



## AIDS DRUG ASSISTANCE PROGRAM (ADAP) FUNDING OVERVIEW

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was enacted in 1990, reauthorized in 1996 and again in 2000 to provide primary care and support services to low-income and uninsured individuals with HIV/AIDS. The CARE Act is administered by the Health Resources and Services Administration and its HIV/AIDS Bureau.

The CARE Act is the largest source of Federal funding specifically directed to provide primary care and support services for low-income, uninsured, and under-insured persons living with HIV disease. Under Title II of the CARE Act, formula grants are awarded to States and eligible U.S. Territories to improve the quality, availability, and organization of HIV health care and support services. In addition to other specific service programs, Title II funds AIDS Drug Assistance Programs (ADAPs). ADAPs provide medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid, in all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam. Territories including American Samoa, the Commonwealth of the Northern Mariana Islands, Palau, the Federated States of Micronesia and the Republic of the Marshall Islands are also eligible to establish ADAPs.

### Increased Demand for ADAPs

The last several years have seen an unprecedented growth in client demand and program costs for ADAPs. This is due to:

- the rapid expansion of the HIV/AIDS epidemic among low-income and uninsured populations;
- the high cost of protease inhibitors and other antiretroviral medications that are used in multiple-drug regimens;
- people with HIV/AIDS who are receiving therapy are living longer; and
- the increasing numbers of people with HIV/AIDS seeking combination therapy as a result of widely publicized research that supports new pharmaceutical therapies for improving their health status and quality of life.

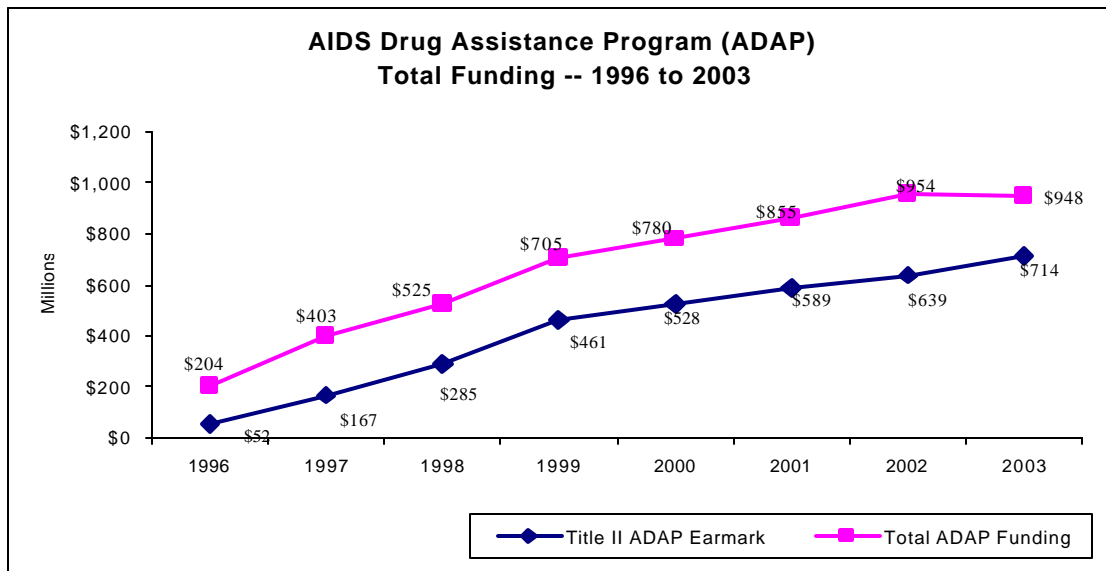
Future demand on ADAP resources is expected to escalate as the standard of care improves for people with HIV/AIDS and as patients continue to respond to new drug therapies.

### Overview of Funding

In response to the increased demand, Federal and other funding of ADAPs have grown significantly (see chart). Federal sources of ADAP funding include:

- Title II-earmarked ADAP funds—awarded to States based on formula. All such funds must be used for ADAP;
- Title II grants—awarded to States based on formula. States have limited discretion in using these funds to provide health care and support services for people living with HIV disease. A portion of these funds may be directed to ADAPs.
- Title I grants to Eligible Metropolitan Areas (EMAs—areas disproportionately affected by the HIV epidemic)—awarded based on formula and need; these grants are used by EMAs to meet needs identified and prioritized by their HIV Services Planning Councils. Funded priorities may include ADAPs.

States also allocate general revenue or other State funds to support their ADAPs. In FY 2003, 37 States projected the appropriation of State funds to ADAPs. In addition, ADAPs use various cost-containment strategies that maximize funds, allowing ADAPs to serve more people living with HIV/AIDS.



### Federal Support

**Title II ADAP Earmark:** In response to fiscal challenges for States, Congress designated dollars specifically to State ADAPs. This Title II supplemental funding is known as the ADAP earmark. In FYs 1996 and 1997, \$219 million in appropriated funds were earmarked specifically for ADAPs. In FY 1998, the earmark climbed to \$285.5 million. That figure rose to \$461 million for FY 1999. By FY 2003 ADAPs received \$714 million, bringing total ADAP funding to over \$3 billion since 1991.

**Title II Support:** In response to the rapid increase in program costs and greater demand for access to antiretroviral medications, some States and Territories have chosen to add some of their Title II base funds to their ADAP. In FY 2003, it is predicted that 16 States will contribute an average of 16% of their Title II base awards to their ADAP.

**Title I EMA Support:** Another source of funding for some ADAPs comes from voluntary allocations from Title I awards. Title I of the CARE Act funds eligible metropolitan areas (EMAs). These are geographic areas (usually cities) with a high population of HIV-infected individuals. By FY 1999, it appeared that some EMAs began to decrease their contributions to their State ADAP due to the increase in ADAP earmark dollars. If increasing drug costs and client enrollment begin to outpace ADAP earmark funding, it is uncertain if Title I programs will be able to continue this trend of decreasing contributions to State ADAPs. In FY 1998, Title I programs in 13 States contributed \$28.8 million to ADAPs. By FY 2003, twelve States project that Title I will contribute just over \$23 million to their ADAP.

**ADAP Supplemental Grants:** Beginning in FY 2001, 3 percent of the ADAP earmark is to be used for supplemental grants to "severe need" States and Territories to increase access to therapeutics. In FY 2003, 17 States and Territories received \$21.4 million in supplemental funding.

### State General Support

Many States also allocate general revenue or other State funds to support their ADAPs. In FY 2003, 37 States projected appropriations of approximately \$165 million to their State ADAP.

### Cost-Containment Strategies

Most States participate in multiple strategies designed to maximize available ADAP funds and assist the greatest number of people living with HIV/AIDS. Generally, these strategies result in savings that revert directly back into the State's ADAP budget. One example of a cost-savings method includes participation in the Section 340B Drug Discount Program, either through a point of purchase discount or through the ADAP rebate option. Other examples include negotiated discounts with wholesalers or pharmacies, purchase of insurance services for clients, and insurance recovery mechanisms for clients who have partial drug benefit coverage through Medicaid or

a private insurer. For example, an ADAP might supplement a State Medicaid or insurance program that limits the number of prescriptions that can be filled per month.

In FY 1998, 24 States received \$37.4 million as a result of these cost-savings mechanisms, funds that were then used to purchase additional pharmaceuticals. By FY 2003, 24 States project a total savings of nearly \$112.2 million through use of cost-saving strategies and carry-over dollars.

### **Current and Emerging Issues**

As new and rapidly changing treatments enhance individuals' overall health status and improve their quality of life, ADAPs will continue to face fiscal challenges. Most ADAPs project program growth, with increasing enrollment and utilization of emerging drug therapies. HIV Clinical Treatment Guidelines emphasizing combination antiretroviral drug therapies continue to impact the overall increase in enrollment and costs. The advent of new, more effective therapeutics require that care providers, ADAPs, and patients view HIV as a treatable and chronic disease, factors that will affect ADAP policies. ADAPs continue to explore resource opportunities such as the use of Ryan White funds to purchase health insurance policies for individuals with HIV/AIDS. Finally, continued budget constraints and the need for HIV-trained and qualified primary health care providers must be anticipated.



### ADAP Funding Information, FY 2003

Grantee	ADAP Earmark	ADAP Supplemental*	TITLE II Base Funds	TITLE I Funds	State Funds	Other Funds
Alabama	\$6,565,936	\$838,770	0	0	\$2,709,693	0
Alaska	\$423,385	\$0	0	0	\$57,731	0
American Samoa (2)	\$2,314	\$0	0	0	0	0
Arizona	\$7,861,540	\$0	0	125,000	\$1,000,000	0
Arkansas	\$3,033,102	\$0	0	0	\$330,810	0
California	\$86,118,340	\$0	11,608,187	0	\$65,568,985	\$22,773,138
Colorado	\$5,300,409	\$677,104	136,000	687,497	\$1,257,548	0
Connecticut	\$10,936,287	\$0	0	0	\$606,678	0
Delaware	\$3,019,220	\$0	0	0	0	\$1,600,000
D.C. (1)	\$12,560,419	\$0	0	0	\$400,000	0
F. Sts. Micronesia (2)	\$0	\$0	0	0	0	0
Florida	\$77,118,519	\$0	1,916,336	0	\$9,000,000	0
Georgia	\$22,615,232	\$2,888,997	0	1,540,022	\$12,027,588	0
Guam	\$80,975	\$10,344	0	0	0	0
Hawaii	\$1,929,525	\$0	0	0	\$540,535	0
Idaho	\$439,580	\$56,154	349,882	0	\$175,995	\$250,000
Illinois	\$23,263,034	0	0	0	\$7,100,000	0
Indiana	\$6,063,890	\$0	1,972,290	0	0	\$180,000
Iowa	\$1,260,900	\$0	0	0	0	0
Kansas	\$2,010,500	\$0	0	0	\$400,000	\$450,000
Kentucky	\$3,930,770	\$502,139	0	0	\$215,535	\$61,562
Louisiana	\$12,696,920	\$1,621,976	0	0	\$405,494	0
Maine	\$791,244	\$0	0	0	\$57,638	\$120,000
Marshall Islands (2)	\$2,314	\$0	0	0	0	0
Maryland	\$24,359,670	\$0	0	57,425	0	\$2,100,000
Massachusetts	\$14,422,850	\$0	0	140,819	\$2,947,990	\$1,200,000
Michigan	\$10,399,536	\$0	0	0	0	\$5,500,000
Minnesota	\$2,949,813	\$0	0	0	\$962,500	\$720,000
Mississippi	\$5,360,562	\$0	1,093,008	0	\$750,000	0
Missouri	\$7,276,205	\$0	500,000	500,000	\$2,134,000	\$1,500,000
Montana	\$298,452	\$0	127,820	0	0	\$65,000
Nebraska	\$1,066,560	\$136,248	54,312	0	\$148,522	0
Nevada	\$4,499,911	\$0	0	65,250	\$1,350,947	0
New Hampshire	\$724,150	\$0	0	912,561	0	\$150,000
New Jersey	\$33,810,639	\$0	0	0	0	\$7,750,000
New Mexico	\$2,052,144	\$0	0	0	0	0
New York	\$120,525,883	\$0	1,800,000	18,000,000	\$9,000,000	\$51,492,994
North Carolina	\$11,274,069	\$1,440,213	0	0	\$8,715,248	\$2,500,000
North Dakota	\$92,543	\$0	94,190	0	0	\$32,000
Northern Mariana (2)	\$4,627	\$0	0	0	0	0
Ohio	\$10,147,356	\$0	0	248,333	\$6,236,019	\$70,000
Oklahoma	\$3,551,343	\$453,669	393,268	0	\$899,417	\$750,000
Oregon	\$4,023,313	\$0	0	250,000	0	\$4,061,400
Pennsylvania	\$25,692,292	\$0	0	0	\$9,365,000	\$4,350,000
Puerto Rico*	\$21,904,963	\$2,798,263	2,799,259	0	\$2,790,000	0
Republic of Palou (2)	\$0	\$0	0	0	0	0
Rhode Island	\$1,830,041	\$0	0	0	0	\$700,000
South Carolina	\$11,065,847	\$1,413,613	0	0	\$853,403	0
South Dakota (1)	\$189,713	\$0	95,791	0	0	0
Tennessee	\$9,927,566	\$0	0	0	0	0
Texas	\$48,434,770	\$6,187,328	119,000	0	\$11,535,176	0
Utah	\$1,904,075	\$0	0	0	\$79,800	0
Vermont	\$381,740	\$0	0	0	\$175,000	\$110,000
Virgin Islands*	\$596,903	\$76,252	0	0	0	0
Virginia	\$13,906,922	\$1,776,548	0	0	\$3,056,337	\$1,814,775
Washington	\$7,722,726	\$0	0	527,000	\$2,201,677	\$925,000
West Virginia	\$1,223,883	\$156,346	350,000	0	\$113,920	\$350,000
Wisconsin	\$3,100,195	\$396,036	0	0	\$203,073	\$585,790
Wyoming	\$150,383	\$0	0	0	0	0
<b>TOTAL</b>	<b>\$692,896,000</b>	<b>\$21,430,000</b>	<b>\$23,409,343</b>	<b>\$23,054,159</b>	<b>\$165,372,259</b>	<b>\$112,161,659</b>

Based on projections reported by States in their Ryan White CARE Act FY 2003 Title II Application Profiles.

\*FY 2003 is the first year that the Guam and Puerto Rico applied for and received ADAP Supplemental Funds.