AIDS Drug Assistance Programs (ADAPs)

What are ADAPs?

AIDS Drug Assistance Programs (ADAPs) provide HIV-related prescription drugs to low-income people with HIV/AIDS who have limited or no prescription drug coverage. With more than 210,000 enrollees in FY 2013, ADAPs reach approximately one third of people with HIV estimated to be receiving care nationally. In June 2013 alone, ADAPs provided medications to more than 152,000 clients—the largest number in ADAP history—and insurance coverage to thousands more.

ADAPs began serving clients in 1987, when Congress first appropriated funds to help states purchase the only approved antiretroviral (ARV) drug at that time, AZT. In 1990, they were incorporated into the newly enacted Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, now known as the Ryan White Program. Since Fiscal Year (FY) 1996, Congress has specifically earmarked funding for ADAPs through Part B of Ryan White, which is allocated by formula to states. Ryan White has been reauthorized by Congress four times since first created and changes have been made to ADAPs over time.

In FY 2013, 59 jurisdictions received ADAP earmark funding; 51 reported data, including 47 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands. ADAPs also receive state funding and contributions from other sources, including other parts of Ryan White, but this support is highly variable and largely dependent on local decisions and resources. ADAPs are not entitlement programs; annual federal appropriations and, where available, other funding, determine how many clients ADAPs can serve and the level of services they can provide. Each state operates its own ADAP, including determining eligibility criteria and other program elements, resulting in significant variation across the country.

ADAP Budget

The ADAP budget has increased over time, although the levels of funding and budget composition are highly variable from year to year, and influenced by a broad range of factors. In recent years, the budget has also included transfers from other parts of Ryan White as well as emergency funding to help alleviate ADAP waiting lists and unmet program needs.

- The national ADAP budget was $2.01 billion in FY 2013, roughly the same as it was in FY 2012 ($2.03 billion).
- Through FY 2012, the federal ADAP earmark was the largest component of the budget. It has declined as a share of the budget in recent years, and accounted for 39% of the FY 2013 budget, just behind drug rebates.
- Drug rebates accounted for 40% of the overall ADAP budget.
- State funding accounted for 11% of the budget.
- ADAP emergency funding accounted for 4% of the budget.
- Part B Supplemental awards accounted for 2% of the overall ADAP budget.
- Transfers to ADAPs from state Part B base awards and from Part A jurisdictions each accounted for 1%, while state Part B supplemental funding represented less than a percent (0.3%).
- In addition to ADAP earmark funding, in FY 2013, 46 ADAPs received drug rebates; 36 received Part B Supplemental awards; 35 received state funds; 22 received transfers of Part B base funds; 20 received emergency funds; 10 received transfers of Part B supplemental funds; and 6 received transfers of Part A funds. Among the 51 states reporting data in both FY 2012 and FY 2013, half (25 states) experienced net decreases in their budgets.

ADAP Expenditures and Prescriptions

Nearly all ADAP expenditures for prescription drugs and drug spending has increased over time (albeit at slower rates in recent years); expenditures increased by 2% between June 2012 and June 2013.

- In June 2013:
  - Drug expenditures totaled $141.4 million, with direct purchases representing 95% of total expenditures, and co-payments the remaining 5%.
  - Per capita drug spending was $927 for drug purchases and co-payments and $526 for insurance purchasing and continuation.
  - ADAPs filled 457,640 prescriptions.
  - ARVs accounted for the bulk of drug expenditures (91%), and expenditures per prescription were more than 4 times higher for ARVs than non-ARVs.
  - ADAPs spent an additional $27.6 million on insurance purchasing/maintenance.

ADAP Formularies

ADAP formularies (the list of drugs covered) vary significantly across the country. At the end of June 2012:

- Of the 32 ARVs currently available (including multi-class combination products), ADAP formularies covered between a low of 28 drugs in Wyoming to all 32 in 18 states.
• 39 ADAPs covered 16 or more of the 31 “A1” drugs highly recommended (“A1”) for the prevention and treatment of opportunistic infections (OIs).\textsuperscript{9}

• In June 2012, 29 ADAPs covered at least one drug for the treatment of hepatitis B; 27 covered at least one drug for the treatment of hepatitis C; and 26 covered vaccines for hepatitis A or B (including the hepatitis A and B combination vaccine).

**ADAP Clients**

ADAP client enrollment and utilization have grown over time and are now at their highest levels to date. Client demographics vary by state and region, but nationally have remained fairly constant over time.

- 210,411 people were enrolled in ADAPs in FY 2013, ranging from 1 in Guam to more than 31,000 in California.

- In June 2013, ADAPs provided medications to 152,487 clients across the country; thousands more were provided with insurance coverage.
  - A majority of clients were people of color (66%) and most were male (78%).
  - Two thirds had incomes at or below 200% of the Federal Poverty Level, or FPL (68% of clients), including over half (53%) with incomes at or below 138% FPL.\textsuperscript{10}
  - Half of clients were between 45-64 years of age (50%), followed by those ages 25-44 (41%).
  - Four in 10 (37%) clients whose CD4 counts were available had counts of 350 or below (at time of enrollment or recertification).

- Client utilization increased by 6% between June 2012 and June 2013.

**ADAP Eligibility Criteria**\textsuperscript{8}

The Ryan White Program requires all ADAP clients to be HIV-positive, low-income, and under- or uninsured, but no income level is specified under current law. Each ADAP determines its own income eligibility as well as other eligibility criteria. As of June 30, 2012:

- All ADAPs require documentation of HIV status. Three use additional clinical eligibility criteria (e.g., specific CD4 counts or viral load ranges).

- All ADAPs have state residency requirements, and many require proof of residency.

- Financial eligibility ranges from 200% FPL in 8 states to 500% FPL in 5 states.\textsuperscript{10} Thirteen ADAPs also use asset limits to determine eligibility and 14 ADAPs include domestic partners in income calculations.
**Cost-Containment Measures and Waiting Lists**

ADAPs must balance client demand with available resources on an ongoing basis. As a result of recent economic conditions, instituting cost-containment measures, including waiting lists, has become increasingly necessary.

- Waiting lists have fluctuated over time and reached their highest point in September 2011 when 9,298 individuals in 11 states were eligible for ADAPs yet unable to access medications.

- After more than five continuous years of waiting lists, on November 21, 2013, South Dakota—the final state to have a waiting list—transitioned individuals into its ADAP program.\(^{11}\) As of February 19, 2014, Utah is the only state to re-open a waiting list, with 3 individuals.

- The elimination of waiting lists was due in large part to the provision of emergency funding to ADAPs. To help alleviate state waiting lists and other unmet needs faced by ADAPs, $25 million in Ryan White funding was reprogrammed to ADAPs in August 2010 and ADAPs received $40 million in emergency federal funding through Ryan White in September 2011 and $75 million in August 2012 (a renewal of the September 2011 emergency funding, plus $35 million in new funding announced on World AIDS Day in 2011). In 2013, the $40 million carried over once again, and another $35 million in emergency funding were transferred to ADAP from other parts of Ryan White and additional sources. Twenty states received the $75 million in 2013 funds, with awards ranging from $247,239 in Alaska to $13.1 million in Florida.\(^ {1,12}\)

- Despite the dramatic reduction of waiting lists, as states continue to experience economic difficulties, other cost-containment measures (e.g., capped enrollment, reduced formularies) remain in place in 11 states.

**Drug Purchasing Models**\(^ {8}\)

- All ADAPs participate in the 340B program, enabling them to purchase drugs at or below the statutorily defined 340B ceiling price.

- 6 ADAPs only purchase drugs directly from wholesalers; 23 only purchase drugs through a pharmacy network; 3 purchase through a hybrid model; and 20 use a dual model of purchasing directly from wholesalers and also seeking rebates for insurance premiums.

**Insurance Purchasing & Coordination**

- 44 ADAPs used funds for purchasing health insurance and/or paying insurance premiums, co-payments, and/or deductibles for clients in 2013, paying for coverage for 52,568 clients in June 2013. ADAPs spent $27.6 million in June 2013 and an estimated $397 million in FY 2013 on insurance coverage – a significant increase from FY 2012, when ADAPs spent $227 million, marking a continuing trend as more states use funds for insurance purchasing and coordination.

- To prepare for the full implementation of the Affordable Care Act (ACA), which will have implications for many ADAP clients, ADAPs have been intensifying their coordination with other health coverage entities, including private insurance mechanisms; state-run high-risk insurance pools created by states to provide coverage for “medically uninsurable” populations; and Medicaid programs.\(^ {13}\)
Medicare Part D

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a new outpatient prescription drug benefit, Part D, to the Medicare program. As the payer of last resort, ADAPs must ensure that any Medicare Part D-eligible client is enrolled in Part D and that ADAP is not paying for their Part D expenses. As of December 31, 2012: 39 ADAPs paid Part D co-payments; 31 paid deductibles; 22 paid premiums; and 36 paid for medications on their ADAP formularies when clients reach the Part D coverage gap (or “doughnut hole”). A provision of the ACA changed the relationship between ADAPs and Medicare. As of January 1, 2011, payments made by ADAPs on behalf of a Medicare Part D beneficiary are now allowed to count toward “TrOOP” (a beneficiary’s true out-of-pocket costs), allowing the client to pass through the doughnut hole into catastrophic coverage.

Looking Ahead

ADAPs continue to play a critical role in providing prescription drugs to low-income people living with HIV who have limited or no access elsewhere. In addition, ADAPs often serve as a bridge to other care and support services. As the number of people living with HIV has increased in the U.S., largely due to advances in HIV treatment, so, too, has the need for ADAPs. ADAPs have recently felt additional strains due to the challenging national and state fiscal conditions, leading to the provision of emergency funding for ADAPs in 2010, 2011, 2012, and 2013. Despite this assistance, ADAPs will likely continue to face significant pressure, waiting lists may re-emerge in more states, and other cost-containment measures may persist. Looking ahead, there are several key developments that will affect ADAPs in the coming years, including full implementation of the ACA and the future of the Ryan White authorizing legislation.

1 Except where noted, data included in this fact sheet are from the National Alliance of State and Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report; February 2014. American Samoa, Delaware, the Federated States of Micronesia, the Marshall Islands, Nebraska, the Northern Mariana Islands, the Republic of Palau, and West Virginia did not report data for FY 2013. See state-level data provided by KFF at: http://www.kff.org/state-category/hivaids.
2 Based on KFF analysis of data from CDC.
3 The term “state” includes states, the District of Columbia, and U.S. territories.
5 HRSA, HIV/AIDS Bureau.
6 Five percent of the ADAP earmark is set-aside for the ADAP Supplemental Drug Treatment Grant.
7 Not including the ADAP Supplemental Drug Treatment Grant set-aside.
8 NASTAD, National ADAP Monitoring Project Annual Report, Modules 1-2; 2013.
9 See AIDS Info’s Clinical Guidelines Portal for current guidelines.
10 The 2013 Federal Poverty Level (FPL) was $11,490 annually (slightly higher in Alaska and Hawaii) for a household of one.
11 NASTAD, ADAP Watch; November 2013 & February 2014.
12 NASTAD, A Coordinated Strategy to Save American ADAPs; May 2011.