National ADAP Monitoring Project Annual Report

SUMMARY AND DETAILED FINDINGS

APRIL 2009

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 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: Gilead Sciences, GlaxoSmithKline, and Tibotec Therapeutics. Outside of the National ADAP Monitoring and Technical Assistance Program, NASTAD 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

APRIL 2009

Prepared by

The Henry J. Kaiser Family Foundation
ALICIA L. CARBAUGH
JENNIFER KATES

National Alliance of State and Territorial AIDS Directors
BETH CRUTSINGER-PERRY
BRITTEN GINSBURG
MURRAY C. PENNER

NASTAD™
NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS

THE HENRY J. KAISER FAMILY FOUNDATION

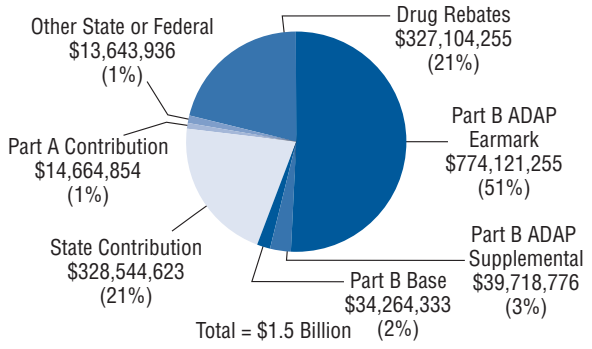
Summary and Highlights

The National ADAP Monitoring Project's *Annual Report* is based on a comprehensive survey of all AIDS Drug Assistance Programs (ADAPs), a key part of the federal Ryan White Program that funds states[1] to provide prescription drugs to low-income people with HIV/AIDS. The Monitoring Project, a partnership between the National Alliance of State and Territorial AIDS Directors (NASTAD) and the Henry J. Kaiser Family Foundation (KFF) that began in 1996, documents new developments and challenges facing ADAPs, assesses key trends over time, and provides the latest available data on the status of these programs. This report updates prior findings with data from fiscal year (FY) 2008 as well as a detailed snapshot of the month of June 2008 (unless otherwise noted) and discusses recent policy and programmatic changes that affect ADAPs.

ADAPs provide access to critical, life-saving medications for low-income, uninsured, and underinsured people with HIV/AIDS. With more than 183,000 enrollees in FY 2007, ADAPs reached over a third of all people with HIV receiving care in the United States. To serve their clients, ADAPs must continually maintain a balance between available resources and demand for services—both of which are unpredictable from year to year. Most programs were able to achieve this balance in FY 2008—the national ADAP budget and the budgets of most individual programs grew, as did client utilization and drug expenditures. However, 21 ADAPs had decreased budgets and for three, demand outweighed resources, resulting in the return of waiting lists. There are also signs that the effects of the economic recession may be trickling down to ADAPs, which may further strain programs in the near future.

These issues and other key findings from the survey are highlighted below.

The National ADAP Budget, by Source, FY 2008



Note: 54 ADAPs reported data. American Samoa, Federated States of Micronesia, Marshall Islands, and Northern Mariana Islands did not report FY 2008 data, but their federal ADAP earmark awards were known and incorporated. The total FY 2008 budget includes federal, state, and drug rebate dollars. Cost recovery funds, with the exception of drug rebate dollars, are not included in the total budget. See Table I.

ADAP SNAPSHOT

- Number of ADAPs, FY 2008: 58
- Total ADAP Budget, FY 2008: $1.5 billion
- Federal ADAP Earmark, FY 2008: $774 million
- Clients Enrolled, FY 2007: 183,299
- Clients Served, June 2008: 110,047
- Drug Spending, June 2008: $109 million

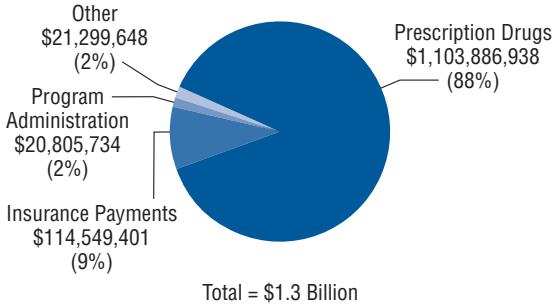
ADAP Budget

The ADAP budget reached $1.5 billion in FY 2008, an increase of more than $100 million (8%) over FY 2007. The federal "ADAP earmark," one of the four main ADAP funding streams and designated specifically for ADAPs by Congress each year, is the largest component of the budget (51%, $774 million in FY 2008), but no longer drives budget growth, as it did early on in the program's history; the earmark decreased slightly between FY 2007 and FY 2008. Other funding streams, particularly drug rebates and state general revenue support, which vary from year to year, are now key budget drivers (and together account for more than 40% of the ADAP budget). While 36 ADAPs had overall budget increases or level funding in the last year, 21 experienced decreases. Most states (34) provide funding to their programs, although 20 do not. Thirteen states decreased their support, including eight that eliminated support all together.

ADAP Expenditures and Services

ADAP spending on prescription drugs (directly and indirectly through insurance coverage) totaled $1.2 billion in FY 2007, accounting for almost all (97%) of program expenditures (the remainder was for program administration and other activities). ADAP formularies ranged from about 30 drugs in one state to more than 400 in another; three states have open formularies. The majority of ADAPs (30) cover all approved antiretrovirals and 36 cover at least half of the medications recommended to prevent and treat HIV-related opportunistic infections. Thirty-seven ADAPs also reported purchasing new health insurance coverage or continuing existing coverage for clients in FY 2008 and many actively coordinate with key sources of public coverage and care, primarily Medicaid and Medicare, as well as private insurance (including state-level high-risk pools[2]) and State Pharmacy Assistance Programs (SPAPs).[3]

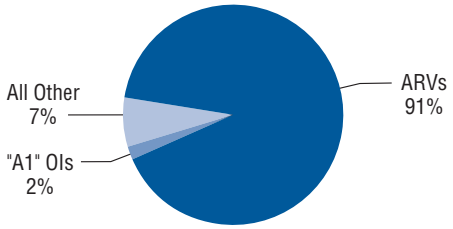
Total ADAP Expenditures, FY 2007



Total = $1.3 Billion

Note: 52 ADAPs reported data. American Samoa, Federated States of Micronesia, Marshall Islands, Northern Mariana Islands, Rhode Island, and Virgin Islands (U.S.) did not report data. Percentages may not total 100% due to rounding.

ADAP Per Capita Drug Expenditures, June 2008



Average Per Capita Spending = $1,004.66

Note: 51 ADAPs reported data. American Samoa, Federated States of Micronesia, Marshall Islands, Northern Mariana Islands, Rhode Island, Vermont, and Virgin Islands (U.S.) did not report data. ARVs=Antiretrovirals; "A1" OIs=Drugs recommended ("A1") for the prevention and treatment of opportunistic infections (OIs). See Tables VI and IX.

ADAP Clients and Eligibility

ADAP client enrollment and utilization have grown over time and reached their highest levels to date. More than 183,000 people were enrolled in ADAPs in FY 2007, including approximately 36,000 clients who were newly enrolled. In the month of June 2008, about 110,000 clients were served (not all enrolled in the program need or access services each month). Forty states experienced increases in clients served in the last year. ADAP clients are primarily people of color, male, low-income, and uninsured. More than 60% of clients are minorities, primarily African Americans and Hispanics; 74% are low-income (at or below 200% of the Federal Poverty Level); and 72% are uninsured, with few reporting any other source of health coverage. Each ADAP determines its own income eligibility criteria, both by balancing between a goal of targeting those who may not qualify for other low-income programs, such as Medicaid, and by seeing how far their budgets can go in a given year. In FY 2008, ADAP income eligibility ranged from 200% FPL in 10 states, above what most state Medicaid income eligibility standards are, to 500% FPL in seven states.

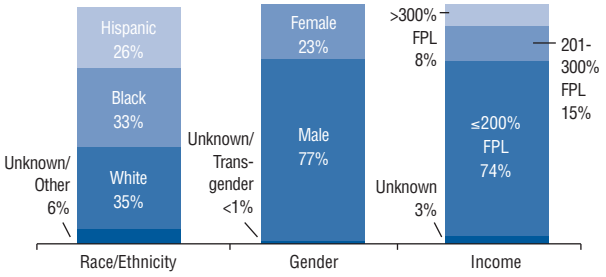
ADAP Cost-Containment Measures and Waiting Lists

ADAPs must balance client demand with available resources on an ongoing basis. As a result, instituting waiting lists for services or other cost-containment measures sometimes becomes necessary. Despite being eliminated in September 2007 for the first time in years, waiting lists reemerged just a few months later, in January 2008. And, as of March 2009, 62 people were on waiting lists in three states—Indiana, Montana, and Nebraska. Montana has also taken additional steps to control costs and seven other ADAPs anticipate the need to do the same in the next year. States cite level federal funding awards and decreases in state revenue support; increased demand for ADAP services (likely due to increased testing efforts and increased unemployment); increased drug costs; and increased insurance/Medicare Part D wrap-around costs as factors likely contributing to the need for cost-containment measures.

RYAN WHITE REAUTHORIZATION

"Title XXVI of the Public Health Service Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006," or the "Ryan White Program," is the single largest federal program designed specifically for people with HIV/AIDS. ADAPs were incorporated into the Ryan White Program when it was first enacted in 1990. The Ryan White Program was reauthorized in 1996, 2000, and 2006. Whereas all prior authorizations were for five-year periods, the 2006 authorization was for three years. Each reauthorization of the Ryan White Program has brought changes and new developments for ADAPs, as well as for other parts of the Ryan White Program, reflecting both past experience and anticipated issues and challenges moving forward (see "Key Dates in the History of ADAPs"). The 2006 reauthorization mandated that all ADAPs cover at least one medication from each of the approved antiretroviral drug classes, the first type of requirement in the program's history; established a new Part B ADAP earmark formula incorporating living HIV and AIDS cases used to determine funding awards (previously only estimated living AIDS cases were included); and increased ADAP supplemental funding and revised the eligibility requirements for this funding. Congress must take action by the end of September 2009 to continue the Ryan White Program. A new authorization could lead to further changes for ADAPs. ◗

Profile of ADAP Clients, June 2008



Note: 54 ADAPs reported data. American Samoa, Federated States of Micronesia, Marshall Islands, and Northern Mariana Islands did not report data. The 2008 Federal Poverty Level (FPL) was $10,400 (slightly higher in Alaska and Hawaii) for a household of one. Percentages may not total 100% due to rounding.

Key Issues Facing ADAP

Looking ahead, there are several key developments that may affect ADAPs in the coming year. Changes from the most recent reauthorization of the Ryan White Program in 2006 are still playing out for ADAPs, including shifts in the distribution of federal funds and new policies related to unobligated funds, which may affect future federal awards. Congress must take action by the end of September 2009 to continue the Ryan White Program; a new authorization could lead to further changes for ADAPs. ADAPs are also reporting increased client demand due to recent changes in national HIV testing recommendations by the Centers for Disease Control and Prevention (CDC)[4] aiming to increase the number of people with HIV who know their status; the CDC's Expanded Testing Initiative (ETI) has already identified nearly 4,000 new HIV cases as of December 2008.[5]

Beyond these issues, the nation's economic recession and the challenging fiscal conditions for states are already being felt by ADAPs, several of whom saw decreases in state funding. More states are anticipating reductions in state support during the upcoming state fiscal year, including some states with the largest ADAP caseloads.[6] ADAP waiting lists have begun to return, and state AIDS programs also report hiring freezes and layoffs, which impact their capacity to serve clients.[6] Moreover, to the extent that states may seek to control rising Medicaid costs as pressure on the program mounts and more people become uninsured due to unemployment[7,8,9], ADAPs could face additional demand for services from those who are no longer able to receive services from other sources.

The full report provides a background and overview of ADAPs, as well as detailed findings on ADAP budgets, drug expenditures, clients, eligibility, and other key aspects of the program. Charts and tables with state-level data can be found in the full report and online.

Background and Overview of ADAPs

The AIDS Drug Assistance Program (ADAP) of the federal Ryan White Program[10,11] is the nation's prescription drug safety net for low-income people with HIV who have limited or no prescription drug coverage. More than a third of all people with HIV receiving care in the U.S. are enrolled in ADAPs each year.[12] In addition to helping to fill gaps in prescription drug coverage, ADAPs often serve as a bridge between a broader array of healthcare and supportive services funded by other Ryan White programs, Medicaid, Medicare, and private insurance.

The purpose of ADAPs, as stated in Ryan White legislation, 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…[10]

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 protease inhibitor approved by FDA, and the highly active antiretroviral therapy (HAART) era begins.

1996: First reauthorization of CARE Act—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 program, using a set-aside of the federal ADAP earmark for states with "severe need."

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 10 states.

2006: Third reauthorization of the CARE Act, now called, "Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006" or the "Ryan White Program." Changes for ADAP include: new formula for determining state awards, which incorporates living HIV and AIDS cases; new minimum formulary requirement; and changes in ADAP supplemental set-aside and eligibility.

2007: New minimum formulary requirement effective July 1; first CCR5 antagonist and integrase inhibitor approved by FDA.

2009: Congress must take action by the end of September 2009 to continue the Ryan White Program. ◗

ADAPs fulfill this purpose by purchasing FDA-approved HIV-related prescription drugs directly (and maintaining formularies), by purchasing health insurance coverage that includes prescription drugs, and by wrapping around existing coverage (e.g., paying co-payments and deductibles).

ADAPs began serving clients in 1987, when Congress first appropriated funds ($30 million over two years[13]) 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 Program as part of its grants to states component (Title II, now called Part B) and became known as "AIDS Drug Assistance Programs," or ADAPs. The Ryan White Program, administered by the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services (DHHS), is the nation's third largest source of federal funding for HIV care, after Medicare and Medicaid.[14]

Since FY 1996, Congress has specifically earmarked funding for ADAPs, through the Ryan White Program, which is allocated by formula to states.[15] The ADAP earmark is the largest component of the overall ADAP budget. In FY 2008, 58 jurisdictions received federal ADAP earmark funding, including all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, American Samoa, Federated States of Micronesia, Guam, Marshall Islands, and Northern Mariana Islands; the Republic of Palau was eligible to receive funding but did not report any HIV/AIDS cases and therefore did not receive a funding award.

In addition to the earmark, many ADAPs also receive funding from other sources, including state general revenue support,[16] other parts of the Ryan White Program, and pharmaceutical manufacturers' drug rebates. These other funding sources, however, which are largely dependent on state and local policy decisions, differing ADAP program management strategies, and resource availability, are highly variable and unpredictable from year to year.

Each state administers its own ADAP and is given flexibility under the Ryan White Program to design many aspects of its program, including client eligibility guidelines, drug purchasing and distribution arrangements, and to a large extent, drug formularies. There is no standard client income eligibility level required by law, although clients must be HIV positive, low-income, and under- or uninsured. The most recent reauthorization of the Ryan White Program instituted a new minimum formulary requirement for all ADAPs,

ALLOCATION OF FEDERAL FUNDING TO ADAPs & STATE MATCH REQUIREMENTS

Each year, Congress specifically earmarks federal funding for ADAPs through Ryan White Part B (funding for care grants to states). Prior to the most recent reauthorization of the Ryan White Program in 2006, the formula used to allocate these funds to state jurisdictions each year was based on their proportion of the nation's estimated living AIDS cases. The 2006 Reauthorization changed the formula by moving from estimated living AIDS cases to actual AIDS cases and by including HIV cases in the formula. AIDS case counts are determined by the Centers for Disease Control and Prevention (CDC) as reported by states. HIV case counts are now determined in one of two ways: (1) as certified by the CDC in states with "mature" HIV name reporting systems; or (2) as reported to the Health Resources and Services Administration (HRSA), by jurisdictions without mature HIV name reporting systems, which then applies a five percent "duplication" penalty to the count. Once these counts are determined, a jurisdiction's proportion of living AIDS and HIV cases is applied to the funding available through the ADAP earmark to determine the award amount.

States with one percent or more of reported AIDS cases during the most recent two-year period must match (with non-federal contributions) their overall Ryan White Part B 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). The state match may consist of in-kind or dollar contributions from the state that are allocated to HIV-related services, not only ADAP.

The 2006 Reauthorization increased the set-aside for ADAP Supplemental Drug Treatment Grants from three to five percent of the ADAP earmark and made changes to state eligibility criteria for these funds. Award amounts are based on the proportion of states' HIV and AIDS cases in those jurisdictions applying. In addition, while ADAPs eligible for supplemental awards are required to provide a $1 state match for every $4 of federal supplemental funds, the most recent reauthorization allows states to apply for a waiver of this requirement if they have met other Ryan White Part B matching requirements, if applicable.

It is important to note that the ADAP fiscal year differs from the federal and state fiscal year periods:

ADAP fiscal year: April 1–March 31

Federal fiscal year: October 1–September 30

State fiscal year (for most states): July 1–June 30

For example, the ADAP FY 2008 began on April 1, 2008 and ended on March 31, 2009. The Federal FY 2008 began on October 1, 2007 and ended on September 30, 2008. The State FY 2008, in most states, began July 1, 2007 and will end on June 30, 2008. ◗

effective July 1, 2007, mandating inclusion of at least one medication from each antiretroviral drug class. ADAPs still determine how many medications from within each antiretroviral class to offer, what, if any, non-antiretroviral, HIV-related medications are covered, and whether cost-sharing, quantity limits, or drug-specific eligibility criteria are instituted.

Like all Ryan White programs, ADAPs serve as "payer of last resort;" that is, they provide prescription medications or health insurance coverage to people with HIV 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 with less generous Medicaid programs, may strain ADAP resources further. But ADAPs are discretionary grant programs, not entitlements,[17] 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. In addition, given that ADAPs are an integral component of the larger Ryan White system, the funding levels and capacity of other Ryan White components may also affect client access to ADAPs. Trend data indicate that when one ADAP revenue source decreases, others appear to increase to fill the gap. However, these "levers" are seldom permanent and usually unpredictable.

Detailed Findings

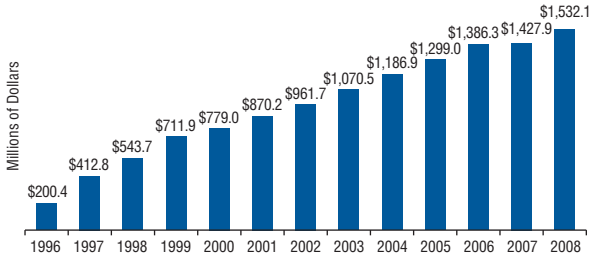
A comprehensive survey was sent to all 58 jurisdictions that received federal ADAP earmark funding in FY 2008; 54 responded (see Methodology). All data are from FY 2008 and June 2008, unless otherwise noted (supplemental data was collected on select issues). The detailed findings of the survey are included below.

ADAP BUDGET

The ADAP budget reached $1.5 billion in FY 2008, an increase of more than $100 million (8%) over FY 2007.[18] Since FY 1996, the budget has grown nearly eight-fold. All funding streams, except for the earmark, increased over the last year. While the ADAP earmark continues to represent the largest share of the budget, it no longer drives budget growth, as it did early on in the program's history (see Charts 1–11 and Tables I–III).

- In FY 2008, the ADAP earmark was $774.1 million. The earmark, specifically appropriated by Congress each year for ADAPs, was one-quarter of the budget in FY 1996, the year it was created, rose to more than two-thirds (68%) of the budget in FY 2000, and has more recently declined as a share of the budget, to 51% in FY 2008.

The National ADAP Budget, FY 1996–2008



- State funding (general revenue support from state budgets) accounted for $328.5 million, or 21% of the ADAP budget in FY 2008, an increase of 12% over FY 2007. States are not required to provide funding to their ADAPs (except in limited cases of matching requirements), although many have historically done so either over a sustained period of time or at critical junctures to address gaps in funding. Such funding is, for the most part, dependent on individual state decisions and budgets; even where states are required to provide a match of federal Part B Ryan White funds, they are not required to put this funding toward ADAP. The only exception to this is the ADAP supplemental, where states must provide a match (or seek a waiver of the requirement).

- Drug rebates accounted for $327.1 million, or 21%, of the national ADAP budget in FY 2008. They represent an increasingly critical component of the ADAP budget, and drove overall budget growth over the period, accounting for more than 60% of growth between FY 2007 and FY 2008. Drug rebates have risen from six percent of the budget in FY 1996 to 21% in FY 2008. ADAPs must actively seek drug rebates and, while not all ADAPs do so (because of varying state drug purchasing mechanisms), drug rebates accounted for a quarter or more of the ADAP budget in 15 states.

- ADAP Supplemental Drug Treatment Grants, which are targeted to states with demonstrated need (16 were funded in FY 2008), accounted for three percent ($39.7 million) of the overall ADAP budget, and increased by just one percent between FY 2007 and FY 2008 following a four-fold increase between FY 2006 and FY 2007. The overall supplemental amount is mandated by law to be five percent of the congressionally appropriated ADAP earmark, although it represented less than this in the national ADAP budget.

- The Part B "base," formula-based funding to states (other than that earmarked for ADAP) accounted for two percent ($34.3 million) of the budget in FY 2008; some states choose to allocate some of this funding to ADAPs, but are not required to do so.

- Part A funding, provided to metropolitan jurisdictions, represented $14.7 million or one percent of the ADAP

budget in FY 2008, similarly reflecting local decisions about whether to allocate funds to ADAPs; seven metropolitan jurisdictions did so in FY 2008 (see Chart 12 and Table IV).

- ADAP budget composition varies by region. The ADAP earmark accounts for the largest share of the budget in the South (62% of the total budget) and Midwest, compared to the Northeast and West. The South receives 88% of ADAP supplemental funding, perhaps reflective of the region's higher needs. Conversely, no states in the Northeast receive supplemental funding. However, ADAPs in the Northeast report significant funding from drug rebates, due in large part to their drug purchasing mechanisms. Budgets in the West are equally distributed across categories.
- ADAP budget composition also varies by state. The earmark is provided to all eligible jurisdictions (58 in FY 2008) based on a formula of living HIV (non-AIDS) and AIDS cases. The breakdown of other sources of funding across the country was as follows (among 54 ADAPs reporting data) (see Chart 4 and Table I):
  - Part B ADAP Supplemental Drug Treatment Grants: 16 ADAPs received funding (34 were eligible to apply);
  - Part B Base Funds: 21 ADAPs received funding, 33 did not;
  - State General Revenue Support: 34 ADAPs received funding, 20 did not;
  - Part A Funds: 7 ADAPs received funding, 47 did not;
  - Other State/Federal Funds: 11 received funding, 43 did not;
  - Drug Rebates: 41 ADAPs received funding, 13 did not.
- While most ADAPs had increases in their budgets between FY 2007 and 2008, some had decreases overall or in specific funding streams (see Chart 5 and Tables II and III):
  - Overall Budget: 36 ADAPs had increases or level funding, 21 had decreases;
  - Part B ADAP Earmark: 33 ADAPs had increases or level funding, 25 had decreases;
  - Part B ADAP Supplemental Drug Treatment Grants: 12 ADAPs had increases, 6 had decreases;
  - Part B Base Funds: 15 ADAPs had increases or level funding, 15 had decreases;
  - State General Revenue Support: 29 ADAPs had increases or level funding, 13 had decreases;
  - Part A Funds: 6 ADAPs had increases or level funding, 4 had decreases;
  - Drug Rebates: 28 ADAPs had increases or level funding, 15 had decreases.
- While not counted as an ADAP budget category in this report (due to its high variability and significant delays), "cost recovery"—reimbursement from third party entities such as private insurers and Medicaid—for medications purchased through ADAP (other than drug rebates), represented $26.2 million in FY 2008. Private insurance recovery, in which an ADAP receives reimbursement from insurance providers, was the largest component of all cost recovery sources (72%). Cost recovery from Medicaid represented 23% of this funding and other sources, including manufacturers' free products, represented five percent (see Chart 13 and Table V).

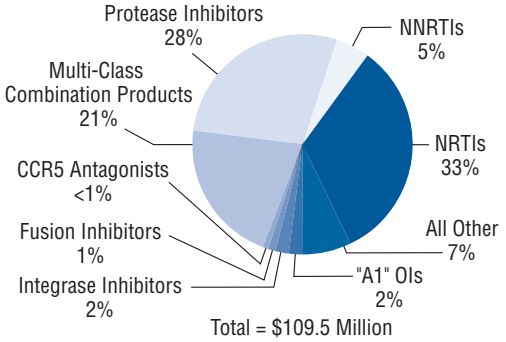
ADAP DRUG EXPENDITURES, PRESCRIPTIONS, AND FORMULARIES

ADAP Drug Expenditures and Prescriptions

Drug spending and utilization have increased over time. The distribution of drug expenditures and prescriptions varies across the country, reflecting differing formularies, drug prices, and prescribing patterns. Antiretrovirals, the standard of care for HIV, account for the majority of ADAP drug expenditures and prescriptions filled.

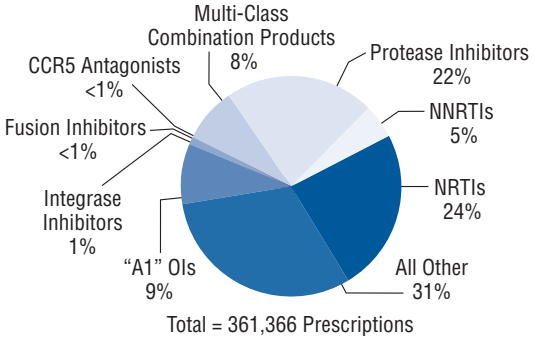
- ADAP spending on prescription drugs (directly and indirectly through insurance coverage) totaled $1.2 billion in FY 2007, accounting for almost all (97%) of program expenditures (the remainder was for program administration and other activities) (see Summary Table III).
- ADAP drug expenditures were $109,463,099 in June 2008, ranging from a low of $17,562 in Guam to a high of $26.7 million in California. Ten states accounted for three-fourths (75%) of all drug spending; five states (California, New York, Texas, New Jersey, and Pennsylvania) accounted for over half (59%) of all drug spending (see Chart 14 and Table VI).
- Drug spending by ADAPs has increased more than seven-fold (617%) since 1996 (in the same 46 states reporting data in both periods), more than twice the rate of client growth over this same period. It, too, has continued to increase but at slower rates. Between June 2007 and June 2008, drug expenditures grew nine percent (see Chart 15).
- Per capita drug expenditures were $1,004.66 in June 2008, ranging from a low of $150 in Massachusetts to $3,512 in Guam. Estimated annual per client expenditures were $12,056 (see Chart 16 and Table VI).[19]
- The average expenditure per prescription was $303. It was significantly higher for antiretrovirals ($458) than non-antiretrovirals ($77 for "A1" OIs and $70 for all other drugs). Among the six classes of antiretroviral drugs, fusion inhibitors represented the highest expenditure per prescription ($1,256), followed by integrase inhibitors ($510), CCR5 antagonists ($494), nucleoside reverse transcriptase inhibitors ($434), protease inhibitors ($383), and non-nucleoside reverse transcriptase inhibitors ($299). Per prescription expenditures for multi-class combination products were $843 (see Chart 17).[20]
- Most ADAP drug spending is on FDA-approved HIV antiretrovirals[21] (91% in June 2008). 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

ADAP Drug Expenditures, by Drug Class, June 2008



Note: 51 ADAPs reported data. American Samoa, Federated States of Micronesia, Marshall Islands, Northern Mariana Islands, Rhode Island, Vermont, and Virgin Islands (U.S.) did not report data. Percentages may not total 100% due to rounding. NRTIs=Nucleoside Reverse Transcriptase Inhibitors; NNRTIs=Non-Nucleoside Reverse Transcriptase Inhibitors; "A1" OIs=Drugs recommended ("A1") for the prevention and treatment of opportunistic infections (OIs). See Table IX.

ADAP Prescriptions Filled, by Drug Class, June 2008



Note: 51 ADAPs reported data. American Samoa, Federated States of Micronesia, Marshall Islands, Northern Mariana Islands, Rhode Island, Vermont, and Virgin Islands (U.S.) did not report data. Percentages may not total 100% due to rounding. NRTIs=Nucleoside Reverse Transcriptase Inhibitors; NNRTIs=Non-Nucleoside Reverse Transcriptase Inhibitors; "A1" OIs=Drugs recommended ("A1") for the prevention and treatment of opportunistic infections (OIs). See Table X.

than prescriptions filled (60%). The 31 "A1" drugs highly recommended for the prevention and treatment of HIV-related opportunistic infections (OIs)[22,23] accounted for two percent of expenditures and nine percent of prescriptions. All other drugs (including medications for depression, hypertension, and diabetes), accounted for seven percent of drug expenditures, but 31% of prescriptions filled (see Charts 20 and 21 and Tables IX and X).

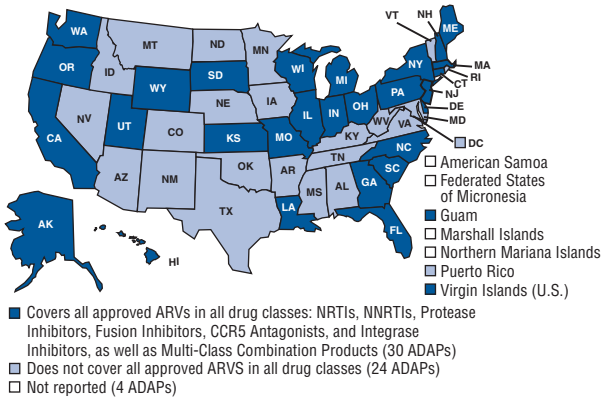
- ADAPs filled a total of 361,366 prescriptions in June 2008, ranging from a low of 42 in Guam to more than 80,500 in California (see Chart 21 and Table X).
- In addition to providing medications, ADAPs spent $9.7 million on insurance purchasing/maintenance in June 2008, and estimate that FY 2008 spending on insurance totaled $106.7 million (see Chart 43 and Table XXV). In FY 2007, insurance payments totaled $114.5 million (see Summary Table III).
- ADAPs also pay for co-payments that clients may face under other insurance mechanisms. Sixteen states paid co-payments in June 2008, which accounted for just one percent of all drug expenditures, although co-payments (meaning prescriptions for which co-payments were made on behalf of the client) accounted for nine percent of total prescriptions provided to clients. Co-payments are a cost-effective way to help clients access medications through existing insurance coverage. In those states where ADAPs largely use their funding to purchase or maintain health insurance coverage, co-payments accounted for a much greater share of expenditures (see Charts 18 and 19 and Tables VII and VIII).

ADAP Formularies

ADAP formularies (the list of drugs covered) vary significantly across the country. Effective July 1, 2007, all ADAPs were required to include at least one drug from each antiretroviral drug class. The minimum formulary requirement does not apply to multi-class combination products (not considered a unique class of drugs), drugs for preventing and treating OIs, hepatitis C treatments, or drugs for other HIV-related conditions (e.g., depression, hypertension, and diabetes).

- As of December 31, 2008, ADAP formularies ranged from 28 drugs covered in Idaho to 466 in New York, as well as open formularies[24] in three states (Massachusetts, New Hampshire, and New Jersey). All ADAPs cover at least one ARV in each of the six ARV drug classes, as required under the Ryan White Program. The majority (30) cover all antiretrovirals in each class (nucleotide/nucleoside reverse transcriptase inhibitors, non-nucleoside reverse transcriptase inhibitors, protease inhibitors, fusion inhibitors, CCR5 antagonists, integrase inhibitors) as well

ADAP Formulary Coverage of Antiretroviral Drugs (ARVs), December 31, 2008



Note: 54 ADAPs reported data. American Samoa, Federated States of Micronesia, Marshall Islands, and Northern Mariana Islands did not report data. See Table XI.

as multi-class combination products on their formularies (see Chart 22 and Table XI).

- Thirty-six ADAPs cover 16 or more of the 31 drugs highly recommended ("A1") for the prevention and treatment of opportunistic infections, including six that cover all 31 (Illinois, Maine, Massachusetts, New Hampshire, New Jersey, and the U.S. Virgin Islands). Eighteen ADAPs cover 15 or fewer of these medications. Louisiana, which historically has not included any medications for OIs or other HIV-related conditions on its ADAP formulary, added 28 "A1" OIs and a few other medications to its formulary in 2008. ADAPs may cover slightly fewer than the full set of "A1" OIs if they cover equivalent medications, also highly recommended, or have other state-level programs that can provide these medications (see Chart 23 and Table XI).
- Hepatitis A, B, and C infections are important considerations for people with HIV, and ADAPs play a unique role in the provision of treatment for the hepatitis C virus (HCV) and vaccines for hepatitis A and B viruses in the U.S. (see Chart 24 and Table XII).
  - Thirty ADAPs cover hepatitis A and B vaccines, which are recommended for those at high risk for and living with HIV.[25]
  - HCV is classified as an HIV-related opportunistic infection, due to the relatively high co-infection rate of HIV and HCV.[26] Because there is no national funding source specifically for HCV treatment, most of the burden for treating co-infected patients has fallen on ADAPs and other Ryan White programs. In June 2008, 29 ADAPs covered treatment for HCV on their formularies, up from 22 in 2007.

ADAP CLIENTS, ELIGIBILITY CRITERIA, ENROLLMENT PROCESSES, AND SPECIAL SERVICES

ADAP Clients

ADAP client enrollment and client utilization were at their highest levels in FY 2008. ADAPs primarily serve low-income, uninsured clients, most of whom are minorities. Client demographics have remained fairly constant over time, although there are significant variations by state and region.

- During FY 2007, 183,299 clients were enrolled in ADAPs nationwide, including 36,354 new clients enrolled throughout the year. Client enrollment ranged from three in Guam to 37,229 in California in FY 2007 (see Chart 25). Typically, fewer clients are served in ADAPs than are enrolled at any given time—ADAPs served 165,383 clients in FY 2007 (see Summary Table III).
- Looking at a one-month snapshot to better examine trends over time, ADAPs provided medications to 110,047 clients across the country in June 2008. ADAPs also paid for insurance coverage (premiums, co-payments, and/or deductibles) for 15,843 clients, some of whom may have also received medications in that month (see Charts 26 and 43 and Table XXV). The number of clients receiving prescription medications has grown significantly since 1996 (254% among the 49 ADAPs reporting data in both periods), but at a decreasing rate in recent years and has generally lagged behind the rate of increase in drug expenditures (see Charts 15, 27, and 28). Client utilization increased by 15% between June 2007 and June 2008—the largest increase reported by the Monitoring Project since June 1999 (also 15%).
- Mirroring the national epidemic, most ADAP clients are concentrated in states with the highest numbers of people living with HIV. For example, 10 states accounted for two-thirds (67%) of total enrollment in FY 2007; five states accounted for half (52%, California, New York, Florida, Texas, and New Jersey) (see Chart 25). The distribution is similar for clients served in June 2008 (see Chart 26). Regionally, more than a third (37%) of clients enrolled in FY 2007 lived in the South, 27% in the West, 25% in the Northeast, and 11% in the Midwest (again, breakdowns are similar by clients served).
- In June 2008, client demographics were as follows (see Charts 29–34 and Tables XIII–XVIII):
  - African Americans and Hispanics represented 59% (33% and 26%, respectively) of clients served. Combined, Asians, Native Hawaiian/Pacific Islanders, and Alaskan Native/American Indians represented approximately two percent of the total ADAP population. Non-Hispanic whites comprised 35%. Regionally, the South has the highest percentage of African Americans among clients served (44% of clients served in the region); the West has the highest percentage of Hispanics (37% of clients served in the region) and the Midwest has the highest percentage of non-Hispanic whites (48% of clients served in the region).
  - More than three-quarters (77%) of ADAP clients were men.
  - Half of clients (50%) were between the ages of 25 and 44, followed by those between the ages of 45 and 64 (45%).
  - Nearly three-quarters (74%) were at or below 200% of the Federal Poverty Level (FPL), including more than four in 10 (42%) who were at or below 100% FPL. In 2008, the FPL was $10,400 annually (slightly higher in Alaska and Hawaii) for a family of one. Regionally, 83% of clients in the South were low-income (200% or less FPL) compared to 57% in the West, 63% in the Northeast, and 78% in the Midwest.
  - A majority of ADAP clients (72%) were uninsured, with few reporting any other source of insurance coverage. Seventeen percent had private insurance,

13% Medicare, 11% Medicaid, and two percent were dual beneficiaries of both Medicaid and Medicare. For those with other sources of coverage, ADAP fills the gaps, such as paying client cost-sharing requirements (e.g., premiums, deductibles, co-payments) and/or providing additional medications for those clients who may be subject to monthly or annual prescription drug limits under other forms of coverage.

– Of ADAP clients whose CD4 was reported, half (51%) had CD4 counts of 350 or below (at time of enrollment or at recertification), one potential indication of more advanced HIV disease. Higher CD4 counts may represent successful treatment or early intervention efforts. CD4 count information was available from 34 ADAPs and reflects clients enrolled in ADAPs over the last 12 months or the most recent 12 months for which data are available.

ADAP Eligibility Criteria

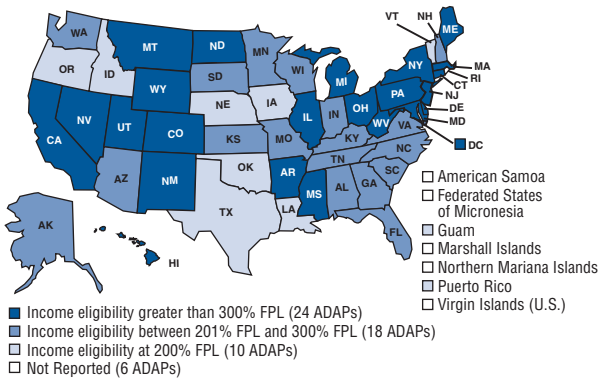
The Ryan White Program requires all ADAP clients to be HIV positive as well as low-income and uninsured or underinsured, but each ADAP determines its own income eligibility criteria, both by balancing between a goal of targeting those who may not qualify for other low-income programs, such as Medicaid, and by seeing how far their budgets can go in a given year. As a result of these factors, eligibility criteria vary by state, although some ADAPs set their eligibility criteria to be consistent with other health programs within their state (see Chart 35 and Table XIX).

- All ADAPs require that individuals provide clinical documentation of HIV infection. Seven ADAPs reported additional clinical eligibility criteria (e.g., specific CD4 or viral load ranges).
- ADAP income eligibility in June 2008 ranged from 200% FPL in 10 states to 500% FPL in seven. Overall, 24 states set income eligibility at greater than 300% FPL. Eighteen states were between 201% and 300% FPL. In addition to using income to determine eligibility, 17 ADAPs reported having asset limits in place in June 2008.
- All ADAPs require enrollees to be residents of the state in which they are seeking medications. Many ADAPs require documentation of residency and a few have specific residency requirements (e.g., must be a resident for 30 days).

ADAP Enrollment Processes

ADAPs use multiple mechanisms to identify and enroll clients, often meeting clients where they are most likely to access the health care system, including community-based organizations (CBOs), AIDS service organizations (ASOs), local health departments, and ADAP offices. Clients are enrolled online, by phone, by mail, and in person (See Chart 36 and Table XX).

ADAP Income Eligibility, June 30, 2008



Note: 52 ADAPs reported data. American Samoa, Federated States of Micronesia, Marshall Islands, Northern Mariana Islands, Rhode Island, and Virgin Islands (U.S.) did not report data. The 2008 Federal Poverty Level (FPL) was $10,400 (slightly higher in Alaska and Hawaii) for a household of one. See Table XIX.

- 38 ADAPs use ASOs, CBOs, or local health departments to enroll clients;
- 18 ADAPs conduct intake at the ADAP Office;
- 19 ADAPs provide intake at private clinical settings;
- 30 ADAPs provide enrollment by mail;
- 23 ADAPs have other enrollment processes including, but not limited to, online applications, phone-in applications, and enrollment via other state programs.

ADAPs and Incarcerated Individuals

ADAP funds, as well as other Ryan White Program funds, can be used to provide services to people with HIV who are incarcerated. HRSA's HIV/AIDS Bureau provides detailed guidance on the requirements around this policy, enabling Ryan White Program funds to be used to support transitional primary care and social services for incarcerated individuals nearing release or in short-term custody.[27] As in all instances, the Ryan White Program must be the payer of last resort and used only when other resources are not available or not reasonably expected to be available. As of June 2008, 16 ADAPs reported providing medications to individuals who are HIV positive and incarcerated in county or city jails. Ten of these programs are funded through federal or a combination of federal and state funds; six are funded only though state general revenue funds (see Table XXI).

ADAP COST-CONTAINMENT MEASURES/MANAGEMENT POLICIES AND WAITING LISTS

ADAPs must balance client demand with available resources on an ongoing basis (given the unpredictability of both). As a result, instituting cost-containment measures or waiting lists for services sometimes becomes necessary (see Charts 37–39 and Table XXII). While waiting lists are the most visible representation of unmet need for ADAP services, ADAPs also control costs or manage resource

constraints in a variety of ways, including reducing or limiting formularies, establishing enrollment caps on particular drugs, instituting patient cost-sharing on medications when it was previously not required, or limiting the number of prescriptions provided per month. When states have had to implement waiting lists, they generally report working with pharmaceutical manufacturer patient assistance programs (PAPs) to help those on waiting lists access medications where possible. These programs, however, are not meant to be permanent sources of drug access and they require people to apply often, sometimes as frequently as every month, and to each drug manufacturer separately. It is important to note that some of these cost-containment measures are also used by ADAPs to ensure efficient use of funds and support appropriate clinical management of patients (see Chart 40 and Table XXIII).

- Fewer ADAPs reported instituting cost-containment measures and maintaining them through the end of the fiscal year compared with last year's report. One state, Montana, instituted additional cost-containment measures (not including waiting lists) as of March 2009, compared to four in the prior year (see Chart 39). However, seven additional states are anticipating that they will need to institute cost-containment measures during the upcoming ADAP fiscal year (before March 31, 2010)—two of these states are also anticipating new waiting lists.
- Since 2002, a total of 20 different ADAPs have instituted a waiting list at some point, and in May 2004, waiting lists reached a peak of 1,629 people, resulting in one-time additional funding from the federal government. This additional funding, Medicare Part D, and improved state fiscal conditions led to the elimination of waiting lists in September 2007, for the first time. However, waiting lists have once again emerged.
- As of March 2009, three states reported a total of 62 people on waiting lists (see Charts 37 and 38 and Table XXII). The number of clients on waiting lists has been slowly growing since September 2007, when no clients were reported on lists.
- The size of waiting lists has fluctuated within and across states over time. Based on bi-monthly surveys conducted between July 2002 and March 2009 (41 surveys overall):
  - The highest number of states reporting a waiting list in any given period was 11.
  - 12 ADAPs had waiting lists in 10 or more of the survey periods.

ADAP COST-CONTAINMENT MEASURES AND WAITING LISTS

Since the beginning of ADAP, states have struggled to meet client demand while facing growing prescription drug costs. As a result, many ADAPs have had to make difficult decisions between client access and services, sometimes leading to the implementation of cost-containment measures and waiting lists.

States use a variety of strategies to contain costs, some of which may affect client access and services. Occasionally, states must implement cost-containment measures multiple times over the course of a year, depending on their fiscal situation and client demand. States may also remove a measure when it is no longer needed. Cost-containment measures used over time by ADAPs have included:

- Implementing waiting lists;
- Lowering financial eligibility criteria;
- Limiting and/or reducing ADAP formularies;
- Limiting access for a particular drug(s), including instituting a drug-specific waiting list;
- Instituting cost-sharing requirements for clients;
- Instituting monthly or annual limits on per capita expenditures.

It is important to note that some of these measures may be used by ADAPs to ensure efficient use of funds and support appropriate clinical management of patients on an ongoing basis, and therefore may be considered standard program management policies.

In certain cases, states have capped program enrollment until more resources become available. When an enrollment cap is reached, the next individual 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 once the program can accommodate them.

Some individuals on waiting lists can get medications through other health programs within their state, or through pharmaceutical 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 them full range of drugs necessary for optimal clinical outcomes.

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. ◗

  - The number of people on waiting lists ranged from a low of one to a high of 1,629 (the average was 594). The highest number of individuals on any one state's waiting list was 891.

- Factors cited by states as contributing to the need for cost-containment measures include level federal funding awards and decreases in state revenue support; increased demand for ADAP services (likely due to increased testing efforts and increased unemployment); increased drug costs; and increased insurance/Medicare Part D wrap-around costs.

DRUG PURCHASING MODELS AND INSURANCE COVERAGE ARRANGEMENTS

Drug Purchasing Models

The federal 340B Drug Discount Program, authorized under the Veterans Health Care Act of 1992, enables ADAPs to purchase drugs at or below the statutorily defined 340B ceiling price, which all ADAPs do (see Chart 41 and Table XXIV).[28] ADAPs may purchase drugs directly from wholesalers at 340B prices ("direct purchase ADAPs") or through retail pharmacy networks at a higher than 340B price ("rebate ADAPs"); in the latter case, ADAPs then submit rebate requests to drug manufacturers, maintaining compliance with the 340B price requirement. Direct purchase ADAPs can also choose to participate in the HRSA Prime Vendor Program[28] created by the federal government to negotiate pharmaceutical pricing below the 340B price.

- 29 ADAPs reported purchasing directly from wholesalers, 18 of which also participated in the HRSA Prime Vendor Program.
- 25 reported purchasing through a pharmacy network and then seeking rebates.
- The District of Columbia participates in the 340B program, but is able to purchase most of its medications through the Department of Defense, allowing it to access the Federal Ceiling Price, a lower price only available to certain federal purchasers. Several other states that participate in the 340B program also have state laws regarding negotiation processes that result in lower prices.
- NASTAD's ADAP Crisis Task Force negotiates directly with manufacturers for pharmaceutical pricing below the 340B price on behalf of both rebate and direct purchase ADAPs. When such agreements are reached, they are provided to all states. There are currently agreements in place with all manufacturers of antiretroviral medications.

Insurance Purchasing/Maintenance Programs

The Ryan White Program 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.[29,30] States are increasingly using ADAP funds for this purpose.

- 37 ADAPs used funds for insurance purchasing/maintenance in 2008 representing $106.7 million in estimated expenditures in FY 2008. ADAPs also reported spending over $100 million on insurance purchasing/maintenance in FY 2007.
- In June 2008, 15,843 ADAP clients were served by such arrangements (see Chart 43 and Table XXV).
- Spending on insurance represented an estimated $610 per capita, about a third less than per capita drug expenditures in that month ($1,005).

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. In calendar year 2008, it is estimated that 16% of ADAP clients were also Medicare-eligible (representing about 17,000 enrolled clients). A subset of these clients were dually eligible for Medicare and Medicaid.

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 at the time manufactured antiretroviral drugs. The goal of the meetings was to obtain multi-year concessions on 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), price freezes, and free products to all ADAPs nationwide. During 2004, the Task Force expanded its negotiations to include companies that manufacture high-cost non-antiretroviral drugs. Additional agreements have been obtained since then and previous agreements were extended and/or enhanced. Agreements are currently in place with 14 manufacturers. The Task Force estimated savings of $180 million in FY 2007, and $605 million since its formation. Current members of the Task Force include representatives from ADAPs in California, Florida, Michigan, New Jersey, New York, Texas, and Utah.

The Task Force also coordinates its efforts with the Fair Pricing Coalition (a coalition of organizations and individuals working with pharmaceutical companies regarding initial pricing of antiretroviral drugs for all payers) and other community partners. ◗

- As the payer of last resort, ADAPs are required to ensure that all Medicare Part D-eligible clients enroll in a Medicare prescription drug plan or at least ensure that ADAP funds are not used for any Medicare-covered prescription drug service for Medicare-eligible ADAP clients. ADAPs are encouraged to coordinate with Medicare prescription drug plans and, in accordance with any applicable state policy, pay for drug plan premiums, deductibles, coinsurance, and co-payments.[29] However, the MMA does not allow ADAP funds to be counted toward a beneficiary's True Out-of-Pocket expenses (TrOOP). This means ADAP enrollees whose income defines them as a standard Part D beneficiary must incur these costs themselves when in the coverage gap before they are eligible to receive catastrophic coverage under their Medicare drug plan.[31] If ADAP enrollees cannot incur these costs themselves, the ADAP can assume the cost of their care; however, the client will not be able to transition out of the coverage gap.
- To meet the federal requirements and maintain appropriate medication coverage for their clients, 52 ADAPs have developed policies to coordinate with the Part D benefit, including 14 that put such policies in place in the last year (see Chart 42 and Table XXVI). As of June 2008:
  - 25 ADAPs pay Part D premiums;
  - 28 ADAPs pay Part D deductibles;
  - 33 ADAPs pay Part D co-payments for ADAP clients eligible for Part D;
  - 29 ADAPs pay for all medications on their ADAP formularies when their Part D clients reach the coverage gap or "doughnut hole". This action meets the requirement of "payer of last resort" but also provides a safety net for continuing HIV treatment access for beneficiaries.
- Some states have turned to enrolling clients in State Pharmacy Assistance Programs (SPAPs),[3] whose contributions do count toward TrOOP, helping to move the beneficiary through the coverage gap and into Part D catastrophic coverage. SPAPs may also create cost savings for ADAPs by enabling eligible clients to move off ADAP program rolls. As of June 2008, 16 states had SPAPs into which the ADAP could enroll some or all of their Medicare Part D clients and nine additional ADAPs were considering implementing an SPAP for individuals living with HIV to assist them with Medicare Part D costs.

CHARTS AND TABLES

Charts for each major finding and tables, with data provided by state, are included in the full report. State-level data from this report are provided on Kaiser's StateHealthFacts.org website: www.statehealthfacts.org/hiv.

METHODOLOGY

Since 1996, the National ADAP Monitoring Project, an initiative of the Kaiser Family Foundation (Kaiser) and the National Alliance of State and Territorial AIDS Directors (NASTAD), has surveyed all jurisdictions receiving federal ADAP earmark funding through Ryan White. In FY 2008, 58 jurisdictions received earmark funding and all 58 were surveyed; 54 responded. American Samoa, Federated States of Micronesia, Marshall Islands, and Northern Mariana Islands did not respond; these jurisdictions represent less than one percent of estimated living HIV and AIDS cases.*

The annual survey requests data and other program information for a one-month period (June), the current fiscal year, and for other periods as specified. After the survey is distributed, NASTAD conducts extensive follow-up to ensure completion by as many ADAPs as possible. Data used in this report are from June 2008 and FY 2008, unless otherwise noted. Supplemental data collection is conducted in certain areas to obtain more current data, including: waiting lists, other cost-containment measures, and formulary composition.

All data reflect the status of ADAPs as reported by survey respondents; however, it is important to note that some program information may have changed between data collection and this report's release. 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. It is also important to note that data from a one-month snapshot may be subject to one-time only events or changes that could in turn appear to impact trends; these are noted where information is available. Data issues specific to a particular jurisdiction are provided on relevant charts and tables. ◗

*CDC, "HIV/AIDS Data through December 2005: Provided for the Ryan White HIV/AIDS Treatment Modernization Act of 2006, for Fiscal Year 2007," HIV/AIDS Surveillance Supplemental Report, Volume 13, Number 3. Available at: http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2008supp_vol13no3/pdf/HIVAIDS_SSR_Vol13_No3.pdf.

References and Notes

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

[2] State programs that offer health insurance to residents who are considered uninsurable and unable to buy coverage in the individual market. Typically, people are considered uninsurable if they have been turned down, charged substantially higher premiums, or if they have been offered private coverage with an elimination rider.

[3] State-funded programs that provide financial assistance for prescription drugs to low-income and medically needy senior citizens and individuals with disabilities. In a number of states, SPAPs have been expanded to include HIV-infected individuals or were created specifically for HIV-infected individuals.

[4] Centers for Disease Control and Prevention, "Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings." *MMWR* 2006; 55(RR14): 1-17.

[5] National Alliance of State and Territorial AIDS Directors, "Report on the Centers for Disease Control and Prevention (CDC) Expanded Testing Initiative: Successes and Challenges for Health Department HIV/AIDS Programs," March 2009. Available at: http://www.nastad.org/Docs/highlight/200935_26632_NASTAD_Brief%20(3).pdf (accessed March 10, 2009).

[6] National Alliance of State and Territorial AIDS Directors, Unpublished Data, March 2009.

[7] Kaiser Commission on Medicaid and the Uninsured, "Medicaid, SCHIP and Economic Downturn: Policy Challenges and Policy Responses," April 2008.

[8] Kaiser Commission on Medicaid and the Uninsured, "Headed for a Crunch: An Update on Medicaid Spending, Coverage and Policy Heading into an Economic Downturn," September 2008.

[9] Center on Budget and Policy Priorities, "Facing Deficits, At Least 40 States Are Imposing or Planning Cuts That Hurt Vulnerable Residents," February 10, 2009. Available at: http://www.cbpp.org/3-13-08sfp.htm (accessed March 10, 2009).

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

[11] Health Resources and Services Administration, HIV/AIDS Bureau, http://hab.hrsa.gov/treatmentmodernization/partb.htm (accessed March 10, 2009).

[12] Based on Kaiser Family Foundation analysis of data from the Centers for Disease Control and Prevention.

[13] Health Resources and Services Administration, HIV/AIDS Bureau, Personal Communication, March 15, 2005.

[14] Kaiser Family Foundation, "The Ryan White Program," Fact Sheet, February 2009.

[15] Up until the most recent reauthorization of Ryan White, three percent of the ADAP earmark was set-aside for the ADAP Supplemental Drug Treatment Grant, grants to states with severe need. As of FY 2007, this amount was increased to five percent. See box on "Allocation of Federal Funding to ADAPs & State Match Requirements."

[16] 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."

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

[18] For purposes of determining the overall ADAP budget, federal, state, and drug rebate funds are counted.

[19] This estimate is based on annualizing June 2008 per capita drug expenditures. It is important to note that June 2008 expenditures may not be representative of monthly expenditures overall.

[20] While the multi-class combination products are not considered a unique class of drugs, the costs for these drugs were broken out in this report. The per prescription cost is difficult to compare, since the one approved multi-class combination product includes three different drugs (two NRTIs and one NNRTI), and can appear higher in cost than it actually is if compared to single class products.

[21] U.S. Food and Drug Administration, "Drugs Used in the Treatment of HIV Infection." Available at: http://www.fda.gov/oashi/aids/virals.html (accessed March 10, 2009).

[22] Centers for Disease Control and Prevention, "Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus." *MMWR* 2002; 51(RR08): 1-46. Available at: http://www.aidsinfo.nih.gov/ (accessed March 10, 2009).

[23] Centers for Disease Control and Prevention, "Treating Opportunistic Infections Among HIV-Infected Adults and Adolescents." *MMWR* 2004; 53(RR15): 1-112. Available at: http://www.aidsinfo.nih.gov/ (accessed March 10, 2009).

[24] Providing any FDA-approved prescription drug.

[25] Centers for Disease Control and Prevention, "Sexually Transmitted Diseases Treatment Guidelines, 2006." *MMWR*, Vol. 55, September 2006.

[26] 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/resources/qa/HIV-HCV_Coinfection.htm (accessed March 10, 2009).

[27] Health Resources and Services Administration, HIV/AIDS Bureau, Policy Notice 01-01, "Use of Ryan White CARE Act Funds for Transitional Social Support and Primary Care Services for Incarcerated Persons," in *The ADAP Manual: AIDS Drug Assistance Program of the Ryan White CARE Act*, Section V, Chapter 2, 2001.

[28] Health Resources and Services Administration, Pharmacy Services Support Center, "What is the 340B Program?" Available at: http://pssc.aphanet.org/about/whatisthe340b.htm (accessed March 10, 2009).

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

[30] Health Resources and Services Administration, 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.

[31] Health Resources and Services Administration, HIV/AIDS Bureau, "Medicare Prescription Drug Benefit and CARE Act Grantees." Available at: http: www.hrsa.gov/medicare/hiv/about.htm (accessed March 10, 2009).

Summary Table I

Matrix of Key ADAP Highlights

State/Territory	Financial Eligibility as % of FPL[1]	Total FY 2008 Budget[2]	State Contribution	State Contribution as % of Total Budget	June 2008 Clients Served	June 2008 Drug Expenditures	June 2008 Prescriptions Filled	June 2008 Per Capita Drug Expenditures[3]
Alabama	250% GR	$16,313,574	$5,075,403	31%	1,207	$1,132,283	3,219	$938.10
Alaska	300% GR	$674,285	$31,221	5%	57	$51,583	163	$904.96
American Samoa	—	$1,978	—	—	—	—	—	—
Arizona	300% GR	$12,723,709	$1,000,000	8%	949	$1,067,035	5,297	$1,124.38
Arkansas	500% GR	$4,245,310	$0	0%	393	$328,028	1,294	$834.68
California	400% GR	$321,887,287	$96,349,000	30%	20,471	$26,723,020	80,522	$1,305.41
Colorado	400% GR	$14,630,225	$5,083,028	35%	934	$852,900	2,775	$913.17
Connecticut	400% NET	$29,997,547	$606,678	2%	1,271	$1,360,911	4,946	$1,070.74
Delaware	500% GR	$4,415,397	$0	0%	380	$158,623	1,493	$417.43
District of Columbia	500% GR	$14,392,258	$0	0%	927	$772,698	3,010	$833.55
Federated States of Micronesia	—	$4,934	—	—	—	—	—	—
Florida	300% GR	$94,009,558	$10,500,000	11%	10,738	$3,860,505	17,792	$359.52
Georgia	300% GR	$41,731,043	$9,500,000	23%	3,600	$3,384,880	10,728	$940.24
Guam	200% GR	$130,055	$0	0%	5	$17,562	42	$3,512.31
Hawaii	400% GR	$2,518,601	$440,535	17%	247	$266,085	832	$1,077.27
Idaho	200% GR	$2,238,972	$779,300	35%	113	$219,238	326	$1,940.16
Illinois	400% GR	$41,442,223	$13,814,074	33%	3,407	$3,341,937	9,122	$980.90
Indiana	300% GR	$12,263,515	$0	0%	1,318	$242,591	6,307	$184.06
Iowa	200% GR	$2,348,431	$555,000	24%	261	$178,617	647	$684.36
Kansas	300% GR	$5,465,222	$0	0%	431	$704,976	1,070	$1,635.68
Kentucky	300% GR	$6,872,876	$0	0%	990	$650,562	3,186	$657.13
Louisiana	200% GR	$19,248,508	$0	0%	1,572	$1,374,192	3,739	$874.17
Maine	500% GR	$1,088,124	$66,550	6%	187	$66,950	517	$358.02
Marshall Islands	—	$2,893	—	—	—	—	—	—
Maryland	500% GR	$72,868,483	$17,372,828	24%	2,748	$2,450,249	9,177	$891.65
Massachusetts	481% GR	$19,954,311	$1,958,523	10%	3,102	$464,425	11,691	$149.72
Michigan	450% GR	$20,681,534	$0	0%	1,690	$1,624,482	6,609	$961.23
Minnesota	300% GR	$9,074,912	$0	0%	914	$257,545	1,529	$281.78
Mississippi	400% GR	$7,585,816	$0	0%	675	$778,240	2,244	$1,152.95
Missouri	300% GR	$16,889,193	$3,649,634	22%	1,206	$1,613,798	4,829	$1,338.14
Montana	330% GR	$757,279	$147,018	19%	77	$52,979	221	$688.04
Nebraska	200% GR	$2,234,366	$900,000	40%	258	$220,746	809	$855.61
Nevada	400% GR	$9,861,493	$1,633,261	17%	655	$493,127	1,430	$752.86
New Hampshire	300% GR	$2,009,571	$500,000	25%	189	$174,429	850	$922.90
New Jersey	500% GR	$69,471,571	$4,700,000	7%	4,746	$6,545,695	21,203	$1,379.20
New Mexico	400% GR	$4,060,585	$0	0%	568	$33,321	108	$812.71
New York	423% GR	$260,483,981	$55,000,000	21%	13,806	$21,414,488	56,169	$1,551.10
North Carolina	250% GR	$33,138,757	$14,551,663	44%	3,286	$3,330,568	11,233	$1,013.56
North Dakota	400% NET	$439,133	$0	0%	33	$37,857	84	$1,147.18
Northern Mariana Islands	—	$3,958	—	—	—	—	—	—
Ohio	500% GR	$19,999,234	$3,000,000	15%	1,806	$154,334	6,993	$85.46
Oklahoma	200% GR	$9,343,712	$1,646,179	18%	768	$589,331	1,976	$767.36
Oregon[4]	200% GR	$11,591,911	$1,157,157	10%	1,663	$349,769	5,754	$210.32
Pennsylvania	337% GR	$57,986,902	$16,267,000	28%	3,383	$4,130,405	13,896	$1,220.93
Puerto Rico	200% NET	$33,747,827	$0	0%	3,210	$2,735,978	7,094	$852.33
Rhode Island	—	$4,284,014	$1,700,000	40%	397	—	—	—
South Carolina	300% GR	$25,820,224	$5,900,000	23%	2,172	$3,513,143	6,009	$1,617.47
South Dakota	300% GR	$502,084	$0	0%	77	$64,078	247	$832.18
Tennessee	300% GR	$23,101,925	$7,300,000	32%	2,016	$1,198,581	3,140	$594.53
Texas	200% GR	$102,703,466	$35,475,307	35%	6,750	$6,067,800	15,650	$898.93
Utah	400% GR	$4,339,509	$0	0%	475	$438,048	1,245	$922.21
Vermont	200% NET	$1,002,212	$0	0%	83	—	—	—
Virgin Islands (U.S.)	—	$640,973	$0	0%	85	—	—	—
Virginia[5]	300% GR	$23,977,929	$2,612,200	11%	1,520	$1,880,534	4,450	$1,237.19
Washington	300% GR	$22,197,091	$8,809,064	40%	1,310	$998,020	6,714	$761.85
West Virginia	325% GR	$2,318,538	$0	0%	184	$164,590	468	$894.51
Wisconsin	300% GR	$9,792,825	$464,000	5%	677	$858,409	2,307	$1,267.96
Wyoming	332% GR	$550,188	$0	0%	60	$72,954	210	$1,215.90
Total		**$1,532,062,032**	**$328,544,623**	**21%**	**110,047**	**$109,463,099**	**361,366**	**$1,004.66**

[1] The 2008 Federal Poverty Level (FPL) was $10,400 (slightly higher in Alaska and Hawaii) for a household of one. GR=Gross income; NET=Net income.

[2] The total FY 2008 budget includes federal, state, and drug rebate dollars. Cost recovery funds, with the exception of drug rebate dollars, are not included in the total budget.

[3] Per capita expenditures calculation based on June 2008 clients served and drug expenditures.

[4] Oregon has an FPL of 200% for standard ADAP clients and 300% for clients who have some form of insurance.

[5] Virginia has an FPL of 333% in Northern Virginia and 300% in all other parts of the state.

Note: The number of ADAPs reporting data for each category varies. See Summary Table II and Tables I, VI, IX, X, and XIX for additional detail. A dash (—) indicates no data available from the ADAP. A zero ($0 or 0%) indicates a response of zero ($0 or 0%) from the ADAP.

Summary Table II

Total Clients Enrolled/Served, Drug Expenditures, and Prescriptions Filled, June 2007 and June 2008

State/Territory	June 2007 Clients Enrolled	June 2008 Clients Enrolled	% Change	June 2007 Clients Served	June 2008 Clients Served	% Change	June 2007 Drug Expenditures	June 2008 Drug Expenditures	% Change	June 2007 Prescriptions Filled	June 2008 Prescriptions Filled	% Change
Alabama	1,182	1,439	22%	981	1,207	23%	$909,660	$1,132,283	24%	2,771	3,219	16%
Alaska	57	63	11%	54	57	6%	$40,244	$51,583	28%	174	163	-6%
American Samoa	—	—	—	—	—	—	—	—	—	—	—	—
Arizona	1,786	2,025	13%	824	949	15%	$890,306	$1,067,035	20%	4,518	5,297	17%
Arkansas	350	511	46%	305	393	29%	$729,460	$328,028	-55%	839	1,294	54%
California	28,723	30,320	6%	18,939	20,471	8%	$22,285,233	$26,723,020	20%	75,869	80,522	6%
Colorado	1,583	1,440	-9%	921	934	1%	$744,646	$852,900	15%	2,341	2,775	19%
Connecticut	1,764	1,771	0.40%	1,351	1,271	-6%	$1,586,003	$1,360,911	-14%	5,771	4,946	-14%
Delaware	387	660	71%	244	380	56%	$85,350	$158,623	86%	911	1,493	64%
District of Columbia	1,030	1,619	57%	740	927	25%	$546,787	$772,698	41%	2,171	3,010	39%
Federated States of Micronesia	—	—	—	—	—	—	—	—	—	—	—	—
Florida	10,052	10,757	7%	8,640	10,738	24%	$4,668,285	$3,860,505	-17%	15,937	17,792	12%
Georgia	5,289	4,190	-21%	3,411	3,600	6%	$2,889,590	$3,384,880	17%	10,021	10,728	7%
Guam	—	5	—	—	5	—	—	$17,562	—	—	42	—
Hawaii	251	272	8%	205	247	20%	$206,857	$266,085	29%	690	832	21%
Idaho	132	149	13%	107	113	6%	$349,320	$219,238	-37%	479	326	-32%
Illinois	4,086	4,528	11%	3,042	3,407	12%	$2,997,094	$3,341,937	12%	8,485	9,122	8%
Indiana	1,172	1,318	12%	1,172	1,318	12%	$261,946	$242,591	-7%	6,451	6,307	-2%
Iowa	337	366	9%	225	261	16%	$147,613	$178,617	21%	610	647	6%
Kansas	982	947	-4%	469	431	-8%	$1,560,997	$704,976	-55%	1,114	1,070	-4%
Kentucky	1,027	1,207	18%	780	990	27%	$417,622	$650,562	56%	2,563	3,186	24%
Louisiana	1,559	1,572	1%	1,559	1,572	1%	$1,291,580	$1,374,192	6%	3,722	3,739	0.5%
Maine	446	543	22%	147	187	27%	$21,195	$66,950	216%	230	517	125%
Marshall Islands	—	—	—	—	—	—	—	—	—	—	—	—
Maryland	4,060	4,341	7%	3,294	2,748	-17%	$2,625,968	$2,450,249	-7%	8,686	9,177	6%
Massachusetts	4,153	4,626	11%	2,833	3,102	9%	$460,393	$464,425	1%	10,661	11,691	10%
Michigan	2,151	1,939	-10%	1,558	1,690	8%	$1,621,669	$1,624,482	0%	7,082	6,609	-7%
Minnesota	969	1,158	20%	474	914	93%	$544,582	$257,545	-53%	1,661	1,529	-8%
Mississippi	1,057	1,039	-2%	690	675	-2%	$730,056	$778,240	7%	2,380	2,244	-6%
Missouri	1,613	1,854	15%	1,062	1,206	14%	$1,245,829	$1,613,798	30%	4,017	4,829	20%
Montana[1]	85	93	9%	66	77	17%	$45,660	$52,979	16%	195	221	13%
Nebraska	409	384	-6%	236	258	9%	$165,068	$220,746	34%	482	809	68%
Nevada	876	844	-4%	603	655	9%	—	$493,127	—	—	1,430	—
New Hampshire	363	350	-4%	136	189	39%	$91,482	$174,429	91%	472	850	80%
New Jersey	5,672	5,841	3%	4,241	4,746	12%	$6,095,718	$6,545,695	7%	23,243	21,203	-9%
New Mexico[2]	69	585	748%	58	568	879%	—	$33,321	—	155	108	-30%
New York	17,516	18,034	3%	13,127	13,806	5%	$19,628,372	$21,414,488	9%	54,853	56,169	2%
North Carolina	3,925	4,501	15%	2,712	3,286	21%	$2,695,867	$3,330,568	24%	8,137	11,233	38%
North Dakota	62	64	3%	28	33	18%	$24,314	$37,857	56%	70	84	20%
Northern Mariana Islands	—	—	—	—	—	—	—	—	—	—	—	—
Ohio	3,130	3,593	15%	1,681	1,806	7%	$728,746	$154,334	-79%	5,988	6,993	17%
Oklahoma	875	1,018	16%	668	768	15%	$467,532	$589,331	26%	1,716	1,976	15%
Oregon	1,499	1,857	24%	1,493	1,663	11%	$172,566	$349,769	103%	4,950	5,754	16%
Pennsylvania	5,965	4,986	-16%	3,259	3,383	4%	$4,375,219	$4,130,405	-6%	13,979	13,896	-1%
Puerto Rico	3,773	3,606	-4%	3,413	3,210	-6%	$3,239,852	$2,735,978	-16%	13,126	7,094	-46%
Rhode Island	809	—	—	304	397	31%	$177,248	—	—	488	—	—
South Carolina	2,328	3,042	31%	1,646	2,172	32%	$1,109,251	$3,513,143	217%	3,346	6,009	80%
South Dakota	167	196	17%	56	77	38%	$43,674	$64,078	47%	113	247	119%
Tennessee	2,315	2,840	23%	2,228	2,016	-10%	$1,053,258	$1,198,581	14%	3,164	3,140	-1%
Texas	11,588	10,443	-10%	7,501	6,750	-10%	$6,439,495	$6,067,800	-6%	17,916	15,650	-13%
Utah	556	475	-15%	472	475	1%	$215,123	$438,048	104%	699	1,245	78%
Vermont	222	259	17%	127	83	-35%	$66,702	—	—	217	—	—
Virgin Islands (U.S.)	178	—	—	87	85	-2%	$49,872	—	—	160	—	—
Virginia	2,550	2,740	7%	1,535	1,520	-1%	$1,948,257	$1,880,534	-3%	4,329	4,450	3%
Washington	3,104	3,206	3%	1,354	1,310	-3%	$743,227	$998,020	34%	4,642	6,714	45%
West Virginia	356	325	-9%	161	184	14%	$134,661	$164,590	22%	382	468	23%
Wisconsin	1,110	1,172	6%	706	677	-4%	$523,765	$858,409	64%	1,509	2,307	53%
Wyoming	99	87	-12%	62	60	-3%	$57,756	$72,954	26%	166	210	27%
Total	**145,799**	**151,200**		**101,987**	**110,047**		**$100,150,973**	**$109,463,099**		**344,651**	**361,366**	
Comparison Total [3]	***144,812***	***151,195***	***4%***	***101,683***	***110,042***	***8%***	***$98,611,321***	***$108,919,090***	***10%***	***343,786***	***359,894***	***5%***

[1] Montana provided updated June 2007 drug expenditure and prescription data that has been included in this report. All other June 2007 data was taken from the *2008 National ADAP Monitoring Project Annual Report.*

[2] Prior to the *2009 National ADAP Monitoring Project Report*, New Mexico included only traditional ADAP program clients in clients enrolled and served. In June 2008, the ADAP reported both traditional ADAP and ADAP insurance clients for clients enrolled and served, accounting for the significant increases in clients when comparing June 2007 to June 2008.

[3] Comparison Totals are based on only those ADAPs that reported data in both time periods.

Note: 52 ADAPs reported data for clients enrolled; 54 ADAPs reported data for clients served; 51 ADAPs reported data for drug expenditures; 51 ADAPs reported data for prescriptions filled. Following reauthorization of the Ryan White Program in 2006, the Republic of Palau was eligible for ADAP funding, but did not receive funding in FY 2008 and is not included above. A dash (—) indicates no data available from the ADAP.

Summary Table III

Total Clients Enrolled/Served and Program Expenditures, FY 2007[1]

State/Territory	FY 2007 Clients Enrolled[2]	FY 2007 New Clients Enrolled	FY 2007 Clients Served[2]	FY 2007 ADAP Expenditures							
				Prescription Drugs	Insurance Payments	Client Outreach	Adherence and Monitoring	Quality Management	Program Administration	Other[3]	Total Expenditures
Alabama	1,305	466	1,305	$12,063,501	$183,093	$0	$70,596	$37,821	$629,244	$0	$12,984,255
Alaska	87	37	85	$532,183	$72,660	$4,412	$0	$0	$22,643	$120,340	$752,238
American Samoa	—	—	—	—	—	—	—	—	—	—	—
Arizona	1,370	413	1,051	$11,612,585	$0	$0	$0	$0	$0	$0	$11,612,585
Arkansas	554	251	552	$3,788,636	$246,410	$0	$0	$0	$0	$0	$4,035,045
California	37,229	4,964	32,387	$254,326,083	$31,847,463	$0	$0	$0	$2,156,500	$0	$288,330,046
Colorado	1,731	1,161	1,730	$7,554	$97,021	$1,014	$31,815	$7,461	$291,058	$0	$435,923
Connecticut	1,951	338	1,607	$16,433,874	$0	$0	$200,504	$0	$525,710	$2,497,858	$19,657,946
Delaware	692	91	637	$1,647,595	$109,741	0.0	$619,100	$6,714	$370,459	$68,431	$2,822,040
District of Columbia	2,108	859	1,646	$9,130,818	$172,090	$0	$597,518	$0	$288,994	$0	$10,189,420
Federated States of Micronesia	—	—	—	—	—	—	—	—	—	—	—
Florida	14,660	2,761	14,099	$81,144,155	$835,511	$0	$0	$0	$4,078,827	$0	$86,058,493
Georgia	3,838	937	5,501	$3,511,295	$0	$0	$0	$0	$142,070	$0	$3,653,365
Guam	3	1	3	$91,084	$0	$0	$0	$0	$0	$0	$91,084
Hawaii	248	103	328	$2,245,955	$95,383	$0	$4,872	$0	$42,700	$103,013	$2,491,923
Idaho	194	68	167	$2,200,969	$0	$0	$14,800	$14,800	$148,000	$0	$2,378,569
Illinois	4,382	1,089	3,917	$26,440,712	$1,487,354	$0	$0	$0	$0	$0	$27,928,066
Indiana	1,477	418	1,477	$486,411	$11,405,681	$0	$0	$209,768	$923,015	$0	$13,024,875
Iowa	407	95	398	$1,774,183	$209,565	$0	$0	$0	$186,703	$0	$2,170,450
Kansas	1,203	239	661	$7,064,858	$91,404	$0	$0	$0	$0	$0	$7,156,263
Kentucky	461	306	1,278	$5,342,474	$760,219	$0	$0	$0	$0	$0	$6,102,693
Louisiana	3,209	860	3,209	$13,974,678	$417,806	$0	$0	$46,850	$286,360	$103,329	$14,829,023
Maine	594	181	321	$298,966	$199,700	$39,000	$85,442	$58,408	$186,686	$0	$868,202
Marshall Islands	—	—	—	—	—	—	—	—	—	—	—
Maryland	5,319	1,044	5,020	$25,518,764	$4,597,158	$0	$1,396,947	$245,847	$776,583	$0	$32,535,299
Massachusetts	5,282	910	4,860	$4,341,427	$11,158,386	$0	$923,364	$0	$2,813,440	$0	$19,236,617
Michigan	2,699	1,522	2,531	$20,261,134	$780,769	$0	$0	$0	$387,973	$63,592	$21,493,468
Minnesota	1,392	292	1,135	$2,331,629	$2,337,711	$0	$0	$7,807	$466,134	$0	$5,143,281
Mississippi	1,273	334	1,267	$8,478,872	$0	$0	$0	$0	$0	$0	$8,478,872
Missouri	2,248	412	1,839	$16,246,326	$795,286	$0	$0	$25,817	$150,280	$0	$17,217,709
Montana	127	49	127	$639,281	$54,477	$0	$0	$2,440	$32,101	$0	$728,299
Nebraska	458	102	458	$2,152,870	$94,429	$0	$0	$0	$127,859	$0	$2,375,158
Nevada	1,265	297	1,334	$4,310,397	$494,540	$0	$211,271	$168,183	$0	$0	$5,184,391
New Hampshire	366	35	366	$1,884,298	$201,609	$0	$0	$0	$0	$0	$2,085,907
New Jersey	7,786	1,279	7,557	$77,826,593	$2,568,270	$0	$1,674,768	$0	$0	$0	$82,069,631
New Mexico	772	287	753	$475,000	$1,993,061	0.0	$0	$0	$0	$0	$2,468,061
New York	22,179	3,425	19,544	$242,760,046	$13,159,824	$807,294	$3,184,831	$807,294	$403,647	$2,018,236	$263,141,172
North Carolina	5,621	2,775	4,671	$28,308,726	$0	$0	$0	$0	$200,000	$1,100,986	$29,609,712
North Dakota	69	16	63	$434,326	$0	$0	$0	$0	$0	$0	$434,326
Northern Mariana Islands	—	—	—	—	—	—	—	—	—	—	—
Ohio	4,380	408	3,482	$9,611,529	$3,945,558	$0	$0	$0	$0	$0	$13,557,087
Oklahoma	1,153	277	1,104	$5,749,986	$880,244	$0	$0	$174,208	$534,848	$228,675	$7,567,960
Oregon	2,041	338	2,005	$2,715,133	$5,271,491	$0	$0	$67,083	$1,475,722	$0	$9,529,429
Pennsylvania	7,166	1,145	4,159	$14,653,166	$0	$0	$0	$0	$0	$0	$14,653,166
Puerto Rico	4,046	189	3,707	$33,304,883	$0	$0	$0	$0	$242,441	$0	$33,547,324

(continued)

Summary Table III *(continued)*

Total Clients Enrolled/Served and Program Expenditures, FY 2007[1]

State/Territory	FY 2007 Clients Enrolled[2]	FY 2007 New Clients Enrolled	FY 2007 Clients Served[2]	FY 2007 ADAP Expenditures							
				Prescription Drugs	Insurance Payments	Client Outreach	Adherence and Monitoring	Quality Management	Program Administration	Other[3]	Total Expenditures
Rhode Island	—	—	—	—	—	—	—	—	—	—	—
South Carolina	3,321	725	2,984	$11,512,670	$1,083,732	$0	$0	$203	$859,803	$0	$13,456,408
South Dakota	186	24	116	$589,259	$0	$0	$0	$0	$0	$0	$589,259
Tennessee	2,729	1,088	2,440	$11,342,522	$6,237,832	$0	$0	$0	$0	$445,649	$18,026,003
Texas	13,447	1,876	12,971	$78,092,750	$0	$0	$0	$0	$0	$0	$78,092,750
Utah	739	104	739	$2,144,638	$543,912	$0	$0	$13,032	$269,073	$0	$2,970,655
Vermont	259	13	83	$380,340	$120,000	$0	$25,928	$28,759	$89,978	$0	$645,005
Virgin Islands (U.S.)	—	—	—	—	—	—	—	—	—	—	—
Virginia	3,546	902	3,263	$23,477,929	$0	$0	$0	$0	$0	$0	$23,477,929
Washington	3,868	499	2,982	$10,263,205	$7,735,885	$0	$0	$129,366	$1,464,433	$2,604,202	$22,197,091
West Virginia	382	80	279	$2,024,452	$0	$0	$0	$0	$29,167	$0	$2,053,619
Wisconsin	1,349	233	1,087	$6,942,789	$2,264,127	$0	$0	$0	$203,282	$0	$9,410,198
Wyoming	128	36	98	$993,431	$0	$0	$0	$0	$0	$0	$993,431
Total	**183,299**	**36,354**	**165,383**	**$1,103,886,938**	**$114,549,401**	**$851,720**	**$9,041,756**	**$2,051,861**	**$20,805,734**	**$9,354,311**	**$1,260,541,721**

[1] This table represents ADAP program expenditures in FY 2007 (April 1, 2007-March 31, 2008). Only expenditure categories requested in the National ADAP Monitoring Survey are represented in this table.

[2] For some states, enrolled clients reported may be a snapshot in time rather than a cumulative unduplicated client count. In this instance, some ADAPs may report a higher number of clients served throughout the fiscal year compared to the number of clients enrolled in the program at the end of the fiscal year.

[3] "Other" includes, but is not limited to, contract services to dispense medications, determine eligibility, and manage enrollment; pharmacy charges, dispensing and shipping fees, central pharmacy fees; as well as medical, dental, lab, and nutritional services.

Note: 52 ADAPs reported data. American Samoa, Federated States of Micronesia, Marshall Islands, Northern Mariana Islands, Rhode Island, and Virgin Islands (U.S.) did not report data. Following reauthorization of the Ryan White Program in 2006, the Republic of Palau was eligible for ADAP funding, but did not receive funding in FY 2008 and is not included above.

NASTAD™
NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS

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

THE HENRY J. KAISER FAMILY FOUNDATION

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

Washington Offices and Barbara Jordan Conference Center
1330 G Street, NW, Washington, DC 20005
Phone: 202.347.5270 Fax: 202.347.5274
www.kff.org

This publication (#7861) is available on the Kaiser Family Foundation's website at www.kff.org and www.NASTAD.org.