THE HENRY J. KAISER FAMILY FOUNDATION

HIV/AIDS

HIV/AIDS POLICY FACT SHEET

April 2002

AIDS Drug Assistance Programs (ADAPs)

What are ADAPs?

AIDS Drug Assistance Programs (ADAPs) provide HIV/AIDS-related prescription drugs to uninsured and underinsured individuals living with HIV/AIDS in the 50 states,[1] the District of Columbia, Puerto Rico, Guam, and the Virgin Islands.[2] ADAPs began serving clients in 1987, when Congress first appropriated funds to help states purchase AZT—the only approved antiretroviral drug at that time. In 1990, they were incorporated under Title II of the newly enacted Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. Federal funding for ADAPs is allocated by formula to states. ADAPs are not entitlement programs; annual federal, and in some cases state, appropriations determine how many clients ADAPs can serve and the level of services they can provide. While Medicaid represents the largest source of public funding for care of persons with HIV/AIDS ($6.9 B in FY 2001), ADAPs are a critical source of prescription drugs for low-income and uninsured populations with HIV, and help to fill the gaps in prescription drug coverage.

Each state or territory administers its own ADAP, including the establishment of financial and clinical eligibility criteria and ADAP drug formularies. As a result, there is wide programmatic variation across states and in client access to ADAPs.

The introduction of combination therapy (the use of two, three, or even more antiretroviral drugs in combination) as the standard of care in late 1995 heralded a new era for state ADAPs. Combination therapy is expensive, estimated to cost $10,000–$12,000 per person per year, and many people with HIV are unable to afford the recommended therapy. As a result, ADAPs have been playing an increasingly important role in providing needed care to individuals with HIV with limited or no access to medication coverage.

- The FY 2001 ADAP budget was **$810.2 M;**
- In June 2001, ADAPs served **76,743**[3] clients and had drug expenditures of **$63.8 M;**
- ADAPs filled **246,062** prescriptions in June 2001.

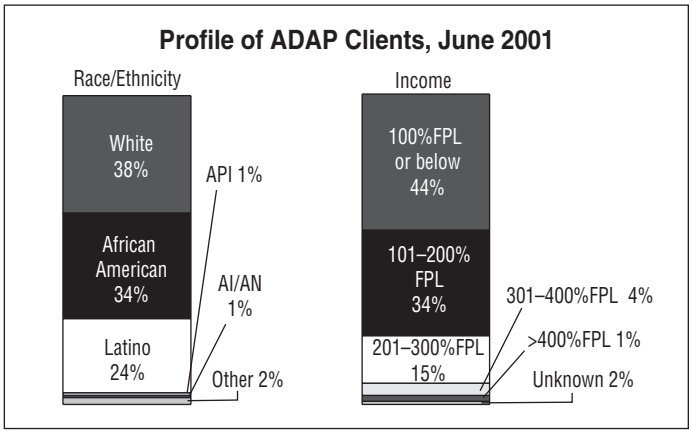
ADAP Eligibility

To be eligible for ADAPs, individuals must have limited or no access to drug coverage and must meet state-specific clinical and financial eligibility criteria. All state ADAPs require an individual to be HIV-positive to meet clinical eligibility. Seven states reported using additional clinical criteria for clients to access ADAP (e.g., specific CD4 counts or viral load ranges) and some use additional clinical criteria for clients to access antiretroviral drugs. Financial eligibility for ADAPs varies, ranging from a low of 125% of the Federal Poverty Level (FPL) in North Carolina to a high of 500% FPL or more in Massachusetts, New Jersey and New York.

The ADAP Client Population

ADAPs serve a racially and ethnically diverse mix of clients who are primarily low income and uninsured. Client demographics have remained fairly constant since 1996. In June 2001:

- Almost 80% of ADAP clients had incomes at or below 200% FPL, including slightly less than half (44%) with incomes below 100% FPL.
- A majority of ADAP clients were uninsured. Six percent were reported to be covered by Medicaid, 10% by Medicare and 11% of clients had some level of private insurance coverage.
- Minority Americans represent the majority of ADAP clients, with African Americans representing about one-third (34%) and Hispanics about one-quarter (24%) of ADAP clients. Asian/Pacific Islanders and American Indians/Alaska Natives represented slightly over 1%. White non-Hispanics represented 38%.
- Eight in ten (80%) ADAP clients were men, and almost all (99%) were over the age of 19.



ADAP Drug Formularies

ADAP formularies (the list of drugs offered) ranged from a low of 18 drugs covered in two states, Louisiana and Utah, to 471 drugs covered in New York:

- Almost all state ADAPs cover all FDA-approved antiretrovirals. South Dakota continues to be the only ADAP that does not cover protease inhibitors due to lack of resources.
- Ten states currently offer all 16 highly recommended drugs for the prevention and treatment of opportunistic infections (OIs) according to the U.S. Public Health Service/Infectious Disease Society of America (PHS/IDSA) Guidelines, up from 8 states last year. Thirty-six states now cover 10 or more of these recommended OI drugs, up from 31 states last year. Only 2 states do not cover any of the recommended OI drugs, compared to 4 states last year.

Trends in Clients Served and Expenditures

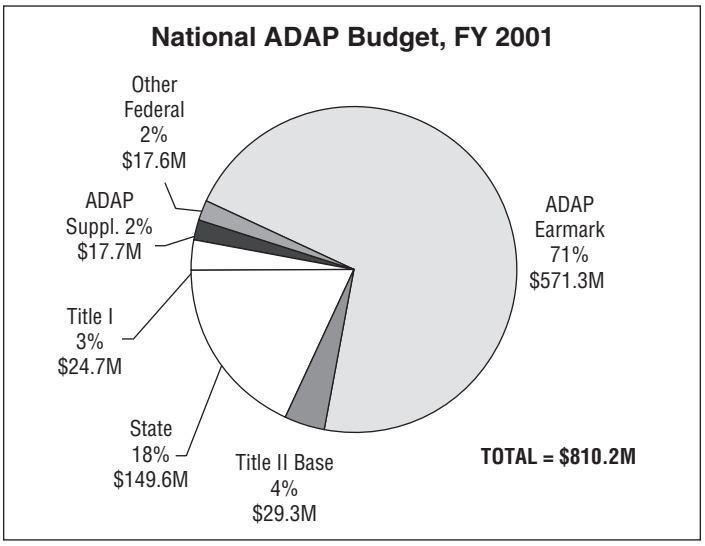
The number of clients served by ADAPs and ADAP drug expenditures continue to grow, but at a slower pace over time:

- The number of clients served increased by 144% between July 1996 and June 2001, from 27,472 to 66,949, including a 10% increase over the last year alone.[4]
- ADAP monthly drug expenditures increased by 320% between July 1996 and June 2001, from $13.3M to $56.1M, including a 16% increase in the last year.[4]
- Antiretroviral expenditures make up the bulk of ADAP drug expenditures (87%).

Trends in the ADAP Budget

As with clients and expenditures, the national ADAP budget has increased over time, but at a slower rate:

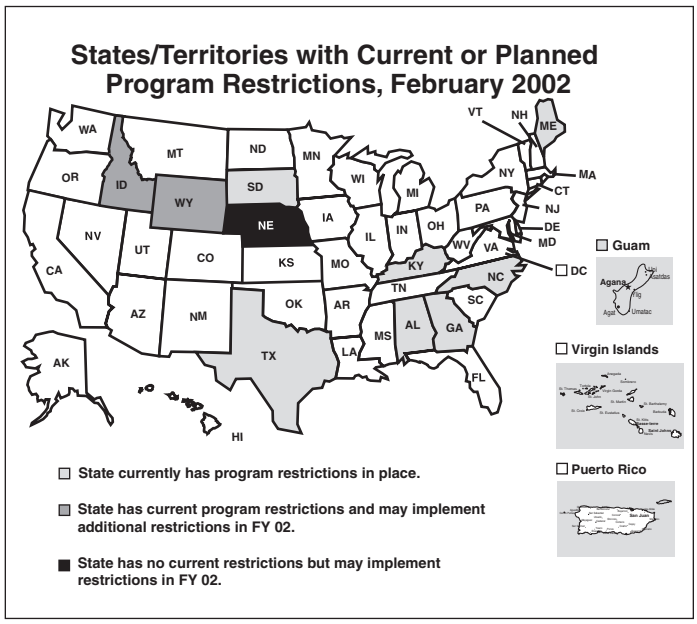
- The national ADAP budget grew to $810 M in FY 2001, an increase of approximately 12% or $86 M over FY 2000. The national ADAP budget has increased more than fourfold since FY 1996 ($188.5M).
- The core of the national ADAP budget continues to be the federal ADAP earmark allocated under Title II of the Ryan White CARE Act (71%). The new ADAP "Supplemental" (part of the Ryan White CARE Act amendments of 2000) in which 3% of the ADAP earmark was set aside for supplemental grants to states with severe needs, began in FY 2001.
- Some states contribute state general revenue support to ADAPs. State funding rose nationally, by 12%, from $129.8 M in FY 2000 to $149.6 M in FY 2001. Sixteen states did not provide any state funding for their ADAPs and rely solely on federal funds to provide ADAP services.



ADAP Restrictions, Budget Shortfalls, and Unexpended Funds

Despite significant growth in the national ADAP budget, several states faced access limitations:

- As of February 2002, ten states—Alabama, Georgia, Idaho, Kentucky, Maine, North Carolina, South Dakota, Texas, Wyoming, and Guam—reported having one or more program restrictions such as capped enrollment, limited antiretroviral access, or expenditure caps.
- All of these states, except Guam, have reported restrictions in four of the last six fiscal years.
- The three states reporting capped or restricted access to antiretroviral drugs were Maine, Texas, and Guam.



The Future of ADAPs

Six years after the introduction of protease inhibitors, trends in ADAP client, expenditure, and budget growth have remained relatively constant, as all three continue to grow but at slower rates. National ADAP budget growth, however, has not eliminated program restrictions and limitations in some states, and access continues to vary across the country due to the availability of other resources—and therefore the size of the gap that ADAPs are asked to fill—as well as state discretion over ADAP program design. Indeed, ADAPs operate within a dynamic environment, and are subject to changes in federal and state political and fiscal priorities and to changes in HIV-related treatment and technology. ADAPs will continue to play a vital role in the healthcare of many uninsured and underinsured HIV infected individuals, and serve as a bridge to comprehensive health care resources including other Ryan White funded programs, Medicaid, and private insurance.

Prepared by Arnold Doyle, Chris Aldridge, and Danielle Davis of the National Alliance of State and Territorial AIDS Directors (NASTAD), Jennifer Kates of the Henry J. Kaiser Family Foundation, and Lei Chou of the AIDS Treatment Data Network (ATDN). Data from this report are part of the *National ADAP Monitoring Project*, a project of the Kaiser Family Foundation conducted by NASTAD and ATDN. The full report can be accessed at www.atdn.org/access/adap, www.nastad.org, and www.kff.org.

ENDNOTES

[1]The term "state" includes both states and territories.

[2]The Federated states of Micronesia and the Marshall Islands, two Pacific U.S. Territories, will receive federal ADAP earmark funding for the first time in FY 2002.

[3]The National ADAP Monitoring Project collects data based on a one-month snapshot each year. The Health Resources and Services Administration (HRSA), which administers the Ryan White CARE Act, estimates that ADAPs served 137,800 unduplicated clients in FY2001 (HRSA, HIV/AIDS Bureau, ADAP Fact Sheet).

[4]Trend analysis includes those states reporting complete client and expenditure data for the entire period of the National ADAP Monitoring Project, 1996 through 2001.