NATIONAL ADAP MONITORING PROJECT

ANNUAL REPORT

Prepared by

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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: Auxilium Pharmaceuticals, Gilead Sciences, GlaxoSmithKline, Roche, Solvay Pharmaceuticals, Inc., Tibotec Therapeutics and Virco Labs, Inc.

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INTRODUCTION

The AIDS Drug Assistance Program (ADAP) has become a critical source of prescription drugs for low-income people with HIV/AIDS in the United States who have no or limited prescription drug coverage. In a given year, ADAPs reach approximately 136,000[1] clients, or about 30%[2] of people with HIV/AIDS estimated to be receiving care nationally. In June 2004 alone, ADAPs provided medications to more than 94,000 clients and insurance coverage to thousands more. 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 gateway to a broader array of healthcare and supportive services funded through the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act[3] and to other sources of coverage including 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.

Still, of the 850,000 to 950,000 people estimated to be living with HIV/AIDS in the U.S., 42%-59% are not yet in the care system, including those who should be receiving highly active antiretroviral therapy (HAART) and other HIV-related medications.[4] The Centers for Disease Control and Prevention (CDC) estimates that, in 2003, 45% of people with HIV/AIDS eligible for HAART, as indicated by current treatment guidelines, were not receiving it.[5] The CDC and other federal partners are working to increase the number of people with HIV who know their status and get them into care through the *Advancing HIV Prevention* (AHP) Initiative, and this will likely result in an increasing number of people with HIV/AIDS needing to rely on ADAPs.[6,7]

This report of the National ADAP Monitoring Project, an 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 at an important time in the program's history. Nearly ten years have passed since the advent of highly active antiretroviral therapy (HAART), a development which significantly altered the clinical course of the epidemic and elevated the role of ADAPs in the United States. Many ADAPs have struggled to meet growing client demand, rising drug costs, and changing HIV treatment standards; limited resources have led some ADAPs to institute waiting lists or otherwise restrict access. Last year, in recognition of this challenge, President Bush announced the one-time availability of $20 million to provide medications to individuals on waiting lists in 10 states, which has served to alleviate their waiting lists.[8] However, other states now have waiting lists in place that are not eligible for the Initiative, and many states without waiting lists have limited access and services. Funding for the Initiative is due to end later this year, and has not been continued in FY 2005. States with individuals receiving medications through the Initiative are expected to begin transitioning them into their regular ADAP, raising concerns about how their medications will be financed.

There are also some important near term developments that stand to affect ADAPs. The CARE Act, under which ADAPs are authorized, is facing its third reauthorization this year and ADAPs are likely to figure prominently in discussions about its future structure. Among the many issues under discussion that directly involve ADAPs are: whether there should be an increased focus on primary medical care, including medications, within the CARE Act; whether minimum formularies and standard income eligibility criteria for ADAPs should be mandated across the country to address variations in access; and what longer term fixes for ADAP waiting lists and other cost containment measures might exist.

Additionally, the implementation of the new Part D Medicare Drug Benefit under the Medicare Modernization Act of 2003 (MMA) will change the way in which ADAPs interface with both Medicaid and Medicare and the role of ADAPs for people living with HIV/AIDS. Finally, both the federal and state governments are exploring ways to limit Medicaid spending, which could have significant implications for ADAPs, as more people with HIV/AIDS may need to access ADAP services. It is within this context that the latest findings on AIDS Drug Assistance Programs are presented.

Allocation of Federal Funding to ADAPs & State Match Requirements

Each year, Congress specifically earmarks federal funding for ADAPs within the Ryan White CARE Act (3% of the earmark is set aside for grants to states with severe need – see below). The formula used to allocate federal earmark funding to state jurisdictions each year 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.

States with 1% 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 1% threshold). The state match, however, is not required to be used for its ADAP, but may be in part or in whole, and may consist of in-kind or dollar contributions from the state. In FY 2004, 57 jurisdictions received federal ADAP earmark funding.

The CARE Act Amendments of 2000 included a new Supplemental Treatment Drug Grant, 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. 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 ten medications on formulary to treat opportunistic infections.

In FY 2004, 27 ADAPs were eligible for Supplemental Award funding and 18 applied; 9 eligible ADAPs 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 2005 began on October 1, 2004 and will end on September 30, 2005. The State FY 2005, in most states, began July 1, 2004 and ends on June 30, 2005. ◗

Overview of ADAPs

The purpose of ADAPs, as stated in the Ryan White CARE Act, 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.[9]

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 people 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[10]) 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 care, after Medicaid and Medicare.[11] Since FY 1996, Congress has specifically earmarked funding within Title II of the CARE Act for ADAPs, which is allocated by formula to states.[12,13]

The federal ADAP earmark is the largest component of the overall national ADAP budget. It is also the largest funded component of the CARE Act, and was the only part of the CARE Act to receive federal funding increases in FY 2004 and FY 2005.[11,14] In addition to the federal earmark, ADAPs may receive funding from other sources, including state general revenue support,[15] funding from other parts of the CARE Act, and negotiated 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. No minimum formulary or client income eligibility level is required under current law.

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 $20 Million ADAP Initiative announced to address ADAP waiting lists in 10 states

2005: Third Reauthorization of the CARE Act will be considered by Congress ◗

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,[16] and their funding may not correspond to the number of people who need prescription drugs or the costs of medications. Therefore, annual federal appropriations, and where provided, state appropriations and contributions from other sources, determine how many clients ADAPs can serve and the level of services they can provide.

Survey Findings

The National ADAP Monitoring Project surveyed all 57 jurisdictions receiving Ryan White federal ADAP earmark funding in FY 2004; 52 of 57 ADAPs responded. The U.S. Virgin Islands, American Samoa, Guam, the Northern Mariana Islands, and the Marshall Islands did not respond; these jurisdictions represent less than 0.1% of estimated living AIDS cases.[17] Data in this report are from June 2004 and FY 2004,[18] unless otherwise noted. For example, supplemental data collection was conducted in early 2005 to assess the latest status of ADAP waiting lists and other cost containment measures. Analysis of trend data since 1996 is also presented (see box on "Methodology"). Major highlights and detailed findings are provided below, followed by charts and appendices. State-level data are provided in the appendices and on State Health Facts: www.statehealthfacts.org/r/hiv.

HIGHLIGHTS

- **Continued Growth in Clients, Drug Expenditures, Prescriptions**. The number of clients served, drug expenditures, and prescriptions increased between June 2003 and June 2004, primarily reflecting an increase in the national ADAP budget allowing ADAPs to serve more people with HIV/AIDS. Almost the entire national ADAP budget is spent on medications. While most states experienced increases in clients served (38 ADAPs), 13 had decreases. Forty-three ADAPs had increases in monthly drug expenditures; 8 had decreases. Between 1996 and 2004, client utilization increased by 217% in the 41 states reporting data over this period; drug expenditures increased at more than twice this rate over the period (591%). In general, both have slowed considerably over time, with the notable exception of drug expenditures over the last period – between June 2003 and June 2004, drug expenditures in these 41 states experienced their greatest annual rate of increase since 1998.

- **Waiting Lists and Other Cost Containment Measures Persist.** Due to ADAP budget shortfalls, some states have turned to waiting lists and other cost containment measures that affect client access. As of March 2005, 21 ADAPs reported having one or more cost containment measures in place, including 11 with waiting lists representing a total of 627 individuals (Alabama, Alaska, Arkansas, Idaho, Iowa, Kentucky, Montana, Nebraska, North Carolina, West Virginia, and Wyoming). Waiting lists fluctuate within and across states over time and many states have waiting lists in place for months, if not years. In addition to waiting lists, 12 ADAPs have recently instituted one or more other cost containment measures including:

  – 3 states capped enrollment but did not have individuals on waiting lists at the time of the survey (Indiana, South Dakota, and Utah)

  – 4 states capped enrollment for Fuzeon (Alabama, Georgia, New Hampshire, Texas)

  – 4 states reduced the number of drugs offered (Arkansas, Missouri, Utah, and Washington)

  – 4 states instituted new or increased cost-sharing for clients (Arkansas, Minnesota, Utah, Washington)

  – 2 states instituted new eligibility requirements and/or lowered income eligibility (New Hampshire, Washington)

  – 2 states instituted monthly or annual per capita expenditures limits (Oklahoma, South Dakota)

  – 13 ADAPs anticipate the need to implement additional cost containment measures by the end of the current ADAP fiscal year (March 31, 2006), including 5 that already have such measures in place.

- **The President's $20 Million ADAP Waiting List Initiative has Alleviated Waiting Lists in Eligible States.** In 2004, the President announced the one-time availability of $20 million to provide medications to individuals in 10 states with waiting lists at that time (see box on "$20 Million ADAP Waiting List Initiative").[8] Since October 2004, the Initiative has provided medications to more than 1,250 eligible individuals; an additional 416 eligible individuals in four states (Alabama, Iowa, Kentucky, and North Carolina) have not yet been processed to receive medications. Nine states, including Iowa and Kentucky, have a total of 211 people on their waiting lists who are not eligible for the Initiative. In addition, some states without waiting lists have turned to other cost containment measures that limit client access and/or have much more limited access to their programs, as measured by eligibility criteria and formulary composition (see below), and not all those in need of medications are counted on waiting lists.

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 enrollment to their programs until more resources become available. When enrollment is capped, 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 when the program can accommodate them. In March 2005, 11 ADAPs had waiting lists, representing 627 people identified as needing services.

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 one, or through pharmaceutical manufacturer patient assistance programs (PAPs). PAPs, however, require people to apply often, sometimes as frequently 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? For example, should a state add a newly approved medication to its formulary if that also would mean having to institute a waiting list.

In recognition of the challenge of waiting lists, in June 2004, President Bush announced the one-time availability of $20 million to provide medications to those on waiting lists in 10 states (see box on "$20 Million ADAP Waiting List Initiative"). This Initiative has reached many of the individuals on waiting lists in these states.

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 varies 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. ◗

Continued funding for the Initiative has not been made available for 2005, and it will end later this year. States with individuals receiving medications through the Initiative are expected to begin transitioning them onto their regular ADAP.

- **What You Get Depends on Where You Live: Variation in Access Across the Country.** Waiting lists are but one measure of unmet need for ADAP services – client access to ADAPs and the level of services available to them vary across the country. These variations are largely the result of resource constraints, with states often facing difficult trade-off decisions, such as between financial eligibility criteria and drugs offered. Variations in access include:
  - Client income eligibility for ADAPs ranges from 125% of the Federal Poverty Level (FPL) in North Carolina to 500% FPL or more in 5 states – Delaware, Maryland, Massachusetts, New Jersey, and Ohio.
  - ADAP formularies range from 25 drugs covered in Louisiana to nearly 500 drugs in New York and open formularies[19] in three states – Massachusetts, New Hampshire, and New Jersey.
  - 17 ADAPs do not provide all FDA-approved antiretroviral medications, including one (South Dakota) that does not provide any protease inhibitors.
  - 10 ADAPs do not cover Fuzeon, the only approved fusion inhibitor.

– 15 ADAPs offer fewer than 10 of the 16 "A1" drugs highly recommended by the U.S. Public Health Service/Infectious Diseases Society of America (USPHS/IDSA) for the prevention of opportunistic infections (OIs).[20,21] One state (Louisiana) does not have any medications for OIs or any other HIV-related conditions on its formulary, and only covers ARVs.

- **National ADAP Budget Continues to Rise, but ADAP Earmark Growth Slows; State Funding and Drug Rebates Play Increasing Role**. The National ADAP budget has increased over time, although its rate of increase has remained fairly constant for several years (it rose by 11% between FY 2003 and FY 2004). In addition, the composition of the budget has changed since FY 1996, when the federal ADAP earmark began. Since that time, the earmark has grown into the main source of funding for ADAPs, followed by state general revenue support and manufacturers' drug rebates. Funding increases for the earmark have slowed in recent years, and between FY 2003 and FY 2004, the earmark experienced its smallest increase since it was initiated. In turn, state funding and drug rebates have become increasingly important sources of funding for ADAPs; for the first time since the ADAP earmark began, state funding increased more than the earmark between FY 2003 and FY 2004, followed by drug rebates; in all prior years, the earmark had the largest dollar increase. While state funding and drug rebates are playing a growing role, it is important to note that state funding is generally dependent on individual state decisions and budgets, and some drug rebates are dependent on negotiations by individual states or state coalitions. In addition, increases in drug rebates are in part a function of rising drug prices (since rebates are based on a percentage of drug price).
- **Within States, Funding From Sources Other than ADAP Earmark Highly Variable.** By definition, all eligible jurisdictions (57) receive federal ADAP earmark funding based on a formula. Other funding sources are also important, but fluctuate significantly and are largely dependent on individual state and local planning, policy, and/or legislative decisions, and resource availability. Not all ADAPs receive funding from other sources, and in FY 2004, two ADAPs received only ADAP earmark funding. Other sources of funding for ADAPs in FY 2004 were: Title II Base Funds[22] (20 ADAPs); Title II Supplemental Treatment Grants[23] (18 ADAPs); Title I EMA Funds[24] (9 ADAPs); State General Revenue Support[25] (40 ADAPs); and Drug Rebates[26] (36 ADAPs).
- **Some State ADAPs Experienced Budget Decreases**. Despite an increase in the national ADAP budget between FY 2003 and FY 2004 of 11%, some states experienced net budget decreases and/or decreases in key funding streams (other than the earmark):
  - 15 had net decreases in their overall budgets (six of these states have waiting lists in place)
  - 14 had decreases in Title II Base Funds
  - 15 had decreases in Title II Supplemental Treatment Grants[27]
  - 4 had decreases in Title I EMA Funds
  - 14 had decreases in State General Revenue Support
  - 6 had decreases in Drug Rebates

ADAP Cost Containment Measures and Other Strategies for Managing Costs

State ADAPs use a variety of strategies to contain costs, some of which may affect client access and services and others that may lead to a more efficient use of funding in an effort to serve more people. In some cases, 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 include:

- Lowering financial eligibility criteria;
- Limiting and/or reducing ADAP formularies;
- 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 instead of medications directly;
- Seeking cost recovery through drug rebates and third party billing; and
- Using non-ADAP Ryan White CARE Act funds (e.g., Title II Base funds) for ADAPs. ◗

- **Antiretrovirals Are Bulk of ADAP Drug Expenditures and Most Expensive**. Antiretrovirals (ARVs) continue to represent the far majority of ADAP drug expenditures, in part due to their high utilization, but also to their cost – in June 2004, ARVs represented a greater share of expenditures (87%) than prescriptions filled (64%). Expenditure per prescription is significantly higher for ARVs ($348) than non-ARVs ($92). Some classes of ARV drugs account for higher per prescription expenditures than others, with fusion inhibitors topping the list ($1,215), followed by protease inhibitors ($431).

DETAILED FINDINGS

Clients, Drug Expenditures and Prescriptions

ADAP Clients

- In June 2004, ADAPs provided medications to 94,577 clients across the country (thousands more had their insurance coverage paid for by ADAPs; see below). Client utilization increased by 10% over June 2003. While most states experienced increases in clients served (38 ADAPs) between June 2003 and June 2004, 13 had decreases (see Appendix I). Between 1996 and 2004, client utilization increased by 217% in the 41 states reporting data over this period; the rate of increase has slowed in recent years (see Chart 4).
- More clients are 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 2004, 133,572 clients were enrolled in ADAPs nationwide (see Chart 3), 71% of whom received medications from ADAPs in that month.
- As found in prior years, ADAP clients are predominantly low-income and uninsured. Most are people of color, male, and many have indicators of advanced HIV disease:
  - African Americans represented approximately one-third (34%) and Hispanics one-quarter (26%) of the national ADAP population in June 2004. Asian/Pacific Islanders, Alaskan Native and American Indians combined represented approximately 2% of the total ADAP population. White non-Hispanics represented 36% of ADAP clients (see Chart 9).
  - More than three-quarters (79%) of ADAP clients in June 2004 were men (see Chart 10).
  - Over half (57%) of clients were between the ages of 25 and 44; 38% were between 45 and 64 (see Chart 10).
  - Eight in ten (80%) of those served in June 2004 reported incomes at or below 200% of FPL; half of ADAP clients (51%) had incomes at or below 100% of FPL (see Chart 11). In 2004, the FPL was $9,310 (slightly higher in Alaska and Hawaii) for a family of one.
  - A majority of ADAP clients were uninsured, with few reporting any other source of insurance coverage – 15% private, 9% Medicare, and/or 7% Medicaid, with less than 1% reported being dual beneficiaries of both Medicaid and Medicare. These clients rely on ADAPs to fill the gaps in their coverage (see Chart 12).
  - Half of ADAP clients had CD4 counts of 350 or below at time of enrollment (see Chart 13).

ADAP Drug Expenditures and Prescriptions

- ADAP drug expenditures grew to $96,880,703 million in June 2004 (see Chart 2). If annualized, this represents approximately $1.163 billion, or most (98%) of the FY 2004 national ADAP budget. Drug expenditures increased by 25% over June 2003, a greater increase than in recent years. Forty-three states had increases in their monthly drug expenditures; 8 had decreases (see Appendix I). Drug expenditures increased by 591% since 1996, in the 41 states that reported data over this period, more than twice the rate of client growth in these states. Drug expenditures increased each year during this period but at slower rates compared to earlier years with the notable exception of the last period – between June 2003 and June 2004, expenditures in these 41 states experienced their greatest annual rate of increase since 1998 (see Chart 5).
- Per capita drug expenditures were $1,024 in June 2004, an increase of 14% over last year ($902 in June 2003). If annualized, this represents $12,288. Per capita expenditures in June 2004 ranged from $376 in Oregon to $1,519 in Maine (see ES Table 1 and Chart 6).

- ADAPs filled a total of 377,271 prescriptions in June 2004, an increase of 26% over the number of prescriptions filled in June 2003 (300,317) (see Appendix I).
- Antiretrovirals continue to represent the bulk of ADAP drug expenditures (87% in June 2004). 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 (87%) than prescriptions filled (64%). The 16 "A1" drugs highly recommended for the prevention of opportunistic infections accounted for 4% of June 2004 expenditures and 10% of prescriptions filled (see Chart 7 and Appendix I).
- The average expenditure per prescription in June 2004 was $257. It was significantly higher for ARVs ($348) than non-ARVs ($92). Some ARV drug classes accounted for higher per prescription expenditures than others, with fusion inhibitors topping the list ($1,215), followed by protease inhibitors ($431), nucleoside reverse transcriptase inhibitors ($318) and non-nucleoside reverse transcriptase inhibitors ($311). The "A1" OI drugs were $96 per prescription filled in June 2004 (see Chart 8).

Eligibility Criteria and Formularies

ADAP Eligibility Criteria

- All states require that individuals document their HIV status. Three states reported additional clinical eligibility criteria (e.g., specific CD4 or viral load ranges) (see ES Table 1).
- Financial eligibility for ADAPs ranged from a low of 125% FPL in North Carolina to 500% FPL or more in Delaware, Maryland, Massachusetts, New Jersey, and Ohio (see ES Table 1).

ADAP Formularies

- ADAP formularies vary significantly across the country, ranging from 25 drugs covered in Louisiana to close to 500 drugs covered in New York and open formularies[19] in three jurisdictions - Massachusetts, New Hampshire, and New Jersey (see ES Table 1).
- While the majority of ADAPs (35) cover all FDA-approved antiretrovirals on their formularies, 17 do not, including one state that does not provide any protease inhibitors (South Dakota). Forty-two ADAPs cover Fuzeon, the only approved fusion inhibitor, up from 33 in last year's report; 10 ADAPs do not cover Fuzeon (see ES Chart 5).
- Coverage of medications to prevent or treat opportunistic infections and other HIV-related conditions is highly variable across the country (see ES Chart 6):
  - 37 ADAPs cover 10 or more of the 16 drugs highly recommended ("A1") for the prevention of opportunistic infections by USPHS/IDSA,[20]

$20 Million ADAP Waiting List Initiative

On June 23, 2004, President Bush announced the one-time, immediate availability of $20 million to provide medications to individuals 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. These funds were made available through a reallocation of Department of Health and Human Services (DHHS) non-AIDS funding. Medications are being provided directly to individuals on waiting lists, not through ADAPs.

A total of 1,738 treatment slots are to be supported by the Initiative, reflecting the number of individuals on waiting lists in these 10 states at that time. Recipients can only receive medications that were included on their state's ADAP formulary as of June 21, 2004. States instituting waiting lists after this date are not eligible for the Initiative. In addition, not all individuals coming onto waiting lists in the 10 eligible states can be accommodated through the Initiative.

The Health Resources and Services Administration (HRSA) is coordinating the Initiative and has contracted with Chronimed Statscript, a pharmacy benefits manager (PBM), to directly purchase and distribute medications to eligible individuals. The first medications were delivered to eligible clients in October 2004; by March 2005, 1,257 individuals were being served through the Initiative.

The FY 2005 ADAP earmark represented an increase of $35.1 million over FY 2004, but did not include a continuation of the $20 million Initiative. Funding from the $20 million is due to end in 2005, and states are expected to transition clients from the Initiative onto ADAP during the ADAP fiscal year 2005, which began on April 1, 2005. ◗

including four ADAPs that cover all 16 (California, Massachusetts, New Hampshire, and New Jersey). Fifteen ADAPs cover fewer than 10 of these medications (it is important to note that ADAPs may cover slightly fewer than the full set of 16 because they cover equivalent medications, also highly recommended, on their formularies).

– One ADAP does not include any medications for OIs or other HIV-related conditions on its formulary, and only covers antiretrovirals (Louisiana).

– 20 ADAPs cover treatments for hepatitis C (HCV), a major co-morbidity for people with HIV, and considered to be an opportunistic infection [20,28] (see Chart 27).

– 24 ADAPs cover Hepatitis A and B vaccines, recommended for those at high risk and living with HIV[29] (see Chart 27).

Waiting Lists and Other Cost Containment Measures

As of March 2005, 21 states reported having one or more cost containment measures in place, including waiting lists:

- 11 had waiting lists totaling 627 individuals across the country (Alabama, Alaska, Arkansas, Idaho, Iowa, Kentucky, Montana, Nebraska, North Carolina, West Virginia, and Wyoming). Four of the states with waiting lists – Alabama, Iowa, Kentucky, and North Carolina – are eligible for the President's $20 million ADAP Initiative, but the 416 people with HIV/AIDS on their waiting lists have not yet been processed to receive medications. Nine states, including Iowa and Kentucky, have a total of 211 people on waiting lists who are not eligible for the Initiative. Iowa and Kentucky also have eligible individuals on their waiting lists (see ES Chart 1).
- 12 states have recently instituted one or more other cost containment measures (see ES Chart 2):
  – 3 states capped enrollment but did not have individuals on waiting lists at the time of the survey (Indiana, South Dakota, and Utah)
  – 4 states capped enrollment for Fuzeon (Alabama, Georgia, New Hampshire, Texas)
  – 4 states reduced the number of drugs offered (Arkansas, Missouri, Utah, and Washington)
  – 4 states instituted new or increased cost-sharing for clients (Arkansas, Minnesota, Utah, Washington)
  – 2 states instituted new eligibility requirements and/or lowered income eligibility (New Hampshire, Washington)
  – 2 states instituted monthly or annual per capita expenditures limits (Oklahoma, South Dakota)
  – 13 states anticipate the need to implement additional cost containment measures by the end of the current ADAP fiscal year (March 31, 2006), including 5 that already have such measures in place.
- 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. Based on bi-monthly surveys conducted between July 2002 and March 2005 (20 surveys overall):
  – The number of people on waiting lists ranged from a low of 537 in 7 states to a high of 1,629 in 11 states; the average was 837 (see ES Table 2 and ES Chart 4).
  – The number of states with waiting lists in any given survey period ranged from a low of six to a high of 11 (see ES Chart 3).
  – 18 ADAPs had waiting lists in place at some point over the period including one state (Alabama) that had a waiting list in each period; seven ADAPs had waiting lists in 10 or more of the survey periods.
  – The highest number of individuals on any one state's waiting list was 891 (North Carolina); the lowest was one (Alaska, Idaho, and Montana). North Carolina had the highest average number of people on its waiting list over the period (396), followed by Alabama (198). The lowest average was four, in Guam and Wyoming.
- Continued funding for the President's $20 Million ADAP Waiting List Initiative has not been made available for 2005, and its funding for medications for individuals in the 10 eligible states will end later this year. At that point, states with individuals receiving medications through the Initiative must begin to transition them onto their ADAP.

ADAP Budget

- The national ADAP budget reached $1.187 billion in FY 2004, an increase of 11%, or $116.5 million, over FY 2003. Since FY 1996, the national ADAP budget has grown by 492% (see Chart 16).[30]
- In FY 2004, the ADAP earmark represented the largest component of the national ADAP budget (61%),[31] followed by state general revenue support (19%), and drug rebates (12%). Other sources of funding each represented 2% or less of the budget (see Charts 14, 17, 19, and 21).
- The composition of the budget has shifted over time (see Chart 15):
  - The ADAP earmark has risen from just 26% of the budget in FY 1996, the year it began, to 61% in FY 2004.
  - State support decreased from 25% in FY 1996 to 19% in FY 2004, but has increased significantly in amount and has been the second largest source of funding over the entire period. It is important to note that state funding is generally dependent on individual state decisions and budgets.
  - Drug rebates rose from 5% to 12% 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. It is important to note that some drug rebates are dependent on negotiations by individual states or state coalitions, 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 2004 than in FY 1996.
- Although the ADAP earmark continues to increase, its growth has slowed over time. As a result, state funding and drug rebates are playing an increasing role in the national ADAP budget. For the first time since the earmark began, state funding increased by a greater amount than the earmark, followed by rebates, between FY 2003 and FY 2004.
  - The ADAP earmark increased by $35.1 million, or 5%, over FY 2003, its smallest increase since it began in FY 1996.
  - State funding increased by $54.7 million over FY 2003, an increase of 32%, its greatest increase since 1997.
  - Drug rebates increased by $36.3 million, or 33%, over FY 2003, and reached their highest level to date.
- Title II base funding decreased between FY 2003 and FY 2004, and has been decreasing since FY 1998 (see Chart 18). Title I EMA funding increased between FY 2003 and FY 2004, reversing three years of steady decline (see Chart 20), although the number of Title I EMAs contributing to ADAP decreased from 12 in FY 2003 to nine in FY 2004.
- 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 2004, 2 ADAPs received only ADAP earmark funding (the District of Columbia and Maine). The breakdown of other sources of funding across the country was as follows (among the 52 ADAPs reporting data):
  - Title II Base Funds: 20 ADAPs received funding, 32 did not
  - Title II Supplemental Treatment Grants: 18 ADAPs received funding, 34 did not
  - Title I EMA Funds: nine ADAPs received funding, 43 did not
  - State General Revenue Support: 40 ADAPs received funding, 12 did not
  - Drug Rebates: 36 ADAPs received funding, 16 did not
- Additionally, despite an increase of 11% in the national ADAP budget between FY 2003 and FY 2004, the ADAP budget decreased in some states, due to fluctuations in other funding streams (see Appendix X):

– Overall Budget: 37 ADAPs had increases, 15 had decreases

– Title II Base Funds: Six ADAPs had increases; 14 had decreases

– Title II Supplemental Treatment Grants: three ADAPs had increases; 15 had decreases

– Title I EMA Funds: Five ADAPs had increases, four had decreases

– State General Revenue Support: 27 ADAPs had increases, 14 had decreases

– Drug Rebates: 29 ADAPs had increases, six had decreases

- State contributions to ADAPs ranged from 0%, in the 12 states that did not provide any state support, to more than half (58%) of the ADAP budget in one state; Title II base funding ranged from 0% to 57%; Title I funding ranged from 0% to 56%; ADAP supplemental funding ranged from 0% to 11%; and drug rebates ranged from 0% to 29% (see Appendix VIII).

ADAP Crisis Task Force

The ADAP Crisis Task Force was formed by a group of the largest AIDS Drug Assistance Programs, convened by NASTAD, in December 2002 to address resource constraints. 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 have been 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 previous agreements were extended and/or enhanced. The Task Force estimated savings of $90 million for ADAPs in 2004.

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 Arizona, California, Florida, Kentucky, New Jersey, New York, North Carolina, Texas, and Utah. ◗

Drug Purchasing Models and Insurance Coverage

ADAP Drug Purchasing Models

- The federal 340B program enables ADAPs to purchase drugs at or below the statutorily defined 340B ceiling price.[32] All but one ADAP (51 of 52 reporting data) participate in the 340B program.
- ADAPs may purchase drugs either directly from wholesalers or through retail pharmacy networks and then apply to drug manufacturers for rebates. As of June 2004, 27 ADAPs reported purchasing directly from wholesalers; 25 reported purchasing through a pharmacy network and then seeking rebates (see Chart 25).
- Direct purchase model 340B ADAPs can choose to participate in the HRSA Prime Vendor Program,[32] which was created to negotiate pharmaceutical pricing below the 340B price. Eleven of the 27 ADAPs that directly purchase drugs reported participating in the Prime Vendor Program in June 2004 (see Chart 25).

ADAP Insurance Purchasing/Maintenance and Other Insurance Coverage Options

- The Ryan White CARE Act allows states to use ADAP earmark dollars to purchase health insurance and pay insurance premiums for individuals eligible for ADAP, provided the insurance has comparable formulary benefits to that of the ADAP.[33] Twenty-six states reported that they used ADAP funds for insurance purchasing and maintenance efforts, representing $37.8 million or 3% of the ADAP FY 2004 budget. In June 2004, 7,277 ADAP clients were served by such arrangements (see Chart 23). These strategies appear to be cost effective – in June 2004, spending on insurance represented an estimated $433 per capita, significantly less than per capita drug expenditures in that month ($1,024). It is important to note that other CARE Act programs (Title I, Title II base) may also purchase and maintain insurance coverage for eligible individuals.
- ADAPs can also use a portion of their earmark dollars to pay for client insurance co-payments and deductibles,[34] as 20 ADAPs reported doing in FY 2004 (see Chart 23).

CONCLUSION

The AIDS Drug Assistance Program plays a critical role in the health care delivery system for uninsured and underinsured people with HIV/AIDS, providing prescription medications to those who cannot get them elsewhere and often serving as a gateway to a broader array of health care and supportive services including other Ryan White funded programs, Medicaid, and private insurance. As the number of people living with HIV/AIDS has increased, largely due to advances in HIV treatment, so too has the importance of and demand for ADAPs. ADAPs are serving more clients as funding permits and adapting to changing treatment environments. However, ADAPs are highly sensitive to changes in federal, state, and other resources, as well as to client demand and increases in drug costs. Because of resource constraints, several ADAPs have waiting lists in place, or use other cost containment measures that may affect client access. In addition, access to ADAPs and the range of drugs offered vary significantly across the country. The challenge for ADAPs of meeting a growing demand with limited resources will likely continue for the foreseeable future.

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 been surveying all states and territories receiving federal ADAP earmark funding through the Ryan White CARE Act (the number of jurisdictions receiving such funding has increased over the course of the project). In FY 2004, 57 jurisdictions received earmark funding and all 57 were sent the ADAP survey; 52 of 57 ADAPs responded. The U.S. Virgin Islands, American Samoa, Guam, the Northern Mariana Islands, and the Marshall Islands did not respond; these jurisdictions represent less than 0.1% of estimated living AIDS cases.[17]

The survey is sent to states on an annual basis. It 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, extensive follow-up is conducted by NASTAD to ensure completion by as many ADAPs as possible.

Data used in this report are from June 2004 and FY 2004, unless otherwise noted. For example, some data are supplemented through other NASTAD data collection efforts, such as its bi-monthly "ADAP Watch" survey. Due to differences in data collection and data availability across ADAPs, some ADAPs did not answer all survey questions. Where trend data are presented, only states that provided relevant data in all periods are included. In addition, in some cases, ADAPs have provided revised program data from prior years and these revised data are used where possible. Therefore, data from prior year reports may not be comparable for assessing trends. This year's report includes drug rebates as part of the national ADAP budget, which was not done in prior year reports (drug rebates were considered separately). In this report, all prior year budgets have been recalculated to include drug rebates for comparison purposes.

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 ADAP are provided on relevant charts and tables. ◗

REFERENCES

1 HRSA, HIV/AIDS Bureau, *2002 Ryan White CARE Act Annual Data Summary*, available at: http://hab.hrsa.gov.

2 CDC estimates that there are approximately 445,000 people living with HIV/AIDS in the U.S. who are receiving care. The 136,000 clients served by ADAPs in 2002 represent approximately 30% of this estimate (see: Fleming, P., et.al., *HIV Prevalence in the United States, 2000*, 9th Conference on Retroviruses and Opportunistic Infections, Abstract #11, Oral Abstract Session 5, February 2002, for CDC estimates; and HRSA, HIV/AIDS Bureau, *Ryan White CARE Act AIDS Drug Data Report, 2002* for 2002 ADAP client utilization).

3 Public Law No. 101-381.

4 Fleming, P., Byers, R., Sweeney, P., Daniels, D., Karon, J., Janssen, R., *HIV Prevalence in the United States, 2000*, 9th Conference on Retroviruses and Opportunistic Infections, Abstract #11, Oral Abstract Session 5, February 2002.

5 Teshale, E., Kamimoto, L., Harris, N., Li, J., Wang, H., McKenna, M., *Estimated Number of HIV-infected Persons Eligible for and Receiving HIV Antiretroviral Therapy, 2003—United States*, 12th Conference on Retroviruses and Opportunistic Infections, Abstract #167, Oral Abstract Session 42, February 2005.

6 CDC, "Advancing HIV Prevention: New Strategies for a Changing Epidemic – United States, 2003", *MMWR*, Vol. 52, No. 15, April 2003.

7 HRSA, *Memo*, *CDC/HRSA Advisory Committee on STD and HIV Prevention and Treatment Information Request*, May 7, 2004.

8 White House, *Press Release*, *Remarks by the President on Compassion and HIV/AIDS, Philadelphia, Pennsylvania*, June 23, 2004; White House, *Fact Sheet: Extending and Improving the Lives of Those Living with HIV/AIDS*, June 23, 2004.

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

10 HRSA, HIV/AIDS Bureau, Personal Communication, March 15, 2005.

11 Kaiser Family Foundation, *Fact Sheet: U.S. Federal Funding for HIV/AIDS: The FY 2006 Budget Request*, February 2005.

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

13 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".

14 HRSA, HIV/AIDS Bureau, CARE Act Funding History, Available at: http://hab.hrsa.gov/.

15 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".

16 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.

17 HRSA, *Estimated Living Cases with AIDS in All States and Territories, July 1, 1994 – June 30, 2004,* December 9, 2004.

18 The federal fiscal year and ADAP fiscal year periods differ – see box on "Allocation of Federal Funding to ADAPs & State Match Requirements."

19 Providing any FDA-approved HIV-related prescription drug.

20 U.S. Public Health Service (USPHS) and Infectious Diseases Society of America (IDSA), *2001 USPHS/IDSA Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus*, November 28, 2001.

21 These guidelines were developed to address the prevention of opportunistic infections, although many of the recommended medications are also used to treat opportunistic infections. Last year, for the first time, the U.S. Public Health Service released guidelines specific to the treatment of opportunistic infections. Because these guidelines were released after data were collected for this report, ADAP formularies were not assessed against them at this time.

22 States receive CARE Act Title II base funds based on a formula and they are not required to allocate these funds to ADAPs. In FY 2004, total Title II base funding available for distribution to states was $285,366,000.

23 Three percent of the ADAP earmark is set aside for ADAP supplemental grants for eligible jurisdictions – see box on "Allocation of Federal Funding to ADAPs & State Match Requirements."

24 Under the Ryan White CARE Act, a Title I Eligible Metropolitan Area's (EMA's) Ryan White HIV Services Planning Council can decide to allocate Title I dollars to their state's ADAP to serve clients within their EMA.

25 Most of the states that provided general revenue support made decisions to do so. States may also be required to provide matching funds for receipt of federal Ryan White dollars in some cases. See box on "Allocation of Federal Funding to ADAPs & State Match Requirements."

26 ADAP Crisis Task Force negotiations have resulted in negotiated agreements with manufacturers that include supplemental rebates beyond 340B discounts. Some ADAPs (11) that purchase drugs through a direct purchase mechanism (no rebates) are now receiving supplemental rebates as a result of these negotiations. The 25 ADAPs that purchase drugs through a retail pharmacy network also receive supplemental rebates.

27 Although the ADAP earmark increased in FY 2004, and thus so did the 3% ADAP Supplemental Grant funding set-aside, $1.7 million was utilized from the ADAP Supplemental set-aside to fund legislative provisions requiring overall Title II awards to states to be equal to that of last year. This resulted in a decrease in most ADAP Supplemental awards to states.

28 CDC, *Frequently Asked Questions and Answers About Coinfection with HIV and Hepatitis C Virus*. Available at: www.cdc.gov/hiv/pubs/facts/HIV-HCV_Coinfection.htm.

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

30 Previous National ADAP Monitoring Project reports did not include drug rebates as part of the national budget; in this report, all prior year budgets have been adjusted to include drug rebates for comparison purposes.

31 Not including the ADAP supplemental, a 3% set aside of the total amount earmarked for ADAPs by Congress.

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

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

34 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.

ES TABLE 1: Summary ADAP Profile

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)	OI Prophylaxis Covered (16 PHS Recommended Drugs)	Other Medications Covered	Total FY 2004 Est. Budget (Federal/State Sources)	State Contribution	State $ Contribution as % of Total Budget	ADAP Clients Served In June 2004	June 2004 Per Capita Drug Expend.	Cost-Containment Measures in Place as of March 2005
Alabama	250%		35	12 (10)	9 (8)	3	1 (0)	7	3	$9,216,638	$560,000	6%	1,220	$902	Frozen program enrollment; waiting list for Fuzeon; waiting list for President's Initiative-eligible individuals
Alaska	300%		68	12 (10)	9 (7)	3	0	15 (14)	29	$555,000	$14,398	3%	35	$950	waiting list
American Samoa	NR	NR	NR	NR	NR	NR	NR	NR	NR	$2,314	NR	NC	NR	NC	
Arizona	300%		83	12 (10)	9 (8)	3	1	9 (6)	49 (5)	$9,392,903	$1,000,000	11%	845	$931	
Arkansas	300%	CD4<350 or VL>55,000	52	12 (10)	8	3	1	10 (11)	18	$5,017,445	—	0%	376	$1,026	waiting list; reduced formulary; cost sharing
California	400%		152	12 (10)	9 (8)	3	1	16 (14)	112	$231,770,465	$65,926,750	28%	18,263	$1,159	
Colorado	300%		46	12 (9)	9 (6)	3	1 (0)	13 (0)	9 (0)	$9,640,532	$980,839	10%	667	$835	
Connecticut	400%		190	12 (10)	9 (7)	3	1	14 (13)	151 (147)	$15,724,925	$606,678	4%	1,112	$1,156	
Delaware	500% - sliding		230	11 (9)	9 (8)	3	1	14	190 (187)	$3,262,722	$10,000	0%	226	$839	
District of Columbia	400%		72	12 (9)	9 (7)	3	1	9 (8)	38 (36)	$13,842,594	—	0%	809	$1,022	
Florida	350%		65	12 (10)	9 (8)	3	1	9	31 (28)	$90,456,773	$9,000,000	10%	9,558	$714	
Georgia	300%	CD4≤350 or, if CD4>350, VL≥55,000 (CD4<500, VL>20,000)	55	12 (10)	9 (8)	3	1 (0)	10 (11)	19	$39,779,664	$11,305,339	28%	3,820	$875	waiting list for Fuzeon
Guam	NR	NR	NR	NR	NR	NR	NR	NR	NR	$94,332	NR	NC	NR	NC	
Hawaii	400%		92	12 (10)	9 (8)	3	0	14	53 (54)	$2,524,512	$440,000	17%	223	$968	
Idaho	200%		42	11 (10)	8	3	0	13 (14)	3	$1,242,476	$177,500	14%	100	$1,327	waiting list
Illinois	400%		81	12 (10)	9 (8)	3	1	12 (13)	44 (36)	$42,723,229	$10,100,000	24%	3,234	$945	
Indiana	300%		93	12 (10)	9 (8)	3	1 (0)	7 (9)	61 (46)	$9,440,661	$2,850,737	30%	13	$1,371	Capped enrollment
Iowa	200%		39	12 (10)	9 (8)	3	1	6	8	$1,382,030	—	0%	203	$708	waiting list for President's initiative–eligible individuals and non eligible individuals
Kansas	300%		53	12 (10)	9 (8)	3	1	7	21	$3,153,495	$400,000	13%	535	$761	
Kentucky	300%		51	12 (10)	9 (8)	3	0	8 (9)	18	$4,995,297	$90,000	2%	555	$868	waiting list for President's initiative–eligible individuals and non eligible individuals
Louisiana	200%		25	12 (10)	9 (8)	3	1	0	0	$15,883,405	—	0%	1,654	$698	
Maine	300%		38	12 (10)	9 (8)	3	1	8 (14)	5 (6)	$833,383	—	0%	42	$1,519	
Marshall Islands	NR	NR	NR	NR	NR	NR	NR	NR	NR	$2,314	NR	NC	NR	NC	
Maryland	500%		113	12 (9)	9 (8)	3	1	15	73 (65)	$29,809,288	—	0%	1,989	$1,202	
Massachusetts	<$50,000 net annual income (<$50,000 gross annual income)		open formulary	12 (10)	9 (8)	3	1	16 (14)	open formulary	$22,363,789	$2,447,990	11%	2,291	$517	
Michigan	450%		191	12 (10)	9 (8)	3	1	14 (13)	152 (140)	$13,202,763	—	0%	1,075	$1,067	
Minnesota	300%		127	12 (10)	8 (7)	3	1	12 (11)	92 (91)	$6,155,523	$911,129	15%	597	$405	cost-sharing; reapplication every 6 months
Mississippi	400%		49	12 (10)	9 (8)	2	1	10	15 (16)	$8,777,477	$750,000	9%	769	$925	
Missouri	300%		268	12 (10)	9 (8)	3	1	11 (12)	232 (241)	$13,536,796	$2,069,000	15%	1,402	$822	Reduced formulary
Montana	330%		142	12 (10)	9 (8)	3	1 (0)	11	106 (102)	$460,518	$27,894	6%	53	$766	waiting list

Data in parentheses are from the prior report, if states made changes since that time.

The 2004 Federal Poverty Level (FPL) was $9,310 (slightly higher in Alaska and Hawaii) for a household of one.

NR indicates not reported.

NC indicates not calculated due to missing data.

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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)	OI Prophylaxis Covered (16 PHS Recommended Drugs)	Other Medications Covered	Total FY 2004 Est. Budget (Federal/State Sources)	State Contribution	State $ Contribution as % of Total Budget	ADAP Clients Served In June 2004	June 2004 Per Capita Drug Expend.	Cost-Containment Measures in Place as of March 2005
Nebraska	200%		104	12 (10)	9 (8)	3	0	7 (2)	73 (4)	$1,611,155	$150,000	9%	181	$702	waiting list
Nevada	400%		65	12 (10)	9 (8)	3	1 (0)	10	30 (27)	$6,089,625	$1,350,947	22%	614	$847	
New Hampshire	300%	CD4<350 or currently on ARV therapy or currently has a designated OI	open formulary	12 (10)	9 (8)	3	1 (0)	16 (14)	open formulary	$2,632,038	—	0%	183	$1,120	New medical eligibility and formulary restrictions*; waiting list for Fuzeon
New Jersey	500%		open formulary	12 (10)	9 (8)	3	1	16 (14)	open formulary	$64,284,345	$13,672,540	21%	4,705	$1,268	
New Mexico	300%		101	12 (10)	9 (8)	3	0	12	65	$5,169,982	$3,000,000	58%	327	$1,018	
New York	<$44,000 gross annual income		479	12 (10)	9 (8)	3	1	15 (13)	440 (439)	$205,912,206	$33,000,000	16%	12,484	$1,502	
North Carolina	125%		58	12 (10)	9 (8)	3	1	11	22	$30,559,609	$11,120,817	36%	1,843	$1,238	Waiting list for President's Initiative-eligible individuals
North Dakota	400%		92	12 (9)	8 (7)	3	0	14 (13)	55	$244,085	—	0%	19	$758	
N. Mariana Islands	NR	NR	NR	NR	NR	NR	NR	NR	NR	$4,627	NR	NC	NR	NC	
Ohio	<$46,550 gross annual income		86	12 (10)	9 (8)	3	1	10 (11)	51 (41)	$11,467,773	$7,843	0%	1,271	$609	
Oklahoma	200%		52	12 (10)	9 (8)	3	1 (0)	13 (14)	14 (13)	$5,412,761	$786,000	15%	533	$733	Annual per capita expenditure limit
Oregon	200%		62	12 (10)	9 (8)	3	1	14	23	$6,925,989	—	0%	656	$376	
Pennsylvania	<$30,000 gross annual income		75	12 (10)	9 (8)	3	1	13 (14)	37 (39)	$46,335,324	$13,545,108	29%	2,971	$1,350	
Puerto Rico	200% (certified as indigent)	None (CD4<350 or VL>10,000)	126	12 (10)	9 (7)	3	1	14 (13)	88 (84)	$30,445,509	$2,093,000	7%	3,154	$857	
Rhode Island	400%		66	12 (10)	9 (7)	3	1	10 (11)	31	$2,661,506	—	0%	315	$808	
South Carolina	300%		54	11 (10)	9 (8)	3	1	10	20	$13,939,209	$500,000	4%	1,531	$730	
South Dakota	300%		44	12 (10)	0	3	0	9	20	$551,360	—	0%	40	$826	Annual per capita expenditure limit; capped enrollment
Tennessee	300%		93	12 (10)	9 (8)	3	1	12 (9)	56 (50)	$13,018,438	$1,000,000	8%	474	$767	
Texas	200%		40	12 (10)	9 (8)	3	1 (0)	8 (7)	10 (11)	$88,265,314	$29,918,504	34%	8,060	$802	waiting list for Fuzeon
Utah	400%		36	10	9 (8)	3	1	9 (14)	4	$2,679,455	$90,000	3%	170	$683	Capped enrollment; reduced formulary; cost-sharing
Vermont	200%		91	12 (10)	9 (8)	3	1	13 (12)	47 (43)	$777,007	$175,000	23%	99	$415	
Virgin Islands	NR	NR	NR	NR	NR	NR	NR	NR	NR	$687,763	NR	NC	NR	NC	
Virginia	300%/333% in Northern VA		67	12 (10)	9 (8)	3	1	13 (14)	29 (25)	$19,272,421	$2,612,200	14%	1,812	$1,098	
Washington	300%		171	10	9 (8)	3	1	12 (11)	136 (115)	$15,396,314	$3,742,723	24%	926	$719	Reduced formulary; lowered income eligibility; cost-sharing
West Virginia	250%		33	12 (10)	9 (8)	3	0	5	4 (5)	$2,087,428	$40,000	2%	151	$1,144	waiting list
Wisconsin	300%		68	12 (10)	9 (8)	3	1	14 (12)	29 (19)	$4,850,190	$93,610	2%	357	$721	
Wyoming	200%		78	11 (10)	9 (8)	3	0	14	40 (24)	$422,847	$62,500	15%	35	$1,423	waiting list

* New Hampshire will only reimburse for non-ARV treatments if a patient is currently receiving ARV therapy.

Data in parentheses are from the prior report, if states made changes since that time.

The 2004 Federal Poverty Level (FPL) was $9,310 (slightly higher in Alaska and Hawaii) for a household of one.

NR indicates not reported.

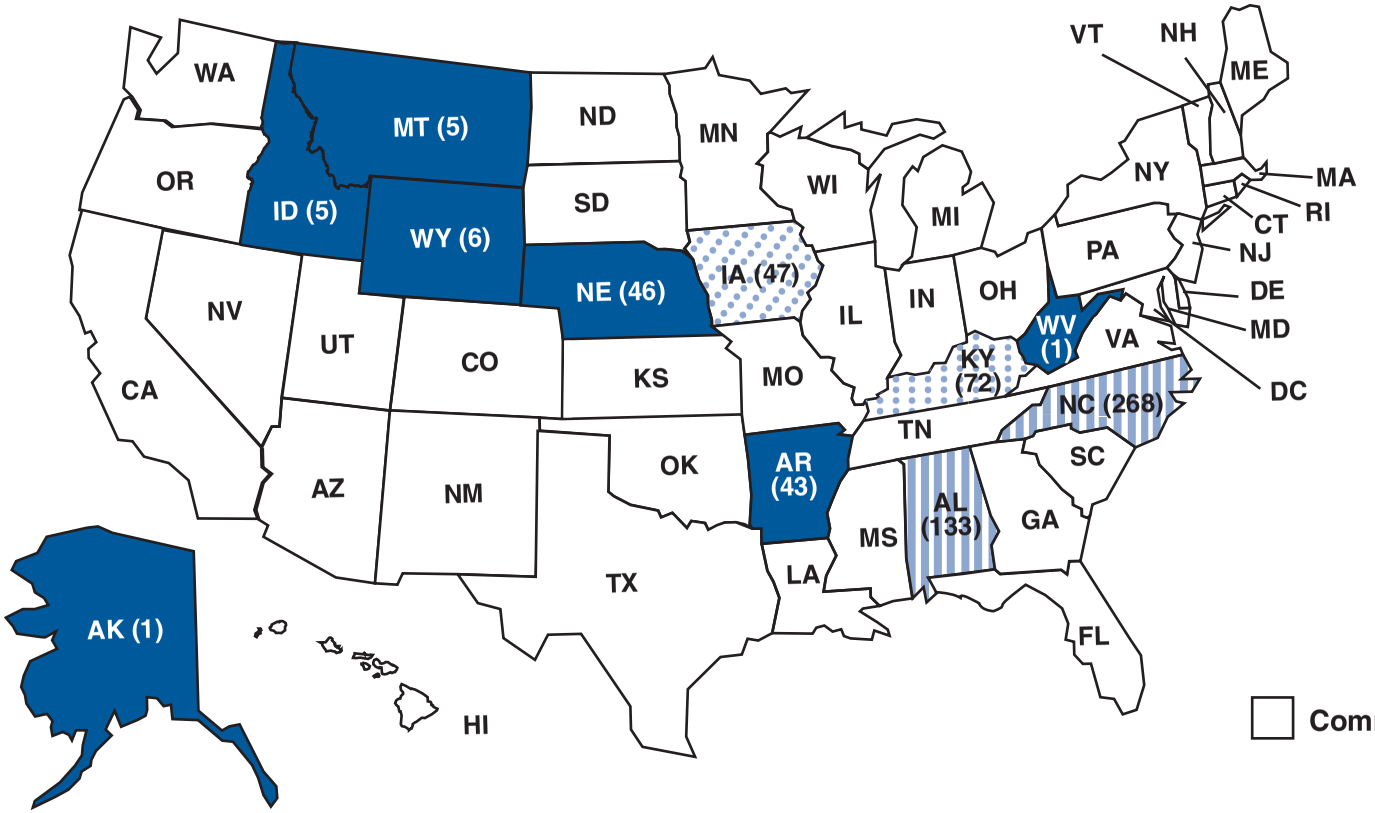
NC indicates not calculated due to missing data.

ES TABLE 2: Trends in ADAP Waiting Lists, by Survey Period and State, July 2002 – March 2005

State/Territory*	Jul–02	Oct–02	Dec–02	Jan–03	Feb–03	Mar–03	Apr–03	May–03	Jun–03	Aug–03	Sep–03	Nov–03	Jan–04	Mar–04	May–04	Jul–04	Sep–04	Nov–04	Jan–05	Mar–05	# of Periods w/ Waiting Lists	Average # 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	20	198
Alaska										1			4	9	7	8	12	4	5	1	9	6
American Samoa																						
Arizona																						
Arkansas															3		11	31	30	43	5	24
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	7	12
Illinois																						
Indiana	30	34	34	34	34	34				47	48	47									9	38
Iowa															6	31	46	12	39	47	6	30
Kansas																						
Kentucky	50	62	121	121	121	121	141	141	130	135	165	140	140	123	113	138	191		27	72	19	119
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	14	6
N. Mariana Islands																						
Nebraska			8	8	15	15	29	29	30	36	30	30						15	27	46	13	24
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	268	15	396
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																						
US Virgin Islands																						
Utah																	11				1	11
Vermont																						
Virginia																						
Washington																						
West Virginia							9	9	10	12	14	21	28	34	35	35	35	5	1	1	14	18
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**	**627**		**837**
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**	**18**	

Note: States in bold eligible for June 2004 $20 Million ADAP Initiative

ES Chart 1: State ADAPs with Waiting Lists, March 2005
(627 Individuals in 11 States)



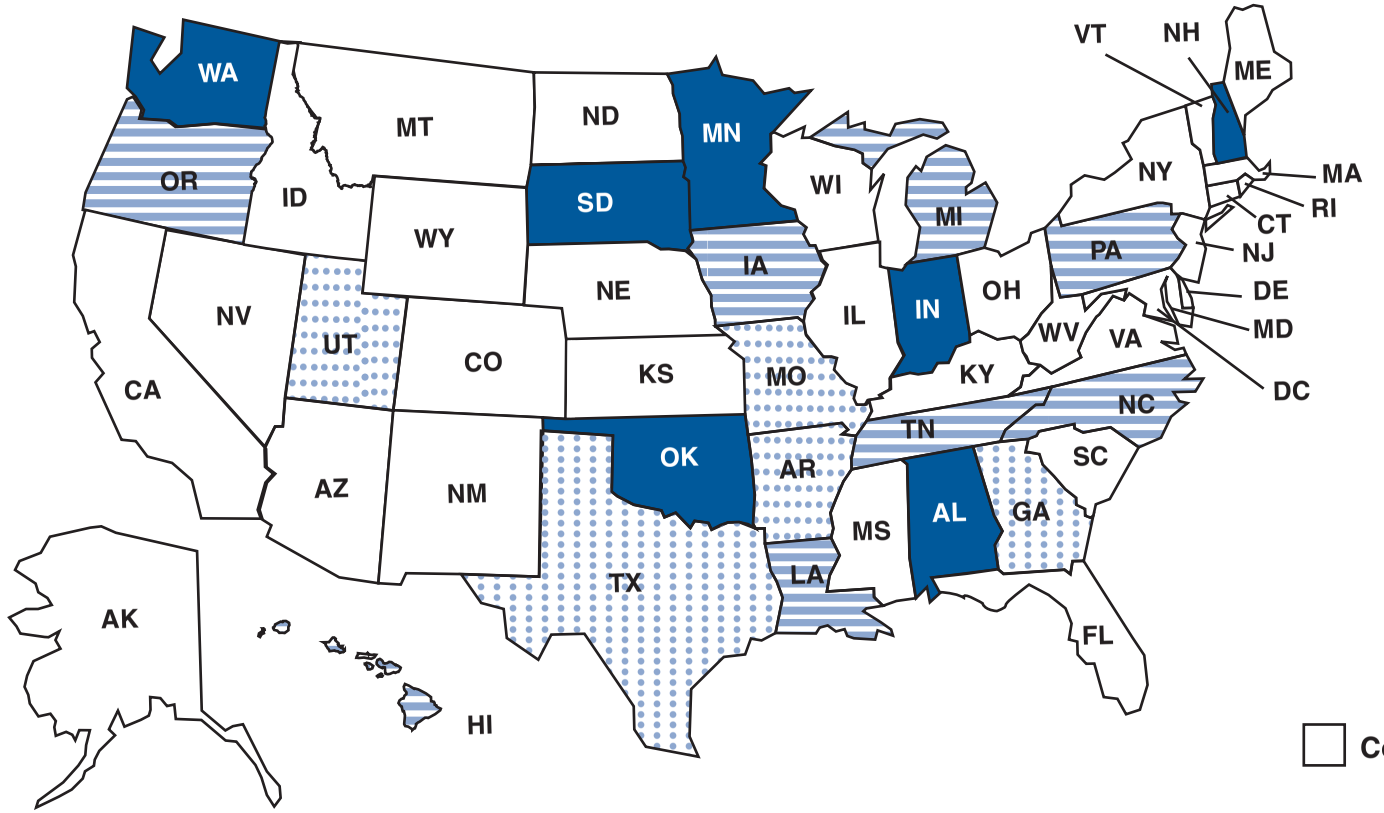
States with waiting lists in place as of March 2005 (107 individuals—7 states).

States with individuals eligible for the President's $20 million ADAP Initiative who are not yet receiving medications (401 individuals—2 states), as of March 2005.

States with waiting lists in place as of March 2005 that also have individuals eligible for the President's Initiative not yet receiving medications (104 individuals not eligible for the initiative and 15 individuals eligible but not yet receiving medications—2 states).

Note: Data not reported by 5 ADAPs: American Samoa, Guam, the N. Mariana Islands, Marshall Islands, and U.S. Virgin Islands.

ES Chart 2: State ADAPs with Current or Planned Cost-Containment Measures (other than waiting lists), March 2005



Commonwealth of Puerto Rico

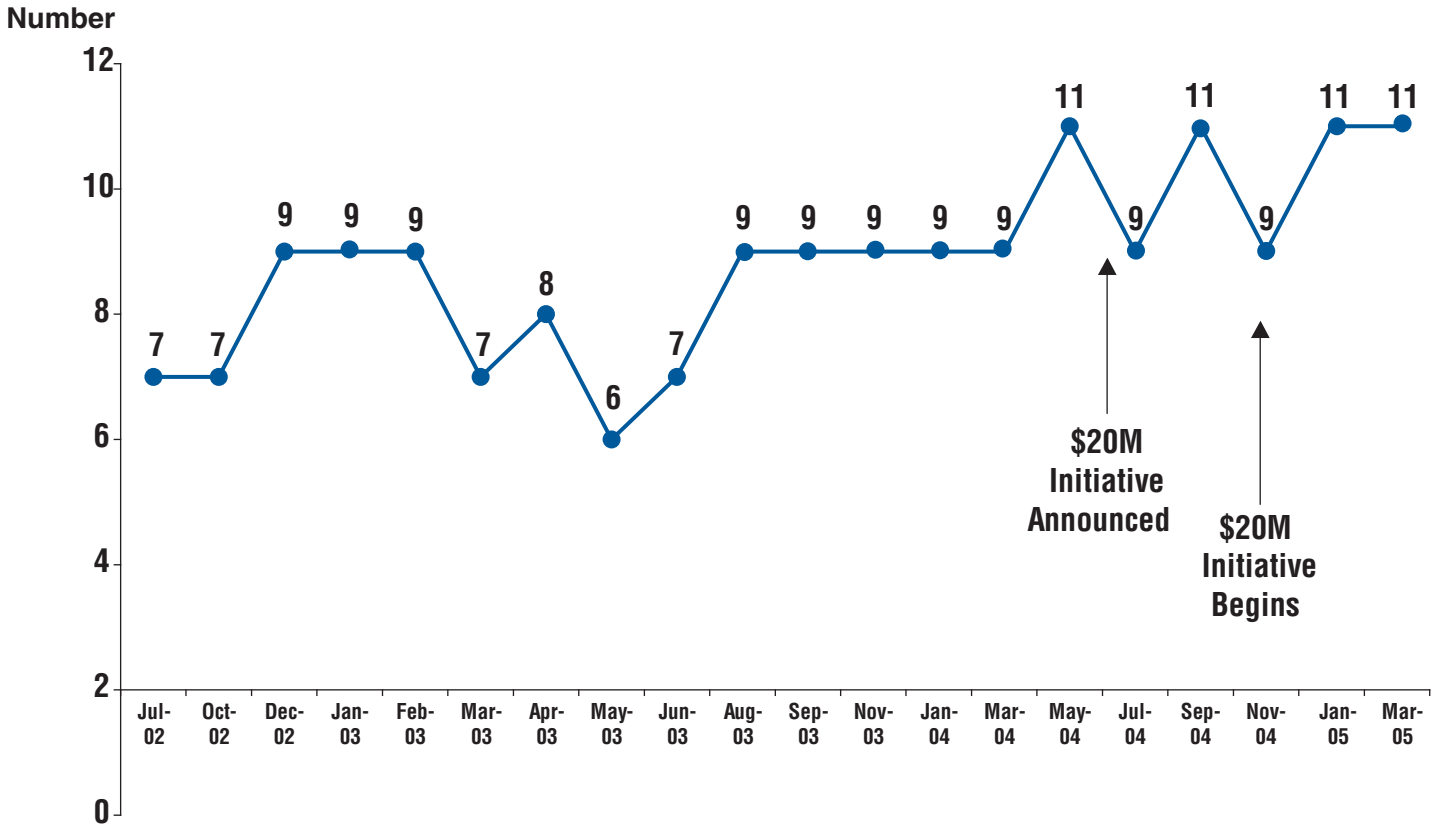
States/territories with cost-containment measures in place (7 states), as of March 2005.

States/territories with current cost-containment measures in place and anticipate the need to implement additional measures in FY 2005 (5 states), as of March 2005.

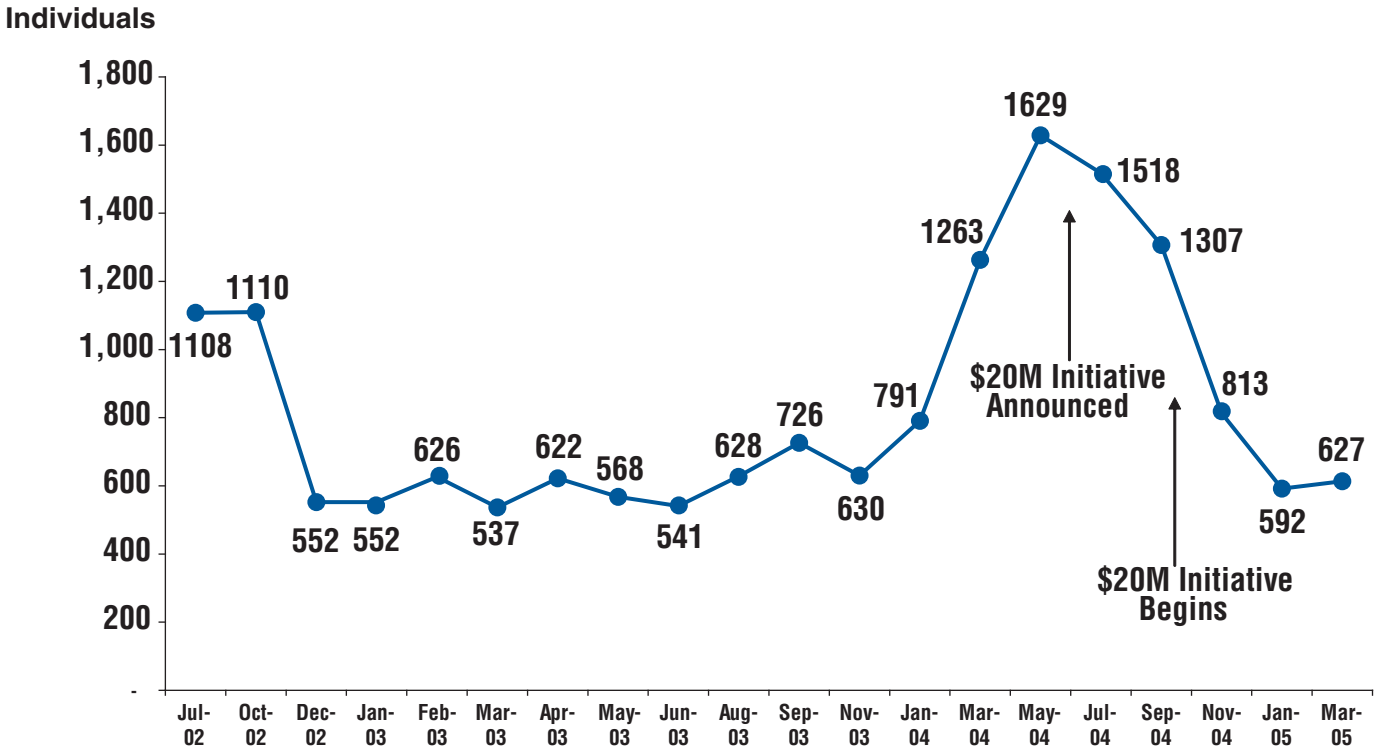
States/territories without current cost-containment measures in place but anticipating the need to implement them in FY 2005 (8 states), as of March 2005.

Note: The ADAP Fiscal Year runs from April 1 through March 31. Data not reported by 5 ADAPs: American Samoa, Guam, the N. Mariana Islands, Marshall Islands, and U.S. Virgin Islands.

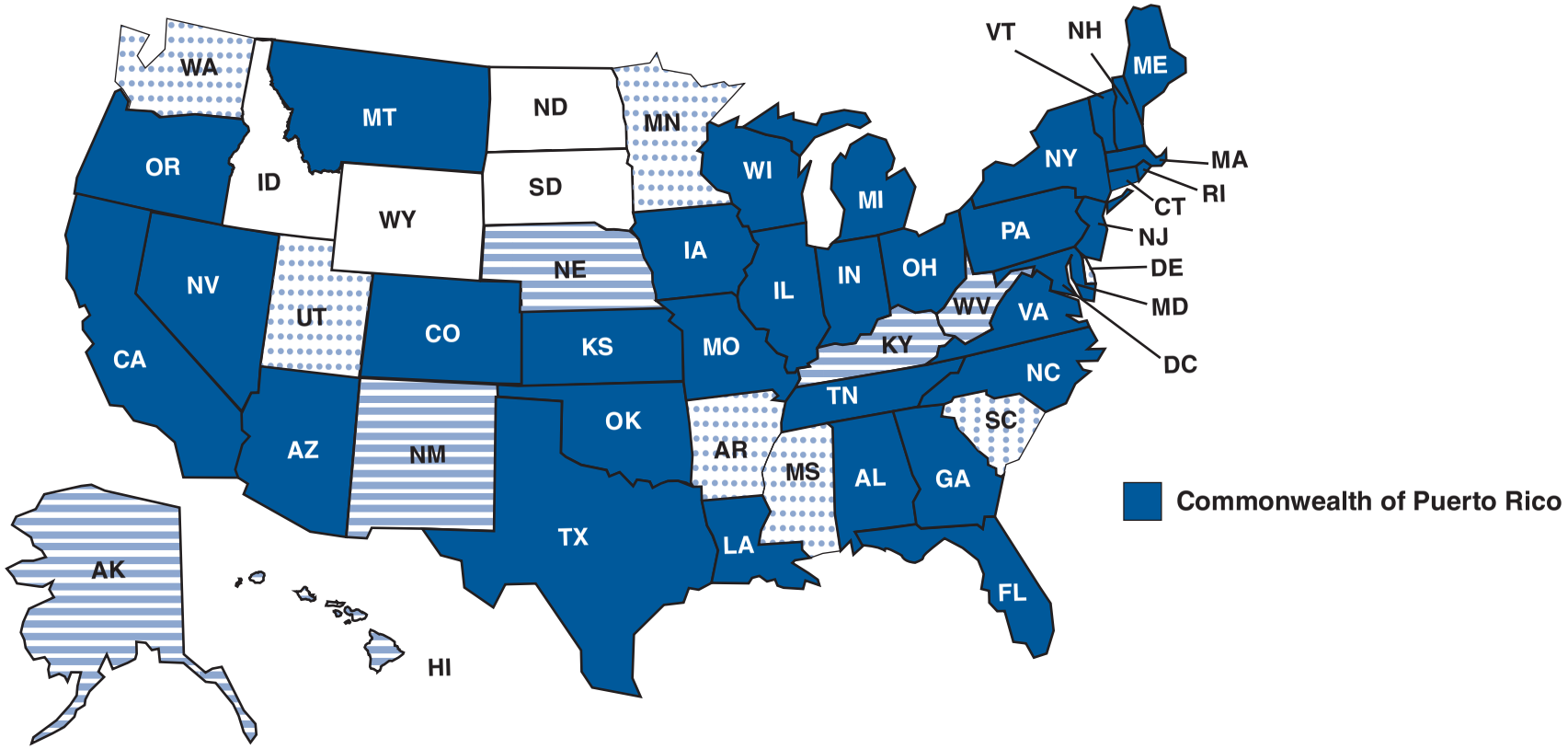
ES Chart 3: Number of States with ADAP Waiting Lists by Survey Period, July 2002–March 2005



ES Chart 4: Number of People with HIV/AIDS on ADAP Waiting Lists by Survey Period, July 2002–March 2005



ES Chart 5: State ADAP Formulary Coverage of Approved Antiretroviral Drugs, as of September 2004



Formulary covers all approved ARVs in all four drug classes, NRTIs, NNRTIs, PIs, and Fusion Inhibitor (35 states)

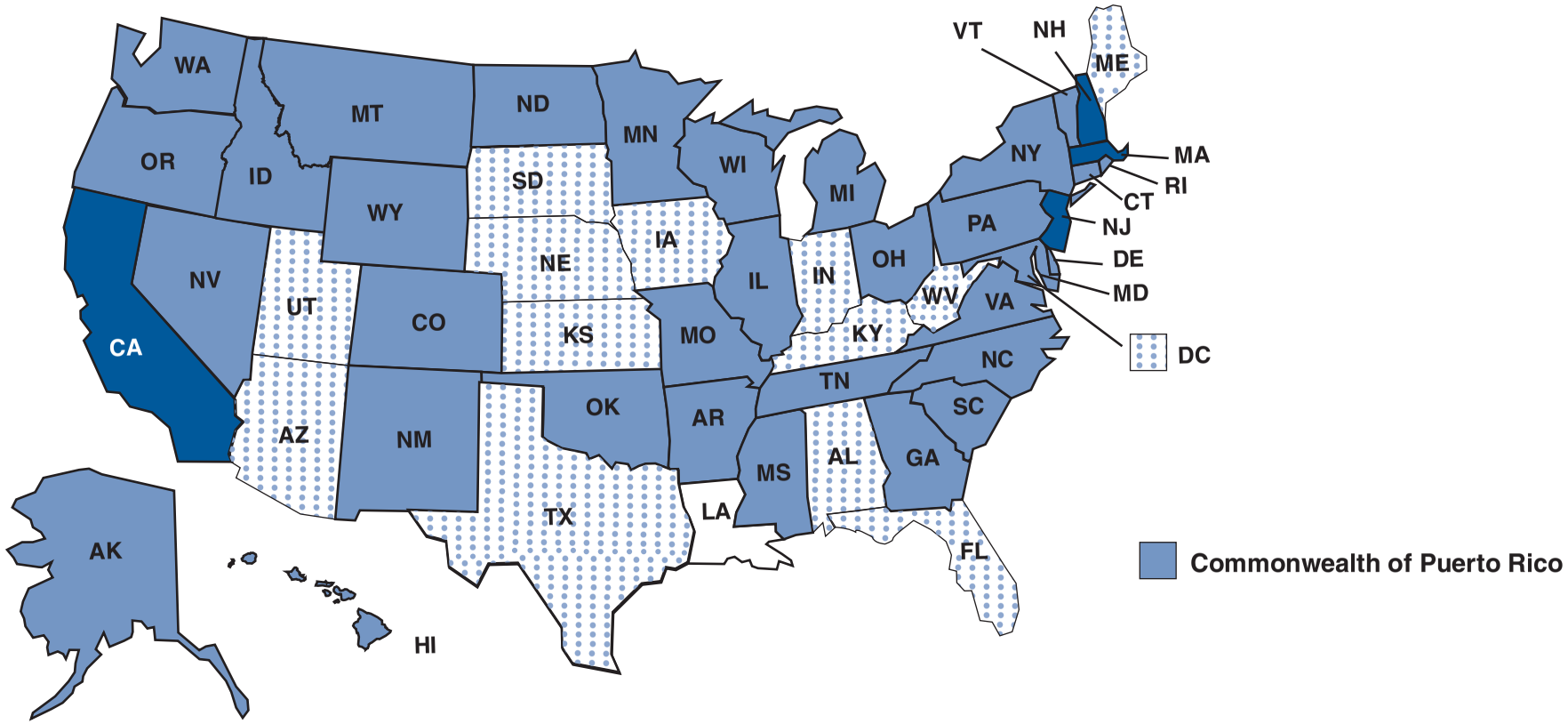
Formulary covers all approved NRTIs, NNRTIs, PIs, but not approved Fusion Inhibitor (6 states)

Formulary covers approved Fusion Inhibitor but not all approved NRTIs, NNRTIs, and PIs (7 states)

Formulary does not cover approved Fusion Inhibitor or all approved drugs in other classes (4 states)

Note: Data not reported by 5 ADAPs: American Samoa, Guam, the N. Mariana Islands, Marshall Islands, and U.S. Virgin Islands; see ES Table 1 for detailed information on ADAP formulary composition.

ES Chart 6: State ADAP Formulary Coverage of Drugs Recommended for the Prevention of Opportunistic Infections (OIs), as of September 2004



Formulary covers all 16 "AI" drugs recommended for the prevention of OIs (4 states)

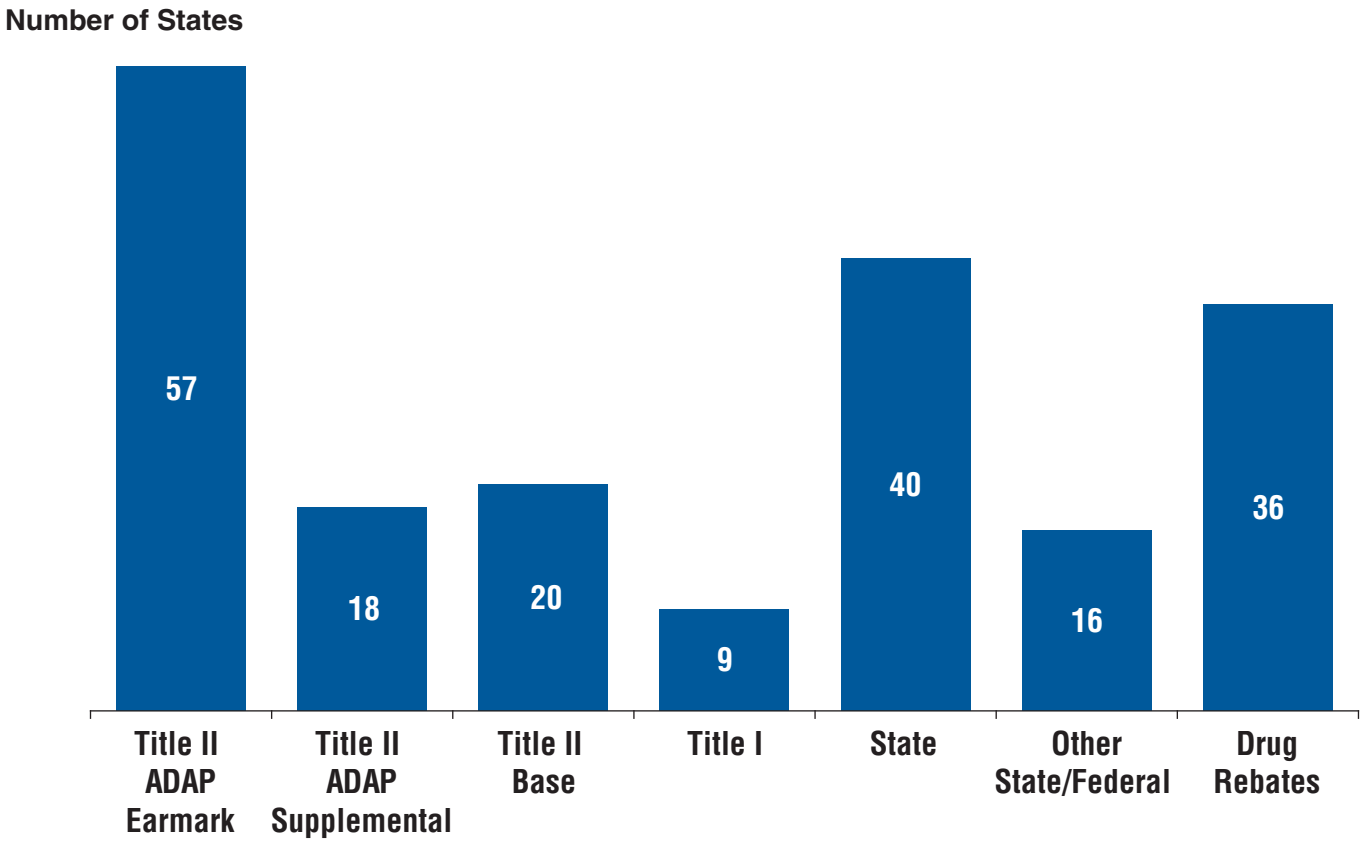
Formulary covers 10-15 "AI" drugs recommended for the prevention of OIs (33 states)

Formulary covers <10 "AI" drugs recommended for the prevention of OIs (14 states)

Formulary does not cover any drugs recommended for the prevention of OIs (1 state)

Notes: Data not reported by 5 ADAPs: American Samoa, Guam, the N. Mariana Islands, Marshall Islands, and U.S. Virgin Islands; see ES Table 1 for detailed information on ADAP formulary composition.

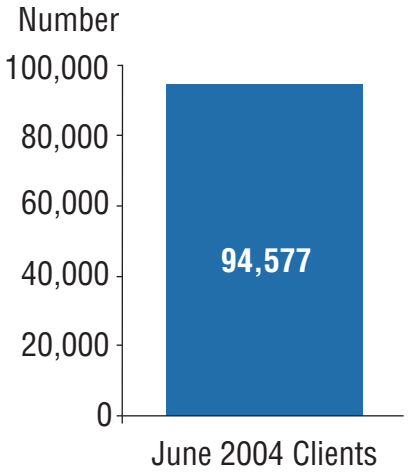
ES Chart 7: Number of ADAPs by Funding Source, FY 2004



Note: American Samoa, Guam, the Marshall Islands, N. Mariana Islands, and U.S. Virgin Islands did not report data and are not included in all categories above, except Title II ADAP Earmark and Title II ADAP Supplemental.

Charts

Chart 1
ADAP Clients Served and Top Ten States, by Clients Served, June 2004



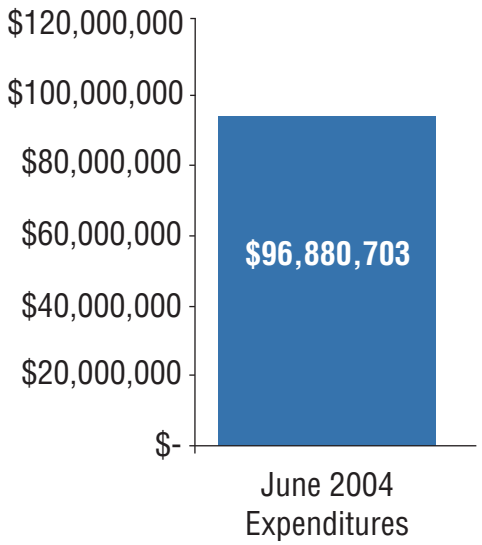
State/Territory	Client Served, June 2004
California	18,263
New York	12,484
Florida	9,558
Texas	8,060
New Jersey	4,705
Georgia	3,820
Illinois	3,234
Puerto Rico	3,154
Pennsylvania	2,971
Massachusetts	2,291
Total	**68,540**

Note: Includes all jurisdictions receiving FY 2004 federal ADAP funding except American Samoa, Guam, the Marshall Islands, N. Mariana Islands, and U.S. Virgin Islands.

In June 2004, ADAPs provided medications to 94,577 clients across the country. Ten states accounted for nearly three-fourths (72%) of all clients served in June 2004, with five states accounting for more than half (56%) of clients served. 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 to states based on estimated living AIDS cases. The number of clients served varies considerably by state, ranging from 13 in Indiana to more than 18,000 in California (see Appendix I). Between June 2003 and June 2004, client utilization increased by 10%; a majority of ADAPs (38) experienced an increase in the number of clients served between the two periods (see Appendix I).

In addition to providing medications to more than 94,000 clients, ADAPs also paid for insurance coverage for 7,277 clients in June 2004 (see Chart 23 and Appendix XII), some of whom may have also received medications from ADAP.

Chart 2
ADAP Drug Expenditures and Top Ten States, by Expenditures, June 2004



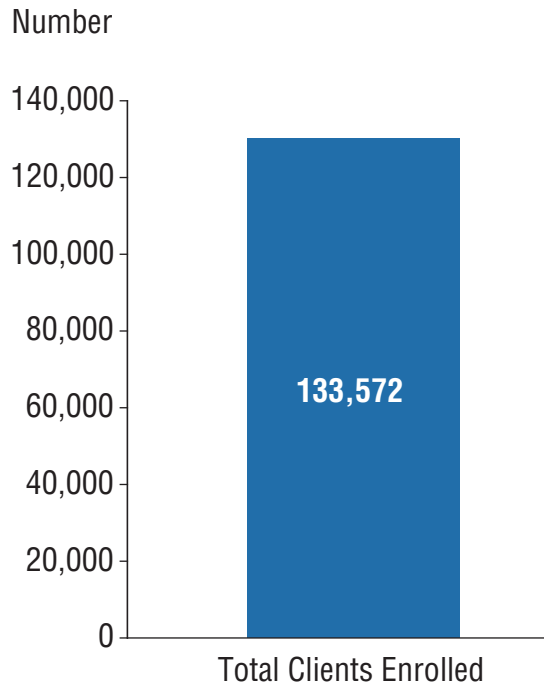
State/Territory	Drug Expenditures, June 2004
California	$21,158,096
New York	$18,756,730
Florida	$6,822,400
Texas	$6,461,692
New Jersey	$5,964,042
Pennsylvania	$4,011,302
Georgia	$3,343,888
Illinois	$3,055,902
Puerto Rico	$2,703,933
Maryland	$2,390,384
Total	**$74,668,369**

Note: Includes all jurisdictions receiving FY 2004 federal ADAP funding except American Samoa, Guam, the Marshall Islands, N. Mariana Islands, and U.S. Virgin Islands.

National ADAP monthly drug expenditures totaled $96,880,703 in June 2004. As with clients served, 10 states accounted for approximately three-fourths (77%) of June 2004 drug expenditures; five states accounted for 61% of drug expenditures. These 10 states are primarily the same set that accounted for the most clients served in June 2004, although their ranking differs slightly. Drug expenditures in June 2004 ranged from $14,410 in North Dakota to $21.2 million in California (see Appendix I). ADAP drug expenditures increased by 25% between June 2003 and June 2004; a majority of ADAPs (43) experienced increasing drug expenditures between the two periods (eight more compared to the previous year) (see Appendix I).

In addition to drug expenditures, 26 ADAPS spent an additional $37.8 million on insurance purchasing/maintenance for ADAP clients (see Chart 23 and Appendix XII).

Chart 3
ADAP Clients Enrolled and Top Ten States, by Clients Enrolled, June 2004

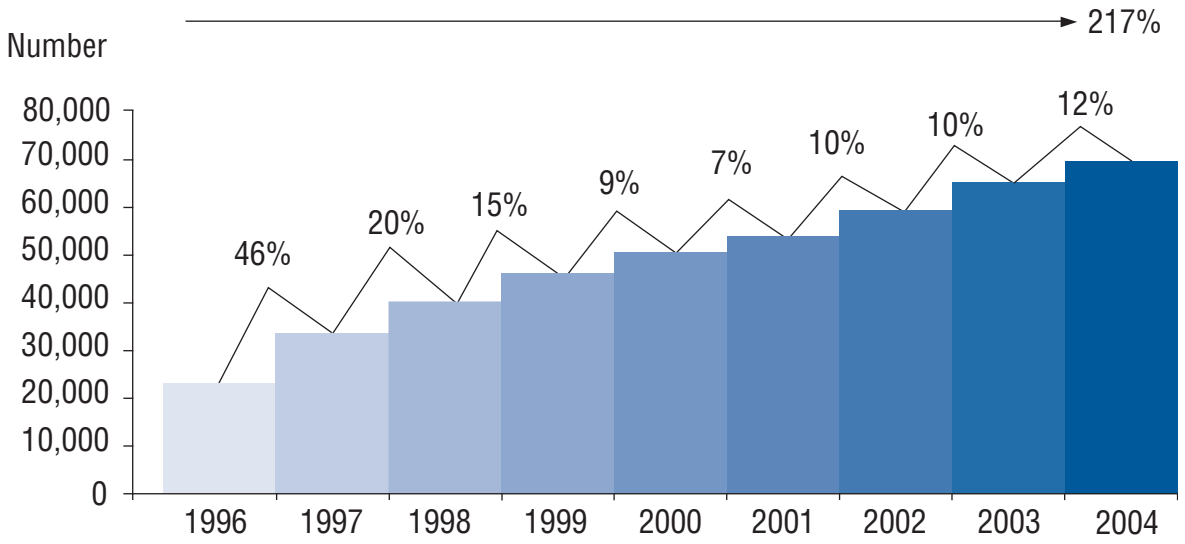


State/Territory	Client Enrolled, June 2004
California	25,013
New York	15,976
Texas	12,226
Florida	11,947
Georgia	5,798
Pennsylvania	5,589
New Jersey	5,366
Illinois	4,836
Massachusetts	3,436
Puerto Rico	3,336
Total	**93,523**

Note: Includes all jurisdictions receiving FY 2004 federal ADAP funding except American Samoa, Guam, the Marshall Islands, N. Mariana Islands, and U.S. Virgin Islands.

Clients may seek ADAP services at different times of the year, depending on their clinical needs, prescription length, availability of other resources for obtaining prescription drugs, and other factors. Some individuals cycle on and off ADAPs throughout the year. Therefore, in a given month, more clients are usually enrolled in ADAPs than seek services. In June 2004, there were 133,572 clients enrolled in ADAPs across the country, more than two-thirds (71%) of whom received services in that month.

Chart 4
Trends in ADAP Client Utilization, 1996–2004
(Among the 41 States Reporting Data Over the Period)

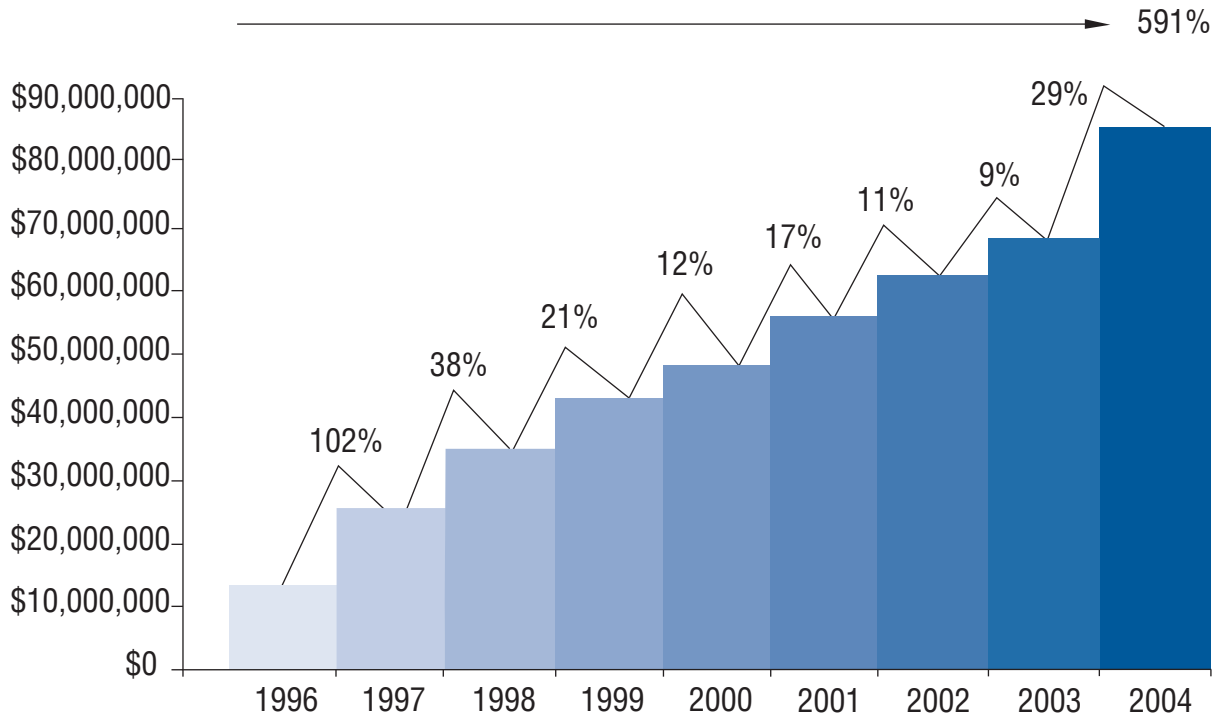


Note: Based on 41 state/territorial ADAPs that provided data for each fiscal year. American Samoa, District of Columbia, Florida, Georgia, Guam, Louisiana, the Marshall Islands, Missouri, New Mexico, North Dakota, Northern Mariana Islands, Puerto Rico, Tennessee, Vermont, U.S. Virgin Islands, and Wyoming not included.

The National ADAP Monitoring Project has been collecting data from state ADAPs since 1996. A majority of ADAPs (41) have provided monthly snapshots of client utilization and expenditure data over this period, and therefore offer an important window into trends over time. The number of clients served by ADAPs increased by 217% between 1996 and 2004 (among the 41 ADAPs that reported data over this period). While the number of clients has grown each year, the rate of growth has slowed considerably.

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; state 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 16 for trends in the national ADAP budget over time).

Chart 5
Trends in ADAP Drug Expenditures, 1996–2004
(Among the 41 States Reporting Data Over the Period)

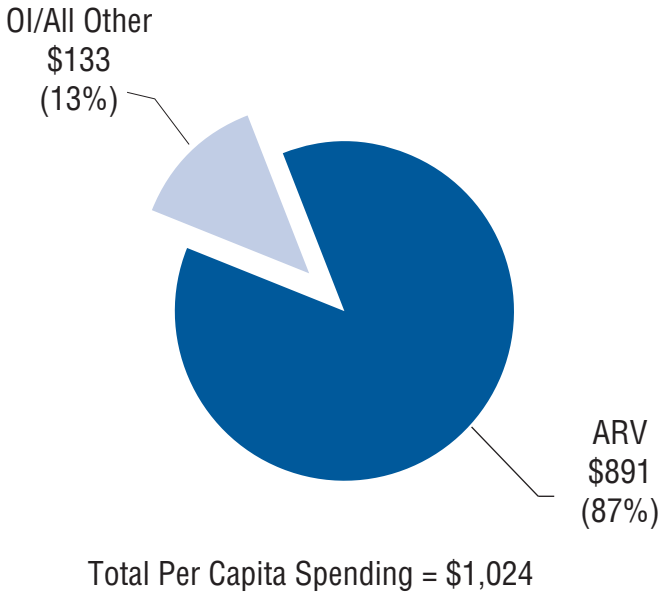


Note: Based on 41 state/territorial ADAPs that provided data for each fiscal year. American Samoa, District of Columbia, Florida, Georgia, Guam, Louisiana, the Marshall Islands, Missouri, New Mexico, North Dakota, Northern Mariana Islands, Puerto Rico, Tennessee, Vermont, U.S. Virgin Islands, and Wyoming not included.

Monthly ADAP drug expenditures have also increased over the past several years and at a faster rate than client growth. Between 1996 and 2004, drug expenditures grew by 591%, more than twice the rate of client growth over this same period (among the 41 states that provided data over this period). Drug expenditures increased each year over this period but at decreasing rates over time with the notable exception of the last period—between June 2003 and June 2004, expenditures in these 41 states experienced their greatest annual rate of increase since 1998.

Expenditure growth is driven by several factors including: increases in the number of clients served; rising drug prices; the increasing complexity of treatment regimens (e.g., moving from 2 or 3, to 5 or more drugs used in combination or the introduction of a new drug class); and increased funding for ADAPs (see Chart 16 for trends in the national ADAP budget over time).

Chart 6
Per Capita Drug Expenditures, June 2004

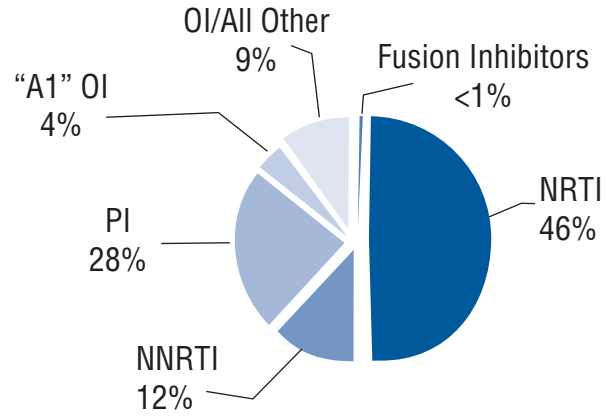


Note: American Samoa, Guam, the Marshall Islands, N. Mariana Islands, and U.S. Virgin Islands are not included.

ADAPs spent an average of $1,024 on prescription drugs per client served in June 2004, a 14% increase over June 2003 per capita expenditures of $902. Per capita spending varies significantly by state, ranging from a low of $376 (in Oregon) to a high of $1,519 (in Maine) (see ES Table 1). These variances are likely the result of differing ADAP formularies, purchasing mechanisms, and/or prices paid by ADAPs across the country.

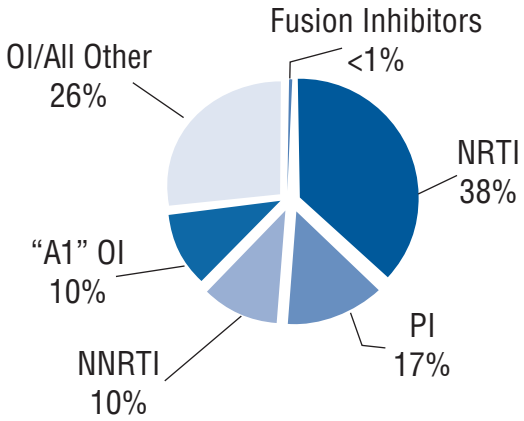
Chart 7

ADAP Drug Expenditures, by Class, June 2004



Total = $96.9 Million

ADAP Prescriptions Filled, by Class, June 2004



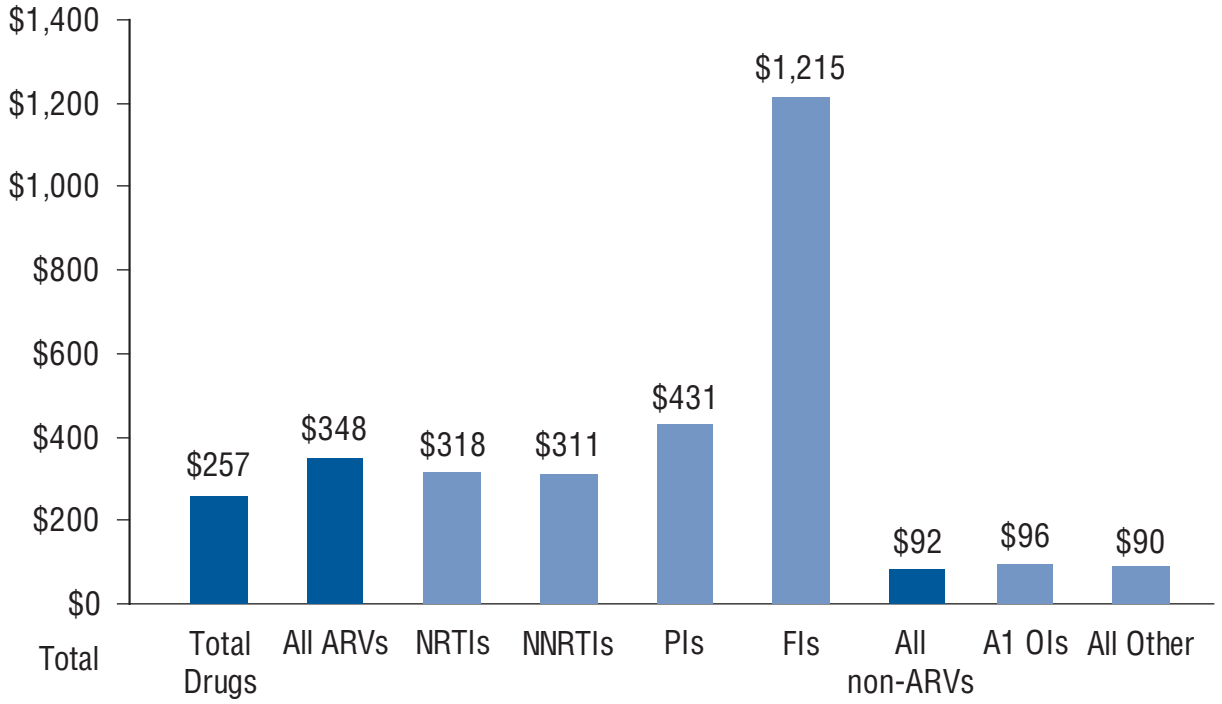
Total = 377,271 Prescriptions

Note: American Samoa, Guam, Maine, the Marshall Islands, N. Mariana Islands, and U.S. Virgin Islands are not included. Partial data for Maine is included in drug expenditures. See Appendix II and III for state by state drug expenditures and prescriptions filled, by class. Percentages may not equal 100% due to rounding.

In June 2004, 51 ADAPs provided drug expenditure data by drug class, including for all four antiretroviral drug classes, the 16 "A1" opportunistic infection drugs highly recommended in the U.S. Public Health Service and Infectious Diseases Society of America, *Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus,* July 2001, and for all other medications. Spending breakdowns were similar to prior year reports. Antiretrovirals continue to account for the bulk of ADAP drug expenditures (87% in June 2004). Nucleoside reverse transcriptase inhibitors (NRTIs) accounted for nearly half of ADAP June 2004 expenditures at 46% (50% in June 2003); followed by protease inhibitors (PIs) at 28% (23% in June 2003); and non-nucleoside reverse transcriptase inhibitors (NNRTIs) at 12% (13% in June 2003). Fusion inhibitors (FIs) accounted for a small percentage of drug expenditures (less than 1%). All other drugs, including drugs to prevent and treat opportunistic infections, accounted for 13% of drug spending (14% in June 2003). The 16 "A1" OI drugs accounted for 4% of total drug spending. The distribution of expenditures by drug class varies across the states, likely reflecting differing formularies, drug prices, and prescribing decisions (see Appendix II).

States filled a total of 377,271 prescriptions in June 2004. As with expenditures by class, prescriptions for ARVs represented the majority of all prescriptions filled (64%); 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 (NRTIs) accounted for more than a third (38%) of June 2004 prescriptions filled (37% in June 2003); followed by protease inhibitors (PIs) at 17% (14% in June 2003), and non-nucleoside reverse transcriptase inhibitors (NNRTIs) at 10% (11% in June 2003). Fusion inhibitors (FIs) accounted for less than 1% of prescriptions filled in June 2004. Prescriptions for all other drugs, including OI drugs, represented 36% of total drug expenditures. Expenditures for "A1" OI drugs were 10% of drug expenditures in June 2004. These percentage breakdowns are similar to those in last year's report. As with drug expenditures, the distribution of prescriptions filled by drug class varies by state (see Appendix III).

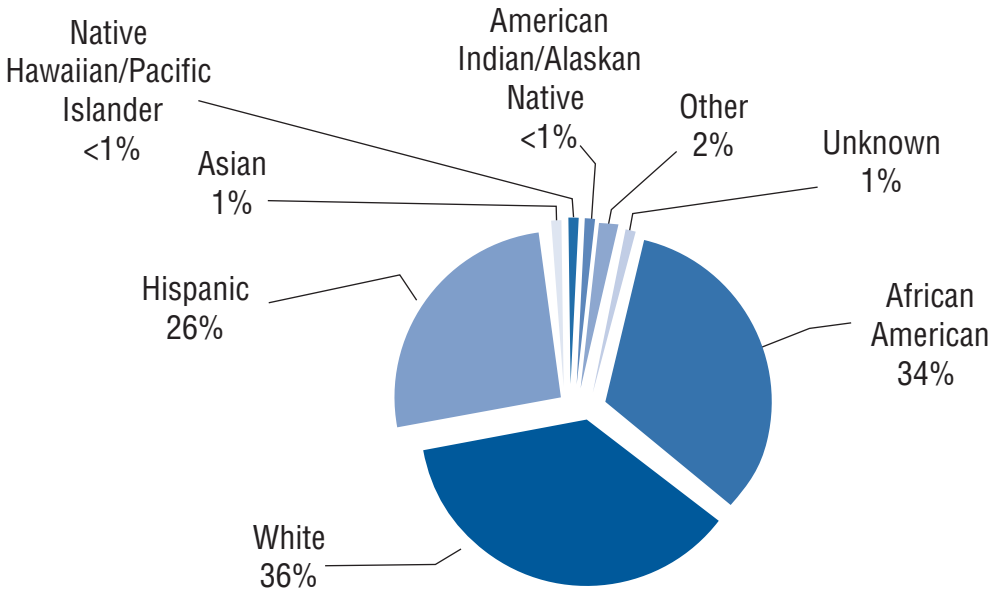
Chart 8
ADAP Expenditures Per Prescription, by Drug Class, June 2004



Note: American Samoa, Guam, the Marshall Islands, N. Mariana Islands, and U.S. Virgin Islands are not included.

The average expenditure per prescription, across all ADAPs and for all medications, was $257 in June 2004. Expenditure per prescription was significantly higher for ARVs ($348 per prescription in June 2004) compared to non-ARVs ($92). Some ARV drug classes accounted for higher per prescription expenditures than others, with fusion inhibitors topping the list ($1,215), followed by protease inhibitors ($431), nucleoside analog reverse transcriptase inhibitors (NRTIs) ($318), and non-nucleoside reverse transcriptase inhibitors (NNRTIs) ($311). "A1" OI infection prevention drugs were $96 per prescription filled in June 2004.

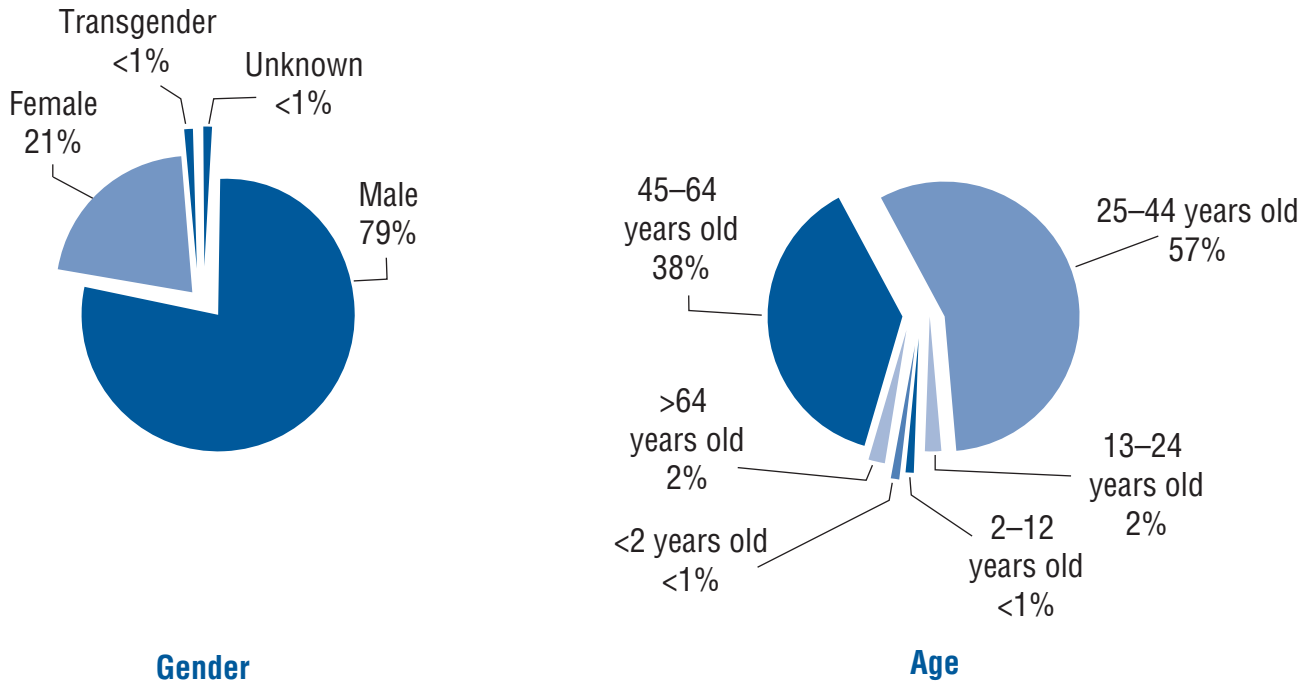
Chart 9
ADAP Clients, by Race/Ethnicity, June 2004



Note: American Samoa, Guam, Maine, the Marshall Islands, N. Mariana Islands, and U.S. Virgin Islands are not included. Percentages do not total 100% due to rounding.

Fifty-one states/territories provided race/ethnicity data for their ADAP client populations served in June 2004. African Americans and Hispanics made up approximately one-third (34%) and one-quarter (26%), respectively, of clients served by ADAPs. White non-Hispanics made up 36% of the total ADAP client population served. Asian/Pacific Islanders, Alaskan Natives and American Indians combined represented approximately 2% of the total ADAP population served. 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. The race/ethnicity breakdown of ADAP clients varies by state/territory (see Appendix IV).

Chart 10
ADAP Clients, by Gender and by Age, June 2004



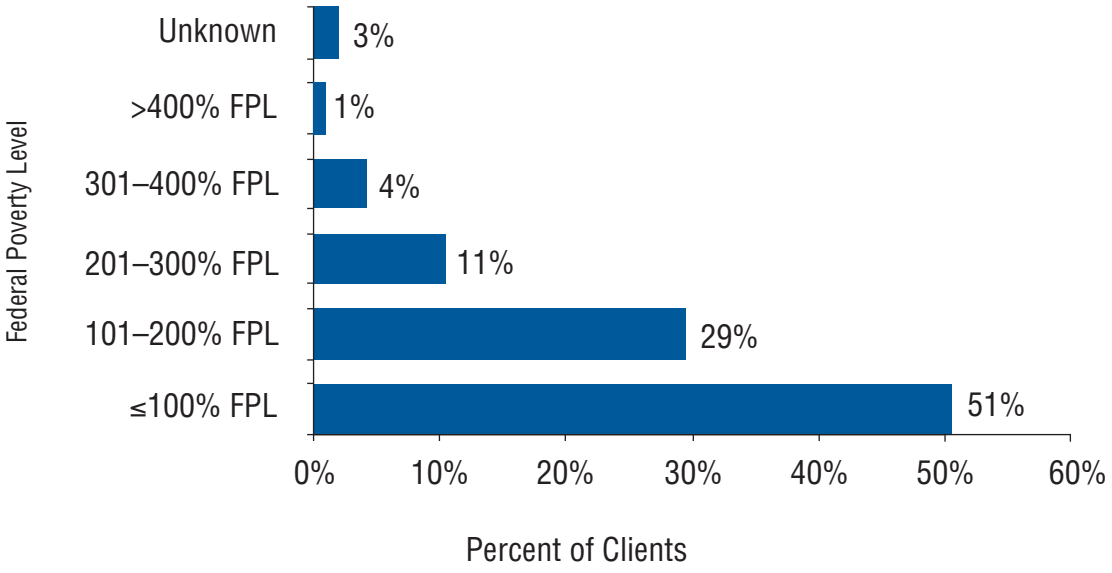
Note: American Samoa, Guam, Maine, the Marshall Islands, N. Mariana Islands, and U.S. Virgin Islands are not included. Percentages do not total 100% due to rounding.

Fifty-two states/territories provided gender and age data for their ADAP client populations served in June 2004. More than three-quarters (79%) of ADAP clients served in June 2004 were male; approximately one-fifth were female (21%), similar to last year's report. Less than 1% of clients served in June 2004 were reported to be transgendered (note: some ADAPs have just begun to collect data on transgendered individuals and this client population may therefore be underreported).

ADAP clients served in June 2004 were most likely to be between the ages of 25 and 44 years (57%). Those ages 45–64 represented 38% of clients served.

Individual states/territories have varying gender and age ADAP client demographics (see Appendix V).

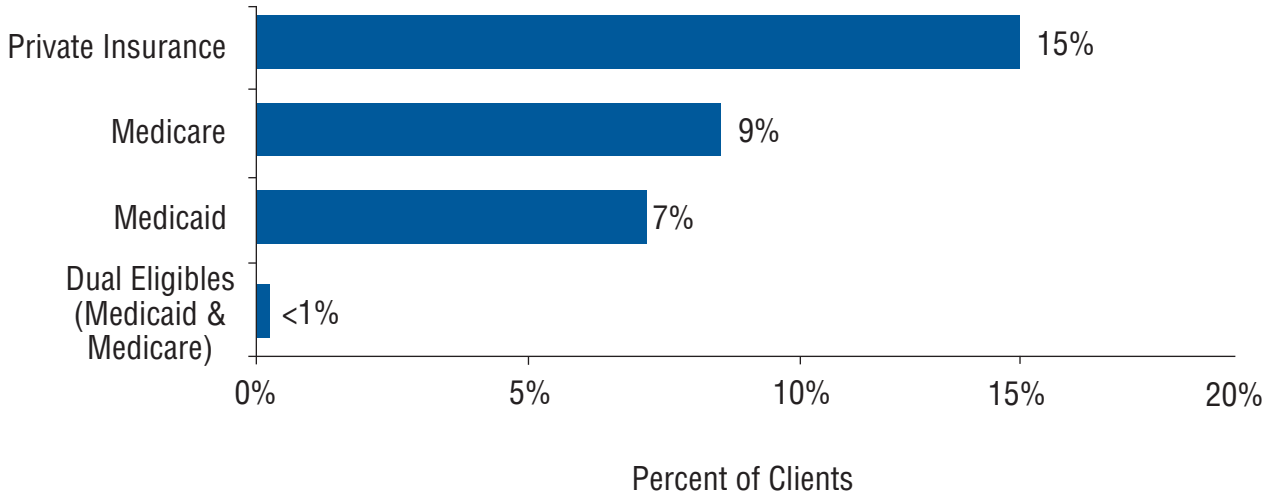
Chart 11
ADAP Clients, by Income Level, June 2004



Note: American Samoa, District of Columbia, Guam, Maine, the Marshall Islands, N. Mariana Islands, and U.S. Virgin Islands are not included. Percentages do not total 100% due to rounding.

Fifty jurisdictions reported data on income of clients served in June 2004 (see Appendix VI). Most ADAP clients are low-income: eighty percent (80%) were at or below 200% of the federal poverty level (FPL), including about half (51%) who were at or below 100% of FPL (in 2004, the FPL was $9,310—slightly higher in Alaska and Hawaii—for a family of one). These figures are consistent with data reported in previous National ADAP Monitoring Project reports.

Chart 12
ADAP Clients with Insurance Coverage, June 2004



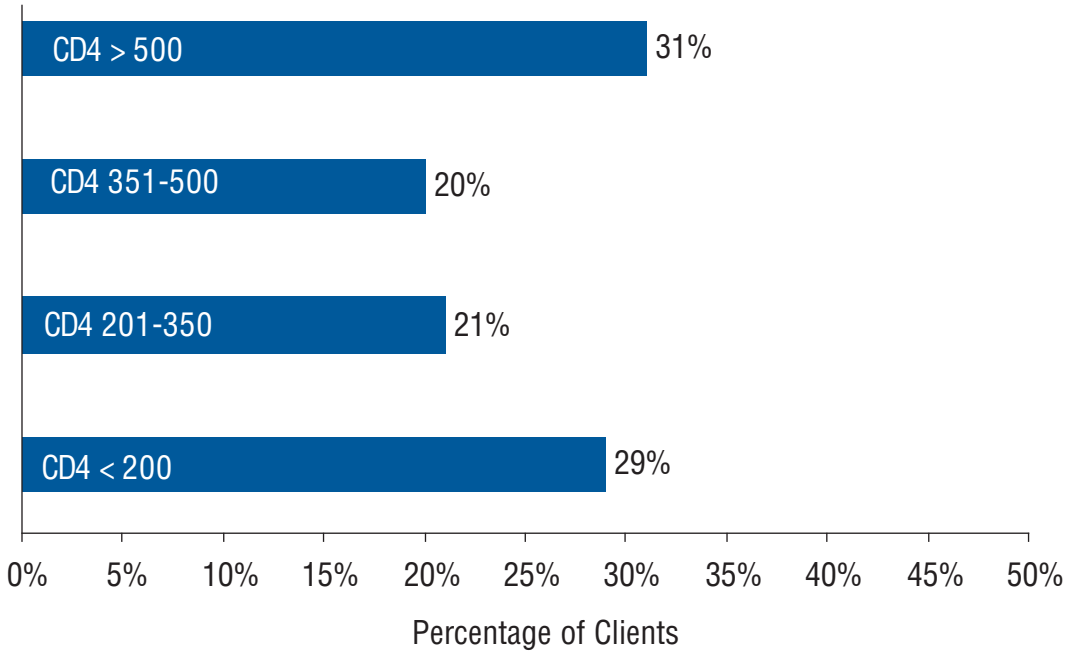
Note: Insurance categories are not mutually exclusive. Overall percentage of clients served is calculated using only states that reported data. See Appendix VI for states that reported data.

Forty-four jurisdictions reported data on insurance status of clients served in June 2004. The majority of ADAP clients lack any other form of private or public insurance: 15% had private insurance; 9% were covered by Medicare; and 7% by Medicaid. Similar proportions were reported last year.

Twenty-four states (representing 43% of the June 2004 ADAP client utilizing population) were able to report data on the number of ADAP clients who were dual Medicaid and Medicare beneficiaries; dual beneficiaries represented less than 1% of clients served in these states in June 2004 (see Appendix VI). It is expected that the implementation of the Part D prescription drug benefit of the Medicare Modernization Act (MMA) will lead more ADAPs to collect data on Medicaid/Medicare dually eligible individuals.

Insurance coverage of ADAP clients varies by state/territory (see Appendix VI).

Chart 13
ADAP Clients, With Reported Health Status (CD4 Count), Enrolled During 12-Month Period, June 2004



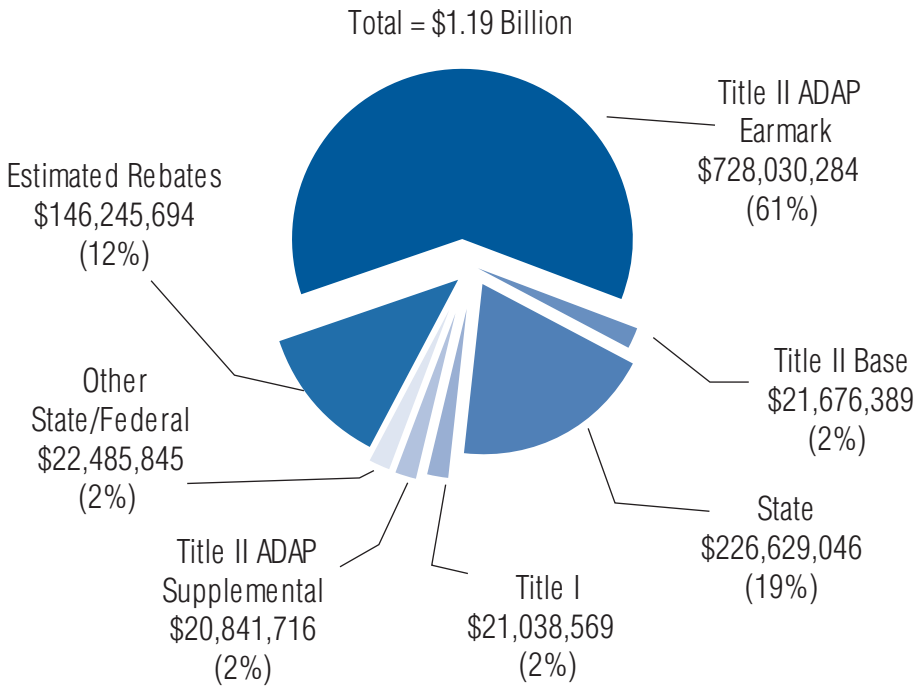
Note: 33 states/territories provided information on health status of clients. See Appendix VII for list of states/territories that provided data on ADAP client health status. Percentages do not total 100% due to rounding.

ADAPs were asked to provide data on CD4 count at the time of enrollment for clients enrolled over a recent 12-month period. CD4 counts are an important marker of the health status of people with HIV/AIDS. Thirty-three jurisdictions were able to provide these data, representing 57,943 ADAP clients (61% of the June 2004 utilizing population) (see Appendix VII).

Half (50%) of ADAP clients had a CD4 count of 350 or under (up from 42% in last year's report), including 29% with CD4 counts less than 200, suggesting that a significant number of ADAP clients continue to enroll well into disease progression. Thirty-one percent of clients had a CD4 count above 500, the same percentage as in the previous year's report. 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 exclusively reflect new clients.

Chart 14
National ADAP Budget, by Source, FY 2004



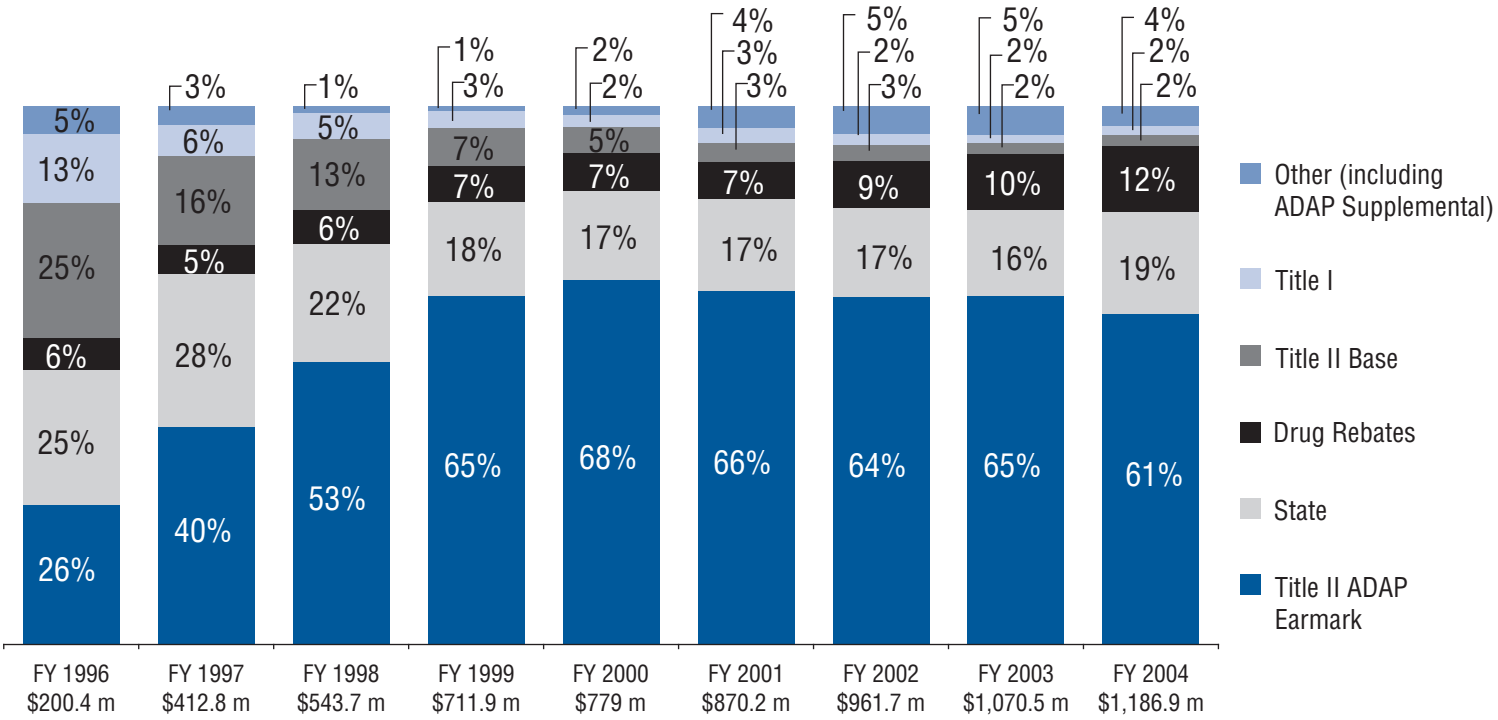
Note: National budget includes FY 2004 federal ADAP earmark only for American Samoa, the Marshall Islands, and N. Mariana Islands. National budget includes FY 2004 federal ADAP Earmark and ADAP Supplemental only for Guam and the U.S. Virgin Islands.

In FY 2004, the national ADAP budget, from all sources, totaled $1.2 billion, up from $1.1 billion in FY 2003. The Title II ADAP earmark represents the largest component of the ADAP budget, accounting for $728 million, or 61%, of total ADAP funding in FY 2004, a slightly smaller percentage of the overall budget compared to last year (65%). State funding followed at $226.6 million, or 19%, of total funding in FY 2004 (compared with 16% in FY 2003). Title I EMA funding, Title II base funding, and Title II ADAP supplemental grants each represented approximately 2% of the total ADAP budget.

Drug rebates accounted for $146.2 million or 12% of the total national ADAP budget in FY 2004, compared with 10% in FY 2003 (note: previous reports did not include drug rebates as part of the national budget; in this report, all prior year budgets have been recalculated to include drug rebates for comparison purposes). Rebates have become an increasingly important source of revenue for ADAPs and accounted for a significant proportion of the budget increase between FY 2003 and FY 2004.

Three percent of Title II ADAP earmark funds ($22.5 million in FY 2004) appropriated by Congress are set aside for the ADAP supplemental awards—grants to states with severe needs as indicated by such factors as financial eligibility set at or below 200% FPL, limited formularies, or program restrictions. Twenty-seven states were eligible for Title II supplemental awards in FY 2004; 18 received such grants, totaling $20.8 million (the remaining $1.7 million was utilized to fund legislative provisions requiring overall Title II awards to states to be equal to that of last year). The other 9 states eligible for supplemental grants in FY 2004 did not apply, either because they were unable to meet the required 1:4 state match or because they no longer had the need for additional funding. Combined Title II ADAP earmark and supplemental grant funding represents 63% of the national ADAP budget.

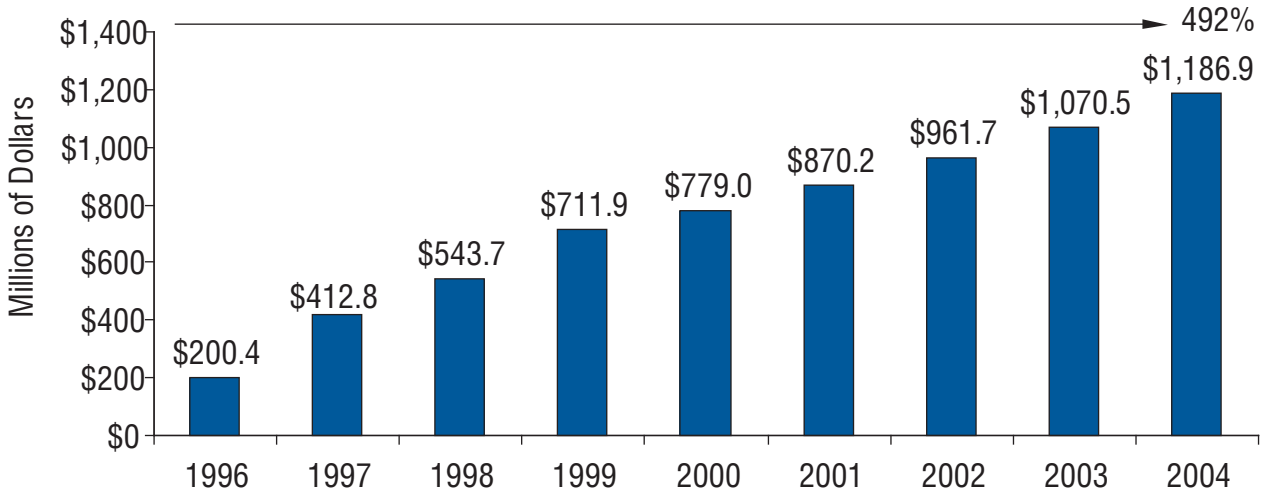
Chart 15
National ADAP Budget, by Source, FY 1996–FY 2004



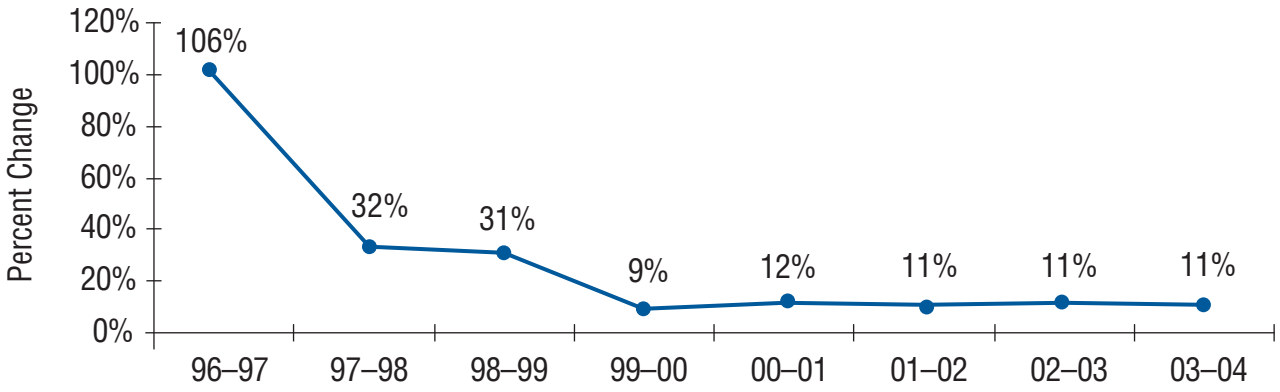
The composition of the national ADAP budget has changed since FY 1996, the year in which the Title II ADAP earmark began. The earmark has grown significantly as a proportion of the budget, rising from 26% of the budget in FY 1996 to 61% in FY 2004. State funding has declined slightly as a proportion of the national ADAP budget (25% in FY 1996 and 19% in FY 2004), 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 5% of the budget in FY 1996 to 12% in FY 2004, 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 2% in FY 2004. Title I EMA funding as a proportion of the budget has also decreased over time (13% in FY 1996 to 2% in FY 2004). In addition to falling as proportions of the national ADAP budget, Title II and Title I EMA contributions are the only two funding sources in the national ADAP budget that were less in FY 2004 than in FY 1996.

Chart 16
Trends in the National ADAP Budget, FY 1996–2004



National ADAP Budget, Rate of Growth, FY 1996-2004

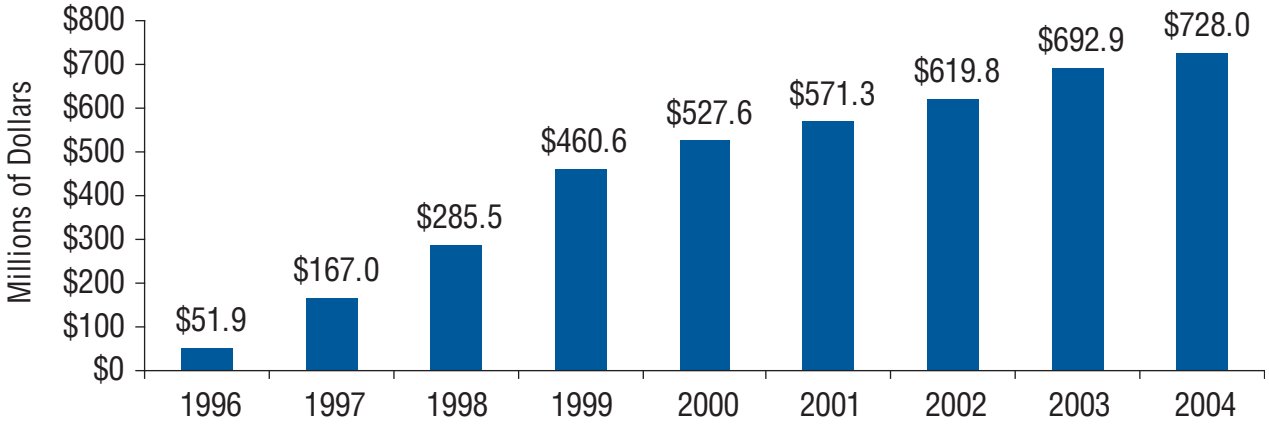


The national ADAP budget grew by $116.4 million (11%) to $1.2 billion between FY 2003 and FY 2004 (the same rate of increase as in the prior two reporting periods). The Title II ADAP earmark increased by $35.1 million (5%), state funding by $54.7 million (32%), and drug rebates by $36.3 million (33%). This was the first year in which the ADAP earmark did not have the largest dollar increase among ADAP budget sources; state funding had the largest increase, followed by rebates, and then the earmark.

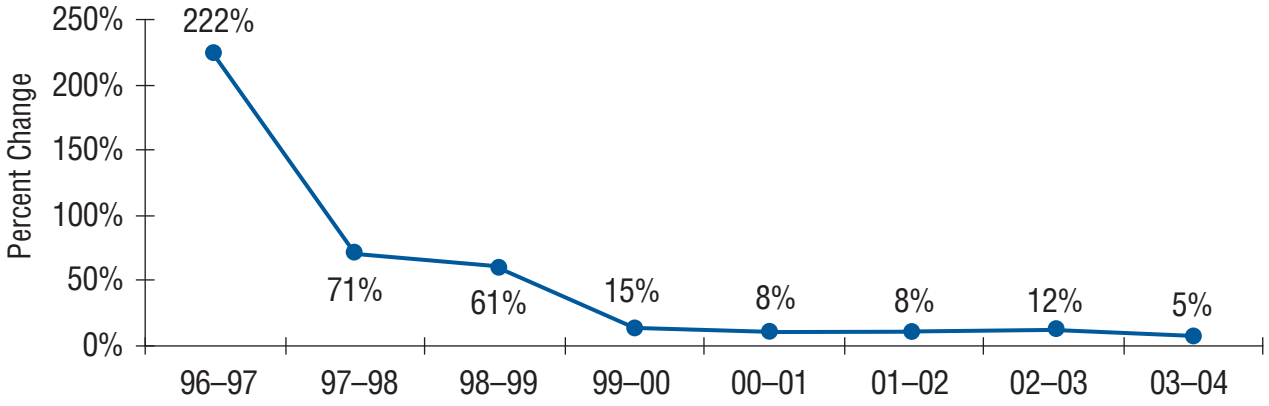
Most states saw an increase in their overall budgets, with one increase as high as 45% (South Dakota) while fifteen states experienced decreases, including one that decreased by 28% (Mississippi) (see Appendix IX).

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 grown by 492%. The budget has grown each year since that time, but generally at slower rates.

Chart 17
Title II ADAP Earmark, FY 1996–2004



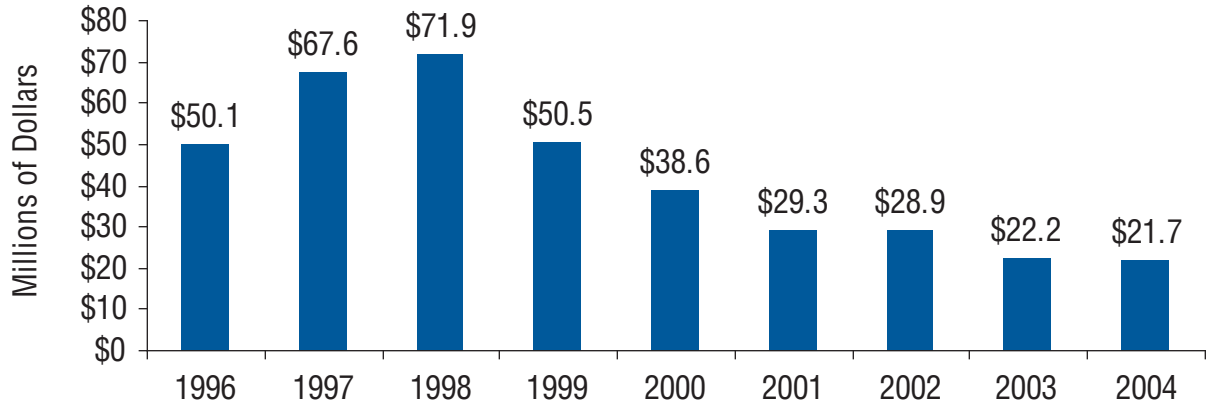
Title II ADAP Earmark, Rate of Growth, FY 1996–2004



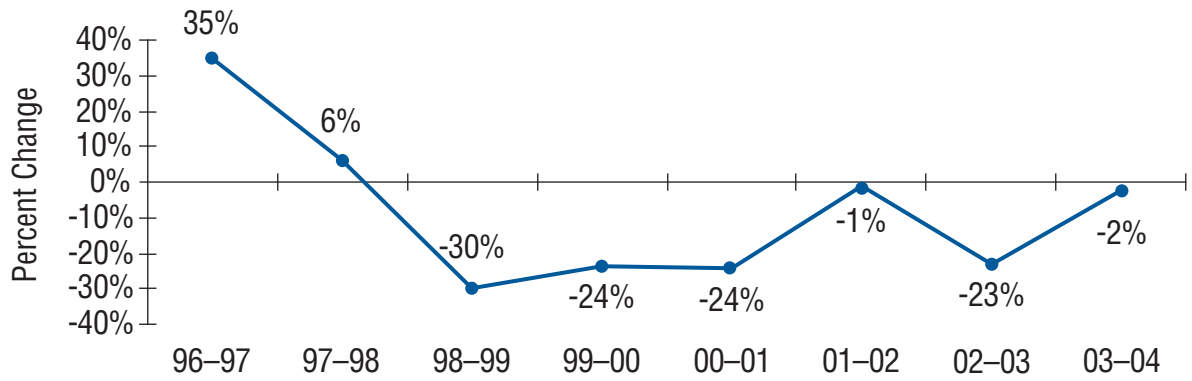
Note: Title II ADAP Earmark does not include Title II ADAP Supplemental Funds set-aside from FY 2001-2004. American Samoa, Guam, the Marshall Islands, N. Mariana Islands, and U.S. Virgin Islands did not report data and are not included.

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 (three percent of ADAP earmark funds are set aside for the ADAP supplemental awards for states with severe need, and these funds are counted separately in this report—see Chart 14). The Title II ADAP earmark—the largest component of the national ADAP budget—grew by $35.1 million (5%) between FY 2003 and 2004, to $728.0 million, its smallest increase since it began.

Chart 18
Title II Base Funding, FY 1996–2004



Title II Base Funding, Rate of Growth, FY 1996–2004

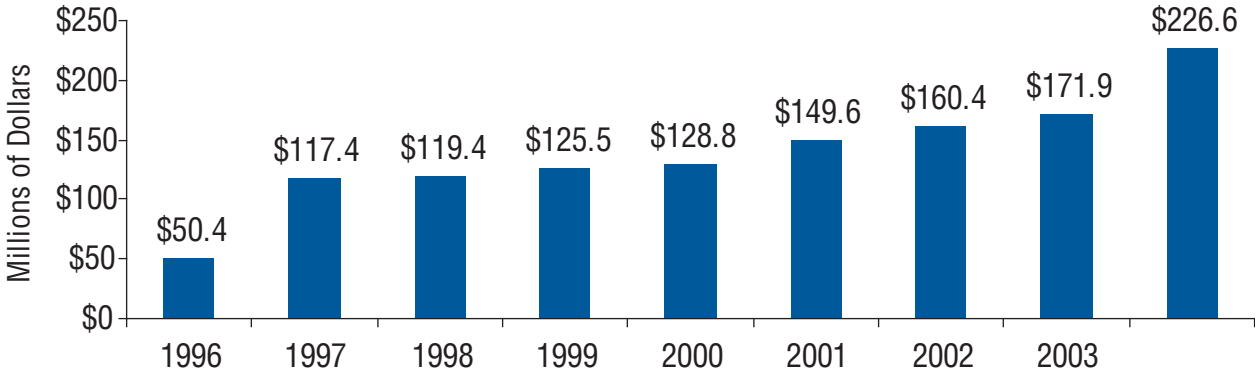


Note: American Samoa, Guam, the Marshall Islands, N. Mariana Islands, and U.S. Virgin Islands did not report data and are not included.

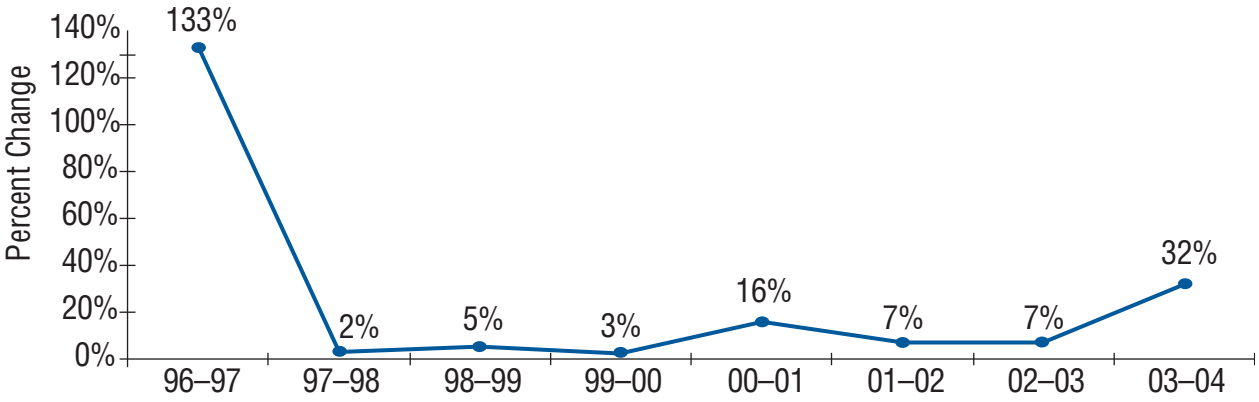
States receive CARE Act Title II base funds based on a formula and they are not required to allocate these funds to ADAPs. Contributions to ADAP from Title II base funds continued the downward trend seen since FY 1999, falling to $21.7 million in FY 2004—a decrease of $0.5 million, or 2%, over FY 2003. In FY 2004, 20 states allocated Title II base funds to their ADAP, down from 24 in FY 2003 (see Appendices VIII and X).

As noted in previous reports, these declines may be related to the need for states to increase funding for other services that can be supported by 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. Finally, these declines could also be related to changes in the amount of Title II base funding in many states; for example, the overall Title II base award declined by $4.1 million in FY 2004 and 35 states experienced declines in Title II base funding.

Chart 19
State Funding, FY 1996–2004



State Funding, Rate of Growth, FY 1996–2004



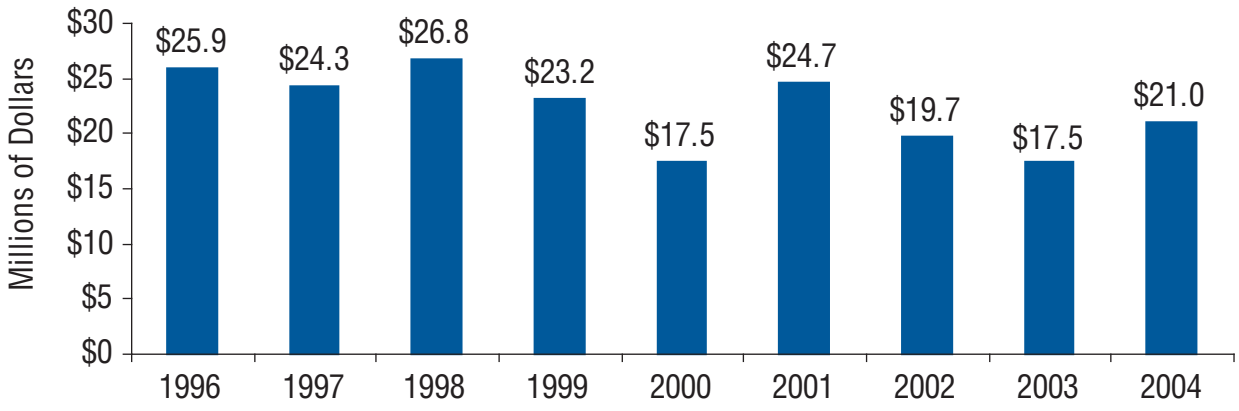
Note: American Samoa, Guam, the Marshall Islands, N. Mariana Islands, and U.S. Virgin Islands did not report data and are not included.

States are generally not required to provide state-only support to ADAPs, although many do. State funding of ADAPs reached $226.6 million in FY 2004, an increase of 32% over FY 2003 (a much greater rate of increase than in the past several years and the largest dollar increase of any component of the ADAP budget). State funding for ADAPs is the second largest component (19%) of the ADAP budget. Forty states contributed general revenue funds to ADAP in FY 2004, up from 39 in FY 2003 (see Appendices VIII and X).

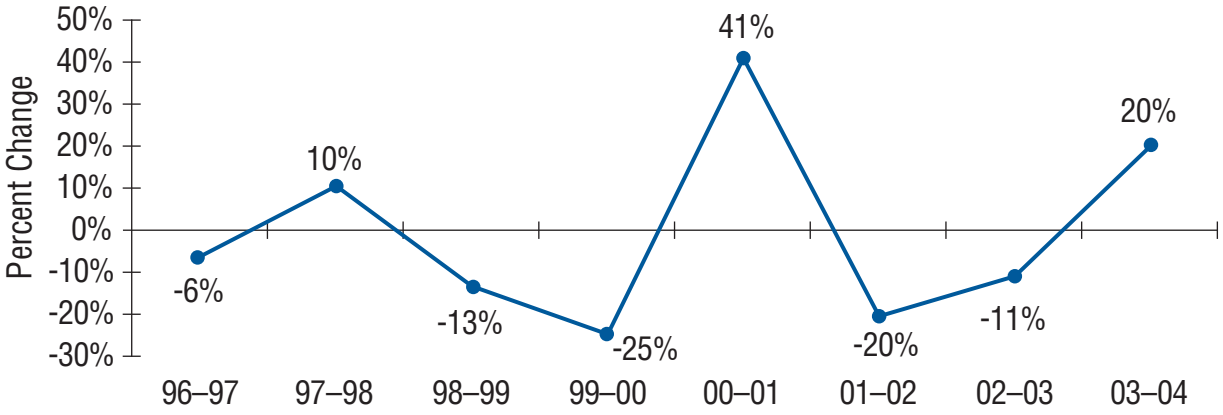
Some of these funds must be provided to ADAPs, due to state matching fund requirements. States are required to provide a 1:4 match (in cash or in-kind services) in order to receive ADAP supplemental award funding. In FY 2004, 15 of the 18 states receiving supplemental awards were required to provide this match: Alabama, Colorado, Georgia, Idaho, Kentucky, Louisiana, Montana, Nebraska, North Carolina, Oklahoma, South Carolina, Texas, Virginia, West Virginia, and Wisconsin. All of these states, except Louisiana, provided state matching funds to their ADAP (Louisiana provided in-kind support); of these 14 states, 12 also provided additional state funding beyond the required match. Three territories—Guam, Puerto Rico, and the U.S. Virgin Islands—received ADAP supplemental funding in FY 2004, but the CARE Act exempts territories from having to provide matching funds. In addition to this specific ADAP supplemental funding match requirement, states with greater than 1% of the nation's AIDS cases are required to match their overall Title II award (including ADAP earmark funds) with state funds. State funding provided to ADAPs counts toward meeting the required state match.

State funding for ADAPs varies significantly across the country, ranging from 0% in those states that did not provide such support to a high of 58% (New Mexico) in FY 2004 (see ES Table 1).

Chart 20
Title I EMA Funding, FY 1996–2004



Title I EMA Funding, Rate of Growth, FY 1996–2004



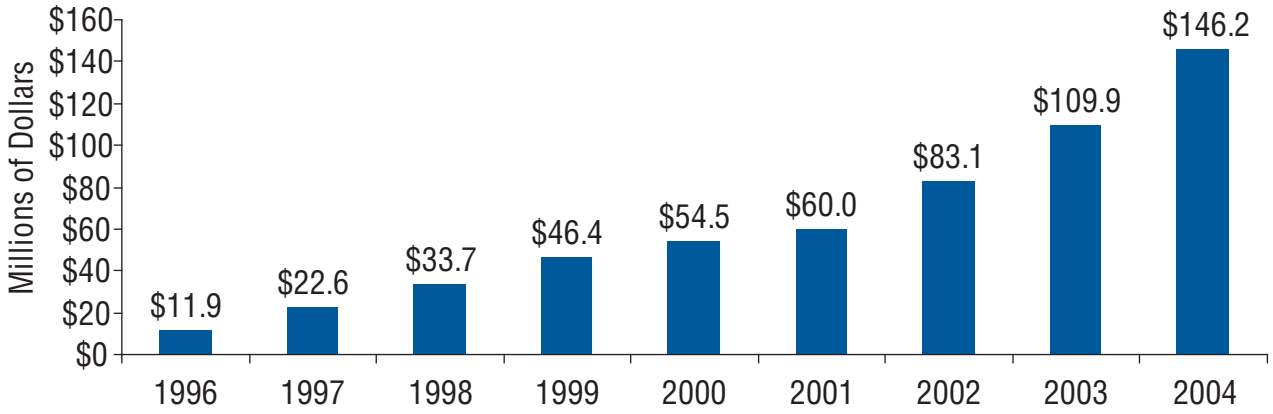
Note: American Samoa, Guam, the Marshall Islands, N. Mariana Islands, and U.S. Virgin Islands did not report data and are not included.

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. If a Planning Council chooses to allocate Title I dollars to their state's ADAP, these funds must be spent to purchase medications for clients living within the Title I eligible metropolitan area (EMA). Contributions to ADAP from Title I EMAs totaled $21.0 million in FY 2004, an increase of $3.5 million, or 20%, over FY 2003. These voluntary Title I contributions to ADAP represented 2% of the national ADAP budget in FY 2004, the same as in FY 2003.

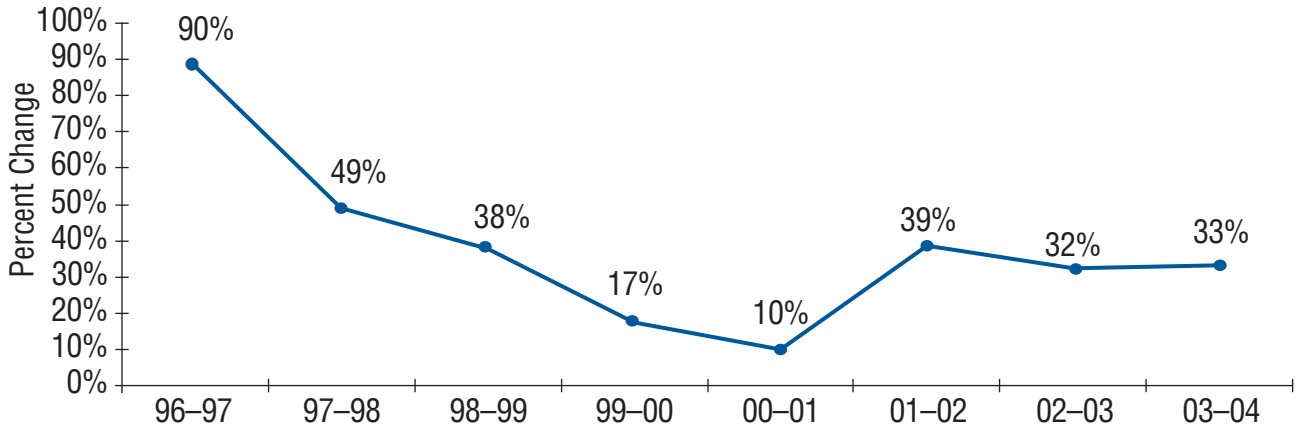
There are a total of 51 Title I EMAs across the country. Twenty-nine states/territories have a Title I EMA or a portion of a Title I EMA in their jurisdiction (four states have only a portion of an EMA in their state, with the grantee located in an adjacent state). In FY 2004, nine state ADAPs received contributions from Title I EMAs in their jurisdictions, compared to 12 in each of the prior two years (see Appendices VIII and X).

Despite fewer EMAs choosing to contribute Title I funding to state ADAPs in FY 2004, total Title I contributions increased over the last fiscal year. This is likely the result of increased Title I EMA contributions to ADAPs in two states.

Chart 21
Estimated Rebates, FY 1996–2004



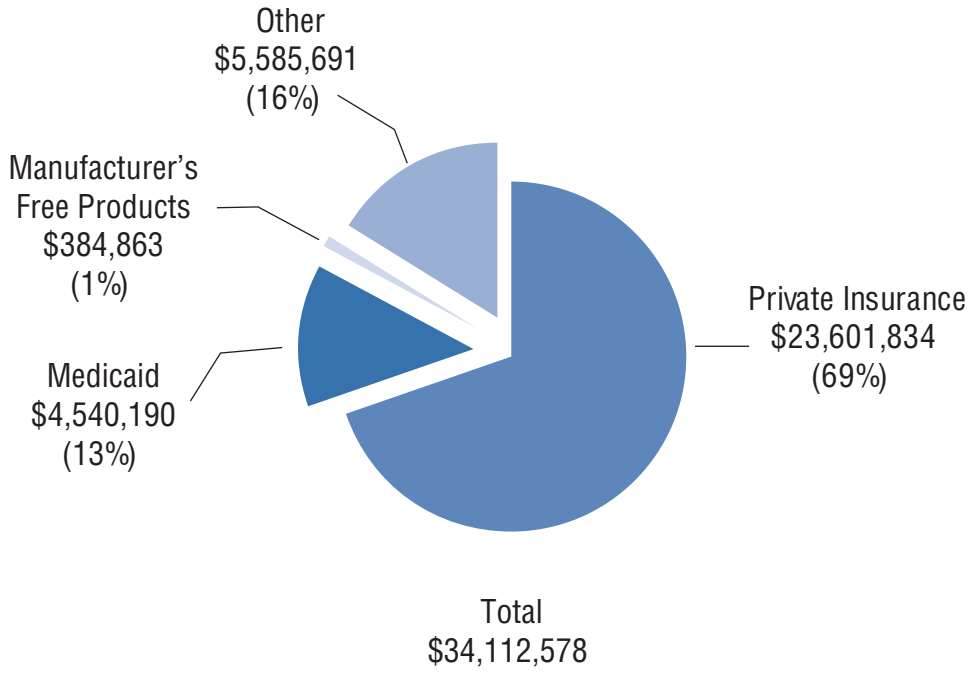
Estimated Rebates, Rate of Growth, FY 1996–2004



Note: American Samoa, Guam, the Marshall Islands, N. Mariana Islands, and U.S. Virgin Islands did not report data and are not included.

Estimated manufacturers' drug rebates totaled $146.2 million in FY 2004, an increase of $36.3 million, or 33%, over FY 2003 (a similar percentage increase as in the last two previous years). Funding from rebates is now the third largest component of the ADAP budget (12%), after the federal earmark and state funding. Drug rebates may be voluntary (such as those negotiated with manufacturers and the ADAP Crisis Task Force), mandated by state law, or mandated and available to ADAPs as 340B entities. The rebate data presented here do not include similar 340B discounts negotiated and mandated for ADAPs that directly purchase medications, since these rebates are realized at the time of purchase.

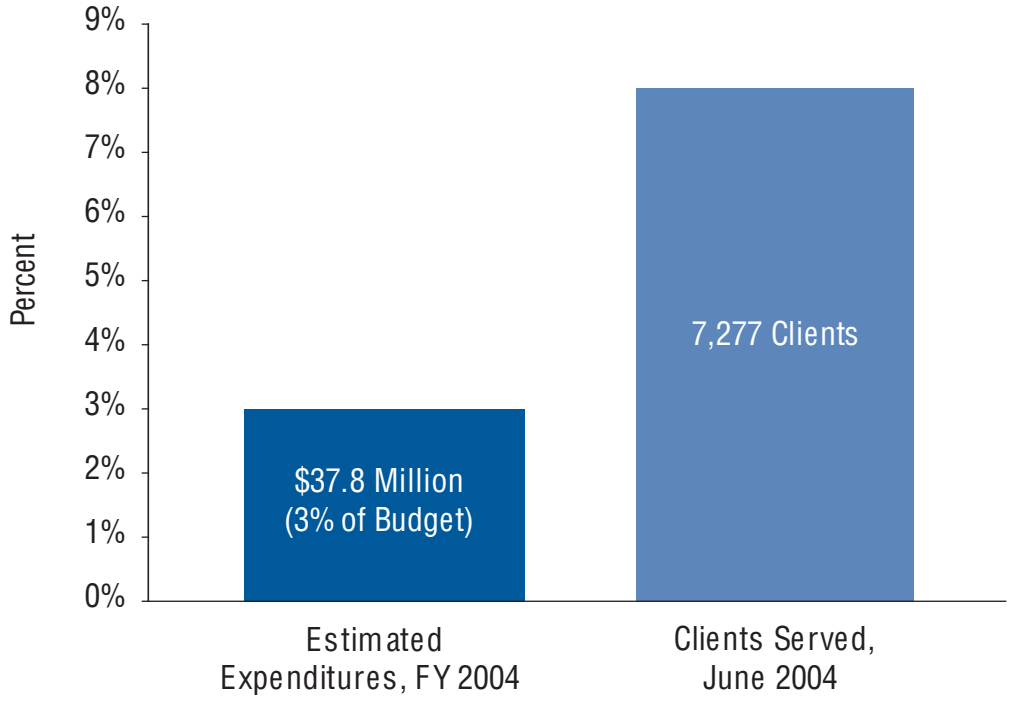
Chart 22
ADAP Cost Recovery and Other Cost Saving Mechanisms (Excluding Rebates), FY 2004



Note: Only states listing funding from cost recovery or other cost saving mechanisms are included (manufacturers' drug rebates are included in the National ADAP Budget—see Charts 14 and 21 for information on drug rebates). See Appendix XI for information on the 14 states that reported data on cost recovery or other cost saving mechanisms.

Cost recovery represents reimbursement to ADAPs from other entities for medications purchased through the ADAP. Cost recovery from sources other than rebates represented $34.1 million to ADAPs in FY 2004. Private insurance recovery, where an ADAP receives reimbursement from insurance providers for medications purchased for their clients, represents the primary recovery source ($23.6 million or 69%). Insurance recovery from Medicaid represents $4.5 million, or 13% of ADAP cost recovery. Other recovery ($6.0 million, or 17%) includes income received from sources such as private contributions or corporate donations as well as free products from manufacturers (negotiated with manufacturers and the ADAP Crisis Task Force).

Chart 23
Insurance Purchasing/Maintenance



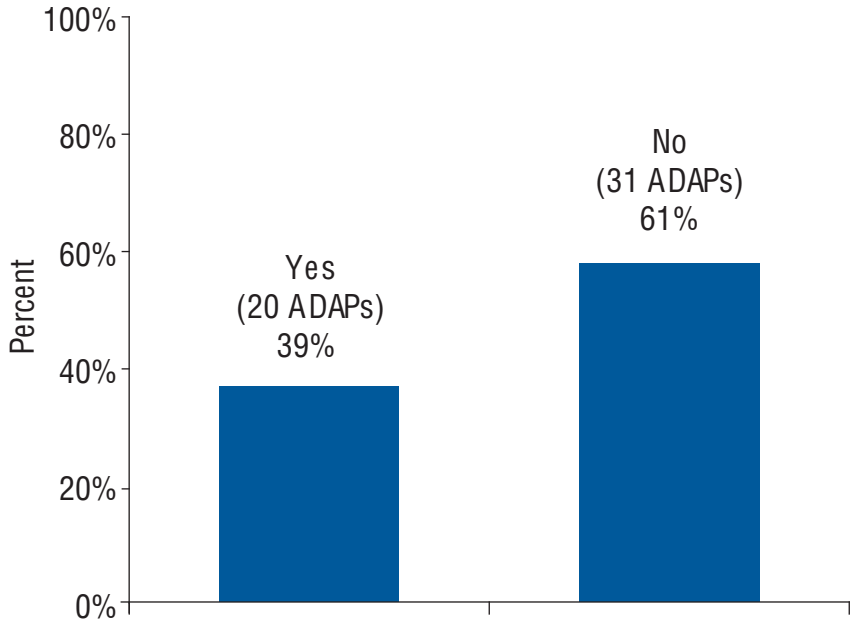
Note: American Samoa, Guam, the Marshal Islands, N. Mariana Islands, and U.S. Virgin Islands not included. See Appendix XII for a list of the 26 states that provide insurance purchasing/maintenance.

The Ryan White CARE Act allows states to use ADAP earmark dollars to purchase health insurance and pay insurance premiums for individuals eligible for ADAP, provided the insurance has comparable formulary benefits to that of the state ADAP. Twenty-six states (up from 22 states in FY 2003) reported that they were using ADAP funds for insurance purchasing and maintenance efforts, representing $37.8 million or 3% of the ADAP FY 2004 budget: Alaska, Colorado, Delaware, Indiana, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New York, Ohio, Oklahoma, Oregon, South Carolina, Tennessee, Utah, Vermont, Washington, and Wisconsin. In June 2004, an estimated 7,277 ADAP clients were served by these ADAPs with such arrangements (some of whom may have also received medications through ADAP).

Insurance purchasing and maintenance strategies appear to be cost effective—in June 2004, spending on insurance represented an estimated $433 per capita, significantly less than per capita drug expenditures in that month ($1,024).

In addition to funding ADAPs, states can also use Title II base and state funds for insurance purchasing/maintenance programs; data presented here represent only the funding provided by ADAPs.

Chart 24
ADAP Coverage of Insurance Co-Payments and/or Deductibles, June 2004

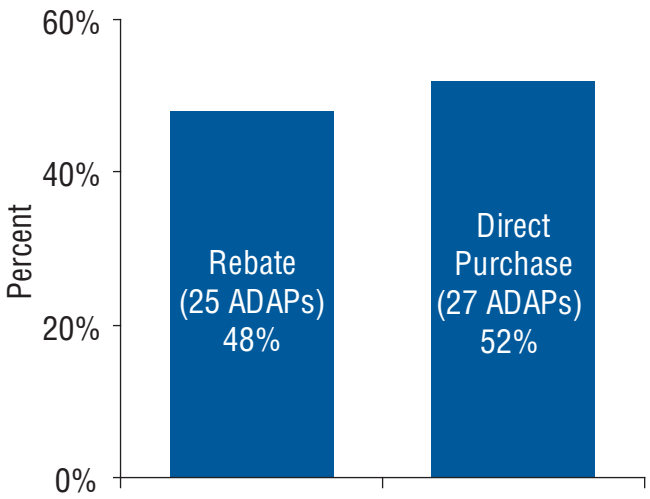


Note: American Samoa, Guam, the Marshall Islands, N. Mariana Islands, Rhode Island and U.S. Virgin Islands did not report this data and are not included.

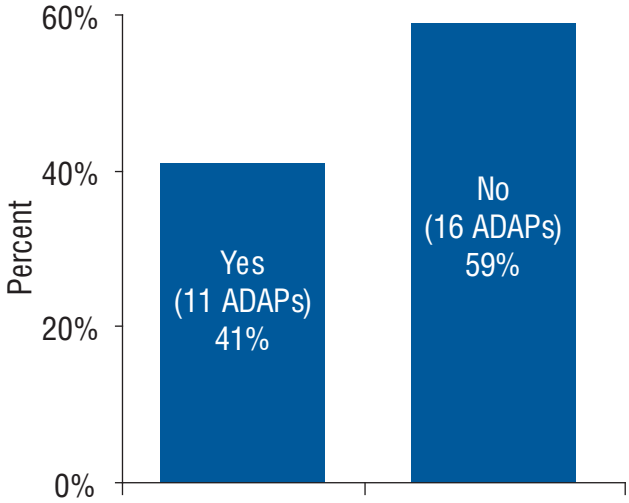
In June 1999, the Health Resources and Services Administration (HRSA), the federal agency responsible for fiscal and administrative oversight of Ryan White CARE Act programs, established a policy to allow states to use a portion of their ADAP earmark to pay for public and private health insurance co-payments and deductibles. In June 2004, 20 states reported using state and/or federal ADAP funds to cover insurance co-payments and deductibles: Alaska, Colorado, Delaware, Indiana, Iowa, Kansas, Louisiana, Maryland, Missouri, Montana, Nebraska, New Hampshire, Ohio, Oklahoma, Oregon, South Carolina, Tennessee, Utah, Vermont, and Washington.

Chart 25

ADAP Drug Purchasing Mechanisms, FY 2004



Direct Purchase ADAPs Participating in Federal Prime Vendor Program, FY 2004



Note: American Samoa, Guam, the Marshall Islands, N. Mariana Islands, and U.S. Virgin Islands not included. See Appendix XIV for information about ADAP drug purchasing and Prime Vendor participation.

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 (see NASTAD/KFF/ATDN, Issue Brief *AIDS Drug Assistance Programs—Getting the Best Price?*, April 2002 for more information).

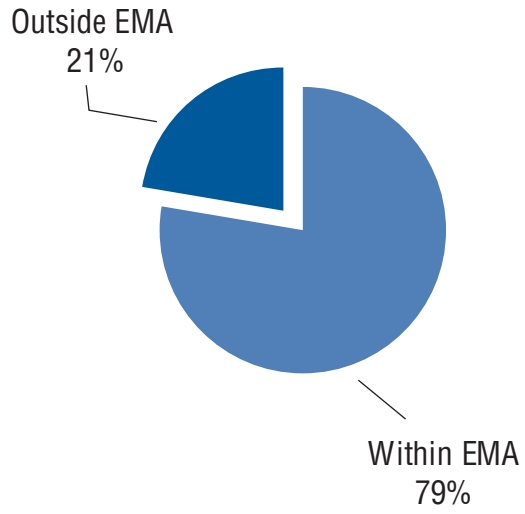
Participation in the 340B program is not mandatory but is strongly encouraged by HRSA, and all but one ADAP participates (51 of the 52 jurisdictions reporting data). States may purchase drugs either directly from wholesalers or through retail pharmacies and then apply to drug manufacturers for rebates. As of June 2004, 27 ADAPs reported purchasing drugs through the direct purchase option while 25 reported participation in the pharmacy network (rebate) option (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. Eleven of the 27 direct purchase ADAPs reported being enrolled in the HRSA prime vendor program in June 2004. As of March 2005, one antiretroviral HIV drug, Epzicom, was included on the list of drugs with negotiated supplemental discounts through the prime vendor.

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. Only one ADAP does not participate in the 340B program, the District of Columbia, which purchases drugs through the Department of Defense. This allows the DC ADAP to access the Federal Ceiling Price, a lower price only available to certain federal purchasers (see *AIDS Drug Assistance Programs—Getting the Best Price?*).

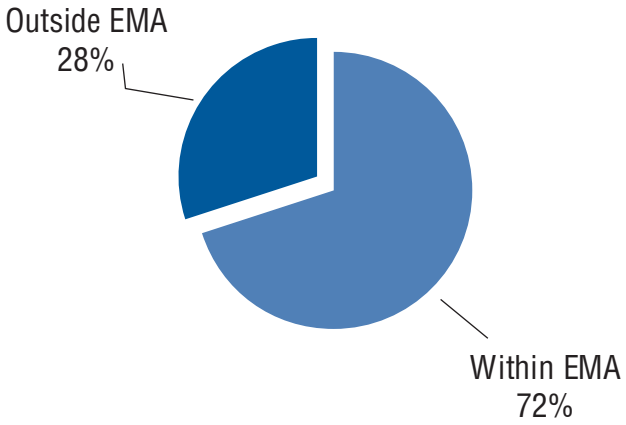
Chart 26

ADAP Clients Served in June 2004 Who Reside within Title I EMAs, in States with EMAs



Note: District of Columbia, North Carolina, Puerto Rico, and Wisconsin did not report data and are not included.

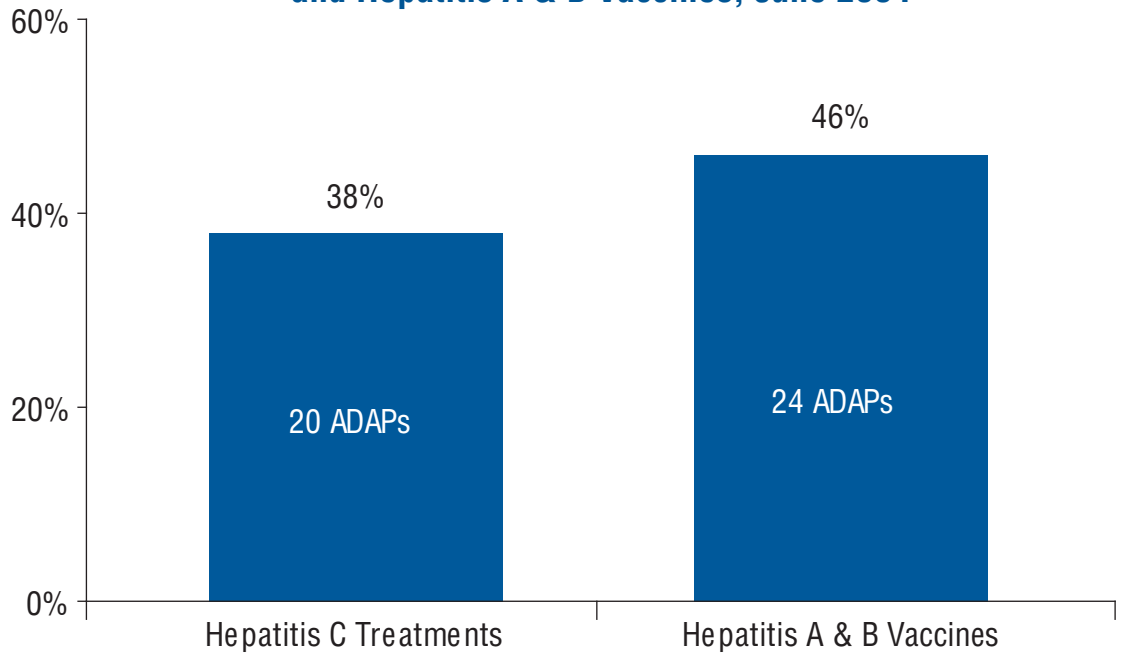
ADAP Clients Served in June 2004 Who Reside within Title I EMAs, in All States



Note: American Samoa, District of Columbia, Guam, the Marshall Islands, N. Mariana Islands, North Carolina, Puerto Rico, U.S. Virgin Islands and Wisconsin did not report data and 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. Fifty-one cities received Title I funding in FY2004. Most ADAP clients reside in Title I jurisdictions. In June 2004, among the 25 states with Title I EMAs reporting data, 79% of ADAP clients resided within a Title I jurisdiction. Seventy-two percent of *all* ADAP clients served in June 2004 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 XIII).

Chart 27
ADAP Formulary Coverage of Hepatitis C Treatments and Hepatitis A & B Vaccines, June 2004



Note: Twenty state/territorial ADAPs report coverage of HCV treatments: California, Connecticut, Delaware, District of Columbia, Maryland, Massachusetts, Michigan, Mississippi, Missouri, New Hampshire, New Jersey, New York, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Tennessee, Virginia, Washington and Wisconsin. Twenty-four state/territorial ADAPs report Hepatitis A & 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, Guam, the Marshall Islands, N. Mariana Islands and U.S. Virgin Islands did not report data and are not included.

Hepatitis A, B, and C infections are important considerations for people with HIV, and ADAPs have begun to play an increasing role in the provision of treatment and vaccines for all three. The relatively high co-infection rate of HIV and hepatitis C (HCV) (CDC estimates that up to 25% of those infected with HIV are co-infected with HCV*) led the Infectious Diseases Society of America/U.S. Public Health Service to define HCV as an opportunistic infection in their *Guidelines for the Prevention of Opportunistic Infections*. 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 to provide these treatments.

In June 2004, twenty states covered treatment for HCV on their ADAP formularies. 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.

In addition to coverage of HCV treatment, two states (New Hampshire and New York) report ADAP coverage of the following HCV diagnostics: HCV screening, qualitative HCV RNA, HCV genotype, and liver biopsy tests. Two additional states (Tennessee and Washington) report ADAP coverage for HCV genotypic tests.

Hepatitis A and B vaccines are recommended for those at high-risk for HIV and people living with HIV. In June 2004, twenty-four states reported covering hepatitis A and B vaccines on their ADAP formularies.

*Centers for Disease Control and Prevention, Frequently Asked Questions and Answers About Coinfection with HIV and Hepatitis C Virus. Available at www.cdc.gov/hiv/pubs/facts/HIV-HCV_Coinfection.htm (accessed March 23, 2005).

Appendices

Appendix I

Total Clients Enrolled/Served, Expenditures and Prescriptions Filled in June 2003 and June 2004

Total Clients Enrolled/Served, Expenditures and Prescriptions Filled in June 2003 and June 2004

State	June 2003 Total Clients Enrolled	June 2004 Total Clients Enrolled	% Change	June 2003 Clients Served	June 2004 Clients Served	% Change	June 2003 Expenditures	June 2004 Expenditures	% Change	June 2003 Total Rx	June 2004 Total Rx	% Change
Alabama	1,342	1,330	-1%	983	1,220	24%	$1,024,258	$1,100,169	7%	3,930	4,328	10%
Alaska	51	38	-25%	28	35	25%	$23,132	$33,241	44%	61	85	39%
American Samoa	NR	NR	NC	NR	NR	NC	NR	NR	NC	NR	NR	NC
Arizona	1,130	952	-16%	720	845	17%	$632,573	$786,422	24%	2,395	3,193	33%
Arkansas	442	413	-7%	350	376	7%	$299,554	$385,806	29%	1,226	1,467	20%
California	23,383	25,013	7%	16,275	18,263	12%	$16,309,776	$21,158,096	30%	66,815	80,991	21%
Colorado	1,070	815	-24%	805	667	-17%	$653,985	$556,710	-15%	2,270	1,974	-13%
Connecticut	1,291	1,524	18%	1,080	1,112	3%	$891,315	$1,285,997	44%	3,621	5,108	41%
Delaware	387	399	3%	198	226	14%	$195,808	$189,634	-3%	851	1,011	19%
District of Columbia	1,496	3,312	121%	906	809	-11%	$705,002	$826,434	17%	3,372	3,346	-1%
Florida	13,566	11,947	-12%	10,175	9,558	-6%	$6,356,906	$6,822,400	7%	8,996	31,252	247%
Georgia	5,167	5,798	12%	3,646	3,820	5%	$3,196,569	$3,343,888	5%	13,194	14,098	7%
Guam	NR	NR	NC	NR	NR	NC	NR	NR	NC	NR	NR	NC
Hawaii	303	259	-15%	181	223	23%	$139,938	$215,909	54%	718	946	32%
Idaho	96	109	14%	90	100	11%	$94,262	$132,732	41%	227	263	16%
Illinois	4,376	4,836	11%	2,899	3,234	12%	$1,356,240	$3,055,902	125%	9,357	10,772	15%
Indiana	134	28	-79%	45	13	-71%	$36,557	$17,818	-51%	120	57	-53%
Iowa	228	302	32%	173	203	17%	$92,682	$143,811	55%	534	691	29%
Kansas	407	535	31%	338	535	58%	$361,836	$407,281	13%	1,172	798	-32%
Kentucky	593	661	11%	467	555	19%	$341,958	$481,538	41%	1,540	1,972	28%
Louisiana	3,246	2,347	-28%	1,748	1,654	-5%	$1,391,062	$1,154,466	-17%	4,785	4,135	-14%
Maine	93	118	27%	50	42	-16%	$61,152	$63,794	4%	23	NR	NR
Marshall Islands	NR	NR	NC	NR	NR	NC	NR	NR	NC	NR	NR	NC
Maryland	2,389	2,697	13%	1,617	1,989	23%	$1,770,911	$2,390,384	35%	5,786	7,923	37%
Massachusetts	2,227	3,436	54%	864	2,291	165%	$689,924	$1,185,327	72%	3,645	12,278	237%
Michigan	1,150	1,400	22%	837	1,075	28%	$797,451	$1,146,876	44%	3,555	5,278	48%
Minnesota	948	998	5%	484	597	23%	$197,760	$241,503	22%	2,261	1,940	-14%
Mississippi	1,121	1,011	-10%	565	769	36%	$512,230	$711,348	39%	1,800	2,512	NA
Missouri	1,990	2,403	21%	1,137	1,402	23%	$957,294	$1,151,982	20%	4,793	5,221	9%
Montana	60	68	13%	50	53	6%	$33,801	$40,611	20%	144	163	13%
Nebraska	219	415	89%	154	181	18%	$88,536	$127,052	44%	411	635	55%
Nevada	678	725	7%	525	614	17%	$425,162	$519,849	22%	1,692	1,996	18%
New Hampshire	325	327	1%	174	183	5%	$185,517	$204,913	10%	1,093	324	-70%
New Jersey	4,711	5,366	14%	3,625	4,705	30%	$4,929,391	$5,964,042	21%	18,147	22,955	26%
New Mexico	431	568	32%	327	327	0%	$285,028	$332,800	17%	1,112	1,270	14%
New York	17,024	15,976	-6%	12,331	12,484	1%	$14,818,126	$18,756,730	27%	54,945	61,822	13%
North Carolina	3,113	2,575	-17%	1,898	1,843	-3%	$2,080,731	$2,281,607	10%	6,506	6,610	2%

Comparison Totals are based on only those states that reported data in both fiscal years. **NR** indicates data not reported. **NC** indicates no calculation due to missing data.

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Total Clients Enrolled/Served, Expenditures and Prescriptions Filled in June 2003 and June 2004

State	June 2003 Total Clients Enrolled	June 2004 Total Clients Enrolled	% Change	June 2003 Clients Served	June 2004 Clients Served	% Change	June 2003 Expenditures	June 2004 Expenditures	% Change	June 2003 Total Rx	June 2004 Total Rx	% Change
North Dakota	49	30	-39%	21	19	-10%	$13,080	$14,410	10%	63	49	-22%
N. Mariana Islands	1	NR	NC	1	NR	NC	$620	NR	NC	3	NR	NC
Ohio	2,452	1,671	-32%	1,941	1,271	-35%	$618,625	$774,009	25%	3,347	5,258	57%
Oklahoma	531	627	18%	504	533	6%	$428,613	$390,537	-9%	1,550	1,511	-3%
Oregon	861	741	-14%	755	656	-13%	$298,537	$246,367	-17%	1,869	2,307	23%
Pennsylvania	5,121	5,589	9%	2,478	2,971	20%	$2,614,051	$4,011,302	53%	7,645	13,019	70%
Puerto Rico	2,988	3,336	12%	2,032	3,154	55%	$2,123,658	$2,703,933	27%	12,679	15,462	22%
Rhode Island	482	642	33%	260	315	21%	$172,667	$254,455	47%	883	1,201	36%
South Carolina	1,953	2,126	9%	1,266	1,531	21%	$957,055	$1,117,558	17%	4,113	4,627	12%
South Dakota	52	83	60%	29	40	38%	$14,348	$33,028	130%	55	103	87%
Tennessee	667	843	26%	356	474	33%	$271,832	$363,351	34%	1,162	326	-72%
Texas	11,399	12,226	7%	7,007	8,060	15%	$5,250,466	$6,461,692	23%	18,367	23,057	26%
Utah	209	286	37%	173	170	-2%	$211,152	$116,136	-45%	6,194	547	-91%
Vermont	128	168	31%	63	99	57%	$29,639	$41,063	39%	149	302	103%
Virgin Islands	160	NR	NC	65	NR	NC	$57,993	NR	NC	197	NR	NC
Virginia	2,608	2,721	4%	1,571	1,812	15%	$1,373,887	$1,989,845	45%	4,999	6,314	26%
Washington	2,426	2,455	1%	1,026	926	-10%	$568,847	$665,866	17%	4,468	4,051	-9%
West Virginia	339	322	-5%	160	151	-6%	$155,890	$172,749	11%	461	438	-5%
Wisconsin	790	923	17%	354	357	1%	$269,548	$257,528	-4%	1,172	1,151	-2%
Wyoming	62	82	32%	18	35	94%	$25,234	$49,801	97%	67	134	100%
Total	**128,465**	**133,572**		**85,825**	**94,577**		**$77,392,171**	**$96,880,703**		**300,540**	**377,271**	
Comparison Total	***128,304***	***133,572***	***4%***	***85,759***	***94,577***	***10%***	***$77,333,558***	***$96,880,703***	***25%***	***300,317***	***377,271***	***26%***

Comparison Totals are based on only those states that reported data in both fiscal years. **NR** indicates data not reported. **NC** indicates no calculation due to missing data.

Appendix II

ADAP Drug Expenditures, by Class, June 2004

ADAP Drug Expenditures, by Class, June 2004

State	June 2004 Total Expenses	June 2004 NRTI Expenses	NRTI % of Total Expenses	June 2004 NNRTI Expenses	NNRTI % of Total Expenses	June 2004 PI Expenses	PI % of Total Expenses	June 2004 Fusion Inhibitor Expenses	Fusion Inhibitor % of Total Expenses	June 2004 PHS "A1" OI Expenses	PHS "A1" OI % of Total Expenses	June 2004 Other OI/Other Expenses	Other OI/Other % of Total Expenses
Alabama	$1,100,169	$579,565	53%	$162,723	15%	$285,509	26%	$4,154	0.4%	$67,881	6%	$336	0%
Alaska	$33,241	$15,522	47%	$4,262	13%	$11,448	34%	NA	NC	$488	1%	$1,521	5%
American Samoa	NR	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC
Arizona	$786,422	$389,331	50%	$81,899	10%	$224,596	29%	$9,744	1%	$60,523	8%	$20,329	3%
Arkansas	$385,806	$185,855	48%	$51,485	13%	$96,451	25%	$4,217	1%	$18,650	5%	$29,148	8%
California	$21,158,096	$9,546,202	45%	$2,410,319	11%	$5,963,610	28%	$86,094	0.4%	$879,283	4%	$2,272,587	11%
Colorado	$556,710	$301,936	54%	$78,398	14%	$176,376	32%	—	0%	—	0%	—	0%
Connecticut	$1,285,997	$573,044	45%	$145,505	11%	$316,829	25%	$25,700	2%	$29,616	2%	$195,302	15%
Delaware	$189,634	$92,660	49%	$18,926	10%	$43,759	23%	$1,253	0.7%	$4,988	3%	$28,048	15%
District of Columbia	$826,434	$397,478	48%	$85,235	10%	$203,279	25%	$1,244	0.2%	$29,421	4%	$109,777	13%
Florida	$6,822,400	$3,649,580	53%	$753,868	11%	$1,854,536	27%	$58,455	0.9%	$184,896	3%	$321,065	5%
Georgia	$3,343,888	$1,684,530	50%	$400,951	12%	$1,014,648	30%	—	0%	$110,196	3%	$133,563	4%
Guam	NR	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC
Hawaii	$215,909	$93,690	43%	$32,897	15%	$58,050	27%	NA	NC	NR	NC	$31,272	14%
Idaho	$132,732	$74,589	56%	$29,411	22%	$28,564	22%	NA	NC	$168	0.1%	—	0%
Illinois	$3,055,902	$1,567,097	51%	$451,510	15%	$622,240	20%	$61,783	2%	$63,587	2%	$289,685	9%
Indiana	$17,818	$8,362	47%	$2,951	17%	$4,786	27%	—	0%	$433	2%	$1,286	7%
Iowa	$143,811	$61,031	42%	$21,008	15%	$36,190	25%	$4,862	3%	$4,111	3%	$16,609	12%
Kansas	$407,281	$208,818	51%	$53,308	13%	$145,155	36%	—	0%	—	0%	—	0%
Kentucky	$481,538	$246,268	51%	$61,803	13%	$141,472	29%	NA	NC	$20,593	4%	$11,403	2%
Louisiana	$1,154,466	$533,237	46%	$184,581	16%	$408,997	35%	$27,652	2%	NA	NC	NA	NC
Maine	$63,794	$39,442	62%	$7,144	11%	$17,208	27%	NR	NC	NR	NC	NR	NC
Marshall Islands	NR	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC
Maryland	$2,390,384	$1,169,521	49%	$275,613	12%	$725,952	30%	$13,278	0.6%	$70,032	3%	$135,988	6%
Massachusetts	$1,185,327	$501,127	42%	$241,676	20%	$211,491	18%	$8,704	0.7%	$21,997	2%	$200,333	17%
Michigan	$1,146,876	$506,254	44%	$129,182	11%	$299,893	26%	$14,814	1%	$31,190	3%	$165,544	14%
Minnesota	$241,503	$131,522	54%	$38,237	16%	$46,283	19%	$2,261	0.9%	$7,852	3%	$15,348	6%
Mississippi	$711,348	$356,878	50%	$125,667	18%	$119,292	17%	$19,760	3%	$32,235	5%	$57,516	8%
Missouri	$1,151,982	$483,383	42%	$127,965	11%	$325,392	28%	$16,720	1%	$32,181	3%	$166,341	14%
Montana	$40,611	$22,078	54%	$7,932	20%	$8,604	21%	—	0%	$56	0.1%	$1,941	5%
Nebraska	$127,052	$69,951	55%	$15,405	12%	$38,344	30%	NA	NC	$2,183	2%	$1,169	1%
Nevada	$519,849	$274,508	53%	$63,161	12%	$157,763	30%	—	0%	$7,520	1%	$16,897	3%
New Hampshire	$204,913	$102,194	50%	$30,344	15%	$64,770	32%	—	0%	$7,605	4%	—	0%
New Jersey	$5,964,042	$2,435,191	41%	$655,710	11%	$1,548,826	26%	$53,056	0.9%	$133,487	2%	$1,137,772	19%

NR indicates data not reported. **NC** indicates not calculated due to missing data. **NA** indicates not applicable (drugs not on ADAP formulary)

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ADAP Drug Expenditures, by Class, June 2004

State	June 2004 Total Expenses	June 2004 NRTI Expenses	NRTI % of Total Expenses	June 2004 NNRTI Expenses	NNRTI % of Total Expenses	June 2004 PI Expenses	PI % of Total Expenses	June 2004 Fusion Inhibitor Expenses	Fusion Inhibitor % of Total Expenses	June 2004 PHS "A1" OI Expenses	PHS "A1" OI % of Total Expenses	June 2004 Other OI/Other Expenses	Other OI/Other % of Total Expenses
New Mexico	$332,800	$170,936	51%	$48,310	15%	$86,260	26%	NA	NC	$13,290	4%	$14,004	4%
New York	$18,756,730	$8,344,797	44%	$2,068,992	11%	$5,066,505	27%	$147,953	0.8%	$660,954	4%	$2,467,529	13%
North Carolina	$2,281,607	$1,196,388	52%	$315,352	14%	$642,101	28%	$21,460	0.9%	$68,082	3%	$38,224	2%
North Dakota	$14,410	$5,316	37%	$2,096	15%	$6,784	47%	NA	NC	$45	0.3%	$169	1%
N. Mariana Islands	NR	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC
Ohio	$774,009	$425,738	55%	$85,804	11%	$205,407	27%	$454	0.1%	$26,561	3%	$30,045	4%
Oklahoma	$390,537	$155,028	40%	$58,411	15%	$153,754	39%	—	0%	$16,245	4%	$7,100	2%
Oregon	$246,367	$28,397	12%	$34,024	14%	$44,923	18%	$6,040	2%	$7,026	3%	$125,957	51%
Pennsylvania	$4,011,302	$1,426,391	36%	$849,693	21%	$1,125,323	28%	$91,958	2%	$517,937	13%	—	0%
Puerto Rico	$2,703,933	$1,071,916	40%	$136,628	5%	$1,214,165	45%	$30,582	1%	$60,397	2%	$190,245	7%
Rhode Island	$254,455	$118,928	47%	$34,351	13%	$69,360	27%	$906	0.4%	$7,311	3%	$23,598	9%
South Carolina	$1,117,558	$619,986	55%	$166,259	15%	$263,878	24%	$13,169	1%	$32,376	3%	$21,889	2%
South Dakota	$33,028	$23,438	71%	$8,116	25%	NA	NC	NA	NC	$1,474	4%	—	0%
Tennessee	$363,351	$160,360	44%	$39,657	11%	$128,626	35%	$10,949	3%	$15,658	4%	$8,101	2%
Texas	$6,461,692	$3,566,748	55%	$754,080	12%	$1,854,679	29%	$35,447	0.5%	$161,130	2%	$89,608	1%
Utah	$116,136	$56,788	49%	$16,737	14%	$33,284	29%	—	0%	$9,326	8%	—	0%
Vermont	$41,063	$20,675	50%	$7,179	17%	$9,519	23%	$45	0.1%	$1,399	3%	$2,247	5%
Virgin Islands	NR	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC
Virginia	$1,989,845	$763,950	38%	$307,173	15%	$526,402	26%	$14,639	0.7%	$77,030	4%	$300,651	15%
Washington	$665,866	$249,179	37%	$96,655	15%	$163,685	25%	$8,285	1%	$16,579	2%	$131,483	20%
West Virginia	$172,749	$98,165	57%	$20,964	12%	$48,962	28%	NA	NC	$4,640	3%	$18	0%
Wisconsin	$257,528	$140,480	55%	$39,560	15%	$59,100	23%	$75	0%	$9,845	4%	$8,468	3%
Wyoming	$49,801	$23,274	47%	$8,165	16.4%	$16,137	32.4%	NA	NC	$914	2%	$1,311	3%
Total	**$96,880,703**	**$44,967,722**	**46%**	**$11,847,280**	**12%**	**$26,919,168**	**28%**	**$795,714**	**0.8%**	**$3,529,391**	**4%**	**$8,821,429**	**9%**

NR indicates data not reported. **NC** indicates not calculated due to missing data. **NA** indicates not applicable (drugs not on ADAP formulary)

Appendix III

ADAP Prescriptions Filled, by Class, June 2004

ADAP Prescriptions Filled, by Class, June 2004

State	June 2004 Total Rx	June 2004 NRTI Rx	NRTI % of Total Rx	June 2004 NNRTI Rx	NNRTI % of Total Rx	June 2004 Fusion Inhibitor Rx	Fusion Inhibitor % of Total Rx	June 2004 PI Rx	PI % of Total Rx	June 2004 "A1" OI Rx	"A1" OI % of Total Rx	June 2004 Other OI/Other Total Rx	Other OI/Other % of Total Rx
Alabama	4,328	2,063	48%	587	14%	3	0.1%	838	19%	738	17%	99	2%
Alaska	85	39	46%	11	13%	NA	NC	20	24%	12	14%	3	4%
American Samoa	NR	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC
Arizona	3,193	1,469	46%	364	11%	8	0.3%	614	19%	514	16%	224	7%
Arkansas	1,467	630	43%	206	14%	3	0.2%	272	19%	225	15%	131	9%
California	80,991	27,558	34%	7,627	9%	100	0%	12,316	15%	8,827	11%	24,563	30%
Colorado	1,974	1,127	57%	344	17%	0	0%	503	25%	0	0%	0	0%
Connecticut	5,108	1,706	33%	455	9%	14	0.3%	695	14%	356	7%	1,882	37%
Delaware	1,011	284	28%	69	7%	2	0.2%	132	13%	81	8%	443	44%
District of Columbia	3,346	1,128	34%	351	10%	1	0.0%	565	17%	442	13%	859	26%
Florida	31,252	16,359	52%	1,546	5%	48	0.2%	5,861	19%	4,033	13%	3,405	11%
Georgia	14,098	6,309	45%	1,731	12%	0	0%	2,988	21%	2,173	15%	897	6%
Guam	NR	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC
Hawaii	946	324	34%	144	15%	NA	NC	152	16%	0	0%	326	34%
Idaho	263	157	60%	59	22%	NA	NC	36	14%	0	0%	11	4%
Illinois	10,772	5,193	48%	1,778	17%	45	0.4%	1,702	16%	501	5%	1,553	14%
Indiana	57	21	37%	7	12%	0	0%	7	12%	4	7%	18	32%
Iowa	691	273	40%	98	14%	4	0.6%	150	22%	92	13%	74	11%
Kansas	798	453	57%	124	16%	0	0%	221	28%	0	0%	0	0%
Kentucky	1,972	888	45%	244	12%	NA	NC	380	19%	223	11%	237	12%
Louisiana	4,135	2,136	52%	808	20%	22	0.5%	1,169	28%	NA	NC	NA	NC
Maine	NR	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC
Marshall Islands	NR	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC
Maryland	7,923	3,310	42%	796	10%	7	0.1%	1,554	20%	871	11%	1,385	17%
Massachusetts	12,278	3,317	27%	1,100	9%	11	0.1%	646	5%	246	2%	6,958	57%
Michigan	5,278	1,526	29%	454	9%	12	0.2%	713	14%	342	6%	2,231	42%
Minnesota	1,940	579	30%	205	11%	6	0.3%	249	13%	67	3%	834	43%
Mississippi	2,512	1,027	41%	434	17%	13	0.5%	315	13%	414	16%	309	12%
Missouri	5,221	1,520	29%	454	9%	13	0.2%	650	12%	305	6%	2,279	44%
Montana	163	72	44%	28	17%	0	0%	27	17%	5	3%	31	19%
Nebraska	635	295	46%	93	15%	NA	NC	123	19%	65	10%	59	9%
Nevada	1,996	1,058	53%	278	14%	0	0%	337	17%	146	7%	177	9%

NR indicates data not reported. **NC** indicates not calculated due to missing data. **NA** indicates not applicable (drugs not on ADAP formulary).

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ADAP Prescriptions Filled, by Class, June 2004

State	June 2004 Total Rx	June 2004 NRTI Rx	NRTI % of Total Rx	June 2004 NNRTI Rx	NNRTI % of Total Rx	June 2004 Fusion Inhibitor Rx	Fusion Inhibitor % of Total Rx	June 2004 PI Rx	PI % of Total Rx	June 2004 "A1" OI Rx	"A1" OI % of Total Rx	June 2004 Other OI/Other Total Rx	Other OI/Other % of Total Rx
New Hampshire	324	63	19%	92	28%	0	0%	128	40%	41	13%	0	0%
New Jersey	22,955	7,379	32%	1,659	7%	34	0.1%	2,905	13%	1,336	6%	9,642	42%
New Mexico	1,270	569	45%	166	13%	0	0%	225	18%	165	13%	145	11%
New York	61,822	18,719	30%	5,070	8%	121	0.2%	7,956	13%	3,205	5%	26,751	43%
North Carolina	6,610	3,127	47%	866	13%	17	0.3%	1,332	20%	641	10%	627	9%
North Dakota	49	28	57%	1	2%	NA	NC	13	27%	3	6%	4	8%
N. Mariana Islands	NR	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC
Ohio	5,258	2,105	40%	682	13%	6	0.1%	840	16%	605	12%	1,020	19%
Oklahoma	1,511	632	42%	242	16%	0	0%	514	34%	70	5%	53	4%
Oregon	2,307	82	4%	145	6%	21	0.9%	185	8%	42	2%	1,832	79%
Pennsylvania	13,019	3,602	28%	2,334	18%	51	0.4%	2,026	16%	5,006	38%	0	0%
Puerto Rico	15,462	3,704	24%	527	3%	24	0.2%	5,272	34%	1,145	7%	4,790	31%
Rhode Island	1,201	496	41%	150	12%	3	0.2%	213	18%	70	6%	269	22%
South Carolina	4,627	2,205	48%	703	15%	11	0.2%	752	16%	520	11%	436	9%
South Dakota	103	59	57%	22	21%	NA	NC	NA	NC	22	21%	NA	NC
Tennessee	326	78	24%	23	7%	3	0.9%	57	17%	92	28%	73	22%
Texas	23,057	13,353	58%	3,260	14%	30	0.1%	4,748	21%	1,365	6%	301	1%
Utah	547	246	45%	79	14%	0	0%	103	19%	119	22%	0	0%
Vermont	302	123	41%	40	13%	1	0.3%	44	15%	30	10%	64	21%
Virgin Islands	NR	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC
Virginia	6,314	2,260	36%	918	15%	13	0.2%	1,067	17%	1,006	16%	1,050	17%
Washington	4,051	1,102	27%	422	10%	5	0.1%	536	13%	328	8%	1,658	41%
West Virginia	438	239	55%	58	13%	NA	NC	88	20%	51	12%	2	0%
Wisconsin	1,151	547	48%	180	16%	3	0.3%	197	17%	133	12%	91	8%
Wyoming	134	49	37%	19	14%	NA	NC	18	13%	20	15%	28	21%
Total	**377,271**	**141,588**	**38%**	**38,053**	**10%**	**655**	**0.2%**	**62,454**	**17%**	**36,697**	**10%**	**97,824**	**26%**

NR indicates data not reported. **NC** indicates not calculated due to missing data. **NA** indicates not applicable (drugs not on ADAP formulary).

Appendix IV

Race/Ethnicity of June 2004 ADAP Clients

Race/Ethnicity of June 2004 ADAP Clients

State	June 2004 Clients	African American	White/ Non-Hispanic	Hispanic	Asian	Native Hawaiian/ Pacific Islander	American Indian/ Alaskan Native	Other	Unknown
Alabama	1,220	58%	39%	1%	1%	0%	1%	0%	0%
Alaska	35	5%	66%	26%	3%	0%	0%	0%	0%
American Samoa	NR	NR	NR	NR	NR	NR	NR	NR	NR
Arizona	845	7%	60%	31%	1%	0%	1%	0%	0%
Arkansas	376	69%	24%	2%	3%	0%	0%	4%	0%
California	18,263	12%	44%	38%	2%	0%	0%	2%	2%
Colorado	667	11%	61%	25%	1%	1%	1%	0%	0%
Connecticut	1,112	38%	37%	24%	0%	0.1%	0.4%	0%	0%
Delaware	226	54%	39%	1%	0%	0%	0.4%	4%	1%
District of Columbia	809	77%	11%	9%	0%	0.4%	0.5%	3%	0%
Florida	9,558	40%	25%	26%	0.2%	0%	0.1%	8%	0%
Georgia	3,820	64%	29%	5%	0%	0%	0%	1%	1%
Guam	NR	NR	NR	NR	NR	NR	NR	NR	NR
Hawaii	223	3%	59%	10%	14%	9%	5%	0%	0%
Idaho	100	1%	80%	15%	1%	0%	3%	0%	0%
Illinois	3,234	40%	35%	22%	1%	0%	0%	1%	1%
Indiana	13	15%	62%	15%	0%	0%	0%	8%	0%
Iowa	203	20%	65%	13%	1%	0%	0%	1%	0%
Kansas	535	21%	64%	12%	1%	1%	1%	0%	0%
Kentucky	555	26%	68%	4%	0.1%	0.1%	0.3%	1%	0.5%
Louisiana	1,654	57%	39%	3%	0%	0%	1%	0%	0%
Maine	42	NR	NR	NR	NR	NR	NR	NR	NR
Marshall Islands	NR	NR	NR	NR	NR	NR	NR	NR	NR
Maryland	1,989	67%	20%	4%	1%	1%	1%	3%	3%
Massachusetts	2,291	22%	43%	23%	2%	0%	0%	10%	0%
Michigan	1,075	37%	55%	6%	1%	0%	0.8%	0%	0%
Minnesota	597	21%	57%	12%	2%	0%	2%	0%	6%
Mississippi	769	70%	28%	0.3%	0.9%	0.0%	0.1%	0.1%	0%
Missouri	1,402	41%	57%	1%	0%	0%	0%	1%	0%
Montana	53	4%	88%	0%	0%	0%	8%	0%	0%
Nebraska	181	20%	56%	20%	0%	0%	1%	3%	0%
Nevada	614	18%	56%	22%	2%	0%	1%	0%	1%
New Hampshire	183	13%	75%	10%	0%	0%	0%	0%	2%
New Jersey	4,705	52%	22%	24%	1%	0%	0%	1%	0%
New Mexico	327	4%	44%	46%	0%	0%	5%	1%	0%
New York	12,484	39%	27%	29%	2%	0%	1%	0%	2%
North Carolina	1,843	55%	34%	9%	0%	0%	1%	1%	0%
North Dakota	19	10%	77%	0%	0%	0%	13%	0%	0%
N. Mariana Islands	NR	NR	NR	NR	NR	NR	NR	NR	NR
Ohio	1,271	29%	62%	5%	0%	0%	0%	2%	2%
Oklahoma	533	17%	70%	5%	0%	0%	7%	1%	0%
Oregon	656	5%	63%	15%	1%	2%	2%	7%	5%
Pennsylvania	2,971	39%	43%	8%	1%	1%	1%	0%	7%
Puerto Rico	3,154	0%	0%	100%	0%	0%	0%	0%	0%
Rhode Island	315	17%	64%	17%	1%	0%	0%	1%	0%
South Carolina	1,531	69%	26%	4%	1%	0%	0%	0%	0%
South Dakota	40	15%	75%	3%	0%	0%	7%	0%	0%
Tennessee	474	61%	29%	9%	0%	0%	0%	1%	0%
Texas	8,060	27%	37%	34%	0.6%	0%	0.2%	0.1%	1%
Utah	170	8%	57%	28%	0%	0%	1%	5%	1%
Vermont	99	6%	85%	6%	1%	0%	0%	2%	0%
Virgin Islands	NR	NR	NR	NR	NR	NR	NR	NR	NR
Virginia	1,812	52%	34%	7%	1%	0%	0%	0%	6%
Washington	926	11%	55%	16%	1%	1%	2%	6%	8%
West Virginia	151	9%	90%	0%	1%	0%	0%	0%	0%
Wisconsin	357	28%	56%	13%	1%	0%	1%	1%	0%
Wyoming	35	6%	76%	13%	1%	0%	4%	0%	0%
Total	**94,577**	**34%**	**36%**	**26%**	**1%**	**<1%**	**<1%**	**2%**	**1%**

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

Appendix V

Gender and Age of June 2004 ADAP Clients

Gender and Age of June 2004 ADAP Clients

State	June 2004 Clients	Gender				Age						
		Male	Female	Transgender	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	1,220	75%	25%	0%	0%	0%	0%	2%	60%	36%	2%	0%
Alaska	35	74%	26%	0%	0%	0%	0%	3%	55%	39%	3%	0%
American Samoa	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Arizona	845	86%	13%	0%	1%	0%	1%	2%	64%	31%	2%	0%
Arkansas	376	89%	11%	0%	0%	0%	0%	13%	69%	18%	0%	0%
California	18,263	91%	9%	0%	0%	0%	0%	1%	60%	37%	2%	0%
Colorado	667	88%	12%	0%	0%	0%	0%	1%	53%	45%	1%	0%
Connecticut	1,112	71%	29%	0%	0%	0%	0.3%	1%	53%	43%	2%	0%
Delaware	226	71%	29%	0%	0%	0%	0%	2%	54%	42%	2%	0%
District of Columbia	809	79%	21%	0%	0%	0%	0%	2%	47%	44%	7%	0%
Florida	9,558	72%	28%	0%	0%	1%	1%	2%	57%	37%	2%	0%
Georgia	3,820	77%	23%	0%	0%	0%	0%	2%	58%	38%	2%	0%
Guam	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Hawaii	223	91%	8%	1%	0%	0%	0%	0%	47%	50%	3%	0%
Idaho	100	79%	21%	0%	0%	0%	0%	3%	55%	38%	4%	0%
Illinois	3,234	84%	16%	0%	0%	0%	0%	2%	59%	35%	2%	2%
Indiana	13	85%	15%	0%	0%	0%	0%	8%	15%	23%	54%	0%
Iowa	203	80%	19%	1%	0%	0%	0%	1%	68%	31%	0%	0%
Kansas	535	78%	21%	1%	0%	0%	1%	1%	57%	40%	1%	0%
Kentucky	555	84%	15%	1%	0%	0%	1%	1%	56%	41%	1%	0%
Louisiana	1,654	77%	23%	0%	0%	0%	0%	2%	56%	40%	2%	0%
Maine	42	86%	14%	0%	1%	0%	1%	2%	44%	50%	3%	0%
Marshall Islands	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Maryland	1,989	65%	35%	0%	0%	0%	0.5%	2%	55%	40%	3%	0%
Massachusetts	2,291	71%	29%	0%	0%	0%	1%	1%	53%	42%	3%	0%
Michigan	1,075	85%	15%	0%	0%	0%	0%	1%	61%	36%	2%	0%
Minnesota	597	82%	18%	0%	0%	0%	1%	1%	63%	34%	1%	0%
Mississippi	769	69%	31%	0%	0%	0.7%	0.4%	3%	62%	33%	2%	0%
Missouri	1,402	84%	16%	0%	0%	0%	0%	3%	68%	28%	1%	0%
Montana	53	77%	23%	0%	0%	0%	0%	4%	52%	40%	4%	0%
Nebraska	181	83%	17%	0%	0%	0%	0%	2%	67%	29%	2%	0%
Nevada	614	82%	17%	1%	0%	0%	1%	3%	61%	33%	2%	0%
New Hampshire	183	73%	27%	0%	0%	0%	0%	1%	60%	39%	0%	0%
New Jersey	4,705	67%	33%	0%	0%	0%	1%	3%	54%	41%	1%	0%
New Mexico	327	93%	6%	1%	0%	0%	0%	1%	58%	40%	1%	0%
New York	12,484	74%	25%	1%	0%	0%	1%	3%	54%	39%	3%	0%
North Carolina	1,843	74%	26%	0%	0%	0%	0%	2%	57%	39%	2%	0%
North Dakota	19	89%	11%	0%	0%	0%	0%	6%	60%	34%	0%	0%
N. Mariana Islands	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Ohio	1,271	83%	16%	0%	1%	0%	1%	2%	58%	37%	2%	0%
Oklahoma	533	83%	17%	0	0%	0%	0%	2%	69%	28%	1%	0%
Oregon	656	88%	12%	0.3%	0%	0.2%	0.1%	1%	52%	44%	3%	0%
Pennsylvania	2,971	79%	20%	0%	1%	0%	1%	1%	52%	43%	3%	0%
Puerto Rico	3,154	66%	34%	0%	0%	0%	2%	4%	48%	42%	4%	0%
Rhode Island	315	80%	20%	0%	0%	0%	0%	2%	49%	47%	2%	0%
South Carolina	1,531	71%	29%	0%	0%	0%	0.8%	2%	58%	38%	1%	0%
South Dakota	40	68%	32%	0%	0%	0%	0%	0%	58%	40%	2%	0%
Tennessee	474	78%	21%	1%	0%	0%	0%	8%	71%	18%	0%	3%
Texas	8,060	81%	19%	0%	0%	0%	0.2%	2%	59%	37%	2%	0%
Utah	170	86%	14%	0%	0%	0%	0%	4%	73%	22%	1%	0%
Vermont	99	85%	15%	0%	0%	0%	0%	2%	51%	47%	0%	0%
Virgin Islands	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Virginia	1,812	71%	29%	0%	0%	0%	0%	2%	60%	36%	2%	0%
Washington	926	87%	12%	1%	0%	0%	0%	2%	64%	33%	1%	0%
West Virginia	151	87%	13%	0%	0%	0%	1%	0%	89%	10%	0%	0%
Wisconsin	357	84%	15%	1%	0%	0%	1%	5%	64%	29%	1%	0%
Wyoming	35	73%	27%	0%	0%	0%	1%	1%	58%	38%	2%	0%
TOTAL	**94,577**	**79%**	**21%**	**0.2%**	**0.1%**	**0.1%**	**0.5%**	**2%**	**57%**	**38%**	**2%**	**0.1%**

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

Appendix VI

Income Level and Insurance Status of June 2004 ADAP Clients

Income Level and Insurance Status of June 2004 ADAP Clients

State	June 2004 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
Alabama	1220	75%	15%	10%	0%	0%	0%	0%	UN	UN	UN
Alaska	35	26%	45%	29%	0%	0%	0%	0%	5%	0%	13%
American Samoa	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Arizona	845	34%	66%	0%	0%	0%	0%	0%	45%	UN	UN
Arkansas	376	23%	70%	4%	2%	0%	0%	0%	31%	0%	0%
California	18,263	40%	35%	16%	8%	1%	0%	12%	UN	UN	22%
Colorado	667	71%	25%	4%	0%	0%	0%	0%	46%	0%	3%
Connecticut	1,112	30%	47%	19%	4%	0%	0%	UN	UN	UN	55%
Delaware	226	32%	40%	17%	7%	3%	1%	6%	5%	0%	21%
District of Columbia	809	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Florida	9,558	91%	8%	1%	0%	0%	0%	1%	1%	1%	2%
Georgia	3,820	48%	43%	9%	0%	0%	1%	UN	UN	UN	UN
Guam	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Hawaii	223	40%	45%	14%	1%	0%	0%	0%	32%	UN	6%
Idaho	100	51%	49%	0%	0%	0%	0%	0%	5%	UN	2%
Illinois	3,234	31%	33%	22%	12%	1%	1%	12%	UN	UN	3%
Indiana	13	8%	76%	16%	0%	0%	0%	0%	8%	0%	0%
Iowa	203	53%	47%	0%	0%	0%	0%	0%	UN	UN	1%
Kansas	535	63%	30%	7%	0%	0%	1%	6%	20%	10%	10%
Kentucky	555	40%	41%	15%	3%	1%	0%	0%	47%	0%	23%
Louisiana	1,654	46%	7%	1%	0%	0%	46%	1%	12%	UN	1%
Maine	42	NR	NR	NR	NR	NR	NR	UN	UN	UN	UN
Marshall Islands	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Maryland	1,989	18%	38%	31%	12%	1%	1%	0%	UN	UN	15%
Massachusetts	2,291	46%	22%	16%	10%	6%	0%	23%	1%	1%	51%
Michigan	1,075	24%	48%	18%	7%	3%	0%	22%	24%	0%	27%
Minnesota	597	36%	44%	20%	0%	0%	25%	UN	UN	UN	UN
Mississippi	769	61%	32%	6%	1%	0%	0.6%	1%	6%	0%	0%
Missouri	1,402	46%	37%	17%	0%	0%	0%	22%	9%	4%	23%
Montana	53	42%	38%	16%	2%	0%	2%	0%	17%	0%	8%
Nebraska	181	20%	80%	0%	0%	0%	0%	0%	12%	15%	15%
Nevada	614	10%	30%	50%	10%	0%	0%	0%	12%	12%	12%
New Hampshire	183	32%	45%	15%	2%	0%	6%	0%	32%	0%	28%
New Jersey	4,705	50%	19%	14%	9%	8%	0%	0%	4%	0%	24%
New Mexico	327	56%	34%	10%	0%	0%	0%	0%	41%	5%	0%
New York	12,484	45%	31%	14%	7%	3%	0%	8%	9%	0%	13%
North Carolina	1,843	90%	10%	0%	0%	0%	0%	UN	UN	UN	0%
North Dakota	19	32%	37%	5%	26%	0%	0%	0%	13%	NR	60%
N. Mariana Islands	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Ohio	1,271	35%	44%	17%	2%	2%	0%	2%	8%	1%	24%
Oklahoma	533	38%	62%	0%	0%	0%	0%	5%	19%	5%	23%
Oregon	656	38%	53%	9%	0%	0%	0%	0%	28%	UN	UN
Pennsylvania	2,971	12%	33%	19%	4%	1%	31%	0%	4%	UN	13%
Puerto Rico	3,154	90%	0%	0%	0%	0%	10%	UN	UN	UN	UN
Rhode Island	315	16%	44%	12%	7%	0%	21%	NR	NR	NR	NR
South Carolina	1,531	60%	26%	10%	3%	1%	0%	0%	0%	UN	15%
South Dakota	40	40%	51%	8%	0%	1%	0%	3%	15%	NR	25%
Tennessee	474	64%	25%	6%	1%	4%	0%	UN	UN	UN	UN
Texas	8,060	65%	35%	0%	0%	0%	0%	11%	8%	UN	5%
Utah	170	48%	32%	16%	4%	0%	0%	2%	4%	UN	21%
Vermont	99	67%	33%	0%	0%	0%	0%	31%	UN	UN	28%
Virgin Islands	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Virginia	1,812	65%	23%	6%	2%	0%	4%	3%	3%	1%	UN
Washington	926	40%	30%	23%	7%	0%	0%	0%	15%	0%	47%
West Virginia	151	55%	30%	15%	0%	0%	0%	UN	UN	UN	4%
Wisconsin	357	43%	31%	26%	0%	0%	5%	5%	4%	0%	49%
Wyoming	35	20%	80%	0%	0%	0%	0%	UN	UN	UN	UN
TOTAL	**94,577**	**51%**	**29%**	**11%**	**4%**	**1%**	**3%**	**7%**	**9%**	**1%**	**15%**

NR indicates data not reported. **UN** indicates unknown—state is unable to report. Percentages may not total 100% due to rounding.

Overall percentage of insured is calculated using only states that reported data.

Appendix VII

ADAP Clients, With Reported Health Status (CD4 Count), Enrolled During 12-Month Period, June 2004

ADAP Clients, With Reported Health Status (CD4 Count), Enrolled During 12-Month Period, June 2004

State	Clients Enrolled With Reported Health Status- 12 Month Period	% with CD4 <200	% with CD4 between 201–350	% with CD4 between 351–500	% with CD4 >500
California	20,210	22%	23%	22%	34%
Colorado	489	51%	20%	12%	16%
Delaware	195	28%	20%	25%	27%
Florida	2,969	46%	24%	14%	16%
Hawaii	268	24%	28%	28%	19%
Idaho	105	13%	28%	24%	35%
Illinois	4,488	44%	8%	14%	34%
Indiana	114	25%	24%	11%	39%
Iowa	132	20%	26%	21%	33%
Kentucky	125	46%	20%	13%	22%
Louisiana	410	27%	22%	20%	31%
Maryland	3,002	29%	23%	21%	27%
Massachusetts	3,607	22%	21%	20%	37%
Michigan	1,075	39%	23%	16%	22%
Minnesota	309	19%	23%	21%	37%
Mississippi	343	44%	27%	14%	15%
Montana	24	42%	38%	8%	13%
New Hampshire	321	37%	23%	19%	21%
New Jersey	6,958	29%	21%	19%	32%
New Mexico	100	28%	25%	17%	30%
New York	2,780	38%	20%	18%	24%
North Carolina	3,809	24%	22%	22%	33%
North Dakota	5	20%	0%	40%	40%
Ohio	2,409	35%	19%	17%	29%
Oklahoma	566	21%	25%	23%	31%
Oregon	486	20%	29%	23%	28%
South Carolina	946	25%	20%	19%	36%
South Dakota	53	47%	0%	6%	47%
Tennessee	98	45%	23%	13%	18%
Utah	253	29%	26%	24%	21%
Vermont	47	32%	21%	19%	28%
Virginia	374	39%	22%	21%	17%
Wisconsin	873	20%	21%	23%	36%
TOTAL	**57,943**	**29%**	**21%**	**20%**	**31%**

Chart reflects only those states able to provide this information.

Some states require annual re-enrollment; therefore chart does not reflect new clients exclusively.

Percentages do not total 100% due to rounding.

Appendix VIII

ADAP Budget FY 2004, by Source

ADAP Budget FY 2004, by Source

State	Title II ADAP Earmark	% of Total Budget	Title II ADAP Supplemental	% of Total Budget	Title II Base	% of Total Budget	State Funding	% of Total Budget	Title I	% of Total Budget	Other State/Federal	% of Total Budget	Estimated Drug Rebates	% of Total Budget	Total Federal/State
Alabama	$7,004,635	76%	$824,913	9%	$827,090	9%	$560,000	6%	—	0%	—	0%	—	0%	$9,216,638
Alaska	$472,602	85%	—	0%	—	0%	$14,398	3%	—	0%	—	0%	$68,000	12%	$555,000
American Samoa	$2,314	NC	—	0%	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC	$2,314
Arizona	$8,392,903	89%	—	0%	—	0%	$1,000,000	11%	—	0%	—	0%	—	0%	$9,392,903
Arkansas	$3,116,716	62%	—	0%	$1,900,729	38%	—	0%	—	0%	—	0%	—	0%	$5,017,445
California	$89,623,465	39%	—	0%	$11,703,250	5%	$65,926,750	28%	—	0%	—	0%	$64,517,000	28%	$231,770,465
Colorado	$5,607,928	58%	$660,427	7%	$136,000	1%	$980,839	10%	—	0%	$2,255,338	23%	—	0%	$9,640,532
Connecticut	$11,315,018	72%	—	0%	—	0%	$606,678	4%	—	0%	—	0%	$3,803,229	24%	$15,724,925
Delaware	$3,202,722	98%	—	0%	—	0%	$10,000	0%	—	0%	—	0%	$50,000	2%	$3,262,722
District of Columbia	$13,842,594	100%	—	0%	—	0%	—	0%	—	0%	—	0%	—	0%	$13,842,594
Florida	$80,386,630	89%	—	0%	—	0%	$9,000,000	10%	—	0%	$1,070,143	1%	—	0%	$90,456,773
Georgia	$23,684,951	60%	$2,789,298	7%	$357,661	1%	$11,305,339	28%	$1,642,415	4%	—	0%	—	0%	$39,779,6654
Guam	$84,393	NC	$9,939	NC	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC	$94,332
Hawaii	$2,084,512	83%	—	0%	—	0%	$440,000	17%	—	0%	—	0%	—	0%	$2,524,512
Idaho	$464,163	37%	$54,663	4%	$246,150	20%	$177,500	14%	—	0%	—	0%	$300,000	24%	$1,242,476
Illinois	$25,746,254	60%	—	0%	—	0%	$10,100,000	24%	—	0%	$5,619,843	13%	$1,257,132	3%	$42,723,229
Indiana	$6,529,924	69%	—	0%	—	0%	$2,850,737	30%	—	0%	—	0%	$60,000	1%	$9,440,661
Iowa	$1,305,985	94%	—	0%	$10,722	1%	—	0%	—	0%	$55,323	4%	$10,000	1%	$1,382,030
Kansas	$2,045,495	65%	—	0%	—	0%	$400,000	13%	$208,000	7%	—	0%	$500,000	16%	$3,153,495
Kentucky	$4,086,741	82%	$481,282	10%	$72,274	1%	$90,000	2%	—	0%	—	0%	$265,000	5%	$4,995,297
Louisiana	$13,829,935	87%	$1,628,705	10%	—	0%	—	0%	—	0%	—	0%	$424,765	3%	$15,883,405
Maine	$833,383	100%	—	0%	—	0%	—	0%	—	0%	—	0%	—	0%	$833,383
Marshall Islands	$2,314	NC	—	0%	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC	$2,314
Maryland	$25,746,254	86%	—	0%	$63,034	0.2%	—	0%	—	0%	—	0%	$4,000,000	13%	$29,809,288
Massachusetts	$14,684,416	66%	—	0%	—	0%	$2,447,990	11%	$140,819	1%	$3,190,564	14%	$1,900,000	8%	$22,363,789
Michigan	$11,002,763	83%	—	0%	—	0%	—	0%	—	0%	—	0%	$2,200,000	17%	$13,202,763
Minnesota	$3,010,727	49%	—	0%	—	0%	$911,129	15%	—	0%	$422,009	7%	$1,811,658	29%	$6,155,523
Mississippi	$5,795,703	66%	—	0%	—	0%	$750,000	9%	—	0%	$2,231,774	25%	—	0%	$8,777,477
Missouri	$7,409,723	55%	—	0%	$667,526	5%	$2,069,000	15%	$1,459,000	11%	—	0%	$1,931,547	14%	$13,536,796
Montana	$310,145	67%	$36,525	8%	$73,285	16%	$27,894	6%	—	0%	$12,669	3%	—	0%	$460,518

NR indicates data not reported. **NC** indicates data not calculated due to missing data or non-applicability.

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ADAP Budget FY 2004, by Source

State	Title II ADAP Earmark	% of Total Budget	Title II ADAP Supplemental	% of Total Budget	Title II Base	% of Total Budget	State Funding	% of Total Budget	Title I	% of Total Budget	Other State/Federal	% of Total Budget	Estimated Drug Rebates	% of Total Budget	Total Federal/State
Nebraska	$1,107,661	69%	$130,445	8%	$63,049	4%	$150,000	9%	—	0%	$160,000	10%	—	0%	$1,611,155
Nevada	$4,738,678	78%	—	0%	—	0%	$1,350,947	22%	—	0%	—	0%	—	0%	$6,089,625
New Hampshire	$755,319	29%	—	0%	—	0%	—	0%	$1,476,719	56%	—	0%	$400,000	15%	$2,632,038
New Jersey	$34,877,598	54%	—	0%	—	0%	$13,672,540	21%	—	0%	$3,309,484	5%	$12,424,723	19%	$64,284,345
New Mexico	$2,127,024	41%	—	0%	—	0%	$3,000,000	58%	—	0%	—	0%	$42,958	1%	$5,169,982
New York	$124,956,784	61%	—	0%	$1,175,422	1%	$33,000,000	16%	$13,430,000	7%	—	0%	$33,350,000	16%	$205,912,206
North Carolina	$12,834,095	42%	$1,511,429	5%	—	0%	$11,120,817	36%	—	0%	—	0%	$5,093,268	17%	$30,559,609
North Dakota	$92,543	38%	—	0%	$85,400	35%	—	0%	—	0%	$31,142	13%	$35,000	14%	$244,085
N. Mariana Islands	$4,627	NC	—	0%	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC	$4,627
Ohio	$10,909,930	95%	—	0%	—	0%	$7,843	0%	$300,000	3%	—	0%	$250,000	2%	$11,467,773
Oklahoma	$3,655,707	68%	$419,165	8%	$342,307	6%	$786,000	15%	—	0%	$104,791	2%	$104,791	2%	$5,412,761
Oregon	$4,225,989	61%	—	0%	—	0%	—	0%	—	0%	$1,700,000	25%	$1,000,000	14%	$6,925,989
Pennsylvania	$27,090,216	58%	—	0%	—	0%	$13,545,108	29%	—	0%	—	0%	$5,700,000	12%	$46,335,324
Puerto Rico	$22,598,388	74%	$2,661,337	9%	$3,092,784	10%	$2,093,000	7%	—	0%	—	0%	—	0%	$30,445,509
Rhode Island	$1,911,506	72%	—	0%	—	0%	—	0%	—	0%	—	0%	$750,000	28%	$2,661,506
South Carolina	$11,736,984	84%	$1,382,225	10%	—	0%	$500,000	4%	—	0%	—	0%	$320,000	2%	$13,939,209
South Dakota	$204,654	37%	—	0%	$311,706	57%	—	0%	—	0%	—	0%	$35,000	6%	$551,360
Tennessee	$12,018,438	92%	—	0%	—	0%	$1,000,000	8%	—	0%	—	0%	—	0%	$13,018,438
Texas	$50,471,351	57%	$5,943,843	7%	—	0%	$29,918,504	34%	$1,931,616	2%	—	0%	—	0%	$88,265,314
Utah	$1,980,565	74%	—	0%	—	0%	$90,000	3%	—	0%	$498,890	19%	$110,000	4%	$2,679,455
Vermont	$382,007	49%	—	0%	—	0%	$175,000	23%	—	0%	—	0%	$220,000	28%	$777,007
Virgin Islands	$615,707	NC	$72,056	NC	NR	NC	NR	NC	NR	NC	NR	NC	NR	NC	$687,763
Virginia	$14,498,751	75%	$1,707,470	9%	—	0%	$2,612,200	14%	—	0%	—	0%	$454,000	2%	$19,272,421
Washington	$7,966,718	52%	—	0%	$108,000	1%	$3,742,723	24%	$450,000	3%	$1,291,250	8%	$1,837,623	12%	$15,396,314
West Virginia	$1,303,875	62%	$153,553	7%	$290,000	14%	$40,000	2%	—	0%	—	0%	$300,000	14%	$2,087,428
Wisconsin	$3,179,514	66%	$374,441	8%	—	0%	$93,610	2%	—	0%	$532,625	11%	$670,000	14%	$4,850,190
Wyoming	$160,347	38%	—	0%	$150,000	35%	$62,500	15%	—	0%	—	0%	$50,000	12%	$422,847
Total	**$728,030,284**	**61%**	**$20,841,716**	**2%**	**$21,676,389**	**2%**	**$226,629,046**	**19%**	**$21,038,569**	**2%**	**$22,485,845**	**2%**	**$146,245,694**	**12%**	**$1,186,947,543**

NR indicates data not reported. **NC** indicates data not calculated due to missing data or non-applicability.

Appendix IX

ADAP Budget, FY 2003–FY 2004

ADAP Budget, FY 2003 – FY 2004

State	ADAP FY 2003 Total Budget	ADAP FY 2004 Total Budget	% Change
Alabama	$10,886,687	$9,216,638	-18%
Alaska	$560,000	$555,000	-5%
American Samoa	$2,314	$2,314	NC
Arizona	$8,861,540	$9,392,903	6%
Arkansas	$3,033,102	$5,017,445	40%
California	$206,877,681	$231,770,465	2%
Colorado	$7,998,807	$9,640,532	17%
Connecticut	$14,147,726	$15,724,925	3%
Delaware	$3,039,220	$3,262,722	6%
District of Columbia	$12,960,419	$13,842,594	6%
Florida	$89,029,606	$90,456,773	2%
Georgia	$38,849,590	$39,779,664	2%
Guam	$91,319	$94,332	NC
Hawaii	$2,370,060	$2,524,512	6%
Idaho	$1,159,989	$1,242,476	3%
Illinois	$32,017,427	$42,723,229	23%
Indiana	$6,837,890	$9,440,661	30%
Iowa	$1,410,664	$1,382,030	-3%
Kansas	$3,112,500	$3,153,495	2%
Kentucky	$4,972,909	$4,995,297	-5%
Louisiana	$14,476,528	$15,883,405	6%
Maine	$951,284	$833,383	-2%
Marshall Islands	$2,314	$2,314	NC
Maryland	$35,595,491	$29,809,288	-26%
Massachusetts	$16,471,659	$22,363,789	25%
Michigan	$11,899,536	$13,202,763	5%
Minnesota	$5,207,008	$6,155,523	1%
Mississippi	$11,211,639	$8,777,477	-28%
Missouri	$11,911,553	$13,536,796	14%
Montana	$475,000	$460,518	-3%

NC indicates no calculation due to missing data.

NOTE: Comparison total does not include American Samoa, Guam, N. Mariana Islands, Marshall Islands, and the U.S. Virgin Islands. FY 2004 funding includes federal ADAP earmark only for American Samoa, Marshall Islands, and N. Mariana Islands, and ADAP earmark and ADAP Supplemental only for Guam and the U.S. Virgin Islands (other funding sources not reported).

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ADAP Budget, FY 2003 – FY 2004

State	ADAP FY 2003 Total Budget	ADAP FY 2004 Total Budget	% Change
Nebraska	$1,426,808	$1,611,155	11%
Nevada	$5,850,858	$6,089,625	4%
New Hampshire	$2,641,901	$2,632,038	-2%
New Jersey	$49,653,028	$64,284,345	19%
New Mexico	$5,352,144	$5,169,982	-4%
New York	$192,817,414	$205,912,206	8%
North Carolina	$25,282,694	$30,559,609	14%
North Dakota	$212,733	$244,085	11%
N. Mariana Islands	$24,627	$4,627	NC
Ohio	$13,116,779	$11,467,773	-17%
Oklahoma	$6,314,819	$5,412,761	-2%
Oregon	$4,847,032	$6,925,989	24%
Pennsylvania	$39,057,292	$46,335,324	14%
Puerto Rico	$29,548,500	$30,445,509	3%
Rhode Island	$1,830,041	$2,661,506	4%
South Carolina	$14,226,097	$13,939,209	-4%
South Dakota	$310,504	$551,360	45%
Tennessee	$9,927,566	$13,018,438	24%
Texas	$66,539,023	$88,265,314	25%
Utah	$2,495,455	$2,679,455	9%
Vermont	$676,740	$777,007	0%
Virgin Islands	$693,155	$687,763	NC
Virginia	$18,295,670	$19,272,421	3%
Washington	$15,666,253	$15,396,314	-1%
West Virginia	$2,069,316	$2,087,428	1%
Wisconsin	$4,893,704	$4,850,190	-2%
Wyoming	$300,000	$422,847	20%
Total	**$1,070,491,615**	**$1,186,947,543**	
Comparison Total	***$1,069,677,886***	***$1,186,156,193***	***11%***

NC indicates no calculation due to missing data.

NOTE: Comparison total does not include American Samoa, Guam, N. Mariana Islands, Marshall Islands, and the U.S. Virgin Islands. FY 2004 funding includes federal ADAP earmark only for American Samoa, Marshall Islands, and N. Mariana Islands, and ADAP earmark and ADAP Supplemental only for Guam and the U.S. Virgin Islands (other funding sources not reported).

Appendix X

Major FY 2004 Budget Categories Compared with FY 2003

Major FY 2004 Budget Categories Compared with FY 2003

State	03 Title II ADAP Earmark	04 Title II ADAP Earmark	% (+/–)	03 Title II ADAP Supplemental	04 Title II ADAP Supplemental	% (+/–)	03 Title II Base	04 Title II Base	% (+/–)	03 State	04 State	% (+/–)	03 Title I	04 Title I	% (+/–)	03 Est. Rebates	04 Est. Rebates	% (+/–)
Alabama	$6,565,936	$7,004,635	7%	$838,770	$824,913	-2%	$621,981	$827,090	33%	$2,860,000	$560,000	-80%	—	—	NA	—	—	NA
Alaska	$423,385	$472,602	12%	—	—	NA	—	—	NA	$86,615	$14,398	-83%	—	—	NA	$50,000	$68,000	36%
American Samoa	$2,314	$2,314	0%	—	—	NA	NR	NR	NC	NR	NR	NC	NR	NR	NC	NR	NR	NC
Arizona	$7,861,540	$8,392,903	7%	—	—	NA	—	—	NA	$1,000,000	$1,000,000	0%	—	—	NA	—	—	NA
Arkansas	$3,033,102	$3,116,716	3%	—	—	NA	—	$1,900,729	NC	—	—	NA	—	—	NA	—	—	NA
California	$86,118,340	$89,623,465	4%	—	—	NA	$12,168,628	$11,703,250	-4%	$65,114,000	$65,926,750	1%	—	—	NA	$43,476,713	$64,517,000	48%
Colorado	$5,300,409	$5,607,928	6%	$677,104	$660,427	-2%	$136,000	$136,000	0%	$1,103,410	$980,839	-11%	$560,254	—	-100%	—	—	NA
Connecticut	$10,936,287	$11,315,018	3%	—	—	NA	—	—	NA	$606,678	$606,678	0%	—	—	NA	$2,604,761	$3,803,229	46%
Delaware	$3,019,220	$3,202,722	6%	—	—	NA	—	—	NA	$5,000	$10,000	100%	—	—	NA	$15,000	$50,000	233%
District of Columbia	$12,560,419	$13,842,594	10%	—	—	NA	—	—	NA	$400,000	—	-100%	—	—	NA	—	—	NA
Florida	$77,118,519	$80,386,630	4%	—	—	NA	$1,560,972	—	-100%	$9,000,000	$9,000,000	0%	—	—	NA	—	—	NA
Georgia	$22,615,232	$23,684,951	5%	$2,888,997	$2,789,298	-3%	$500,000	$357,661	-28%	$11,305,339	$11,305,339	0%	$1,540,022	$1,642,415	7%	—	—	NA
Guam	$80,975	$84,393	4%	$10,344	$9,939	-4%	NR	NR	NC	NR	NR	NC	NR	NR	NC	NR	NR	NC
Hawaii	$1,929,525	$2,084,512	8%	—	—	NA	—	—	NA	$440,535	$440,000	0%	—	—	NA	—	—	NA
Idaho	$439,580	$464,163	6%	$56,154	$54,663	-3%	$236,755	$246,150	4%	$177,500	$177,500	0%	—	—	NA	$250,000	$300,000	20%
Illinois	$23,263,034	$25,746,254	11%	—	—	NA	$686,223	—	-100%	$7,000,000	$10,100,000	44%	—	—	NA	—	$1,257,132	NC
Indiana	$6,063,890	$6,529,924	8%	—	—	NA	—	—	NA	—	$2,850,737	NC	—	—	NA	$300,000	$60,000	-80%
Iowa	$1,260,900	$1,305,985	4%	—	—	NA	—	$10,722	NC	—	—	NA	—	—	NA	—	$10,000	NC
Kansas	$2,010,500	$2,045,495	2%	—	—	NA	—	—	NA	$400,000	$400,000	0%	$202,000	$208,000	3%	$500,000	$500,000	0%
Kentucky	$3,930,770	$4,086,741	4%	$502,139	$481,282	-4%	$100,000	$72,274	-28%	$90,000	$90,000	0%	—	—	NA	—	$265,000	NC
Louisiana	$12,696,920	$13,829,935	9%	$1,621,976	$1,628,705	0%	—	—	NA	—	—	NA	$157,632	—	-100%	—	$424,765	NC
Maine	$791,244	$833,383	5%	—	—	NA	—	—	NA	$60,040	—	-100%	—	—	NA	$100,000	—	-100%
Marshall Islands	$2,314	$2,314	0%	—	—	NA	NR	NR	NC	NR	NR	NA	NR	NR	NA	NR	NR	NC
Maryland	$24,359,670	$25,746,254	6%	—	—	NA	$65,250	$63,034	-3%	$500,000	—	-100%	$75,444	—	-100%	$3,000,000	$4,000,000	33%
Massachusetts	$14,422,850	$14,684,416	2%	—	—	NA	—	—	NA	$707,990	$2,447,990	246%	$140,819	$140,819	0%	$1,200,000	$1,900,000	58%
Michigan	$10,399,536	$11,002,763	6%	—	—	NA	—	—	NA	—	—	NA	—	—	NA	$1,500,000	$2,200,000	47%
Minnesota	$2,949,813	$3,010,727	2%	—	—	NA	—	—	NA	$969,450	$911,129	-6%	—	—	NA	$900,000	$1,811,658	101%
Mississippi	$5,360,562	$5,795,703	8%	—	—	NA	—	—	NA	$750,000	$750,000	0%	—	—	NA	—	—	NA
Missouri	$7,276,205	$7,409,723	2%	—	—	NA	$771,089	$667,526	-13%	$669,000	$2,069,000	209%	$1,210,000	$1,459,000	21%	$1,985,259	$1,931,547	-3%
Montana	$298,452	$310,145	4%	—	$36,525	NC	$101,548	$73,285	-28%	—	$27,894	NC	—	—	NA	—	—	NA
Nebraska	$1,066,560	$1,107,661	4%	$136,248	$130,445	-4%	$74,000	$63,049	-15%	$150,000	$150,000	0%	—	—	NA	—	—	NA
Nevada	$4,499,911	$4,738,678	5%	—	—	NA	—	—	NA	$1,350,947	$1,350,947	0%	—	—	NA	—	—	NA
New Hampshire	$724,150	$755,319	4%	—	—	NA	$249,452	—	-100%	—	—	NA	$1,310,299	$1,476,719	13%	$358,000	$400,000	12%
New Jersey	$33,810,639	$34,877,598	3%	—	—	NA	—	—	NA	—	$13,672,540	NC	—	—	NA	$7,500,000	$12,424,723	66%
New Mexico	$2,052,144	$2,127,024	4%	—	—	NA	—	—	NA	$3,300,000	$3,000,000	-9%	—	—	NA	—	$42,958	NC
New Mexico	$2,052,144	$2,127,024	4%	—	—	NA	—	—	NA	$3,300,000	$3,000,000	-9%	—	—	NA	—	$42,958	NC

NR indicates data not reported. **NA** indicates calculation not applicable due to no change. **NC** indicates no calculation possible due to missing data or new funding added.

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Major FY 2004 Budget Categories Compared with FY 2003

State	03 Title II ADAP Earmark	04 Title II ADAP Earmark	% (+/–)	03 Title II ADAP Supplemental	04 Title II ADAP Supplemental	% (+/–)	03 Title II Base	04 Title II Base	% (+/–)	03 State	04 State	% (+/–)	03 Title I	04 Title I	% (+/–)	03 Est. Rebates	04 Est. Rebates	% (+/–)
North Carolina	$11,274,069	$12,834,095	14%	$1,440,213	$1,511,429	5%	—	—	NA	$8,355,195	$11,120,817	33%	—	—	NA	$3,300,000	$5,093,268	54%
North Dakota	$92,543	$92,543	0%	—	—	NA	$94,190	$85,400	-9%	—	—	NA	—	—	NA	$26,000	$35,000	35%
N. Mariana Islands	$4,627	$4,627	0%	—	—	NA	$20,000	NR	NC	NR	NR	NC	NR	NR	NC	NR	NR	NC
Ohio	$10,147,356	$10,909,930	8%	—	—	NA	—	—	NA	$2,669,423	$7,843	-100%	$300,000	$300,000	0%	—	$250,000	NC
Oklahoma	$3,551,343	$3,655,707	3%	$453,669	$419,165	-8%	$463,807	$342,307	-26%	$786,000	$786,000	0%	—	—	NA	$910,000	$104,791	-88%
Oregon	$4,023,313	$4,225,989	5%	—	—	NA	$70,000	—	-100%	$403,719	—	-100%	—	—	NA	$350,000	$1,000,000	186%
Pennsylvania	$25,692,292	$27,090,216	5%	—	—	NA	—	—	NA	$9,365,000	$13,545,108	45%	—	—	NA	$4,000,000	$5,700,000	43%
Puerto Rico	$21,904,963	$22,598,388	3%	$2,798,263	$2,661,337	-5%	$2,752,274	$3,092,784	12%	$2,093,000	$2,093,000	0%	—	—	NA	—	—	NA
Rhode Island	$1,830,041	$1,911,506	4%	—	—	NA	—	—	NA	—	—	NA	—	—	NA	—	$750,000	NC
South Carolina	$11,065,847	$11,736,984	6%	$1,413,613	$1,382,225	-2%	—	—	NA	$500,000	$500,000	0%	—	—	NA	$30,000	$320,000	967%
South Dakota	$189,713	$204,654	8%	—	—	NA	$95,791	$311,706	225%	—	—	NA	—	—	NA	$25,000	$35,000	40%
Tennessee	$9,927,566	$12,018,438	21%	—	—	NA	—	—	NA	—	$1,000,000	NC	—	—	NA	—	—	NA
Texas	$48,434,770	$50,471,351	4%	$6,187,328	$5,943,843	-4%	—	—	NA	$11,600,058	$29,918,504	158%	$316,867	$1,931,616	510%	—	—	NA
Utah	$1,904,075	$1,980,565	4%	—	—	NA	—	—	NA	—	$90,000	NC	—	—	NA	$150,000	$110,000	-27%
Vermont	$381,740	$382,007	0%	—	—	NA	—	—	NA	$175,000	$175,000	0%	—	—	NA	$120,000	$220,000	83%
Virgin Islands	$596,903	$615,707	3%	$76,252	$72,056	-6%	$20,000	NR	NC	—	NR	NC	NR	NR	NC	NR	NR	NC
Virginia	$13,906,922	$14,498,751	4%	$1,776,548	$1,707,470	-4%	—	—	NA	$2,612,200	$2,612,200	0%	—	—	NA	—	$454,000	NC
Washington	$7,722,726	$7,966,718	3%	—	—	NA	$308,000	$108,000	-65%	$4,889,641	$3,742,723	-23%	$800,487	$450,000	-44%	$1,945,399	$1,837,623	-6%
West Virginia	$1,223,883	$1,303,875	7%	$156,346	$153,553	-2%	$250,000	$290,000	16%	$139,087	$40,000	-71%	—	—	NA	$300,000	$300,000	0%
Wisconsin	$3,100,195	$3,179,514	3%	$396,036	$374,441	-5%	—	—	NA	$99,009	$93,610	-5%	—	—	NA	$625,764	$670,000	7%
Wyoming	$150,383	$160,347	7%	—	—	NA	$24,617	$150,000	509%	$125,000	$62,500	-50%	—	—	NA	—	$50,000	NC
Total	**$692,896,000**	**$728,030,284**	**5%**	**$21,430,000**	**$20,841,716**	**-3%**	**$22,205,368**	**$21,676,389**	**-2%**	**$171,858,836**	**$226,629,046**	**32%**	**$17,513,824**	**$21,038,569**	**20%**	**$109,921,896**	**$146,245,694**	**33%**

NR indicates data not reported. **NA** indicates calculation not applicable due to no change. **NC** indicates no calculation possible due to missing data or new funding added.

Appendix XI

ADAP Cost Recovery and Other Cost Saving Mechanisms (Excluding Rebates), FY 2004

ADAP Cost Recovery and Other Cost Saving Mechanisms (Excluding Rebates), FY 2004

State	Private Insurance Reimbursements	Medicaid Reimbursements	Manufacturers' Free Products	Other	Total
Arizona	—	—	$78,546	—	$78,546
Arkansas	—	$90,000	—	—	$90,000
Minnesota	—	—	—	$167,250	$167,250
Missouri	$56,797	$1,457,606	—	—	$1,514,403
Montana	—	—	$2,000	—	$2,000
New Jersey	$2,267,685	$720,000	—	$5,418,441	$8,406,126
New Mexico	—	—	$16,098	—	$16,098
New York	$15,500,000	$2,000,000	—	—	$17,500,000
Ohio	$20,000	$30,000	$80,000	—	$130,000
Oklahoma	—	—	$40,000	—	$40,000
Pennsylvania	$5,727,517	—	—	—	$5,727,517
South Carolina	—	—	$40,000	—	$40,000
Virginia	—	$157,000	$128,219	—	$285,219
Wisconsin	$29,835	$85,584	—	—	$115,419
Totals	**$23,601,834**	**$4,540,190**	**$384,863**	**$5,585,691**	**$34,112,578**

NOTE: Only states listing funding from cost recovery or other cost saving mechanisms are included (manufacturers' drug rebates are included in the National ADAP Budget — see Charts 14 and 21 for information on drug rebates).

Appendix XII

ADAP Funds Used for Insurance Purchasing/Maintenance, FY 2004, and Clients Served, June 2004

ADAP Funds Used for Insurance Purchasing/Maintenance, FY 2004, and Clients Served, June 2004

State	Estimated Expenditures FY 2004	Clients Served June 2004
Alaska	$64,000	10
Colorado	$463,328	91
Delaware	$50,000	3
Indiana	$6,142,924	1,180
Iowa	$163,290	79
Kansas*	$30,000	71
Louisiana	$300,000	142
Maryland	$500,000	38
Massachusetts	$3,881,000	888
Michigan	$538,835	107
Minnesota	$2,739,598	335
Missouri *	$852,000	321
Montana*	$3,650	2
Nebraska*	$58,000	33
New Hampshire	$110,000	53
New Jersey*	$1,700,000	80
New York	$8,400,000	1,106
Ohio	$1,000,000	264
Oklahoma	$152,500	50
Oregon	$2,600,000	441
South Carolina	$800,000	248
Tennessee	$2,531,366	481
Utah	$516,752	164
Vermont*	$5,260	17
Washington	$3,742,723	828
Wisconsin	$500,000	245
Total	**$37,845,226**	**7,277**

*Indicates new state reporting since 2003 report.

Appendix XIII

ADAP Clients Served Who Reside in Title I EMAs, June 2004

ADAP Clients Served Who Reside in Title I EMAs, June 2004

State	June 2004 Clients Served	June 2004 Number of Clients Served in EMA	% of Clients Served in June 2004 who Reside Within EMAs
Alabama	1,220	NA	NC
Alaska	35	NA	NC
American Samoa	NR	NA	NC
Arizona	845	605	72%
Arkansas	376	NA	NC
California	18,263	16,987	68%
Colorado	667	528	65%
Connecticut	1,112	995	65%
Delaware	226	NA	NC
District of Columbia	809	NR	NC
Florida	9,558	8,268	69%
Georgia	3,820	2,211	38%
Guam	NR	NA	NC
Hawaii	223	NA	NC
Idaho	100	NA	NC
Illinois	3,234	2,683	55%
Indiana	13	NA	NC
Iowa	203	NA	NC
Kansas*	535	101	19%
Kentucky	555	NA	NC
Louisiana	1,654	645	27%
Maine	42	NA	NC
Marshall Islands	NR	NA	NC
Maryland	1,989	1,890	70%
Massachusetts	2,291	1,689	49%
Michigan	1,075	508	36%
Minnesota	597	514	52%
Mississippi	769	NA	NC
Missouri	1,402	1,195	50%
Montana	53	NA	NC
Nebraska	181	NA	NC
Nevada	614	479	66%
New Hampshire*	183	127	39%
New Jersey	4,705	4,140	77%
New Mexico	327	NA	NC
New York	12,484	10,362	65%
North Carolina*	1,843	NA	NC
North Dakota	19	NA	NC
N.Mariana Islands	NR	NA	NC
Ohio	1,271	321	19%
Oklahoma	533	NA	NC
Oregon	656	488	66%
Pennsylvania	2,971	1,485	27%
Puerto Rico	3,154	NR	NC
Rhode Island	315	NA	NC
South Carolina	1,531	NA	NC
South Dakota	40	NA	NC
Tennessee	474	NA	NC
Texas	8,060	6,040	49%
Utah	170	NA	NC
Vermont	99	NA	NC
Virgin Islands	NR	NA	NC
Virginia	1,812	917	34%
Washington	926	653	27%
West Virginia*	151	13	4%
Wisconsin*	357	NA	NC
Wyoming	35	NA	NC
Total	**94,577**	**63,844**	**—**
Comparison Total for States with EMAs	***80,875***	***63,844***	***79%***
Comparison Total for All States	***88,414***	***63,844***	***72%***

NOTE: Comparison total for states with EMAs does not include District of Columbia, North Carolina, Puerto Rico, and Wisconsin (did not report data), nor any states without EMAs. Comparison total for all states does not include American Samoa, District of Columbia, Guam, the Marshall Islands, North Carolina, Puerto Rico, the N. Mariana Islands, U.S. Virgin Islands, and Wisconsin.

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

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

NC indicates not calculated as data is not available.

Appendix XIV

ADAP Drug Purchasing and Prime Vendor Participation, June 2004

ADAP Drug Purchasing and Prime Vendor Participation, June 2004

State	Section 340B Participant	Direct Purchase Option	Pharmacy Network (Rebate) Option	HRSA Prime Vendor (340B Direct Purchase)
Alabama	✓	✓		
Alaska	✓		✓	
American Samoa	NR	NR	NR	NR
Arizona	✓	✓		
Arkansas	✓	✓		✓
California	✓		✓	
Colorado	✓	✓		✓
Connecticut	✓		✓	
Delaware	✓	✓		✓
District of Columbia		✓		
Florida	✓	✓		
Georgia	✓	✓		
Guam	NR	NR	NR	NR
Hawaii	✓	✓		✓
Idaho	✓		✓	
Illinois	✓	✓		✓
Indiana	✓		✓	
Iowa	✓	✓		
Kansas	✓	✓		
Kentucky	✓	✓		
Louisiana	✓	✓		
Maine	✓		✓	
Marshall Islands	NR	NR	NR	NR
Maryland	✓		✓	
Massachusetts	✓		✓	
Michigan	✓		✓	
Minnesota	✓		✓	
Mississippi	✓	✓		✓
Missouri	✓		✓	
Montana	✓	✓		✓
Nebraska	✓	✓		
Nevada	✓	✓		
New Hampshire	✓		✓	
New Jersey	✓		✓	
New Mexico	✓	✓		✓
New York	✓		✓	
North Carolina	✓		✓	
North Dakota	✓		✓	
N.Mariana Islands	NR	NR	NR	NR
Ohio	✓	✓		✓
Oklahoma	✓	✓		
Oregon	✓		✓	
Pennsylvania	✓		✓	
Puerto Rico	✓	✓		
Rhode Island	✓		✓	
South Carolina	✓	✓		
South Dakota	✓		✓	
Tennessee	✓	✓		✓
Texas	✓	✓		
Utah	✓	✓		
Vermont	✓		✓	
Virgin Islands	NR	NR	NR	NR
Virginia	✓	✓		✓
Washington	✓		✓	
West Virginia	✓		✓	
Wisconsin	✓		✓	
Wyoming	✓		✓	
Total	**51**	**27**	**25**	**11**

NOTE: 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.

NR: Indicates data not reported

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