,301	34%	$0	0%	$11,377,873	4%	$84,961,250	32%	$0	0%	$0	0%	$77,923,750	29%	$264,291,174
Colorado	$5,706,243	50%	$594,438	5%	$136,000	1%	$4,413,606	39%	$517,558	5%	$0	0%	$58,133	1%	$11,425,978
Connecticut	$12,052,389	65%	$0	0%	$0	0%	$1,776,352	10%	$0	0%	$0	0%	$4,572,815	25%	$18,401,556
Delaware	$3,379,483	100%	$0	0%	$0	0%	$40	0%	$0	0%	$0	0%	$0	0%	$3,379,523
District of Columbia	$14,648,361	100%	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%	$14,648,361
Florida	$86,648,817	87%	$0	0%	$0	0%	$9,000,000	9%	$0	0%	$0	0%	$4,053,667	4%	$99,702,484
Georgia	$26,509,592	61%	$2,781,061	6%	$458,118	1%	$11,305,339	26%	$1,875,000	4%	$276,729	1%	$0	0%	$43,205,839
Guam	$92,039	91%	$9,656	9%	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%	$101,695
Hawaii	$2,161,042	81%	$0	0%	$0	0%	$440,535	17%	$0	0%	$0	0%	$67,000	3%	$2,668,577
Idaho	$464,915	36%	$48,773	4%	$217,885	17%	$177,500	14%	$0	0%	$0	0%	$375,000	29%	$1,284,073
Illinois	$27,326,143	72%	$0	0%	$0	0%	$10,100,000	27%	$0	0%	$0	0%	$500,000	1%	$37,926,143
Indiana	$7,072,843	98%	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%	$170,000	2%	$7,242,843
Iowa	$1,390,025	68%	$145,824	7%	$0	0%	$375,000	18%	$0	0%	$73,808	4%	$45,000	2%	$2,029,657
Kansas	$2,123,977	65%	$0	0%	$0	0%	$400,000	12%	$206,000	6%	$0	0%	$530,000	16%	$3,259,977
Kentucky	$4,441,472	80%	$465,945	8%	$72,274	1%	$180,000	3%	$0	0%	$0	0%	$400,000	7%	$5,559,691
Louisiana	$15,670,230	90%	$1,643,928	9%	$0	0%	$0	0%	$0	0%	$0	0%	$128,823	1%	$17,442,981
Maine	$832,631	78%	$0	0%	$0	0%	$60,000	6%	$0	0%	$94,600	9%	$75,600	7%	$1,062,831
Marshall Islands	$2,360	100%	$0	0%	NR	NR	NR	NR	$0	0%	NR	NR	NR	NR	$2,360
Maryland	$27,583,380	61%	$0	0%	$63,034	0.14%	$0	0%	$91,803	0.20%	$9,550,988	21%	$8,000,000	18%	$45,289,205
Massachusetts	$15,168,804	70%	$0	0%	$0	0%	$4,216,175	20%	$319,919	1%	$0	0%	$1,900,000	9%	$21,604,898
Michigan	$11,764,472	77%	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%	$3,600,000	23%	$15,364,472
Minnesota	$3,155,286	52%	$0	0%	$0	0%	$1,150,000	19%	$0	0%	$0	0%	$1,775,008	29%	$6,080,294
Mississippi	$5,795,703	89%	$0	0%	$0	0%	$700,000	11%	$0	0%	$0	0%	$0	0%	$6,495,703
Missouri	$7,693,516	56%	$0	0%	$550,000	4%	$2,096,000	15%	$1,460,000	11%	$0	0%	$2,000,000	14%	$13,799,516
Montana	$310,671	66%	$32,185	7%	$86,469	18%	$9,000	2%	$0	0%	$16,000	3%	$13,787	3%	$468,112

NR indicates data not reported.

(continued on next page)

(continued from previous page)

Appendix X
ADAP Budget, by Source, FY 2005

State	Title II ADAP Earmark	% of Total Budget	Title II ADAP Supplemental	% of Total Budget	Title II Base	% of Total Budget	State	% of Total Budget	Title I	% of Total Budget	Other State or Federal	% of Total Budget	Drug Rebates	% of Total Budget	Total Federal/State
Nebraska	$1,164,119	79%	$119,581	8%	$40,857	3%	$150,000	10%	$0	0%	$0	0%	$0	0%	$1,474,557
Nevada	$5,038,545	72%	$0	0%	$0	0%	$1,565,704	22%	$252,196	4%	$0	0%	$140,000	2%	$6,996,445
New Hampshire	$702,308	26%	$0	0%	$0	0%	$180,000	7%	$1,290,835	47%	$145,781	5%	$400,000	15%	$2,718,924
New Jersey	$35,019,792	54%	$0	0%	$0	0%	$9,000,000	14%	$72,363	0.11%	$0	0%	$20,500,000	32%	$64,592,155
New Mexico	$2,293,895	100%	$0	0%	NR	NR	NR	NR	$0	0%	NR	NR	NR	NR	$2,293,895
New York	$129,645,186	54%	$0	0%	$1,400,000	1%	$37,350,000	16%	$10,955,614	5%	$3,366,043	1%	$55,200,000	23%	$237,916,843
North Carolina	$13,836,529	46%	$1,451,559	5%	$0	0%	$12,120,856	40%	$0	0%	$0	0%	$3,000,000	10%	$30,408,944
North Dakota	$106,199	41%	$0	0%	$72,158	28%	$0	0%	$0	0%	$31,136	12%	$50,000	19%	$259,493
N. Mariana Islands	$4,720	100%	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%	$4,720
Ohio	$11,405,756	70%	$0	0%	$3,928,799	24%	$338,787	2%	$300,000	2%	$210,666	1%	$30,000	0.19%	$16,214,008
Oklahoma	$3,775,959	69%	$396,127	7%	$143,070	3%	$884,032	16%	$0	0%	$169,961	3%	$105,000	2%	$5,474,149
Oregon	$4,380,112	60%	$0	0%	$0	0%	$977,678	13%	$0	0%	$0	0%	$2,000,000	27%	$7,357,790
Pennsylvania	$29,037,124	68%	$0	0%	$0	0%	$13,448,000	32%	$0	0%	$0	0%	$0	0%	$42,485,124
Puerto Rico	$23,024,279	73%	$2,323,286	7%	$2,861,706	9%	$1,199,828	4%	$0	0%	$2,307,508	7%	$0	0%	$31,716,607
Rhode Island	$2,109,545	100%	$0	0%	NR	NR	NR	NR	$0	0%	NR	NR	NR	NR	$2,109,545
South Carolina	$12,673,062	84%	$1,329,502	9%	$0	0%	$500,000	3%	$0	0%	$0	0%	$585,000	4%	$15,087,564
South Dakota	$226,558	48%	$0	0%	$190,134	40%	$0	0%	$0	0%	$0	0%	$55,000	12%	$471,692
Tennessee	$10,144,000	58%	$0	0%	$0	0%	$0	0%	$0	0%	$7,364,704	42%	$104,195	1%	$17,612,899
Texas	$54,812,764	58%	$5,750,282	6%	$0	0%	$30,509,949	32%	$0	0%	$0	0%	$4,000,000	4%	$95,072,995
Utah	$2,225,184	86%	$197,073	8%	$0	0%	$180,000	7%	$0	0%	$0	0%	$0	0%	$2,602,257
Vermont	$382,594	61%	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%	$240,000	39%	$622,594
Virgin Islands (U.S.)	$643,097	91%	$66,848	9%	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%	$709,945
Virginia	$15,188,795	77%	$1,593,422	8%	$0	0%	$2,612,200	13%	$0	0%	$0	0%	$450,000	2%	$19,844,417
Washington	$8,274,070	50%	$0	0%	$115,212	1%	$5,587,602	34%	$600,000	4%	$0	0%	$1,865,011	11%	$16,441,895
West Virginia	$1,406,545	65%	$147,557	7%	$300,000	14%	$36,890	2%	$0	0%	$0	0%	$275,000	13%	$2,165,992
Wisconsin	$3,263,844	61%	$342,402	6%	$0	0%	$464,000	9%	$0	0%	$141,319	3%	$1,123,147	21%	$5,334,712
Wyoming	$169,918	23%	$0	0%	$50,000	7%	$367,500	50%	$0	0%	$0	0%	$150,000	20%	$737,418
Total	**$764,679,401**	**59%**	**$20,244,082**	**2%**	**$23,089,829**	**2%**	**$252,833,455**	**19%**	**$17,941,288**	**1%**	**$23,749,243**	**2%**	**$196,472,936**	**15%**	**$1,299,010,233**
Total # of ADAPs Receiving Funds	**57**		**20**		**19**		**39**		**12**		**13**		**39**		

NR indicates data not reported.

Appendix XI

ADAP Budget, FY 2004–FY 2005

Appendix XI
ADAP Budget, FY 2004–FY 2005

State	ADAP FY 2004 Total Budget	ADAP FY 2005 Total Budget	% Change
Alabama	$9,216,638	$13,305,055	44%
Alaska	$555,000	$517,035	-7%
American Samoa	$2,314	$2,360	2%*
Arizona	$9,392,903	$10,326,619	10%
Arkansas	$5,017,445	$3,393,643	-32%
California	$231,770,465	$264,291,174	14%
Colorado	$9,640,532	$11,425,978	19%
Connecticut	$15,724,925	$18,401,556	17%
Delaware	$3,262,722	$3,379,523	4%
District of Columbia	$13,842,594	$14,648,361	6%
Florida	$90,456,773	$99,702,484	10%
Georgia	$39,779,664	$43,205,839	9%
Guam	$94,332	$101,695	8%
Hawaii	$2,524,512	$2,668,577	6%
Idaho	$1,242,476	$1,284,073	3%
Illinois	$42,723,229	$37,926,143	-11%
Indiana	$9,440,661	$7,242,843	-23%
Iowa	$1,382,030	$2,029,657	47%
Kansas	$3,153,495	$3,259,977	3%
Kentucky	$4,995,297	$5,559,691	11%
Louisiana	$15,883,405	$17,442,981	10%
Maine	$833,383	$1,062,831	28%
Marshall Islands	$2,314	$2,360	2%*
Maryland	$29,809,288	$45,289,205	52%
Massachusetts	$22,363,789	$21,604,898	-3%
Michigan	$13,202,763	$15,364,472	16%
Minnesota	$6,155,523	$6,080,294	-1%
Mississippi	$8,777,477	$6,495,703	-26%
Missouri	$13,536,796	$13,799,516	2%
Montana	$460,518	$468,112	2%
Nebraska	$1,611,155	$1,474,557	-8%
Nevada	$6,089,625	$6,996,445	15%
New Hampshire	$2,632,038	$2,718,924	3%
New Jersey	$64,284,345	$64,592,155	0%
New Mexico	$5,169,982	$2,293,895	-56%*
New York	$205,912,206	$237,916,843	16%
North Carolina	$30,559,609	$30,408,944	0%
North Dakota	$244,085	$259,493	6%
N. Mariana Islands	$4,627	$4,720	2%
Ohio	$11,467,773	$16,214,008	41%
Oklahoma	$5,412,761	$5,474,149	1%
Oregon	$6,925,989	$7,357,790	6%
Pennsylvania	$46,335,324	$42,485,124	-8%
Puerto Rico	$30,445,509	$31,716,607	4%
Rhode Island	$2,661,506	$2,109,545	-21%*
South Carolina	$13,939,209	$15,087,564	8%
South Dakota	$551,360	$471,692	-14%
Tennessee	$13,018,438	$17,612,899	35%
Texas	$88,265,314	$95,072,995	8%
Utah	$2,679,455	$2,602,257	-3%
Vermont	$777,007	$622,594	-20%
Virgin Islands (U.S.)	$687,763	$709,945	3%
Virginia	$19,272,421	$19,844,417	3%
Washington	$15,396,314	$16,441,895	7%
West Virginia	$2,087,428	$2,165,992	4%
Wisconsin	$4,850,190	$5,334,712	10%
Wyoming	$422,847	$737,418	74%
Total	**$1,186,947,543**	**$1,299,010,233**	
Comparison Total	***$1,178,324,705***	***$1,293,785,713***	***10%***

*FY 2005 funding includes federal ADAP earmark only for American Samoa, the Marshall Islands, New Mexico and Rhode Island; other funding sources were not reported.

Comparison Total does not include American Samoa, Guam, the Marshall Islands, New Mexico, N. Mariana Islands, Rhode Island, and the Virgin Islands (U.S.).

Appendix XII

Major FY 2005 Budget Categories Compared with FY 2004

Appendix XII
Major FY 2005 Budget Categories Compared with FY 2004

State	2004 Title II ADAP Earmark	2005 Title II ADAP Earmark	% Change	2004 Title II ADAP Supplemental	2005 Title II ADAP Supplemental	% Change	2004 Title II Base	2005 Title II Base	% Change	2004 State	2005 State	% Change	2004 Title I	2005 Title I	% Change	2004 Drug Rebates	2005 Drug Rebates	% Change
Alabama	$7,004,635	$8,474,550	21%	$824,913	$804,633	-2%	$827,090	$1,026,240	24%	$560,000	$2,999,632	436%	$0	$0	—	$0	$0	—
Alaska	$472,602	$505,035	7%	$0	$0	—	$0	$0	—	$14,398	$0	-100%	$0	$0	—	$68,000	$12,000	-82%
American Samoa	$2,314	$2,360	2%	$0	$0	—	NR	NR	NR	NR	NR	NR	$0	$0	—	NR	NR	NR
Arizona	$8,392,903	$9,326,619	11%	$0	$0	—	$0	$0	—	$1,000,000	$1,000,000	0%	$0	$0	—	$0	$0	—
Arkansas	$3,116,716	$3,393,643	9%	$0	$0	—	$1,900,729	$0	-100%	$0	$0	—	$0	$0	—	$0	$0	—
California	$89,623,465	$90,028,301	0.5%	$0	$0	—	$11,703,250	$11,377,873	-3%	$65,926,750	$84,961,250	29%	$0	$0	—	$64,517,000	$77,923,750	21%
Colorado	$5,607,928	$5,706,243	2%	$660,427	$594,438	-10%	$136,000	$136,000	0%	$980,839	$4,413,606	350%	$0	$517,558	—	$0	$58,133	—
Connecticut	$11,315,018	$12,052,389	7%	$0	$0	—	$0	$0	—	$606,678	$1,776,352	193%	$0	$0	—	$3,803,229	$4,572,815	20%
Delaware	$3,202,722	$3,379,483	6%	$0	$0	—	$0	$0	—	$10,000	$40	-100%	$0	$0	—	$50,000	$0	-100%
District of Columbia	$13,842,594	$14,648,361	6%	$0	$0	—	$0	$0	—	$0	$0	—	$0	$0	—	$0	$0	—
Florida	$80,386,630	$86,648,817	8%	$0	$0	—	$0	$0	—	$9,000,000	$9,000,000	0%	$0	$0	—	$0	$4,053,667	—
Georgia	$23,684,951	$26,509,592	12%	$2,789,298	$2,781,061	-0.30%	$357,661	$458,118	28%	$11,305,339	$11,305,339	0%	$1,642,415	$1,875,000	14%	$0	$0	—
Guam	$84,393	$92,039	9%	$9,939	$9,656	-3%	$0	$0	—	$0	$0	—	$0	$0	—	$0	$0	—
Hawaii	$2,084,512	$2,161,042	4%	$0	$0	—	$0	$0	—	$440,000	$440,535	0%	$0	$0	—	$0	$67,000	—
Idaho	$464,163	$464,915	0.2%	$54,663	$48,773	-11%	$246,150	$217,885	-11%	$177,500	$177,500	0%	$0	$0	—	$300,000	$375,000	25%
Illinois	$25,746,254	$27,326,143	6%	$0	$0	—	$0	$0	—	$10,100,000	$10,100,000	0%	$0	$0	—	$1,257,132	$500,000	-60%
Indiana	$6,529,924	$7,072,843	8%	$0	$0	—	$0	$0	—	$2,850,737	$0	-100%	$0	$0	—	$60,000	$170,000	183%
Iowa	$1,305,985	$1,390,025	6%	$0	$145,824	—	$10,722	$0	-100%	$0	$375,000	—	$0	$0	—	$10,000	$45,000	350%
Kansas	$2,045,495	$2,123,977	4%	$0	$0	—	$0	$0	—	$400,000	$400,000	0%	$208,000	$206,000	-1%	$500,000	$530,000	6%
Kentucky	$4,086,741	$4,441,472	9%	$481,282	$465,945	-3%	$72,274	$72,274	0%	$90,000	$180,000	100%	$0	$0	—	$265,000	$400,000	51%
Louisiana	$13,829,935	$15,670,230	13%	$1,628,705	$1,643,928	1%	$0	$0	—	$0	$0	—	$0	$0	—	$424,765	$128,823	-70%
Maine	$833,383	$832,631	-0.1%	$0	$0	—	$0	$0	—	$0	$60,000	—	$0	$0	—	$0	$75,600	—
Marshall Islands	$2,314	$2,360	2%	$0	$0	—	NR	NR	NR	NR	NR	NR	$0	$0	—	NR	NR	NR
Maryland	$25,746,254	$27,583,380	7%	$0	$0	—	$63,034	$63,034	0%	$0	$0	—	$0	$91,803	—	$4,000,000	$8,000,000	100%
Massachusetts	$14,684,416	$15,168,804	3%	$0	$0	—	$0	$0	—	$2,447,990	$4,216,175	72%	$140,819	$319,919	127%	$1,900,000	$1,900,000	0%
Michigan	$11,002,763	$11,764,472	7%	$0	$0	—	$0	$0	—	$0	$0	—	$0	$0	—	$2,200,000	$3,600,000	64%
Minnesota	$3,010,727	$3,155,286	5%	$0	$0	—	$0	$0	—	$911,129	$1,150,000	26%	$0	$0	—	$1,811,658	$1,775,008	-2%
Mississippi	$5,795,703	$5,795,703	0%	$0	$0	—	$0	$0	—	$750,000	$700,000	-7%	$0	$0	—	$0	$0	—
Missouri	$7,409,723	$7,693,516	4%	$0	$0	—	$667,526	$550,000	-18%	$2,069,000	$2,096,000	1%	$1,459,000	$1,460,000	0.1%	$1,931,547	$2,000,000	4%
Montana	$310,145	$310,671	0.2%	$36,525	$32,185	-12%	$73,285	$86,469	18%	$27,894	$9,000	-68%	$0	$0	—	$0	$13,787	—
Nebraska	$1,107,661	$1,164,119	5%	$130,445	$119,581	-8%	$63,049	$40,857	-35%	$150,000	$150,000	0%	$0	$0	—	$0	$0	—
Nevada	$4,738,678	$5,038,545	6%	$0	$0	—	$0	$0	—	$1,350,947	$1,565,704	16%	$0	$252,196	—	$0	$140,000	—
New Hampshire	$755,319	$702,308	-7%	$0	$0	—	$0	$0	—	$0	$180,000	—	$1,476,719	$1,290,835	-13%	$400,000	$400,000	0%
New Jersey	$34,877,598	$35,019,792	0.4%	$0	$0	—	$0	$0	—	$13,672,540	$9,000,000	-34%	$0	$72,363	—	$12,424,723	$20,500,000	65%
New Mexico	$2,127,024	$2,293,895	8%	$0	$0	—	$0	NR	—	$3,000,000	NR	—	$0	$0	—	$42,958	NR	—
New York	$124,956,784	$129,645,186	4%	$0	$0	—	$1,175,422	$1,400,000	19%	$33,000,000	$37,350,000	13%	$13,430,000	$10,955,614	-18%	$33,350,000	$55,200,000	66%

NR indicates data not reported.

(continued on next page)

(continued from previous page)

Appendix XII
Major FY 2005 Budget Categories Compared with FY 2004

State	2004 Title II ADAP Earmark	2005 Title II ADAP Earmark	% Change	2004 Title II ADAP Supplemental	2005 Title II ADAP Supplemental	% Change	2004 Title II Base	2005 Title II Base	% Change	2004 State	2005 State	% Change	2004 Title I	2005 Title I	% Change	2004 Drug Rebates	2005 Drug Rebates	% Change
North Carolina	$12,834,095	$13,836,529	8%	$1,511,429	$1,451,559	-4%	$0	$0	—	$11,120,817	$12,120,856	9%	$0	$0	—	$5,093,268	$3,000,000	-41%
North Dakota	$92,543	$106,199	15%	$0	$0	—	$85,400	$72,158	-16%	$0	$0	—	$0	$0	—	$35,000	$50,000	43%
N. Mariana Islands	$4,627	$4,720	2%	$0	$0	—	$0	$0	—	$0	$0	—	$0	$0	—	$0	$0	—
Ohio	$10,909,930	$11,405,756	5%	$0	$0	—	$0	$3,928,799	—	$7,843	$338,787	4220%	$300,000	$300,000	0%	$250,000	$30,000	-88%
Oklahoma	$3,655,707	$3,775,959	3%	$419,165	$396,127	-5%	$342,307	$143,070	-58%	$786,000	$884,032	12%	$0	$0	—	$104,791	$105,000	0.2%
Oregon	$4,225,989	$4,380,112	4%	$0	$0	—	$0	$0	—	$0	$977,678	—	$0	$0	—	$1,000,000	$2,000,000	100%
Pennsylvania	$27,090,216	$29,037,124	7%	$0	$0	—	$0	$0	—	$13,545,108	$13,448,000	-1%	$0	$0	—	$5,700,000	$0	-100%
Puerto Rico	$22,598,388	$23,024,279	2%	$2,661,337	$2,323,286	-13%	$3,092,784	$2,861,706	-7%	$2,093,000	$1,199,828	-43%	$0	$0	—	$0	$0	—
Rhode Island	$1,911,506	$2,109,545	10%	$0	$0	—	NR	NR	NR	NR	NR	NR	$0	$0	—	$750,000	NR	—
South Carolina	$11,736,984	$12,673,062	8%	$1,382,225	$1,329,502	-4%	$0	$0	—	$500,000	$500,000	0%	$0	$0	—	$320,000	$585,000	83%
South Dakota	$204,654	$226,558	11%	$0	$0	—	$311,706	$190,134	-39%	$0	$0	—	$0	$0	—	$35,000	$55,000	57%
Tennessee	$12,018,438	$10,144,000	-16%	$0	$0	—	$0	$0	—	$1,000,000	$0	-100%	$0	$0	—	$0	$104,195	—
Texas	$50,471,351	$54,812,764	9%	$5,943,843	$5,750,282	-3%	$0	$0	—	$29,918,504	$30,509,949	2%	$1,931,616	$0	-100%	$0	$4,000,000	—
Utah	$1,980,565	$2,225,184	12%	$0	$197,073	—	$0	$0	—	$90,000	$180,000	100%	$0	$0	—	$110,000	$0	-100%
Vermont	$382,007	$382,594	0.2%	$0	$0	—	$0	$0	—	$175,000	$0	-100%	$0	$0	—	$220,000	$240,000	9%
Virgin Islands (U.S.)	$615,707	$643,097	4%	$72,056	$66,848	-7%	$0	$0	—	$0	$0	—	$0	$0	—	$0	$0	—
Virginia	$14,498,751	$15,188,795	5%	$1,707,470	$1,593,422	-7%	$0	$0	—	$2,612,200	$2,612,200	0%	$0	$0	—	$454,000	$450,000	-1%
Washington	$7,966,718	$8,274,070	4%	$0	$0	—	$108,000	$115,212	7%	$3,742,723	$5,587,602	49%	$450,000	$600,000	33%	$1,837,623	$1,865,011	1%
West Virginia	$1,303,875	$1,406,545	8%	$153,553	$147,557	-4%	$290,000	$300,000	3%	$40,000	$36,890	-8%	$0	$0	—	$300,000	$275,000	-8%
Wisconsin	$3,179,514	$3,263,844	3%	$374,441	$342,402	-9%	$0	$0	—	$93,610	$464,000	396%	$0	$0	—	$670,000	$1,123,147	68%
Wyoming	$160,347	$169,918	6%	$0	$0	—	$150,000	$50,000	-67%	$62,500	$367,500	488%	$0	$0	—	$50,000	$150,000	200%
Total	**$728,030,284**	**$764,679,401**	**5%**	**$20,841,716**	**$20,244,082**	**-3%**	**$21,676,389**	**$23,089,829**	**7%**	**$226,629,046**	**$252,833,455**	**12%**	**$21,038,569**	**$17,941,288**	**-15%**	**$146,245,694**	**$196,472,936**	**34%**

NR indicates data not reported.

Appendix XIII

Cost Recovery and Other Cost Saving Mechanisms (Excluding Drug Rebates), FY 2005

Appendix XIII
Cost Recovery and Other Cost Saving Mechanisms (Excluding Drug Rebates), FY 2005

State	Private Insurance Reimbursements	Medicaid Reimbursements	Manufacturers' Free Products	Other	Total
Arizona	$146,400	$0	$0	$0	$146,400
Colorado	$0	$36,000	$56,170	$0	$92,170
Florida	$0	$0	$1,007,504	$0	$1,007,504
Hawaii	$0	$0	$29,000	$0	$29,000
Illinois	$0	$0	$100,000	$0	$100,000
Minnesota	$0	$0	$0	$249,711	$249,711
Montana	$0	$0	$3,564	$0	$3,564
New Jersey	$300,000	$2,000,000	$0	$6,590,656	$8,890,656
New York	$10,500,000	$1,000,000	$0	$0	$11,500,000
North Carolina	$0	$2,000,000	$0	$1,000,000	$3,000,000
Ohio	$5,000	$20,000	$6,000	$0	$31,000
Oklahoma	$51,000	$34,224	$40,000	$0	$125,224
Oregon	$0	$0	$144,000	$0	$144,000
Texas	$0	$0	$450,000	$0	$450,000
Utah	$0	$0	$50,000	$0	$50,000
Virginia	$0	$300,821	$56,165	$0	$356,986
Washington	$356,509	$122,636	$0	$0	$479,145
Wisconsin	$42,365	$187,538	$0	$0	$229,903
Totals	**$11,401,274**	**$5,701,219**	**$1,942,403**	**$7,840,367**	**$26,885,263**
Total # of ADAPs Using Mechanism	**7**	**9**	**11**	**3**	**18**

Includes those states indicating funding received from cost recovery or other cost saving mechanisms. Cost recovery and cost saving mechanisms are not included in the National ADAP Budget (manufacturers' drug rebates are included in the National ADAP Budget).

Appendix XIV

ADAP Drug Purchasing and Prime Vendor Participation, June 2005

Appendix XIV
ADAP Drug Purchasing and Prime Vendor Participation, June 2005

State	Participates in 340 B	Direct Purchase	Pharmacy Network (Rebate)	HRSA Prime Vender (340B Direct Purchasers Only)
Alabama	✓	✓		
Alaska	✓		✓	
American Samoa	NR	NR	NR	NR
Arizona	✓	✓		
Arkansas	✓	✓		✓
California	✓		✓	
Colorado	✓	✓		✓
Connecticut	✓		✓	
Delaware	✓	✓		
District of Columbia*		✓		
Florida	✓	✓		
Georgia	✓	✓		
Guam			✓	
Hawaii	✓	✓		
Idaho	✓		✓	
Illinois	✓	✓		✓
Indiana	✓		✓	
Iowa	✓	✓		
Kansas	✓		✓	
Kentucky	✓	✓		✓
Louisiana	✓	✓		
Maine	✓		✓	
Marshall Islands	NR	NR	NR	NR
Maryland	✓		✓	
Massachusetts	✓	✓		
Michigan	✓		✓	
Minnesota	✓		✓	
Mississisippi	✓	✓		
Missouri	✓		✓	
Montana	✓	✓		✓
Nebraska	✓	✓		
Nevada	✓	✓		
New Hampshire	✓		✓	
New Jersey	✓		✓	
New Mexico	✓	✓		
New York	✓		✓	
North Carolina	✓	✓		
North Dakota	✓		✓	
N. Mariana Islands		✓		
Ohio	✓	✓		✓
Oklahoma	✓	✓		
Oregon	✓		✓	
Pennsylvania	✓		✓	
Puerto Rico	✓	✓		
Rhode Island	NR	NR	NR	NR
South Carolina	✓	✓		✓
South Dakota	✓		✓	
Tennessee	✓	✓		
Texas	✓	✓		
Utah	✓	✓		
Vermont	✓		✓	
Virgin Islands (U.S.)	✓	✓		
Virginia	✓	✓		
Washington	✓		✓	
West Virginia	✓		✓	
Wisconsin	✓		✓	
Wyoming	✓		✓	
Total Number of ADAPs	**51**	**30**	**24**	**7**

NR indicates data not reported.

*District of Columbia receives Department of Defense pricing allowing it to receive prices at the Federal Ceiling Price (at or below 340B prices) and is therefore not required to participate in the 340B program.

Appendix XV

Federal ADAP Funds Used for Insurance Purchasing/Maintenance and Client Enrollment and Utilization in These Programs

Appendix XV
Federal ADAP Funds Used for Insurance Purchasing/Maintenance and Client Enrollment and Utilization in These Programs

State	FY 2005 Est. Expenditures	June 2005 Expenditures	June 2005 Enrollment	June 2005 Clients Served
Alaska	$75,000	$6,038	13	13
California	$24,007,060	$1,870,624	4,214	3,980
Colorado	$332,000	$21,270	34	34
Delaware	$400,000	$358,159	158	96
Florida	$1,834,979	$16,405	154	154
Indiana	$6,788,083	$155,232	57	57
Iowa	$150,000	$12,218	NR	58
Louisiana	$300,000	$20,402	79	79
Maine*	$0	$0	0	0
Maryland	$600,000	$39,644	143	50
Massachusetts	$8,257,039	$677,207	2,349	2,177
Michigan	$500,000	$47,376	106	106
Minnesota	$3,781,197	$272,105	761	394
Missouri	$1,140,719	$98,894	366	366
Montana	$15,000	$962	6	4
Nebraska	$70,186	$8,787	62	58
New Hampshire	$213,000	$8,504	43	43
New Jersey	$1,800,000	$150,000	220	220
New York	$9,000,000	$748,931	1,777	1,253
Ohio	$1,091,800	$128,320	375	375
Oklahoma	$227,000	$20,276	116	93
Oregon	$3,750,000	$222,402	953	859
South Carolina	$1,000,000	$96,161	594	385
Tennessee	$5,500,000	$182,520	572	572
Utah	$386,432	$16,161	114	114
Vermont	NR	$7,377	46	42
Virgin Islands (U.S.)	$10,000	$1,254	20	13
Washington	$3,645,447	$897,729	926	459
Wisconsin	$575,000	$229,194	428	257
Total	**$75,449,942**	**$6,314,153**	**14,686**	**12,311**

New states since 2004 reported in **bold**. **NR** indicates data not reported.

*Maine reports having an insurance purchasing/maintenance program, but no clients were enrolled or served and there were no expenditures for June 2005.

Appendix XVI

ADAP Policies Related to Medicare Part D, as of November 2005

Appendix XVI
ADAP Policies Related to Medicare Part D, as of November 2005

State	Pay Part D Premiums?	Pay Part D Copays?	Provide Medications During Coverage Gap?	Disenroll Clients Eligible for Low Income Subsidy?	Collaborative Agreement with SPAP that Covers HIV	Plan to Coordinate with SPAP	Contacted SPAP to Include HIV	Will Look at Creating a SPAP
Alabama				No				No
Alaska	Yes	Yes	Yes	No				No
Arizona			Yes	Yes				No
Arkansas								
California	No	Yes	Yes	No				No
Colorado	Yes	Yes	Yes					No
Connecticut		Yes	Yes		Yes	No		No
Delaware	Yes				Yes	Yes	Yes	
District of Columbia								
Florida	No	Yes	No	No	No	N/A	N/A	No
Georgia		Yes	No	Yes				
Hawaii	Yes	Yes	Yes					
Idaho	No	No	No	Yes				No
Illinois	No	No	No	Yes	Just changed to include HIV	Yes	Yes	No
Indiana		Yes	Yes	Yes				No
Iowa	Yes	Yes	Yes	No	No	N/A	N/A	No
Kansas		Yes	No	No				
Kentucky	No	Yes	Yes	No				No
Louisiana	Yes	Yes	Yes	Yes-only full LIS	No	No	No	No
Maine	Yes	Yes	Yes	No	Yes	Yes	N/A	N/A
Maryland	Yes	Yes	Yes	No	MD has SPAP, but it excludes people eligible for Medicare	Yes	N/A	No
Massachusetts	Yes	Yes	Yes	No				
Michigan	Yes	Yes	Yes	No				No
Minnesota		Yes			Yes	No	No	No
Mississippi		Yes	No	Yes				No
Missouri	No	No	No	Yes				Yes
Montana	Yes		Yes	Yes				Yes
Nebraska								No
Nevada								
New Hampshire	Yes	Yes	Yes	No				No
New Jersey	Yes	Yes	Yes	No	Yes	Yes	Yes	
New Mexico				Yes				
New York	Yes	Yes	Yes	No				Yes
North Carolina				Yes				No
North Dakota		Yes	Yes					No
Ohio	Yes	Yes	Yes	No				No
Oklahoma		Yes	Yes	No				No
Oregon	Yes	Yes	Yes	No				
Pennsylvania	Yes	Yes	Yes		Yes	No		No
Puerto Rico								No
Rhode Island								
South Carolina								No
South Dakota								No
Tennessee			No					No

Notes: This information represents preliminary responses to surveys completed in June and November, 2005. ADAPs are still in the process of developing policies regarding Medicare Part D as the implementation of the benefit progresses. Blank slots above represent that the ADAP has not determined a policy or that the ADAP did not report its policy.

(continued on next page)

(continued from previous page)

Appendix XVI
ADAP Policies Related to Medicare Part D, as of November 2005

State	Pay Part D Premiums?	Pay Part D Copays?	Provide Medications During Coverage Gap?	Disenroll Clients Eligible for Low Income Subsidy?	Collaborative Agreement with SPAP that Covers HIV	Plan to Coordinate with SPAP	Contacted SPAP to Include HIV	Will Look at Creating a SPAP
Texas	No	No	No	Yes				Yes
Utah	Yes	Yes	Yes	No				No
Vermont	Yes	Yes	Yes	No	Yes	Yes	Yes	
Virginia	No	No	No	Yes, but eligibility exceptions process for those with incomes 135% to 150% FPL	No	No	No	Yes
Washington	Yes	Yes	Yes					No
West Virginia	Yes	Yes	Yes	No				
Wisconsin		Yes	Yes	Yes	Yes	No		Yes
Wyoming	Yes	Yes	Yes	No				No
Total "Yes"	**22**	**32**	**29**	**14**	**8**	**6**	**4**	**6**

Notes: This information represents preliminary responses to surveys completed in June and November, 2005. ADAPs are still in the process of developing policies regarding Medicare Part D as the implementation of the benefit progresses. Blank slots above represent that the ADAP has not determined a policy or that the ADAP did not report its policy.

Appendix XVII

ADAP Clients Served Who Reside in Title I EMAs, June 2005

Appendix XVII
ADAP Clients Served Who Reside in Title I EMAs, June 2005

State	June 2005 Clients Served	June 2005 Number of Clients Served Who Reside Within EMAs	% of Clients Served in June 2005 Who Reside Within EMAs
Alabama	915	NA	—
Alaska	37	NA	—
American Samoa	NR	NA	—
Arizona	918	677	74%
Arkansas	272	NA	—
California	18,275	16,987	93%
Colorado	1,045	812	78%
Connecticut	1,205	1,068	89%
Delaware	249	NA	—
District of Columbia	726	726	100%
Florida	8,682	6,715	77%
Georgia	4,162	2,580	62%
Guam	5	NA	—
Hawaii	211	NA	—
Idaho	76	NA	—
Illinois	3,459	2,888	83%
Indiana	62	NA	—
Iowa	161	NA	—
Kansas*	315	115	37%
Kentucky	401	NA	—
Louisiana	1,704	814	48%
Maine	43	NA	—
Marshall Islands	NR	NA	—
Maryland	2,301	2,179	95%
Massachusetts	2,368	1,836	78%
Michigan	1,337	670	50%
Minnesota	726	663	91%
Mississippi	772	NA	—
Missouri	1,200	996	83%
Montana	49	NA	—
Nebraska	265	NA	—
Nevada	704	545	77%
New Hampshire*	137	101	74%
New Jersey	3,964	3,171	80%
New Mexico	NR	NA	—
New York	12,686	10,790	85%
North Carolina*	1,887	NR	—
North Dakota	33	NA	—
N.Mariana Islands	6	NA	—
Ohio	1,371	356	26%
Oklahoma	611	NA	—
Oregon	1,028	753	73%
Pennsylvania	3,186	1,707	54%
Puerto Rico	3,750	NR	—
Rhode Island	NR	NA	—

*Indicates states that have a portion of an EMA within the state, but the grantee for Title I is not located within the state.

States in bold have EMAs or a portion of an EMA within the state.

NR indicates not reported. **NA** indicates not applicable—no EMA within the state.

Comparison Total for states with EMAs does not include North Carolina, Puerto Rico, and Wisconsin, nor any states without EMAs. Comparison total for all states does not include American Samoa, the Marshall Islands, New Mexico, North Carolina, Puerto Rico, Rhode Island, and Wisconsin.

(continued on next page)

(continued from previous page)

Appendix XVII
ADAP Clients Served Who Reside in Title I EMAs, June 2005

State	June 2005 Clients Served	June 2005 Number of Clients Served Who Reside Within EMAs	% of Clients Served in June 2005 Who Reside Within EMAs
South Carolina	1,793	NA	—
South Dakota	59	NA	—
Tennessee	346	NA	—
Texas	8,802	6,659	76%
Utah	225	NA	—
Vermont	136	NA	—
Virgin Islands (U.S.)	57	NA	—
Virginia	1,781	908	51%
Washington	1,194	898	75%
West Virginia*	183	17	9%
Wisconsin*	477	NR	—
Wyoming	47	NA	—
Total	**96,404**	**65,631**	
Comparison Total for States with EMAs	***83,459***	***65,631***	***79%***
Comparison Total for All States	***90,290***	***65,631***	***73%***

*Indicates states that have a portion of an EMA within the state, but the grantee for Title I is not located within the state.

States in bold have EMAs or a portion of an EMA within the state.

NR indicates not reported. **NA** indicates not applicable—no EMA within the state.

Comparison Total for states with EMAs does not include North Carolina, Puerto Rico, and Wisconsin, nor any states without EMAs. Comparison total for all states does not include American Samoa, the Marshall Islands, New Mexico, North Carolina, Puerto Rico, Rhode Island, and Wisconsin.

NASTAD™
NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS

The National Alliance of State and Territorial AIDS Directors
444 North Capitol Street, N.W., Suite 339, Washington, DC 20001
Phone: 202.434.8090 Fax: 202.434.8092 www.NASTAD.org

THE HENRY J. KAISER FAMILY FOUNDATION

The Kaiser Family Foundation is a non-profit, private operating foundation dedicated to providing information and analysis on health care issues to policymakers, the media, the health care community, and the general public. The Foundation is not associated with Kaiser Permanente or Kaiser Industries.

The Henry J. Kaiser Family Foundation: 2400 Sand Hill Road, Menlo Park, CA 94025 USA
Phone: 650.854.9400 Fax: 650.854.4800

Washington Office: 1330 G Street N.W., Washington, DC 20005 USA
Phone: 202.347.5270 Fax: 202.347.5274 www.kff.org

Additional copies of this publication (#7464) are available on the Kaiser Family Foundation's website at www.kff.org and www.NASTAD.org.