National ADAP Monitoring Project

Annual Report

APRIL 2007

NASTAD™
NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS

THE HENRY J. KAISER FAMILY FOUNDATION

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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: Abbott Laboratories, Boehringer Ingelheim Pharmaceuticals, Gilead Sciences, GlaxoSmithKline, Pfizer, Roche, Solvay Pharmaceuticals and Tibotec Therapeutics. Outside of the National ADAP Monitoring and Technical Assistance Program, NASTAD has a Training and Technical Assistance Cooperative Agreement with the Health Resources and Services Administration (HRSA) to provide technical assistance to ADAPs.

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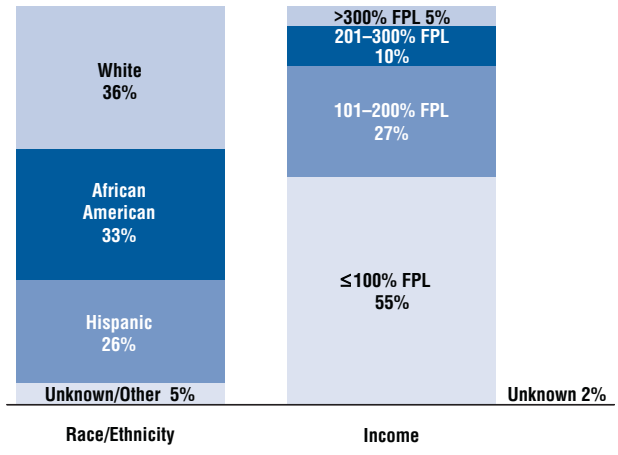
Summary & Highlights

The *National ADAP Monitoring Project* Annual Report is based on a comprehensive survey of all state and territorial AIDS Drug Assistance Programs (ADAPs), state-level[1] programs that provide prescription drug medications to low-income people with HIV/AIDS. The *ADAP Monitoring Project* is a more than 10-year effort of the National Alliance of State and Territorial AIDS Directors (NASTAD) and the Kaiser Family Foundation (Kaiser). Each year, the project documents new developments and challenges facing ADAPs, assesses key trends over time, and provides the latest available data on the status of these programs. Data in the current report are from FY 2006 and June 2006, unless otherwise noted. Key highlights from this year's report are as follows:

- ADAPs are the **nation's prescription drug safety-net for people with HIV/AIDS, serving primarily low-income, people of color who have limited or no access to needed medications**. Acting as payer of last resort, ADAPs provide HIV medications, the linchpin of HIV care today, to people with HIV/AIDS who would otherwise fall through the cracks in the larger U.S. health care system. With close to 142,000 enrollees, ADAPs reach approximately one-quarter of all people with HIV/AIDS in care. About two-thirds of those served are people of color, more than half have incomes at or below 100% of the Federal Poverty Level (FPL was $9,800 annually for a family of one in 2006), and almost three-quarters are uninsured.

Profile of ADAP Clients, June 2006



Note: Delaware, Guam, and New Mexico are not included in race/ethnicity and income data. The Federal Poverty Level (FPL) was $9,800 for a single person in 2006. Percentages may not total 100% due to rounding.

ADAP SNAPSHOT

- Number of ADAPs, FY 2006: 54
- Total ADAP Budget, FY 2006: $1.4 billion
- Federal ADAP Earmark, FY 2006: $789 million
- Clients Enrolled, June 2006: 141,856
- Spending on Prescription Drugs/Insurance, June 2006: $101 million

- The ADAP safety-net, however, varies significantly across the country and, ultimately, **what one gets depends on where one lives**. For example, ADAP income eligibility in June 2006 ranged from 125% FPL in one state to 500% FPL or more in four. Formulary coverage varies from just a few medications in some states, including one state that does not cover any protease inhibitors and several that do not cover the one approved fusion inhibitor, to open formularies in others. This variation is the result of the way in which ADAPs, and the Ryan White Program overall, are structured—as discretionary grant programs, not entitlements, they are dependent on annual federal appropriations and funding from states and other sources where available, resources that are not necessarily tied to the number of people who need services and the cost of their care.

- ADAPs must therefore **delicately balance available program capacity with client demand**. To do so, ADAPs use the "levers" available to them, particularly through setting income and other eligibility criteria and determining the composition of their formularies. In some cases, this balancing act becomes one of difficult trade-offs between serving more people with less services and serving less people with more.

- **Waiting lists, while much fewer in number than in previous reports, do continue and after falling from their peak, may be showing signs of increase again.** Waiting lists reached their peak in mid-2004 but began to decline soon after, largely due to the introduction of the President's ADAP Initiative, time-limited funds to address waiting lists, and to increases in state funding; some ADAPs also report that the new Medicare Part D prescription drug benefit helped to alleviate their waiting lists. Still, in March 2007, four states reported waiting lists, totaling 571 people, the highest number of people on waiting lists in more than 12 months.

- Importantly**, states have come to the fore as a major source of ADAP funding, and key driver of budget increases.** While not required to provide funding to their ADAPs (except in limited cases), state funding contributions to ADAPs increased more than any other budget component between FY 2005 and 2006, driving 60 percent of overall national ADAP budget growth. States have also been increasingly active in seeking drug rebates, another key source of funding used by programs.
- **One of the most significant developments to affect ADAPs was the implementation of the new Medicare Part D drug benefit.** Soon after implementation in January 2006, ADAPs began transferring some or all of their eligible clients to Part D, and/or moved from paying for medications in full to picking up ADAP client Part D cost-sharing expenses and were required to do so by May 15, 2006. For the first time in the history of tracking ADAPs, the *National ADAP Monitoring Project* is reporting stabilization in the number of clients served between the June 2005 and June 2006 monthly snapshots and a decrease in drug expenditures. ADAPs report that client stabilization was due to the one-time transfer of some clients to Part D and is not expected to continue; in fact, client enrollment has continued to increase, as has the number of clients served by ADAPs through insurance purchasing and maintenance arrangements.

  It is less clear what will happen with ADAP drug expenditures in the context of the new benefit. While it generally costs less for ADAPs to pay Medicare Part D cost-sharing than for medications directly, the timing of Part D implementation for ADAP clients (May 15, 2006) and this year's survey data (June 2006) mean that ADAPs had not yet experienced what may happen when those same clients reach Part D's coverage limit (the so-called "doughnut hole") due to the high cost of HIV medications, and must pay in full for their costs.

Medicare Part D

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established a new outpatient prescription drug benefit known as Part D, effective January 1, 2006. Enrollment in Part D is voluntary, except for those who are dually eligible for Medicaid and Medicare. Part D provides prescription drug coverage up to an initial coverage limit ($2,250 in 2006; $2,400 in 2007), after which enrollees reach a coverage gap (the so-called "doughnut hole") where they must pay 100% of their drug costs until they reach a catastrophic coverage level ($3,600 in 2006; $3,850 in 2007). The costs that must be incurred by enrollees to reach the catastrophic level are called *True Out of Pocket Costs* (TrOOP). Low-income Part D enrollees are eligible for substantial premium and cost-sharing assistance.

Approximately 17,000 ADAP enrollees are estimated to be Medicare-eligible. As the payer of last resort, as specified in Ryan White legislation, ADAPs must ensure that all of their Medicare Part D-eligible clients enroll in a Medicare Part D drug plan (or at least ensure that they are not paying for any Medicare covered prescription drug service for Medicare eligible ADAP clients). At the same time, ADAPs are permitted, but not required, to coordinate with Medicare prescription drug plans and, in accordance with state policy, pay for all or part of an ADAP-eligible Medicare beneficiary's prescription drug premiums, deductibles, coinsurance, and/or co-payments. Any Part D payments made by an ADAP on behalf of its clients, however, are prohibited from being applied toward TrOOP. This means that ADAP-eligible Medicare enrollees must incur these costs themselves before they reach catastrophic coverage levels under Part D, and may find themselves in the coverage gap. Since HIV-related medications are expensive and many ADAP-eligible Medicare clients are low-income, most ADAPs have developed policies to coordinate with Part D in order to help maintain appropriate medication coverage for their clients, including paying for their drug costs during the coverage gap. Some ADAPs report coordinating with their state's pharmacy assistance program (SPAP) to cover costs during the coverage gap, since SPAP payments do count towards TrOOP. However, this option is only available to a small number of states.

During 2006, the first year of Part D implementation, ADAPs were required to ensure that their Medicare eligible clients were enrolled in a Part D prescription drug plan by May 15 (or that the ADAP was no longer paying for any Medicare-eligible prescription drug service on their behalf). It is important to note that this deadline immediately preceded the time period represented by much of the data in this year's ADAP Monitoring Report. As noted in the report, the stabilization of client utilization in June 2006 compared to June 2005, and drop in drug expenditures between these two monthly snapshot periods, is due in large part to the one-time transfer of some Medicare-eligible ADAP clients to Part D. This trend in stable client utilization is not expected to continue for ADAPs, with growth again expected between FY 2006 and FY 2007. It is unclear what will happen with expenditures moving forward. ◗

In some cases, these individuals may need to turn back to ADAP. Moreover, where ADAPs pick up their costs, as about half of states said they will do, the costs will not count towards a client's *True Out of Pocket Costs* (TrOOP), needed to reach Part D's catastrophic coverage levels and return to Medicare coverage. This could mean that ADAPs will continue to need to pay for their costs once again and for an indefinite period. Still, Part D has allowed some ADAPs to accommodate new clients who were not previously able to access the program, including one state that reported being able to eliminate its waiting list. The *National ADAP Monitoring Project* will continue to closely track the impact of Part D on ADAPs moving forward.

- Finally, the latest **reauthorization of the Ryan White program, particularly its new minimum ADAP formulary requirement, is likely to offer both new opportunities and challenges** to ADAPs and ADAP clients. The minimum ADAP formulary is the first in the program's history. As of July 1, 2007, ADAPs will be required to cover at least one medication from each approved antiretroviral drug class (currently there are four, but this provision will apply to any future classes of ARVs). As this report shows, this will require one state to add at least one protease inhibitor and six to add the only approved fusion inhibitor, currently one of the most expensive antiretrovirals available. In addition, it is very likely that medications in new classes of ARVs will be approved over the next couple

Ryan White Reauthorization

The Ryan White CARE Act, now called "Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006," or the "Ryan White Program," is the single largest federal program designed specifically for people with HIV/AIDS. ADAPs, which saw their precursor in the 1980s when federal assistance was initially provided to states for purchasing the first approved antiretroviral medication, AZT, were incorporated into Ryan White when it was first enacted in 1990. Ryan White was reauthorized in both 1996 and 2000, and was just reauthorized for the third time in December 2006. Whereas all prior authorizations were for five-year periods, the recent authorization extends for three years.

Each reauthorization of Ryan White has brought changes and new developments for ADAPs, as well as for other parts of Ryan White, reflecting both past experience and anticipated issues and challenges moving forward. The 1996 reauthorization created the federal ADAP earmark. The 2000 reauthorization created the Supplemental Treatment Drug Grant Program, included a provision allowing ADAPs to use funds for insurance purchasing and maintenance, and increased their flexibility to provide other limited services (e.g., adherence support and outreach).

The 2006 reauthorization brought further changes to ADAPs, which will go into effect in the near future, including:

- **Minimum ADAP Formulary:** for the first time in the program's history, ADAPs will be required to cover at least one medication from each of the approved major antiretroviral drug classes, as indicated in the Department of Health and Human Services "Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents" (currently there are four classes, but this provision will apply to any future classes of ARV medications that are incorporated into the Guidelines). The new provision will go into effect on July 1, 2007.
- **Earmark Formula:** the formula used for distribution of federal ADAP earmark funding will change. Previously, estimated living AIDS cases were utilized in determining ADAP formula awards. The new formula will move from estimated living AIDS cases to actual AIDS cases and will also include HIV cases. This change will likely result in funding shifts for ADAP earmark awards, although they will be limited by the hold harmless requirement which will ensure each state receives at least 95% of its FY 2006 amount.
- **ADAP Supplemental:** several changes were made to the ADAP supplemental grant program. The set-aside will increase from three to five percent of the ADAP earmark; eligibility requirements will change; and matching requirements can now be waived if certain other requirements are met. At the time of this report, HRSA was still finalizing new supplemental award funding distribution guidelines based on changes made in the reauthorization, for FY 2007 and beyond (see box on "Allocation of Federal Funding to ADAPs & State Match Requirements" for more detail).

Beyond these ADAP-specific changes, reauthorization has brought changes to other parts of the Ryan White Program that may affect ADAPs, such as changes in the way overall state Title II funding will be distributed across the country, which in turn could affect the amount of funds states have available to provide to ADAPs. ◗

of years. It is unclear what the effects of this new requirement will be—it may serve to expand access to highly effective medications not previously available in some cases, while straining ADAP resources in others, which itself could result in access limitations to other components of the program. Reauthorization will also bring changes to the way in which funding is distributed to states through Ryan White, including to the federal ADAP earmark and ADAP Supplemental Drug Treatment Grants, and likely result in funding shifts in some places.

In addition to these overarching trends and findings concerning ADAPs, a background and overview on ADAPs are provided below, followed by detailed findings on clients, drug expenditures, budgets, eligibility, and other key aspects of the program. The full report contains charts and appendices with state-level data.

Background and Overview of ADAPs

The AIDS Drug Assistance Program (ADAP) of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, now called "Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006," or the "Ryan White Program," [2,3] is a critical source of prescription drugs for low-income people with HIV/AIDS in the United States who have limited or no prescription drug coverage. With almost 142,000 enrollees, ADAPs reach approximately one quarter of people with HIV/AIDS estimated to be receiving care nationally.[4] ADAPs provided medications to more than 96,000 clients and insurance coverage to thousands more in the month of June 2006 alone. In addition to helping to fill gaps in prescription drug coverage, ADAPs serve as a bridge between a broader array of healthcare and supportive services funded by Ryan White, 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.

The purpose of ADAPs, as stated in Ryan White legislation, is to:

> … provide therapeutics to treat HIV disease or prevent the serious deterioration of health arising from HIV disease in eligible individuals, including measures for the prevention and treatment of opportunistic infections … .[2]

Key Dates in the History of ADAPs

1987: First antiretroviral, (AZT, an NRTI), approved by the FDA; Federal government provides grants to states to help them purchase AZT, marking beginning of federally-funded, state administered "AZT Assistance Programs."

1990: ADAPs incorporated into Title II of the newly created Ryan White CARE Act.

1995: First protease inhibitor approved by FDA, and the highly active antiretroviral therapy (HAART) era begins.

1996: First Reauthorization of CARE Act—Federal ADAP earmark created; first non-nucleoside reverse transcriptase inhibitor (NNRTI) approved by FDA.

2000: Second Reauthorization of CARE Act, changes for ADAPs include: allowance of insurance purchasing and maintenance; flexibility to provide other limited services (e.g., adherence support and outreach); and creation of ADAP supplemental grants program, using a set-aside of the federal ADAP earmark for states with "severe need."

2003: NASTAD's ADAP Crisis Task Force formed to negotiate with pharmaceutical companies on pricing of antiretroviral medications; first fusion inhibitor approved by FDA.

2004: President's ADAP Initiative (PAI) announced, allocating $20 million in one-time funding outside of the ADAP system to reduce ADAP waiting lists in ten states.

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

ADAPs accomplish this 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. ADAPs began serving clients in 1987, when Congress first appropriated funds ($30 million over two years)[5] to help states purchase AZT, the only FDA-approved antiretroviral drug at that time. In 1990, these federally-funded, state administered "AZT Assistance Programs" were incorporated into the newly created Ryan White Program under Title II (grants to states, now known as "Part B") and became known as "AIDS Drug Assistance Programs," or ADAPs. The Ryan White Program is the nation's third largest source of federal funding for HIV care, after Medicaid and Medicare.[6]

Since FY 1996, Congress has specifically earmarked funding within Title II of Ryan White for ADAPs, which is allocated by formula to states.[7] The ADAP earmark has become the largest component of the overall ADAP budget. ADAPs may also receive funding from other sources, including state general revenue support,[8] and from other parts of Ryan White, and programs may seek manufacturers' drug rebates, but these other 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 Ryan White Program. In FY 2006, 54 jurisdictions were eligible for federal ADAP earmark funding, including all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam; HRSA determined that some previously funded territories were not eligible for ADAP funding in FY 2006. The recent reauthorization of Ryan White specified that all territories will again be eligible for ADAP funding beginning in FY 2007.

Each state administers its own ADAP and is given flexibility under Ryan White to design many aspects of its program, including client eligibility, drug purchasing

Allocation of Federal Funding to ADAPs & State Match Requirements

Each year, Congress specifically earmarks federal funding for ADAPs through Ryan White Title II (funding for care grants to states, now called Part B). To date, the formula used to allocate these funds to state jurisdictions each year has been based on their proportion of the nation's estimated living AIDS cases. The recent reauthorization of the Ryan White Program will change the formula by moving from estimated living AIDS cases to actual AIDS cases and by including HIV cases. HIV and AIDS case counts will be determined in one of two ways: (1) as certified by the Centers for Disease Control and Prevention (CDC) in states with "mature" HIV name reporting systems; or (2) as reported to the Health Resources and Services Administration (HRSA) by jurisdictions without mature HIV name reporting systems (in this case, a five percent duplication penalty will be applied to a jurisdiction's count). A jurisdiction's proportion of AIDS and HIV cases will be applied to the funding available through the ADAP earmark to determine the award amount. In FY 2006, 54 jurisdictions were eligible for federal ADAP earmark funding, including all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam; some previously funded territories were determined by HRSA not to be eligible for ADAP funding in FY 2006. Beginning in FY 2007, all territories will again be eligible for ADAP funding, as specified in the recent reauthorization of Ryan White.

States with one percent or more of reported AIDS cases during the most recent two-year period must match (with non-federal contributions) their overall Ryan White 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 one percent threshold). States are not required, however, to use all or even part of the state match for ADAP and the match may consist of in-kind or dollar contributions from the state.

The 2000 reauthorization of Ryan White created a new "Supplemental Treatment Drug Grant Program" which awards grants, using a set-aside of the ADAP earmark (until the most recent reauthorization, this set-aside was three percent), to states with "severe need." To be eligible for supplemental awards, states were required to have at least one restriction in place as of January 1, 2000 related to ADAP income eligibility standards, formulary composition, or the number of eligible individuals at or below 200% of FPL to whom the state is unable to provide therapeutics. Award amounts were 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 was applied to the number of dollars available under the supplemental grant to determine each state's award amount. States applying for supplemental grants were required to 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). In FY 2006, 27 ADAPs were eligible for supplemental award funding and 20 applied for and met the matching requirements; the other eligible jurisdictions did not apply either because they could not meet the state match requirement or did not require supplemental funding. Beginning in FY 2007, the matching requirement can be waived if other Title II matching requirements are met, if applicable.

(continued on next page)

Allocation of Federal Funding to ADAPs & State Match Requirements *(continued)*

In FY 2006, while a three percent set-aside of the ADAP earmark was the basis for ADAP supplemental grants, the "hold harmless" clause in Ryan White legislation required that adjustments be made in ADAP earmark awards so that each overall state Title II award was at least equal to the previous year. In order to accomplish this in FY 2006, funding from the set-aside was taken from the supplemental grant pool before awards were made to states. This meant that the total ADAP supplemental amount available for awards was less than three percent of the ADAP earmark. Beginning in FY 2007, the hold harmless requirement is not tied to the ADAP supplemental grant set-aside and so the entire supplemental amount should be available for distribution to eligible states.

The 2006 reauthorization of Ryan White made a number of changes to the ADAP supplemental grant program including: increasing the supplemental set-aside of the ADAP earmark from three to five percent each year; moving from eligibility based on "severe need" to eligibility based on "demonstrated need," as measured by ADAP income eligibility criteria, formulary composition, the number of eligible individuals to whom a state is unable to provide medications, and an unanticipated increase in eligible individuals with HIV/AIDS; elimination of the requirement that these factors had to be tied to January 1, 2000; adding a requirement that states must have less than two percent of unobligated Title II funds remaining from the previous grant year to be eligible for supplemental grants; and providing an option for the state matching requirement to be waived (see above). At the time of this report, HRSA was still finalizing new funding distribution guidelines for the supplemental grants based on changes made in the reauthorization, for FY 2007 and beyond.

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

ADAP fiscal year: April 1–March 31
Federal fiscal year: October 1–September 30
State fiscal year (for most states): July 1–June 30

For example, the ADAP FY 2006 began on April 1, 2006 and ended on March 31, 2007. The Federal FY 2006 began on October 1, 2005 and ended on September 30, 2006. The State FY 2006, in most states, began July 1, 2006 and will end on June 30, 2007. ◗

and distribution arrangements, and to some extent, drug formularies. There is no client income eligibility level required, although clients must be HIV-positive, low-income, and under- or uninsured. Until the recent third reauthorization of Ryan White, no minimum drug formulary was required. The reauthorization added a new minimum formulary requirement for all ADAPs, effective July 1, 2007, to include, at a minimum, one medication from within each antiretroviral drug class (of which there are currently four). ADAPs will still be able to determine how many medications from within each ARV class are offered, what, if any, non-ARV medications are covered, and whether cost-sharing, quantity limits, or drug specific eligibility criteria are instituted.

Like all Ryan White programs, ADAPs serve as "payer of last resort"; that is, they provide prescription medications to, or pay for health insurance premiums or maintenance (premiums, co-pays, and/or deductibles) 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,[9] and their funding may not correspond to the number of people who need prescription drugs or to the costs of medications. Therefore, annual federal appropriations, and where provided, state funding and contributions from other sources, determine how many clients ADAPs can serve and the level of services they can provide. In addition, given that ADAPs are an integral component of the larger Ryan White system, the funding levels and capacity of other Ryan White components may also affect client access to ADAPs.

Detailed Findings

Detailed findings below are based on a comprehensive survey sent to all 54 jurisdictions that received federal ADAP earmark funding in FY 2006; 51 responded (see Methodology). All data are from FY 2006 and June 2006, unless otherwise noted (supplemental data collection was conducted in select areas).

CLIENTS, DRUG EXPENDITURES, AND PRESCRIPTIONS

ADAP Clients

- 141,856 clients were enrolled in ADAPs nationwide as of June 2006 (see Chart 2 and Appendix I). Client enrollment is an important measure of the aggregate number of clients who use ADAP services over time, since more clients are typically enrolled in ADAPs than seek services in any given month, reflecting changing clinical needs, differing 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 2006, 68% of those enrolled received prescription drugs through ADAP and additional clients received insurance coverage.
- ADAPs provided medications to 96,121 clients across the country in June 2006, and also paid for insurance coverage (premiums, co-pays, and/or deductibles) for 13,744 clients, some of whom may have also received medications (see Charts 3, 37 and Appendices I, XVIII).
- ADAP clients are predominantly low-income and uninsured. Most are people of color, male, and many have indicators of advanced HIV disease (see Charts 5–9 and Appendices IV–VII). In June 2006:
  - African Americans and Hispanics represented 59% (33% and 26%, respectively) of clients. Asian, Native Hawaiian/Pacific Islanders, and Alaskan Native/American Indians combined represented approximately two percent of the total ADAP population. White non-Hispanics comprised 36%.
  - More than three-quarters (78%) of ADAP clients were men and the majority of clients (54%) were between the ages of 25 and 44.
  - Eight in ten (82%) were at or below 200% of the Federal Poverty Level (FPL), including more than half (55%) at or below 100% FPL. In 2006, the FPL was $9,800 annually (slightly higher in Alaska and Hawaii) for a family of one.
  - A majority of ADAP clients (71%) were uninsured, with few reporting any other source of insurance coverage—17% private, 12% Medicare, and/or six percent Medicaid; three percent were dual beneficiaries of both Medicaid and Medicare. For those with other sources of coverage, ADAP fills their gaps, such as paying client cost-sharing requirements (e.g., co-pays, deductibles, etc.) and/or providing additional medications for those clients who may be subject to monthly or annual prescription drug limits under other forms of coverage.
  - More than half of ADAP clients (54%) had CD4 counts of 350 or below (at time of enrollment or at recertification), one potential indication of more advanced HIV disease.

ADAP Drug Expenditures and Prescriptions

- ADAP drug expenditures were $95,297,158 in June 2006, ranging from $22,411 in North Dakota to $19.9 million in California (see Chart 10 and Appendices I and II). In addition to providing medications, ADAPs spent $5.4 million on insurance purchasing/maintenance in June 2006 and report that FY 2006 spending on insurance totaled $83.5 million (see Chart 37 and Appendix XVIII). Estimated annualized ADAP spending on medications[10] and insurance was approximately $1.2 billion in 2006, or most (89%) of the ADAP budget.
- ADAPs filled a total of 344,904 prescriptions in June 2006, ranging from a low of 77 in North Dakota to almost 72,000 in California (see Chart 13 and Appendix III).
- Per capita drug expenditures were $991 in June 2006, or an estimated $11,897 in annual drug costs per client. Per capita expenditures in June 2006 ranged from a low of $87 in Oregon to $1,476 in New York (see Charts 1 and 12).
- Most ADAP drug spending is for FDA-approved antiretrovirals[11] (89% in June 2006). 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 than prescriptions filled (63% of prescriptions). The 29 "A1" drugs highly recommended for the prevention and treatment of HIV-related opportunistic infections[12,13] accounted for three percent of expenditures and nine percent of prescriptions (see Chart 13 and Appendices II and III).
- The average expenditure per prescription in June 2006 was $276. It was significantly higher for ARVs ($392) than non-ARVs ($76 for "A1" OIs and $82 for all other drugs). Among ARV drug classes, fusion inhibitors represented the highest expenditure per prescription ($1,260), followed by protease inhibitors ($410), nucleoside reverse transcriptase inhibitors ($399) and non-nucleoside reverse transcriptase inhibitors ($306).

Trends in Clients and Drug Expenditures

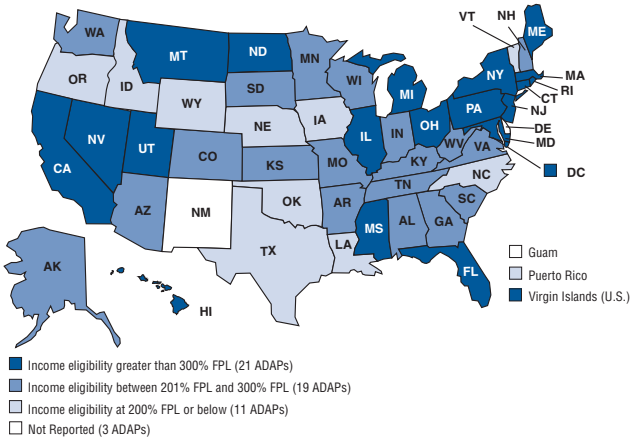
- Client enrollment has grown over time, reaching more than 141,000 in June 2006, a five percent increase over the prior period.
- Client utilization (the number of clients receiving prescription medications) has grown significantly since 1996 (203% among the 49 ADAPs reporting data in both periods), but growth has slowed considerably in recent years and has generally lagged behind the rate of increase in drug expenditures. For the first time since the *National ADAP Monitoring Project* began tracking ADAPs, however, client utilization remained relatively stable between June 2005 and June 2006 (a decrease of less than one percent) (see Chart 4). This relative stability between the two periods is attributable to the implementation of the Medicare Part D benefit and the one-time move of Medicare-eligible ADAP clients into Part D. This shift is not expected to continue, as some states are now able to accommodate additional clients, and not all states experienced it to the same degree—27 ADAPs reported decreases in clients served between the two periods; 21 reported increases (see Appendix I). In addition, the number of clients served by ADAPs through insurance purchasing/maintenance strategies continued to rise, increasing by 12% between June 2005 (12,311 clients) and June 2006 (13,744) and has almost doubled over a two-year period (see Chart 37).
- Drug spending by ADAPs has increased more than six-fold (508%) since 1996, more than twice the rate of client growth over this same period (in the same 49 states reporting data on clients). It too has continued to increase but at slower rates and, for the first time, was less in the current one-month snapshot compared to last year (a seven percent decrease among the 49 ADAPs reporting in both June 2005 and June 2006) (see Chart 11). ADAPs reported that this decrease is largely the result of the expected one-time move of Medicare-eligible ADAP clients into Part D, and/or the transition by ADAPs to paying for client cost-sharing for Medicare Part D (versus direct drug expenditures). In fact, drug expenditures likely decreased more than client numbers because many clients were maintained on ADAP while ADAPs shifted from paying full drug costs to Part D cost-sharing. As with clients, not all states experienced the same shift. Twenty-nine ADAPs had lower drug expenditures in June 2006 compared to June 2005; 20 had higher expenditures (see Appendix I). It is unclear what will happen with drug expenditures over time, and if such decreases will continue. While it generally costs less for ADAPs to pay Medicare Part D cost-sharing than for medications directly, the timing of Part D implementation for ADAP clients (May 15, 2006) and this year's survey data (June 2006) means that ADAPs had not yet experienced what may happen when those same clients reach Part D's coverage limit (the so called "doughnut hole") due to the high cost of HIV medications, and must pay in full for their costs. In some cases, they may need to turn back to ADAP. Moreover, where ADAPs pick up these costs, as about half of states said they will do, the costs will not count towards a client's TrOOP, needed to reach Part D's catastrophic coverage levels and return to Medicare coverage (see box on "Medicare Part D"). This could mean that ADAPs will continue to need to pay for their costs once again. In addition, since the start of the new benefit, different plans have entered or left the Part D market and some plans have changed their benefit structure, factors which could also affect beneficiaries with HIV. This impact will need to be closely monitored.
- As with drug expenditures, the number of prescriptions filled between the monthly snapshots fell (by nine percent), but has generally been increasing over time (see Appendix I).

ELIGIBILITY CRITERIA AND FORMULARIES

ADAP Eligibility Criteria

- All ADAPs require that individuals provide clinical documentation of HIV infection. Seven states reported additional clinical eligibility criteria (e.g., specific CD4 or viral load ranges), three more states than last year (see Appendix VIII).
- ADAP income eligibility in June 2006 ranged from 125% FPL in one state (North Carolina) to 500% FPL or more in four (Maryland, Massachusetts, New Jersey, and Ohio). Overall, 21 states set income eligibility at greater than 300% FPL, 19 between 201% and 300% FPL; 10 at 200% FPL and one at 125% FPL (see Chart 15). In November 2006, North Carolina raised its FPL from 125% to 200% FPL, representing the first time in the history of the project that no state currently has income eligibility below 200% FPL. In addition to income, 16 ADAPs reported having asset limits in place in June 2006.
- All ADAPs require enrollees to be residents of the state in which they are seeking medications. Some ADAPs require documentation of residency.

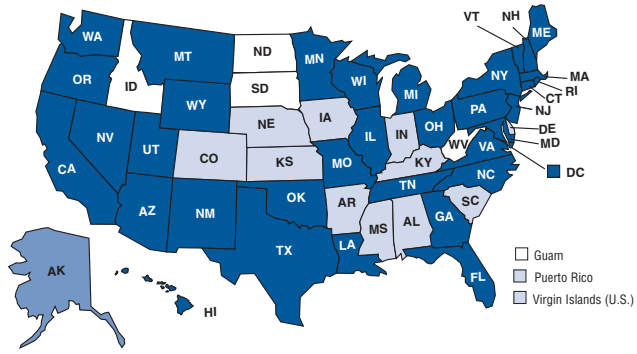
ADAP Income Eligibility by State, as of June 2006



Income eligibility greater than 300% FPL (21 ADAPs)
Income eligibility between 201% FPL and 300% FPL (19 ADAPs)
Income eligibility at 200% FPL or below (11 ADAPs)
Not Reported (3 ADAPs)

Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data and are not included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006. Florida changed its income eligibility level from 350% to 300% FPL in March 2007. North Carolina changed its income eligibility level from net family income of 125% to gross family income of 200% on November 1, 2006. The 2006 Federal Poverty Level (FPL) was $9,800 (slightly higher in Alaska and Hawaii) for a household of one.

ADAP Formulary Coverage of Antiretroviral Drugs by State, as of November 2006



Covers all ARVs in all four drug classes, NRTIs, NNRTIs, PIs, and Fusion Inhibitor (35 ADAPs)
Covers all NRTIs, NNRTIs, PIs, but not Fusion Inhibitor (1 ADAP)
Covers Fusion Inhibitor but not all NRTIs, NNRTIs, and PIs (13 ADAPs)
Does not cover Fusion Inhibitor or all drugs in other classes (5 ADAPs)

Note: 44 ADAPs reported data. For the states that did not report formulary coverage, last year's information was used. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006. Atripla is a multi-class combination product that includes efavirenz (NNRTI), emtricitabine (NRTI), and tenofovir disoproxil fumarate (NRTI). For the purposes of the *National ADAP Monitoring Project Annual Report*, Atripla is included in the NRTI class.

ADAP Formularies

- ADAP formularies vary significantly across the country, ranging from 19 drugs covered in Guam to nearly 500 in New York, as well as open formularies[14] in three states (see Appendix IX).
- While the majority of ADAPs (35) cover all antiretrovirals on their formularies, 19 ADAPs do not, including one that does not provide any protease inhibitors (South Dakota). There has been a steady increase in the number of ADAPs covering Fuzeon, the only approved fusion inhibitor for people with HIV/AIDS, and now most (48) provide this medication; six do not cover Fuzeon (see Chart 16 and Appendix IX).
- Coverage of medications to prevent and treat opportunistic infections and other HIV-related conditions is also highly variable across the country (see Charts 17, 18 and Appendices IX, X):
  - 37 ADAPs cover 15 or more of the 29 drugs highly recommended ("A1") for the prevention and treatment of opportunistic infections, including four that cover all 29 (Georgia, Massachusetts, New Hampshire, and New Jersey). Seventeen ADAPs cover less than 15 of these medications. One of these ADAPs does not include any medications for OIs or other HIV-related conditions on its formulary, and only covers antiretrovirals (Louisiana). It is important to note that ADAPs may cover slightly fewer than the full set of highly recommended OI medications because they cover equivalent medications, also highly recommended, on their formularies or have other state-level programs that can provide these medications.
  - 25 ADAPs cover treatments for hepatitis C (HCV), a major co-morbidity for people with HIV, and considered to be an HIV-related opportunistic infection.[13,15]
  - 21 ADAPs cover hepatitis A and B vaccines, recommended for those at high risk for and living with HIV.[16]

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 program enrollment until more resources become available. When an enrollment cap is reached, the next individual who seeks services cannot get them through the ADAP. States that have enrollment caps have often turned to waiting lists in order to facilitate client access when the program can accommodate them. In March 2007, four ADAPs had waiting lists, with a total of 571 individuals.

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 these programs, or through pharmaceutical manufacturer patient assistance programs (PAPs). PAPs, however, require people to apply often, sometimes as frequently as every month, and separate applications must be sent to the manufacturer of each medication needed. For someone on a multiple drug regimen, this process can be quite cumbersome and may not provide 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.

In recognition of the challenges waiting lists pose to ADAPs, in June 2004, President Bush announced the one-time availability of $20 million for HIV-related drug therapies, targeted at 10 states with waiting lists at that time. The "President's ADAP Initiative (PAI)" served to alleviate most waiting lists in the eligible states over the life of the Initiative (which ended in September 2006).

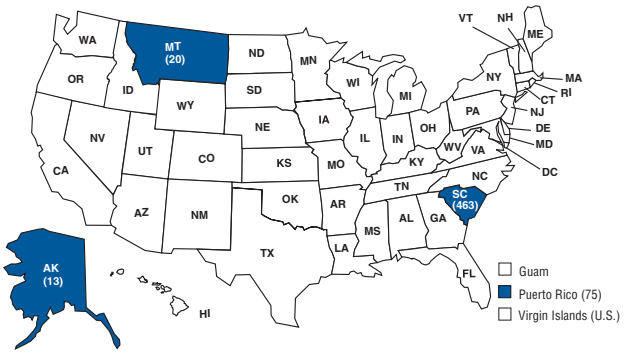
It is important to note that waiting lists are but one measure of unmet need for ADAP services. Some people who need ADAP services may not be counted on a waiting list. And, the level of services provided by ADAPs and the number of clients they serve vary across the country, so those receiving ADAP services in a state with a less comprehensive formulary may have unmet needs compared to others receiving services in a state with a more expansive formulary.

WAITING LISTS AND OTHER COST-CONTAINMENT MEASURES

Waiting Lists

- As of March 2007, four ADAPs had waiting lists in place, totaling 571 people with HIV who could not gain access to medications through their state's ADAP, despite meeting eligibility criteria (see Chart 19 and Appendix XI). Prior to July 2006, two of these states (Puerto Rico and South Carolina) had never implemented a waiting list before. The remaining two states (Alaska and Montana) have had an ADAP waiting list for almost two full years. In some cases, states and client case managers work with pharmaceutical manufacturer patient assistance programs (PAPs) to help those on waiting lists access medications. PAPs, however, are not meant to be permanent sources of drug access and they require people to apply often, sometimes as frequently as every month, and to apply to each drug manufacturer separately.

State ADAPs with Waiting Lists, March 2007 (571 Individuals in 4 States)



States with waiting lists in place as of March 1, 2007 (571 individuals—4 states)

Note: 52 ADAPs reported data. Delaware and Guam did not report data. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included in FY 2006 data because they did not receive ADAP funding.

- There is significant fluctuation in the size of waiting lists within and across states over time (see Charts 20 and 21). Based on bi-monthly surveys conducted between July 2002 and March 2007 (32 surveys overall), the number of people on waiting lists reached its peak in mid-2004 and was at its lowest in September 2006. Since that time, it has been increasing again. Between 2002 and 2007:
  - 20 ADAPs reported having a waiting list in place at some point over the period.
  - The fewest number of states reporting a waiting list in any given period was three; the most was 11.
  - 12 ADAPs had waiting lists in 10 or more of the survey periods.
  - The number of people on waiting lists ranged from a low of 302 to a high of 1,629 (the average was 729). The highest number of individuals on any one state's waiting list was 891 (North Carolina); the lowest was one (Alaska, Idaho, Montana, and West Virginia). North Carolina also had the highest average number of people on its waiting list over the period (337), followed by Alabama (188). The lowest average was four in Guam and Wyoming.

Other Cost-Containment Measures

- In addition to waiting lists, some ADAPs have instituted other measures to contain costs in FY 2006 (see Charts 22 and 23). Eight ADAPs reported implementing such measures including:
  - Two reduced the number of drugs on their formularies
  - Three further restricted eligibility to the program
  - One introduced client cost-sharing
  - Two capped enrollment
  - An additional three ADAPs anticipate having to newly institute cost-containment measures during ADAP FY 2007 (April 1, 2007–March 31, 2008).

ADAP BUDGET

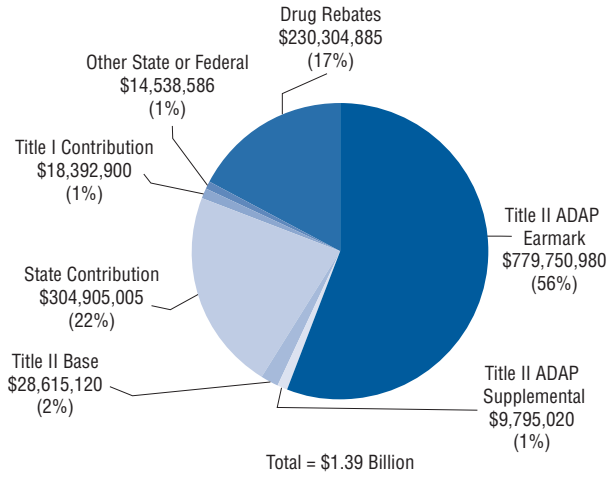
- The national ADAP budget reached $1.39 billion in FY 2006, an increase of seven percent over FY 2005. Since FY 1996, the budget has increased more than six-fold (see Charts 24, 28 and Appendices XIII, XIV). For purposes of determining the budget, federal, state, and drug rebate funds are counted. While rebates are variable and require states to actively pursue them, they have become an important source of revenue for ADAPs.
- The ADAP earmark (not including ADAP supplemental funding, which is a set-aside from the earmark) represented the largest share of the ADAP budget (56%), followed by state general revenue support (22%), and drug rebates (17%). Other sources of funding each represented two percent or less of the budget (see Chart 24 and Appendix XIII).
- States have increasingly come to the fore as a major source of funding, and key driver of budget increases, for ADAPs. While not required to provide funding to their ADAPs (except in limited cases), state funding contributions to ADAP increased more than any other budget component and drove 60% of overall national ADAP budget growth between FY 2005 and FY 2006. Such state support is, for the most part, dependent on individual state decisions and budgets; even where states are required to provide a match of federal Title II Ryan White funds, they are not required to

ADAP COST-CONTAINMENT MEASURES AND OTHER STRATEGIES FOR MANAGING COSTS

State ADAPs use a variety of strategies to contain costs. Some of these strategies may affect client access and services, whereas others may lead to a more efficient use of funding enabling ADAPs to serve more people. Occasionally 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 have included:

- Instituting waiting lists;
- Lowering financial eligibility criteria;
- Limiting and/or reducing ADAP formularies;
- Limiting access for a particular drug(s), including instituting a drug-specific waiting list;
- Instituting 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 (premiums, co-payments, deductibles) instead of medications directly;
- Seeking cost recovery through drug rebates and third party billing; and
- Using other, non-ADAP, Ryan White funds or other sources of funding (e.g., Ryan White Title II base funding, state funding) for ADAPs. ◗

National ADAP Budget, by Source, FY 2006



Note: 51 ADAPs reported data. Although Delaware, Guam, and New Mexico did not report, data on their Title II earmark and supplemental were available and included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006. ADAP supplemental funds are only available for states meeting the required eligibility and matching funds.

put this funding toward ADAP. In the case of ADAP supplemental funding, states are required to provide a state match, but this generally represents a relatively small share ($2.5 million, or less than one percent, in FY 2006) of state funding for ADAPs. States have also been increasingly active in seeking drug rebates, another key source of funding used by programs, and rebates were the second largest driver of budget growth over the last year.

- By definition, all eligible jurisdictions (54 in FY 2006) 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 2006, two ADAPs received only ADAP earmark funding. The breakdown of other sources of funding across the country was as follows (among 51 ADAPs reporting data) (see Chart 25 and Appendix XIII):
  - Title II ADAP Supplemental Treatment Grants: 20 ADAPs received funding, 34 did not;
  - Title II Base Funds: 21 ADAPs received funding, 30 did not
  - State General Revenue Support: 40 ADAPs received funding, 11 did not
  - Title I EMA Funds: 12 ADAPs received funding, 39 did not
  - Other State/Federal Funds: 14 received funding, 37 did not
  - Drug Rebates: 39 ADAPs received funding, 12 did not.
- Additionally, despite a seven percent increase in the national ADAP budget across all ADAPs between FY 2005 and FY 2006, some ADAPs had decreases either in their overall budget or for specific funding streams (see Chart 26 and Appendices XIV and XV):
  - Overall Budget: 34 ADAPs had increases or level funding, 20 had decreases
  - Title II ADAP Earmark: 48 ADAPs had increases; 6 had decreases
  - Title II ADAP Supplemental Treatment Grants: all 20 had decreases—See Chart 30 and box on "Allocation of Federal Funding to ADAPs & State Match Requirements"
  - Title II Base Funds: 15 ADAPs had increases or level funding; 10 had decreases
  - State General Revenue Support: 35 ADAPs had increases or level funding, 7 had decreases
  - Title I EMA Funds: 5 ADAPs had increases or level funding, 8 had decreases
  - Drug Rebates: 30 ADAPs had increases or level funding, 13 had decreases.
- State contributions to ADAPs ranged from 0%, in the 11 states that did not provide any state support, to 52% of the ADAP budget; Title II base funding ranged from 0% to 39%; Title I funding ranged from 0% to 34%; ADAP supplemental funding ranged from 0% to 5%; and drug rebates ranged from 0% to 43% of the ADAP budget (see Appendix XIII).
- The composition of the ADAP budget has shifted significantly over the past decade (see Chart 27):
  - The ADAP earmark has risen from one quarter (26%) of the budget in FY 1996, the year it began, to its current share of 56%. The earmark amount has risen each year over this period as well.
  - State general revenue support, while declining slightly as a proportion of the budget (from 25% in FY 1996 to 22% in FY 2006), has increased significantly in amount and has been the second largest source of funding over the entire period.
  - Drug rebates rose from six to 17% 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 NASTAD's ADAP Crisis Task Force in working to obtain rebates. 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 2006 than in FY 1996.

- Although the ADAP earmark continues to increase, its growth has slowed over time and it is no longer the largest driver of national ADAP budget growth as it was in earlier years. As noted above, the largest driver is now state funding, followed by drug rebates (see Charts 29–34 and Appendix XV).
  - The ADAP earmark increased by $15.1 million, or two percent, over FY 2005, the smallest increase since the earmark began.
  - State funding increased by $52.1 million, or 21%, over FY 2005.
  - Drug rebates increased by $33.8 million, or 17%, reaching their highest level to date.
  - After declining for several years in a row, Title II base funds allocated by states to ADAPs rose for the second year in a row to $28.6 million.
  - Contributions from Title I jurisdictions have fluctuated over time; they increased by $0.5 million between FY 2005 and 2006.
  - ADAP supplemental funds of $9.8 million in FY 2006, were their lowest since the program began. ADAP supplemental awards were provided to 20 states that met the federal eligibility criteria, applied for funding, and were able to meet the mandated matching requirement (27 were eligible). It is important to note that supplemental awards were reduced by 52% overall in FY 2006, in order to adjust the ADAP earmark awards in states that would otherwise have received an overall Title II award less than that of the previous year (per one of the hold harmless provisions of Ryan White that protects programs from this kind of overall decrease) (see box on "Allocation of Federal Funding to ADAPs & State Match Requirements").

- While not included as a budget category because this source of revenue is highly variable and often subject to lengthy delays for states to obtain, cost recovery, that is, reimbursement from third party entities such as private insurers and Medicaid, for medications purchased through ADAP (other than drug rebates), represented $31.4 million in FY 2006. Private insurance recovery was the largest component (64%) (see Chart 35 and Appendix XVI).

DRUG PURCHASING MODELS AND INSURANCE COVERAGE ARRANGEMENTS

Drug Purchasing Models

- The federal 340B program enables ADAPs to purchase drugs at or below the statutorily defined 340B ceiling price.[17] All ADAPs but one (the District of Columbia) participate (see Chart 36 and Appendix XVII).
  - ADAPs may purchase drugs either directly from wholesalers or through retail pharmacy networks and then apply to drug manufacturers for rebates. As of June 2006, 29 ADAPs reported purchasing directly; 25 reported purchasing through a pharmacy network and then seeking rebates.

ADAP CRISIS TASK FORCE

The ADAP Crisis Task Force was formed by a group of state AIDS Directors and ADAP Coordinators in December 2002 to address resource constraints within ADAPs. NASTAD serves as the convening organization for the Task Force, which originally consisted of 10 representatives of the largest ADAP programs. Beginning in March 2003, the Task Force met with the eight companies that at the time manufactured antiretroviral (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 were reached with all eight manufacturers to provide supplemental rebates and discounts (in addition to mandated 340B rebates and discounts), price freezes, and free products to all ADAPs nationwide. During 2004, the Task Force expanded its negotiations to include companies that manufacture high-cost non-ARV drugs. Additional agreements have been obtained since then and previous agreements were extended and/or enhanced. Agreements are currently in placed with 14 manufacturers. The Task Force estimates savings of $145 million in FY 2006, and $425 million since its formation. Current members of the Task Force include representatives from ADAPs in California, Florida, Ohio, New Jersey, New York, North Carolina, Texas, and Utah.

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

– Direct purchase ADAPs can also choose to participate in the HRSA Prime Vendor Program,[17] which was created to negotiate pharmaceutical pricing below the 340B price. Seven of the 29 ADAPs that purchase directly from wholesalers participate in the HRSA Prime Vendor Program.
– NASTAD's ADAP Crisis Task Force also negotiates directly with manufacturers for pharmaceutical pricing below the 340B price on behalf of both rebate and direct purchase ADAPs. When such agreements are reached, they are provided to all states (see box on "ADAP Crisis Task Force").

Insurance Purchasing/Maintenance Programs

- The Ryan White CARE Act allows states to use ADAP earmark dollars to purchase health insurance and pay insurance premiums, co-payments, and/or deductibles for individuals eligible for ADAP, provided the insurance has comparable formulary benefits to that of the ADAP.[18,19] States are increasingly using ADAP funds for this purpose. Most ADAPs (31, up from 29 last year) reported doing so in 2006, representing $83.5 million in expenditures in FY 2006, an 11% increase over FY 2005. In June 2006, 13,744 ADAP clients were served by such arrangements—12% higher than in June 2005 (see Chart 37 and Appendix XVIII).
- These strategies appear to be cost effective—in June 2006, spending on insurance represented an estimated $395 per capita, less than half of per capita drug expenditures in that month ($991).

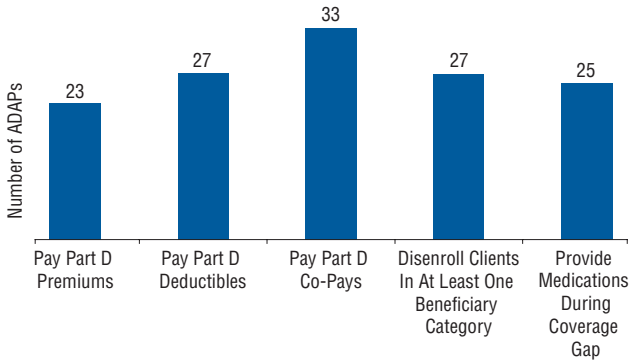
Coordination with Medicare Part D

- The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a new outpatient prescription drug benefit, Part D, to the Medicare program effective January 1, 2006. An estimated 12% of ADAP clients are Medicare eligible (representing more than 11,500 of clients who used prescription drug services in June 2006, and more than 17,000 of all enrolled clients). A subset of these clients is dually eligible for Medicare and Medicaid.
- As the payer of last resort, ADAPs were required by HRSA to ensure that all Medicare Part D eligible clients enroll in a Medicare prescription drug plan by May 15, 2006 (or at least ensure that they are not paying for any Medicare covered prescription drug service for Medicare eligible ADAP clients). ADAPs are permitted to coordinate with Medicare prescription drug plans and, in accordance with state policy, pay for drug plan premiums, deductibles, coinsurance, and co-payments.[18] However, the MMA does not allow ADAP funds to be counted toward TrOOP. This means ADAP enrollees must incur these costs themselves when in the coverage gap before they are eligible to receive catastrophic coverage under their Medicare drug plan.[20] To meet these federal requirements and maintain appropriate medication coverage for their clients, most ADAPs have developed policies to coordinate with the Part D benefit (see Chart 38 and Appendix XIX). As of November 2006:

  – 23 pay Part D premiums
  – 27 pay Part D deductibles
  – 33 Part D co-payments for ADAP clients eligible for Part D
  – 25 pay for all medications on their ADAP formularies when their Part D clients reach the coverage gap or "doughnut hole."

In addition to these cost-sharing policies, 27 ADAPs reported that they have disenrolled some or all of their Medicare eligible clients from ADAP, particularly those dually eligible for Medicare and Medicaid, as these clients have guaranteed coverage through Part D. In some cases, states continue to provide cost-sharing where needed, and will cover medication costs in the coverage gap. Some ADAPs report coordinating with their state's pharmacy assistance program (SPAP) to cover costs during the coverage gap, since SPAP payments do count towards TrOOP. However, this option is only available to a small number of states.

ADAP Policies Related to Medicare Part D, as of November 2006



Note: 48 ADAPs reported data.

CONCLUSION

The *National ADAP Monitoring Project* will continue to assess the multiple issues affecting ADAPs over the next year, tracking data on the critical role ADAPs play in providing low-income people with HIV access to needed medications. Particular issues to be monitored include:

the ongoing interaction between ADAPs and Medicare Part D; the impact of Ryan White reauthorization and its new ADAP minimum formulary requirement; and the status of ADAP waiting lists and other cost-containment measures over time.

Charts for each major finding and appendices, with data by state, are provided in the full report. Chart 1 provides key data by state across a range of indicators. State-level data from this report are also provided on Kaiser's State Health Facts website, www.statehealthfacts.org/hiv, where they can be accessed and downloaded for free. Finally, a separate document is available that provides a listing of all drugs on ADAP formularies by state.

Methodology

Since 1996, the *National ADAP Monitoring Project*, an initiative of the Kaiser Family Foundation (Kaiser) and the National Alliance of State and Territorial AIDS Directors (NASTAD), has surveyed all jurisdictions receiving federal ADAP earmark funding through Ryan White. In FY 2006, 54 jurisdictions received earmark funding and all 54 were surveyed; 51 responded. Delaware, Guam, and New Mexico did not respond; these jurisdictions represent less than one percent of estimated living AIDS cases.*

The annual survey requests data and other program information for a one month period (June), the current fiscal year, and for other periods as specified. After the survey is distributed, NASTAD conducts extensive follow-up to ensure completion by as many ADAPs as possible. Data used in this report are from June 2006 and FY 2006, unless otherwise noted. Supplemental data collection is conducted in certain areas to obtain more current data, including for: waiting lists, other cost-containment measures; Medicare Part D coordination; and formulary composition.

All data reflect the status of ADAPs as reported by survey respondents; however, it is important to note that some program information may have changed between data collection and this report's release. In addition, due to differences in data collection and availability across ADAPs, some are not able to respond to all survey questions. Where trend data are presented, only states that provided data in relevant periods are included. In some cases, ADAPs have provided revised program data from prior years and these revised data are incorporated where possible. Therefore, data from prior year reports may not be comparable for assessing trends. It is also important to note that data from a month snapshot may be subject to one-time only events or changes that could in turn appear to impact trends; these are noted where information is available. Data issues specific to a particular jurisdiction are provided on relevant charts and tables.

*CDC, "Persons living with HIV/AIDS or AIDS, by geographic area and Ryan White CARE Act eligible metropolitan area of residence, December 2004", *HIV/AIDS Surveillance Supplemental Report 2006*; 12 (No. 1). Available at: www.cdc.gov/HIV/topics/surveillance/resources/reports/2006supp_vol12no3/table1.htm.

REFERENCES

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

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

3 HRSA HIV/AIDS Bureau.

4 Based on Kaiser Family Foundation analysis of data from the Centers for Disease Control and Prevention (CDC) and the Joint United Nations Programme on HIV/AIDS (UNAIDS).

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

6 White House, Office of Management and Budget, March 2007.

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

8 Some of these funds must be provided to ADAPs, due to state matching fund requirements for the ADAP supplemental. See box on "Allocation of Federal Funding to ADAPs & State Match Requirements."

9 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.

10 This estimate is based on annualizing June 2006 drug expenditures and combining the 12-month total with reported insurance spending for FY 2006. It is important to note that June 2006 expenditures may not be representative of monthly expenditures overall, especially in this year's report, due to the timing of Medicare Part D implementation. In fact, June 2006 drug expenditures may be lower than average, which would result in a lower than average annual estimate.

11 FDA, "Drugs Used in the Treatment of HIV Infection." Available at: http://www.fda.gov/oashi/aids/virals.html (accessed March 21, 2007).

12 CDC, "Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus," *MMWR* 2002; 51(No. RR08):1-46. Available at: http://www.aidsinfo.nih.gov/ (accessed March 21, 2007).

13 CDC, "Treating Opportunistic Infections Among HIV-Infected Adults and Adolescents," *MMWR* 2004; 53(No. RR15):1-112. Available at: http://www.aidsinfo.nih.gov/ (accessed March 21, 2007).

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

15 CDC, Frequently Asked Questions and Answers About Coinfection with HIV and Hepatitis C Virus. Available at http://www.cdc.gov/hiv/resources/qa/HIV-HCV_Coinfection.htm (accessed March 21, 2007).

16 CDC, "Sexually Transmitted Diseases Treatment Guidelines, 2006," *MMWR,* Vol. 55, September 2006.

17 HRSA, Pharmacy Services Support Center, "What is the 340B Program?" Available at: http://pssc.aphanet.org/about/whatisthe340b.htm (accessed March 21, 2007).

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

19 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.

20 HRSA, HIV/AIDS Bureau, "Medicare Prescription Drug Benefit and CARE Act Grantees." Available at: http://www.hrsa.gov/medicare/hiv/about.htm (accessed March 21, 2007).

Charts

Chart 1

Key ADAP Highlights

State/Territory	Financial Eligibility as % of FPL	Total FY 2006 Budget*	State Contribution	State $ Contribution as % of Total Budget	June 2006 Clients Served	June 2006 Drug Expenditures	June 2006 Prescriptions Filled	June 2006 Per Capita Drug Expenditures	Waiting Lists and Other Cost-Containment Measures, as of March 2007
Alabama	250%	$15,567,729	$5,991,044	39%	920	$1,032,443	3,190	$1,122.22	Capped enrollment
Alaska	300%	$534,924	$0	0%	49	$54,413	173	$1,110.47	Waiting list
Arizona	300%	$10,623,252	$1,000,000	9%	856	$884,249	4,330	$1,033.00	
Arkansas	300%	$3,712,458	$0	0%	198	$164,015	552	$828.36	
California	400%	$301,320,001	$107,740,000	36%	17,306	$19,889,704	71,816	$1,149.30	
Colorado	300%	$11,128,584	$4,366,482	39%	852	$718,502	2,328	$843.31	
Connecticut	400%	$17,264,871	$606,678	4%	1,339	$1,598,359	6,356	$1,193.70	
Delaware	—	$3,486,482	—	—	—	—	—	—	
District of Columbia	400%	$15,188,675	$0	0%	563	$481,576	1,970	$855.38	
Florida**	350%	$101,358,137	$10,500,000	10%	8,267	$6,276,117	19,552	$759.18	Lowered income eligibility
Georgia	300%	$41,991,541	$11,805,339	28%	3,473	$3,427,413	11,712	$986.87	
Guam	—	$97,000	—	—	—	—	—	—	
Hawaii	400%	$2,655,868	$440,535	17%	144	$160,584	632	$1,115.17	
Idaho	200%	$1,944,657	$779,300	40%	63	$86,202	169	$1,368.29	
Illinois	400%	$39,900,193	$12,100,000	30%	3,097	$3,350,554	10,443	$1,081.87	
Indiana	300%	$7,515,481	$0	0%	1,000	$100,872	273	$100.87	Capped enrollment
Iowa	200%	$2,367,158	$822,606	35%	315	$143,067	617	$454.18	
Kansas	300%	$4,072,787	$400,000	10%	294	$334,223	735	$1,136.81	
Kentucky	300%	$5,422,637	$250,000	5%	574	$293,460	1,922	$511.26	
Louisiana	200%	$17,193,806	$0	0%	1,391	$1,284,521	3,723	$923.45	
Maine	400%	$945,187	$60,000	6%	93	$25,170	308	$270.65	
Maryland	500%	$43,377,292	$0	0%	2,558	$2,877,431	9,045	$1,124.88	
Massachusetts	510%	$21,053,293	$2,802,358	13%	2,665	$530,415	10,890	$199.03	
Michigan	450%	$20,131,032	$0	0%	1,526	$1,639,116	7,290	$1,074.13	Implemented various formulary management strategies
Minnesota	300%	$4,488,877	$0	0%	565	$193,206	1,333	$341.96	
Mississippi	400%	$7,977,861	$750,000	9%	666	$618,932	2,432	$929.33	Lowered medical eligibility
Missouri	300%	$16,270,913	$4,390,224	27%	1,032	$1,252,643	4,509	$1,213.80	
Montana	330%	$556,375	$54,979	10%	52	$45,683	152	$878.53	Waiting list
Nebraska	200%	$2,162,425	$900,000	42%	246	$123,504	393	$502.05	
Nevada	400%	$7,529,342	$1,813,437	24%	416	$450,724	1,300	$1,083.47	
New Hampshire	300%	$2,734,691	$180,000	7%	109	$116,138	469	$1,065.49	
New Jersey	500%	$70,759,043	$9,000,000	13%	4,015	$5,878,562	23,633	$1,464.15	
New Mexico	—	$2,361,780	—	—	—	—	—	—	
New York	449%	$246,888,472	$41,295,245	17%	12,467	$18,407,214	55,427	$1,476.48	
North Carolina***	125%	$28,697,785	$12,120,856	42%	2,093	$1,936,635	6,503	$925.29	

(continued on next page)

Chart 1 *(continued)*

Key ADAP Highlights

State	Financial Eligibility as % of FPL	Total FY 2006 Budget*	State Contribution	State $ Contribution as % of Total Budget	June 2006 Clients Served	June 2006 Drug Expenditures	June 2006 Prescriptions Filled	June 2006 Per Capita Drug Expend.	Waiting Lists and Other Cost-Containment Measures, as of March 2007
North Dakota	400%	$196,548	$0	0%	25	$22,411	77	$896.45	
Ohio	500%	$15,422,837	$3,515,299	23%	1,606	$1,115,040	6,195	$694.30	
Oklahoma	200%	$5,612,861	$1,287,340	23%	583	$399,865	1,725	$685.87	
Oregon	200%	$7,879,340	$952,451	12%	1,312	$113,812	3,318	$86.75	
Pennsylvania	350%	$51,749,948	$14,822,515	29%	3,296	$4,022,076	14,590	$1,220.29	
Puerto Rico	200%	$30,616,270	$1,728,396	6%	3,576	$3,124,797	9,863	$873.82	Waiting list
Rhode Island	400%	$4,407,383	$2,280,000	52%	338	$267,166	1,118	$790.43	Lowered income eligibility
South Carolina	300%	$16,080,570	$800,000	5%	1,798	$1,351,515	5,706	$751.68	Reduced formulary; waiting list
South Dakota	300%	$397,980	$0	0%	70	$43,089	154	$615.56	
Tennessee	300%	$32,226,995	$8,000,000	25%	2,150	$475,660	2,242	$221.24	
Texas	200%	$93,513,947	$34,622,983	37%	7,455	$6,384,476	19,773	$856.40	
Utah	400%	$2,978,514	$180,000	6%	330	$178,596	609	$541.20	
Vermont	200%	$708,997	$0	0%	101	$64,399	306	$637.61	
Virgin Islands (U.S.)	400%	$888,813	$154,000	17%	57	$39,168	143	$687.16	Client cost-sharing
Virginia	300%	$19,500,323	$2,612,200	13%	1,477	$1,841,255	4,665	$1,246.62	
Washington	300%	$15,002,481	$2,761,238	18%	1,940	$858,797	8,426	$442.68	
West Virginia	250%	$2,235,881	$188,000	8%	118	$101,874	316	$863.34	
Wisconsin	300%	$6,842,435	$464,000	7%	647	$486,795	1,395	$752.39	
Wyoming	200%	$759,764	$367,500	48%	38	$30,718	106	$808.37	
Total		**$1,386,302,496**	**$304,905,005**	**22%**	**96,121**	**$95,297,158**	**344,904**	**$991.43**	

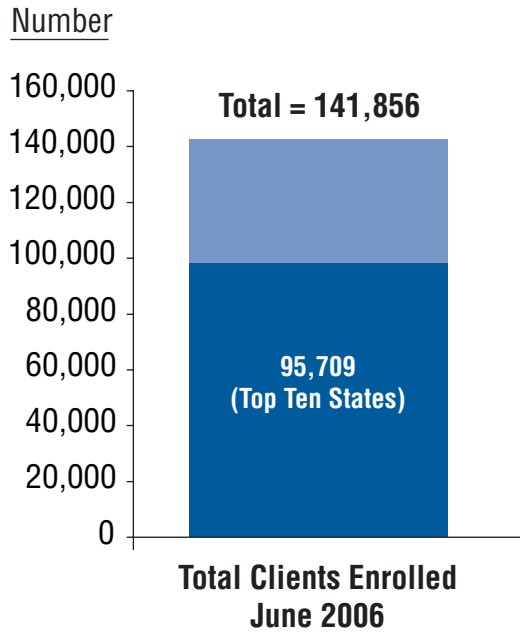
*Total FY 2006 Budget includes Federal, state, and drug rebate dollars and does not include other cost recovery funds.

**Florida changed its income eligibility level from 350% to 300% FPL in March 2007.

***North Carolina changed its income eligibility level from net family income of 125% to gross family income of 200% on November 1, 2006.

Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data and are not included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006.

Chart 2
ADAP Clients Enrolled and Top Ten States, by Clients Enrolled, June 2006



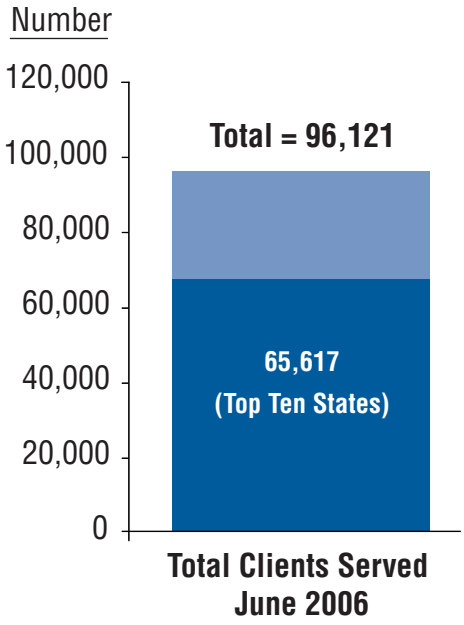
State	Clients Enrolled June 2006
California	26,505
New York	16,481
Texas	13,512
Florida	11,258
Pennsylvania	5,705
New Jersey	5,125
Georgia	4,923
Illinois	4,526
Massachusetts	3,840
Puerto Rico	3,834
Total	**95,709**

Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data and are not included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006.

In June 2006, there were 141,856 clients enrolled in ADAPs across the country. Enrollment varies by state and is concentrated in certain areas—ten states accounted for two-thirds (67%) of total enrollment. In general, these states represent those with the highest numbers of people living with AIDS, and the concentration of clients within these states largely reflects the allocation of Ryan White funding based on estimated living AIDS cases.

In any given month, more clients are typically enrolled in ADAPs than seek either pharmaceutical or insurance services (in June 2006, 68% of those enrolled received medications and others also were provided with insurance coverage). This is because clients may seek ADAP services at different times of the year, depending on their clinical needs, length of prescriptions, availability of other resources for obtaining prescription drugs, and other factors. Some individuals cycle on and off ADAPs throughout the year, particularly those with Medicaid or Medicare Part D coverage. Medicaid beneficiaries may face limits in their coverage in some states and/or are in the Medicaid spend-down process. Medicare Part D beneficiaries might not use ADAP until they reach the coverage gap (the time when Medicare Part D beneficiaries are responsible for all their drug costs), necessitating a return to ADAP.

Chart 3
ADAP Clients Served and Top Ten States, by Clients Served, June 2006



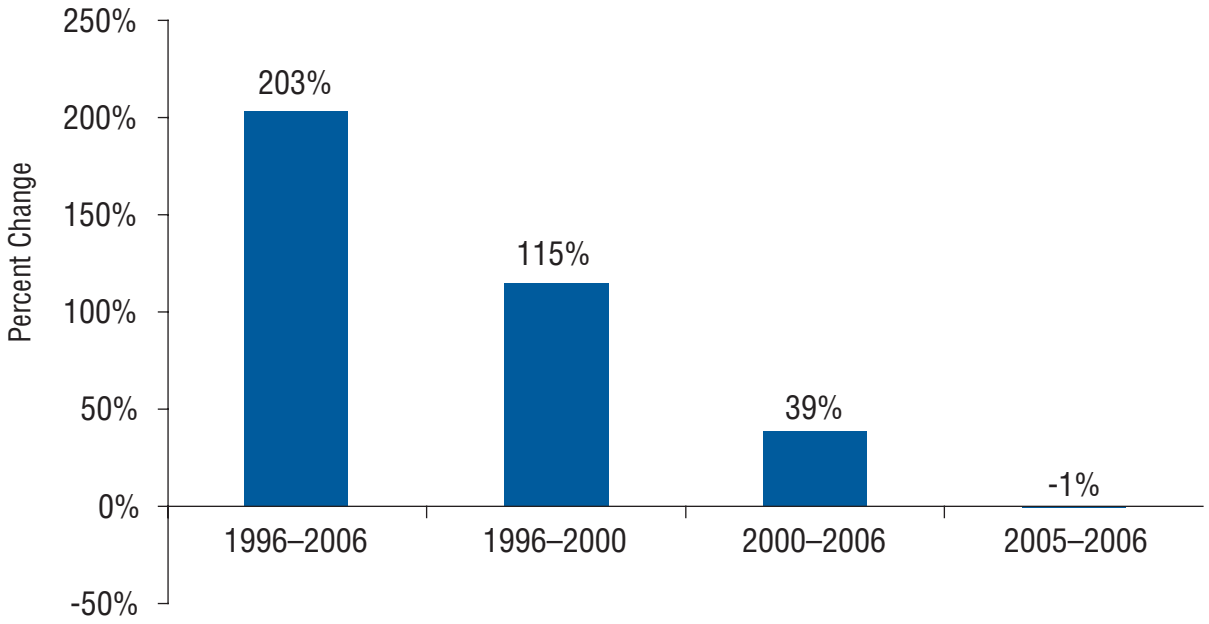
State	Clients Served June 2006
California	17,306
New York	12,467
Florida	8,267
Texas	7,455
New Jersey	4,015
Puerto Rico	3,576
Georgia	3,473
Pennsylvania	3,296
Illinois	3,097
Massachusetts	2,665
Total	**65,617**

Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data and are not included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006.

ADAPs provided medications to 96,121 clients across the country in June 2006. The number of clients served varies considerably by state, ranging from 25 in North Dakota to more than 17,000 in California. Similar to clients enrolled, ten states accounted for two-thirds (68%) of all ADAP clients served in June 2006, with five states accounting for half (52%) of clients served (see Appendix I).

In addition to providing medications, increasing numbers of ADAPs are also paying for insurance coverage (premiums, co-pays and/or deductibles). In June 2006, 13,744 clients benefited from ADAP funds through some form of insurance coverage payment (some of whom may have also received medications) (see Chart 37 and Appendix XVIII).

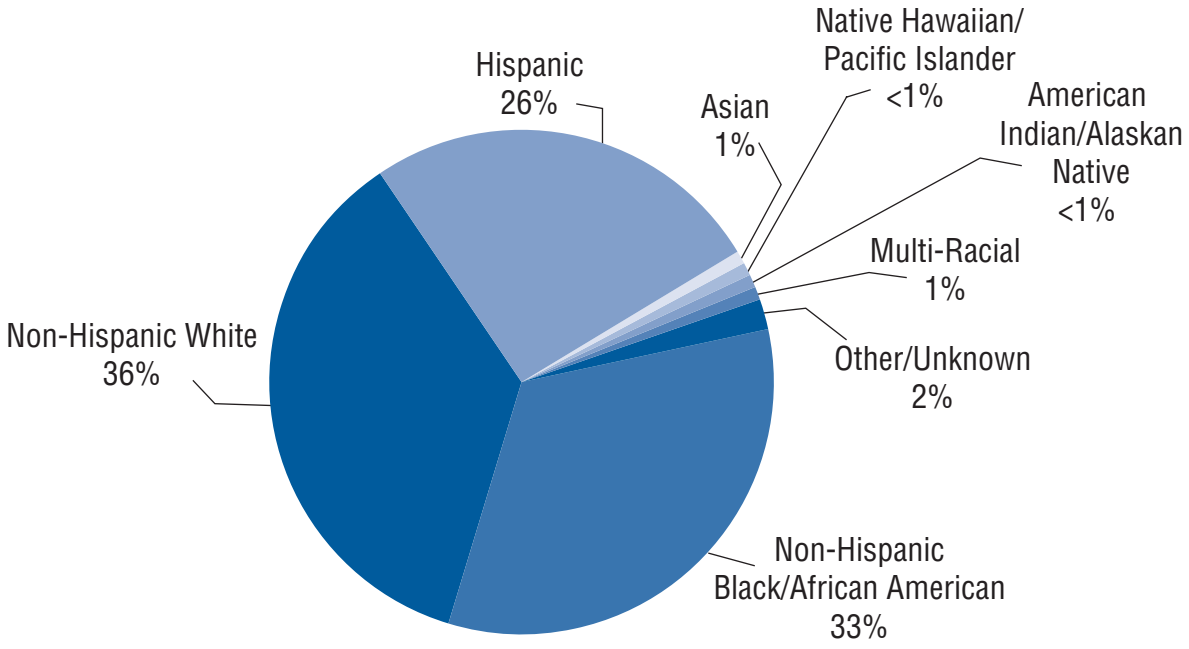
Chart 4
Trends in ADAP Client Utilization, June 1996–2006



Note: Comparisons over time based on 49 ADAPs reporting in each comparison period.

Client utilization (the number of clients receiving prescription medications) has more than tripled since 1996 (an increase of 203% among the 49 ADAPs that reported data in both periods), but the rate of growth has slowed over time. In addition, for the first time since the *National ADAP Monitoring Project* began tracking ADAPs, client utilization remained stable between June 2005 and June 2006 (a decrease of less than one percent among the 49 ADAPs reporting in both periods). The relative stability in client utilization between the two periods is attributable to one major factor—the implementation of the Medicare Part D prescription drug benefit in 2006. A number of ADAPs reported that the initial implementation of Medicare Part D caused a "one time exodus" of ADAP clients who are eligible for Medicare or dually eligible for Medicare and Medicaid. ADAPs expect that, as a result, additional clients that previously could not be served by ADAP will be added to the rolls, and client utilization will once again increase. In fact, overall enrollment increased between June 2005 and June 2006. In addition, some of the clients who transitioned to Part D may need to return to ADAP when they hit the Medicare Part D coverage gap, and become responsible for the full costs of their medications.

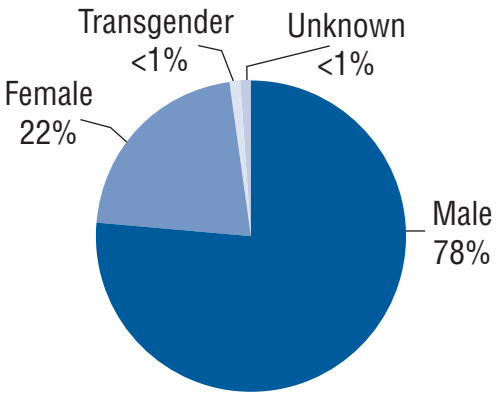
Chart 5
ADAP Clients Served, by Race/Ethnicity, June 2006



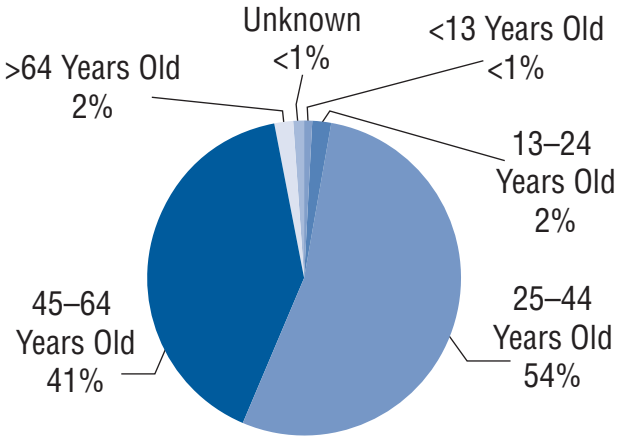
Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data and are not included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006. Percentages may not total 100% due to rounding.

The majority of clients served by ADAPs are racial/ethnic minorities (61%). African Americans and Hispanics represented 59% (33% and 26%, respectively) of clients served in June 2006; white non-Hispanics represented 36%; and Asian, Native Hawaiian/Pacific Islanders and American Indians/Alaskan Natives combined represented approximately two percent. The race/ethnicity breakdown of ADAP clients varies by state (see Appendix IV) but national 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.

Chart 6
ADAP Clients Served, by Gender and by Age, June 2006



Gender

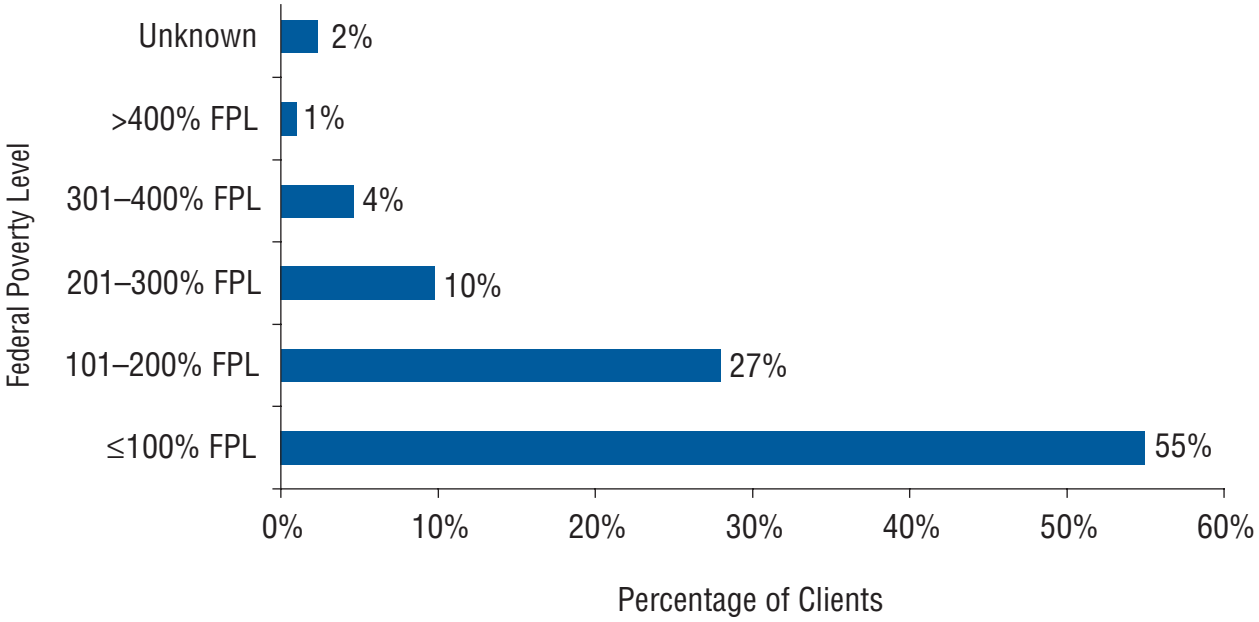


Age

Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data and are not included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006. Percentages may not total 100% due to rounding.

Most ADAP clients are male (78% of those served in June 2006); approximately one-fifth (22%) are female. Less than one percent of clients served in June 2006 self-identified as transgender. The majority of ADAP clients served are between the ages of 25 and 44 years (54%), followed by those between the ages of 45 and 64 (41%). The gender and age breakdown of ADAP clients varies by state (see Appendix V).

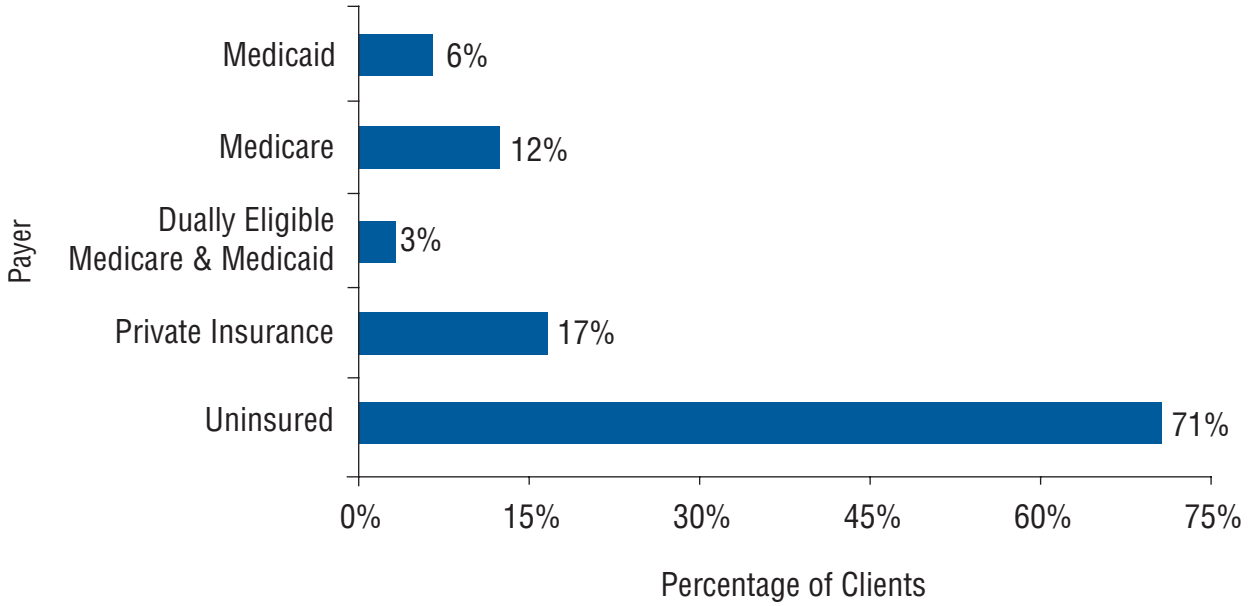
Chart 7
ADAP Clients Served, by Income Level, June 2006



Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data and are not included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006.

More than eight in ten ADAP clients are low-income—82% served in June 2006 were at or below 200% of the Federal Poverty Level (FPL), including more than half (55%) at or below 100% of FPL (in 2006, the FPL was $9,800 annually—slightly higher in Alaska and Hawaii—for a family of one). These figures are consistent with data reported in previous periods (see Appendix VI).

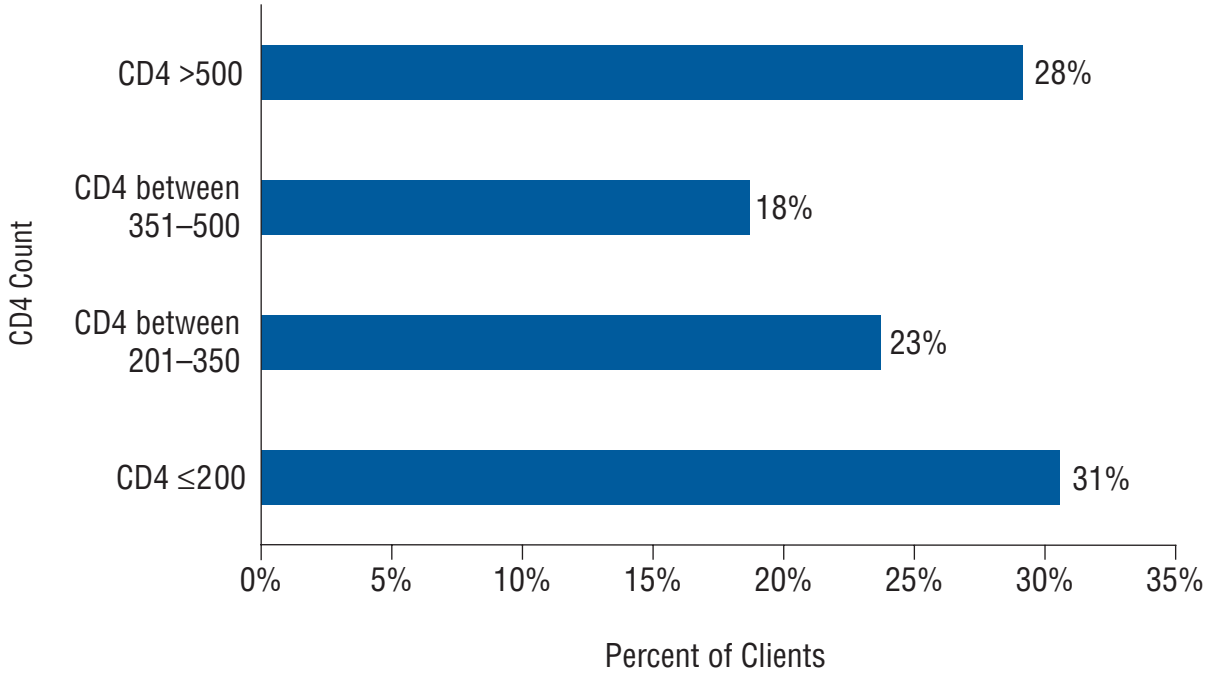
Chart 8
ADAP Clients Served, by Insurance Coverage, June 2006



Note: 51 ADAPs reported data. Not all ADAPs reported data for each insurance category. Delaware, Guam, and New Mexico did not report data and are not included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006. Insurance categories are not mutually exclusive. The overall percentage of clients insured in each category is calculated separately based on reported data.

Most ADAP clients (71%) lack any other form of private or public insurance. Relatively small shares had other sources of coverage, including 17% with private insurance (based on 41 responses), 12% by Medicare (based on 45 responses), and/or six percent by Medicaid (based on 43 responses). ADAP clients dually eligible for both Medicaid and Medicare represented three percent of clients served, among the 41 ADAPs that were able to report these data. Insurance coverage in June 2006 is similar to coverage reported for the same period last year, with the exception of Medicaid (10% in 2005). Insurance coverage of ADAP clients varies by state (see Appendix VI).

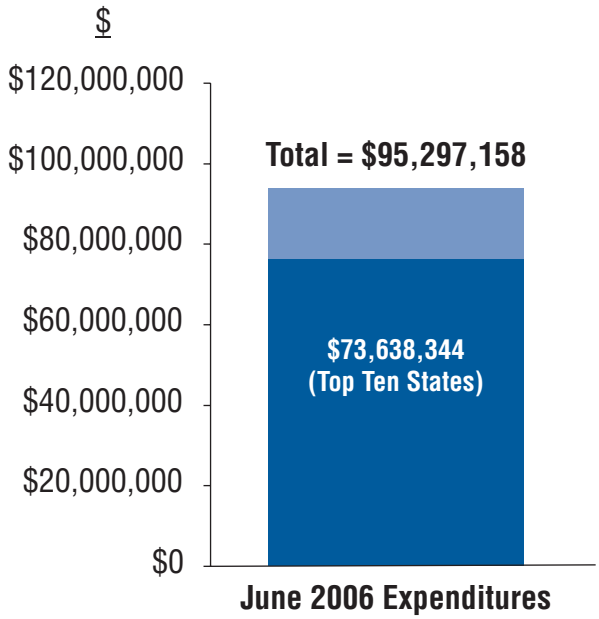
Chart 9
ADAP Clients by CD4 Count, Enrolled During 12-Month Period, June 2006



Note: 34 ADAPs reported data.

CD4 count information, an important marker of the health status of people with HIV/AIDS, was available from 34 ADAPs, representing approximately 59% of ADAP clients served in June 2006. More than half (54%) of ADAP clients in these states had a CD4 count of 350 or less, including 31% with CD4 counts at or below 200, suggesting that a significant number of clients continue to enroll well into disease progression. More than a quarter (28%) of clients had CD4 counts above 500. Higher CD4 counts may represent successful treatment or early intervention efforts. It should be noted that the CD4 data reflects clients enrolled in ADAP over the last 12 months or the most recent 12 months for which data are available. In addition, ADAPs are required to recertify clients two times a year. As a result, these figures do not necessarily represent CD4 counts of new clients (see Appendix VII).

Chart 10
ADAP Drug Expenditures and Top 10 States, by Expenditures, June 2006



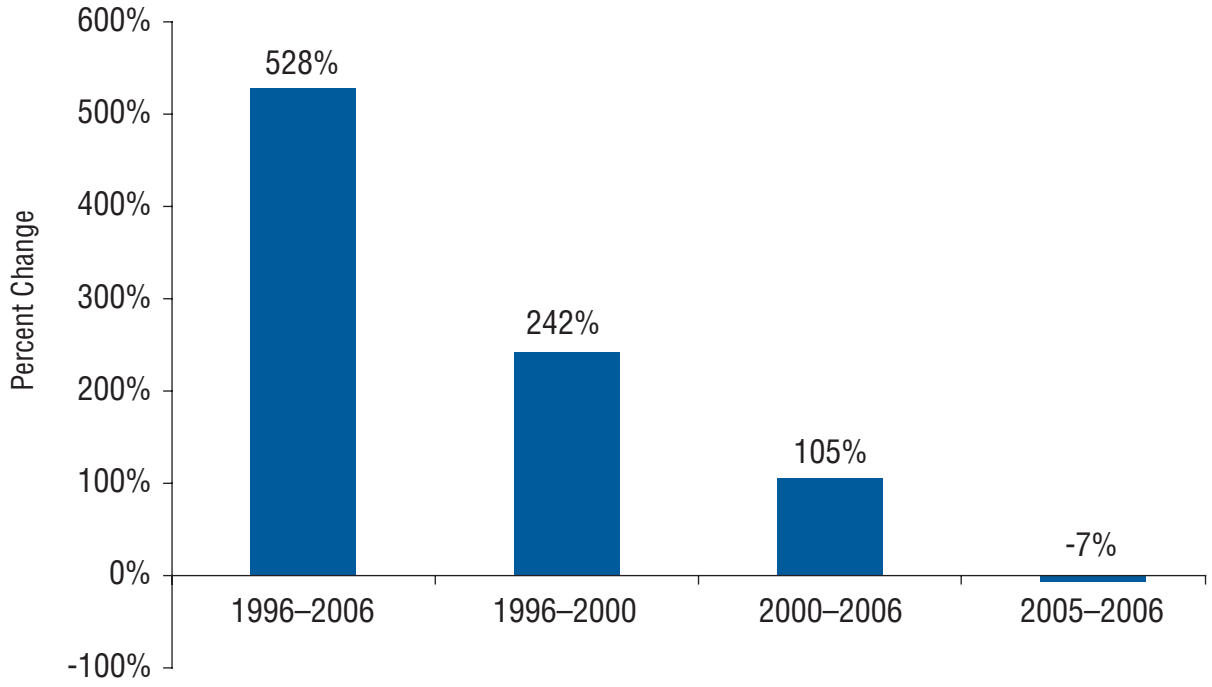
State	Drug Expenditures June 2006
California	$19,889,704
New York	$18,407,214
Texas	$6,384,476
Florida	$6,276,117
New Jersey	$5,878,562
Pennsylvania	$4,022,076
Georgia	$3,427,413
Illinois	$3,350,554
Puerto Rico	$3,124,797
Maryland	$2,877,431
Total	**$73,638,344**

Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data and are not included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006.

ADAP drug expenditures totaled $95,297,158 in June 2006. Ten states accounted for more than three-fourths (77%) of all drug spending; two states (California and New York) accounted for 40%. These 10 states are primarily the same set that served the majority of ADAP clients. Drug expenditures varied across states, ranging from $22,411 in North Dakota to nearly $20 million in California in June 2006 (see Appendix I).

In addition to drug expenditures, 31 ADAPS spent $5.4 million on insurance purchasing/maintenance for ADAP clients in June 2006 (see Appendix XVIII).

Chart 11
Trends in ADAP Drug Expenditures, June 1996–2006

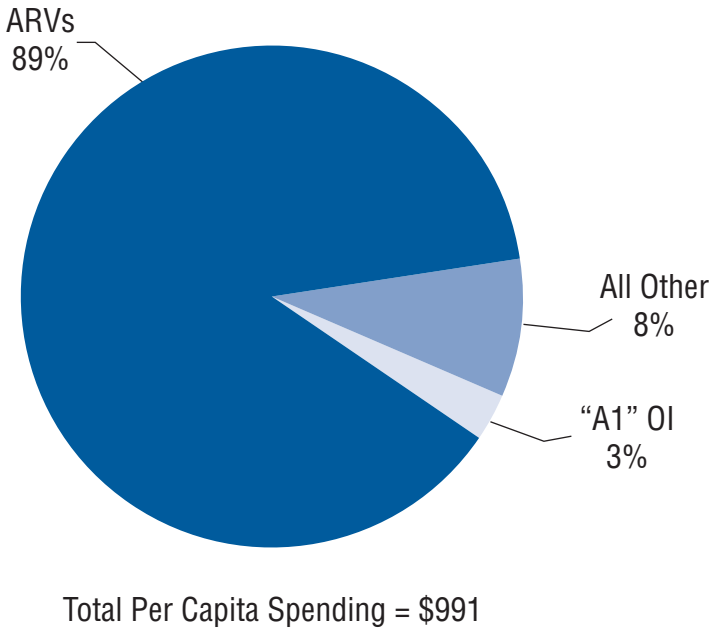


Note: Comparisons over time based on 49 ADAPs reporting in each comparison period.

Monthly ADAP drug expenditures have increased significantly since 1996 and at a faster rate than client growth. Between 1996 and 2006, drug expenditures grew by 528%, more than twice the rate of client growth over this same period (among the 49 ADAPs reporting in both periods).

As with client utilization, the rate of growth in drug expenditures has slowed and, for the first time, decreased between June 2005 and June 2006 (a seven percent decrease among the 49 ADAPs reporting in both periods). ADAPs reported that this decrease is largely the result of a one-time move of some Medicare-eligible clients into Part D, and/or the transition to co-payments for Medicare Part D (versus direct drug expenditures through ADAP). It is unclear what will happen with drug expenditures over time, and if such decreases will continue. While it generally costs less for ADAPs to pay Medicare Part D cost-sharing than for medications directly, ADAPs may be able to accommodate new clients due to the shift, in which case expenditures could rise again. In addition, some clients who transition to Part D may need to return to ADAP when they reach the Medicare Part D coverage gap, and become responsible for the full costs of their medications. Where ADAPs do pick up these costs, they will not count towards a client's *True Out Of Pocket Costs* (TrOOP) needed to reach Part D's catastrophic coverage levels and return to Medicare coverage. This could mean that ADAPs will need to pay for these costs for an indefinite period of time each year.

Chart 12
Per Capita Drug Expenditures, June 2006

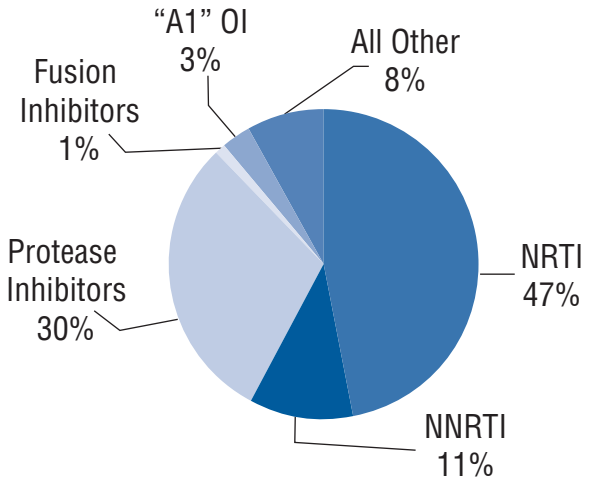


Note: 51 ADAPs reported data to determine June 2006 per capita drug spending. Delaware, Guam, and New Mexico did not report data and are not included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006.

ADAPs spent an average of $991 on prescription drugs per client served in June 2006. Antiretroviral drugs (ARVs) accounted for most (89%) of per capita drug expenditures in June 2006. Per capita spending varies by state, ranging from a low of $87 in Oregon to a high of $1,476 in New York (see Chart 1). These variations are likely the result of differing ADAP formularies, purchasing mechanisms, and/or prices paid by ADAPs across the country (indeed, until the most recent reauthorization of Ryan White, each state ADAP was allowed to determine its own formulary composition; as of July 1, 2007, new minimum formulary standards will go into effect).

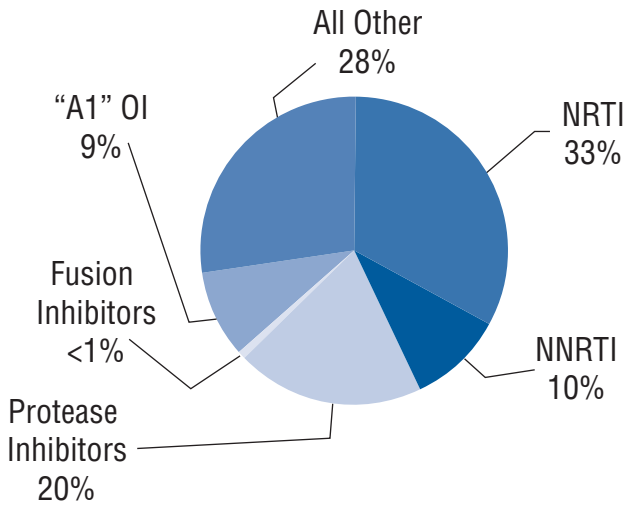
Chart 13

ADAP Drug Expenditures, by Drug Class, June 2006



Total = $95.3 Million

ADAP Prescriptions Filled, by Drug Class, June 2006



Total = 344,904 Prescriptions

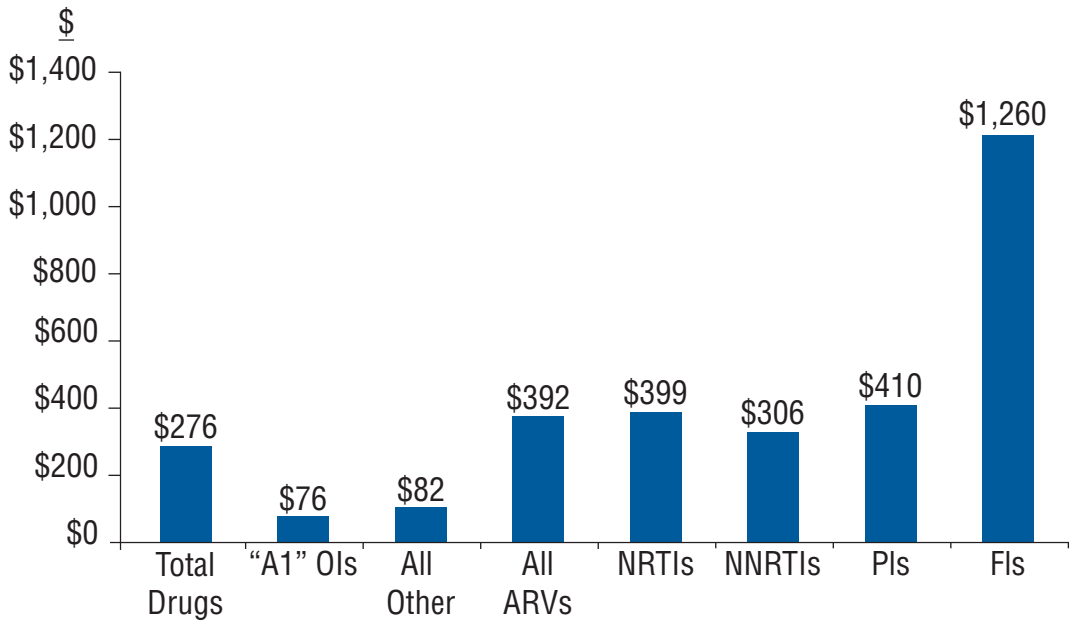
Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data and are not included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006. Percentages may not total to 100% due to rounding.

Antiretrovirals continue to account for the bulk of ADAP drug expenditures (89% in June 2006). Nucleoside reverse transcriptase inhibitors (NRTIs) accounted for nearly half (47%) of June 2006 expenditures; followed by protease inhibitors (PIs) at 30%; and non-nucleoside reverse transcriptase inhibitors (NNRTIs) at 11%. Fusion inhibitors accounted for one percent of drug expenditures. The 29 "A1" OI drugs (those highly recommended for the prevention and treatment of opportunistic infections*) accounted for three percent of total drug spending and all other drugs accounted for eight percent. The distribution of expenditures by drug class varies across the states, likely reflecting differing formularies, drug prices, and prescribing decisions (as noted earlier, prior to the most recent reauthorization of Ryan White, there was no minimum formulary requirement) (see Appendices II and IX).

States filled a total of 344,904 prescriptions in June 2006. As with expenditures by class, ARVs represented the majority of all prescriptions filled (63%); ARVs represented a smaller proportion of prescriptions filled than of drug expenditures, reflecting their relatively higher price compared to non-ARV medications. NRTIs accounted for one third (33%) of June 2006 prescriptions filled, followed by PIs at 20%, and NNRTIs at 10%. Fusion inhibitors accounted for less than one percent of prescriptions filled in June 2006. Prescriptions for "A1" OI drugs accounted for nine percent. All other drugs accounted for 28%. The distribution of prescriptions by class varies by state (see Appendix III).

*See: Centers for Disease Control and Prevention, "Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus." *MMWR* 2002; 51(No. RR08):1-46; Centers for Disease Control and Prevention, "Treating Opportunistic Infections Among HIV-Infected Adults and Adolescents." *MMWR* 2004; 53(No. RR15):1-112.

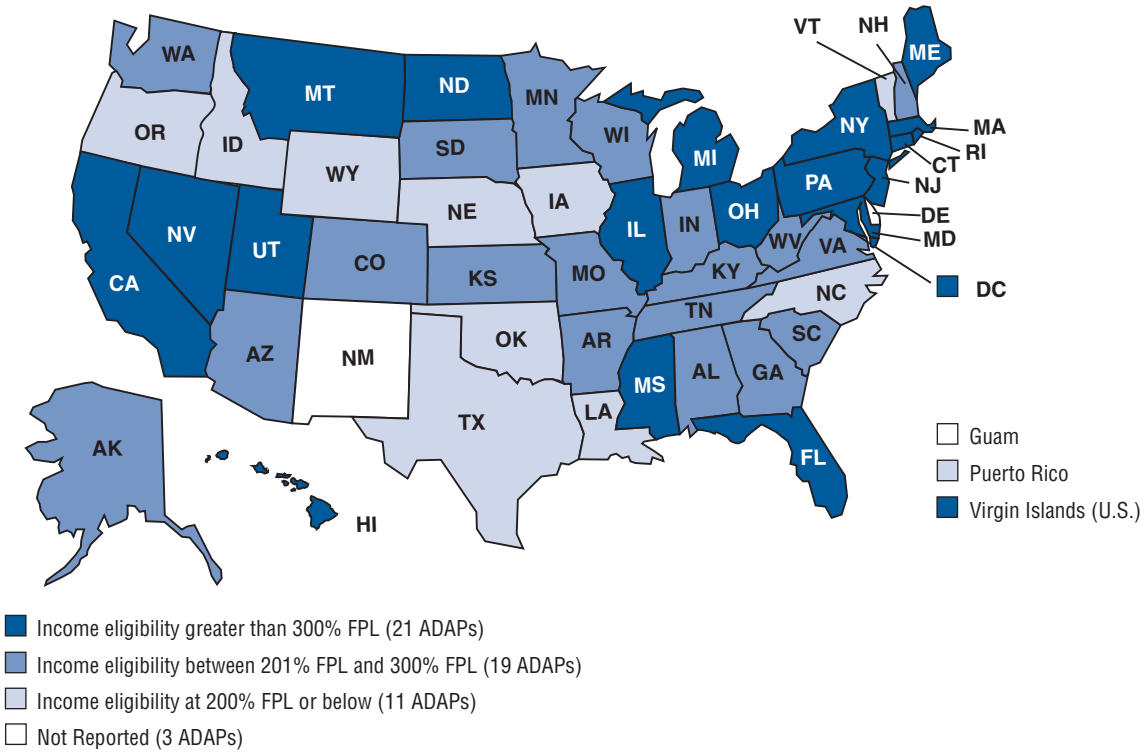
Chart 14
ADAP Expenditures Per Prescription, by Drug Class, June 2006



Note: 51 ADAPs reported data to determine ADAP expenditures per prescription. Delaware, Guam, and New Mexico did not report data and are not included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006.

The average expenditure per prescription, across all ADAPs and for all medications, was $276 in June 2006. Expenditure per prescription was significantly higher for ARVs ($392), compared to non-ARVs ($76 for "A1" OIs and $82 for all others). Some ARV drug classes accounted for higher per prescription expenditures than others, with fusion inhibitors (FIs) topping the list at $1,260—more than three times that of PIs ($410), NRTIs ($399), and NNRTIs ($306).

Chart 15
ADAP Income Eligibility by State, as of June 2006

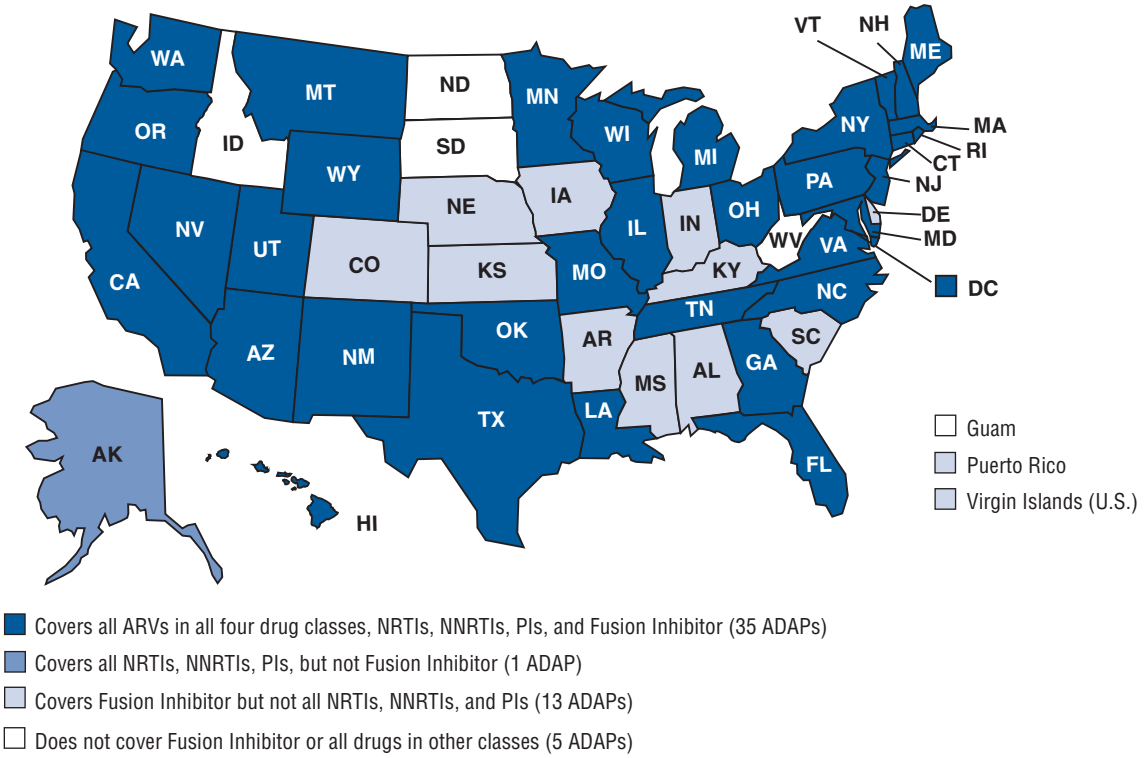


Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data and are not included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006. Florida changed its income eligibility level from 350% to 300% FPL in March 2007. North Carolina changed its income eligibility level from net family income of 125% to gross family income of 200% on November 1, 2006. The 2006 Federal Poverty Level (FPL) was $9,800 annually (slightly higher in Alaska and Hawaii) for a household of one.

There is no minimum ADAP income eligibility threshold set by the federal government, and eligibility criteria are determined by each state, although clients are required by law to be low-income and must have limited or no insurance coverage. ADAP income eligibility decisions reflect budget conditions within a state and the size of the population living with HIV/AIDS needing services. As a result of these factors, income eligibility levels in June 2006 for ADAPs vary widely across the country, ranging from a low of 125% FPL in North Carolina to 500% FPL or more in four states: Maryland, Massachusetts, New Jersey, and Ohio. Income eligibility was greater than 300% FPL in 21 ADAPs; between 201%–300% in 19 ADAPs; and at or below 200% FPL in 11 ADAPs (see Chart 1 and Appendix VIII).

In addition to income eligibility criteria, many ADAPs use other criteria for eligibility. For example, 16 ADAPs also have asset limits in place, ranging from greater than $2,000 to $25,000 (typically excluding one residence and one car). All ADAP enrollees must be residents of the state in which they are seeking medication, and some ADAPs require documentation of residency. Seven ADAPs report also using medical eligibility criteria, four of which require a client to have a CD4 count of less than 350 (see Appendix VIII).

Chart 16
ADAP Formulary Coverage of Antiretroviral Drugs by State, as of November 2006

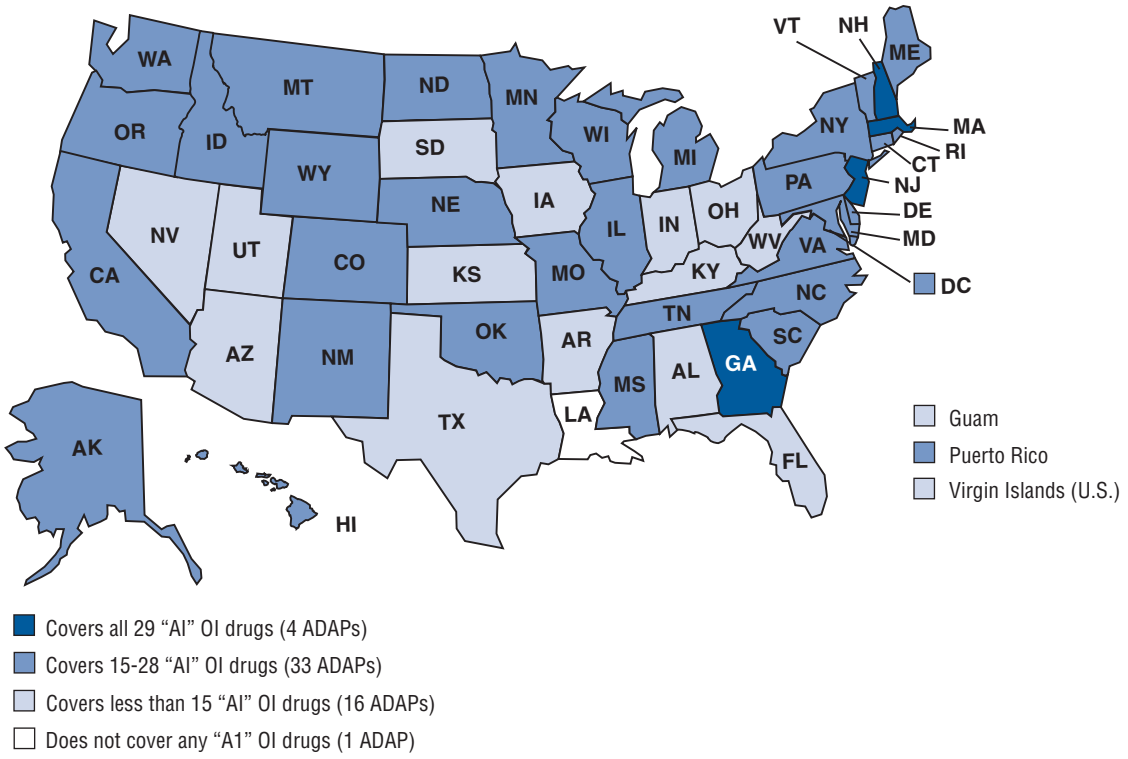


Note: 44 ADAPs reported data. For the states that did not report formulary coverage, last year's information was used. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006. Atripla is a multi-class combination product that includes efavirenz (NNRTI), emtricitabine (NRTI), and tenofovir disoproxil fumarate (NRTI). For the purposes of the *National ADAP Monitoring Project Annual Report,* Atripla is included in the NRTI class.

ADAP formularies (the list of drugs available) vary significantly across the country. Until the most recent Ryan White Reauthorization, there were no minimum requirements for ADAP formularies, although federal law specified that states use ADAP funds "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." The recent Ryan White Reauthorization added a minimum ADAP formulary requirement, effective July 1, 2007, at which time all state ADAP formularies must include, at a minimum, one medication from within each antiretroviral drug class (there are currently four antiretroviral drug classes, but this provision will apply to any new class in the future).

As of November 2006, formularies range from 19 drugs covered in Guam to nearly 500 drugs in New York, with open formularies in a small number of ADAPs. Thirty-five ADAPs report covering all ARVs in all four ARV drug classes, 19 did not. It is important to note that of the ADAPs not covering all ARVs, six of them are lacking only one drug from the list of 26. In addition to a cost-containment rationale, this omission could be attributed to a delay in adding one of the new drugs approved in 2006 (Atripla and Prezista), low utilization of a particular drug, or differing prescribing patterns. All ADAPs covered most if not all of the approved NRTIs, NNRTIs, and PIs with the exception of South Dakota which did not provide any PIs. Forty-eight ADAPs cover fusion inhibitors, up from 44 in last year's report (see Appendix IX).

Chart 17
ADAP Formulary Coverage of Drugs Recommended ("A1") for Prevention and Treatment of Opportunistic Infections (OIs) by State, as of November 2006

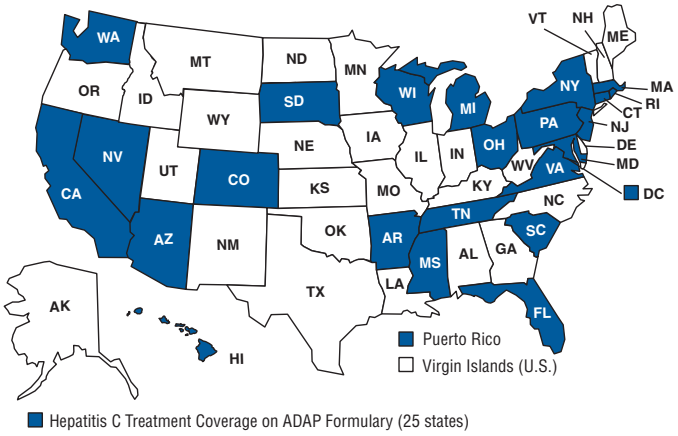


Note: 44 ADAPs reported data. For the states that did not report formulary coverage, last year's information was used.

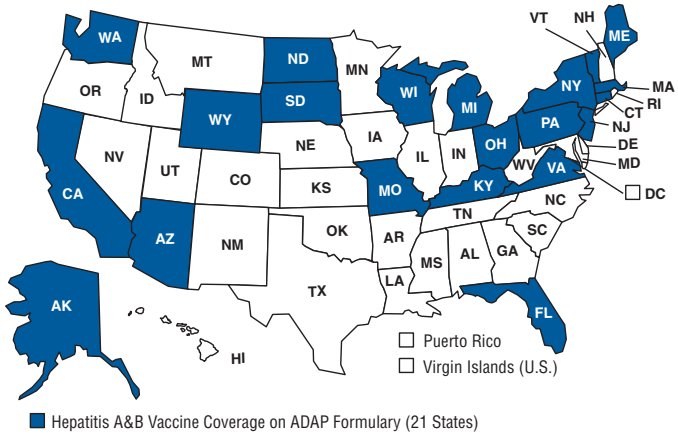
As with formulary coverage of antiretrovirals, coverage of medications to prevent or treat opportunistic infections and other HIV-related conditions is also highly variable across the country. Thirty-seven ADAPs report covering 15 or more of the 29 drugs highly recommended ("A1") for the prevention and treatment of opportunistic infections, including four that cover all 29 (Georgia, Massachusetts, New Hampshire, and New Jersey). Seventeen ADAPs cover less than 15 of these medications. One of these states, Louisiana, did not cover any "A1" OI drugs. It is important to note that ADAPs may cover less than the full set of recommended drugs because they cover equivalent medications, also highly recommended, on their formularies, or these medications are available from other sources (see Appendix IX).

Chart 18

Hepatitis C Treatment Coverage on ADAP Formulary, as of June 2006



Hepatitis A & B Vaccine Coverage on ADAP Formulary, as of June 2006



Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data and are not included. Oklahoma did not repond to question regarding formulary coverage of hepatitis C treatment and Tennessee did not repond to questions regarding formulary coverage of hepatitis A and B vaccines. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006.

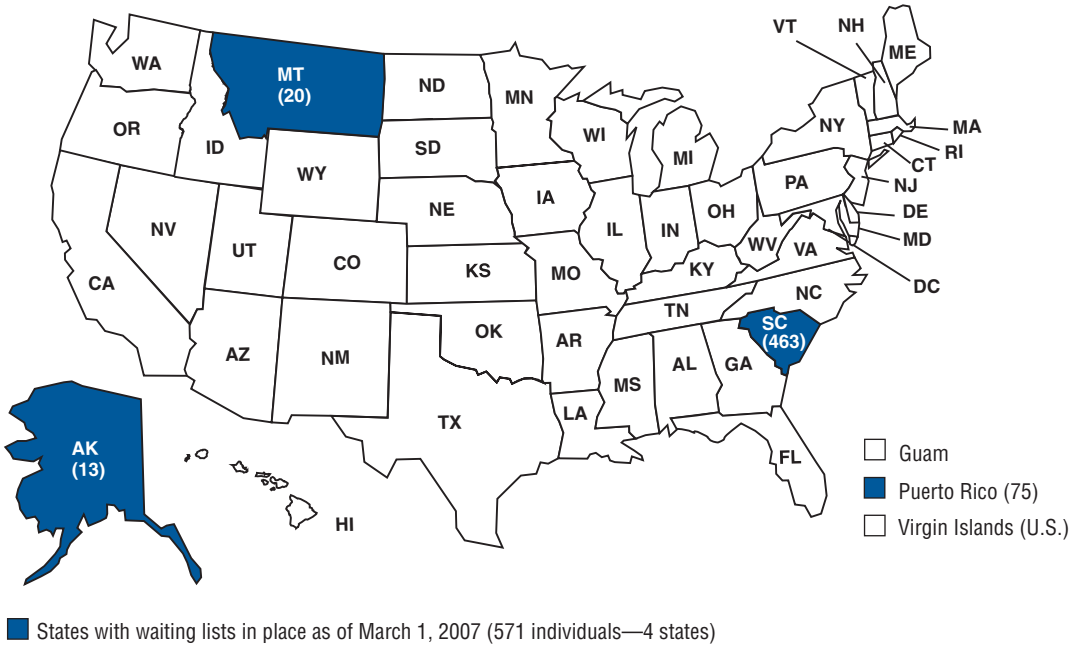
Hepatitis A, B, and C infections are important considerations for people with HIV/AIDS, and ADAPs have begun to play an increasing role in the provision of treatment for hepatitis C and vaccines for hepatitis A and B.

Hepatitis C Virus (HCV) is considered to be an opportunistic infection among those with HIV, due to the relatively high co-infection rate of HIV and HCV.* Currently, no national funding infrastructure exists to provide treatment to those infected only with HCV, and state and local resources for such treatment vary greatly. Without HCV treatment programs, much of the burden for treating co-infected patients has fallen on ADAPs and other Ryan White programs. In June 2006, 25 of the 46 ADAPs responding covered treatment for HCV on their ADAP formularies, down one from 26 in 2005 (see Appendix X). In 2005, NASTAD's 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. This agreement remains and has been renewed. Some states that take advantage of this program do not otherwise include HCV drugs on their formularies. It is important to note that beyond medications, treatment of HCV also requires considerable and costly tests that most ADAPs cannot afford to (or do not) cover, and HCV medication cannot be initiated without such testing. As a result, ADAPs that cover HCV medications have reported lower than expected utilization.

Hepatitis A and B vaccines are recommended for those at high risk for HIV and people living with HIV. In June 2006, 21 ADAPs reported covering hepatitis A and B vaccines on their formularies (see Appendix X). Some ADAPs are adding the A and B vaccines to their formularies because their clients are unable to secure the vaccine through other public health programs. For example, while some state health departments offer hepatitis A and B vaccines to adults at risk through their immunization program, persons living with HIV may not always be eligible. In an effort to provide these vaccinations to ADAP clients, NASTAD's ADAP Crisis Task Force negotiated an agreement for low-cost hepatitis A and B vaccines for rebate ADAPs. Direct purchase ADAPs are able to access HRSA's Prime Vendor Program to obtain vaccines at a significantly reduced price. It is hoped that the reduced price will allow more ADAPs to provide the A and B vaccines to their HIV positive clients.

*See: Centers for Disease Control and Prevention, "Frequently Asked Questions and Answers About Coinfection with Hepatitis C Virus." Available at http://www.cdc.gov/hiv/resources/qa/HIV-HCV_Coinfection.htm (accessed March 7, 2007); Centers for Disease Control and Prevention, National Institutes of Health, HIV Medicine Association/Infectious Diseases Society of America, "Treating Opportunistic Infections Among HIV-Infected Adults and Adolescents," *MMWR*, December 17, 2004 / 53(RR15).

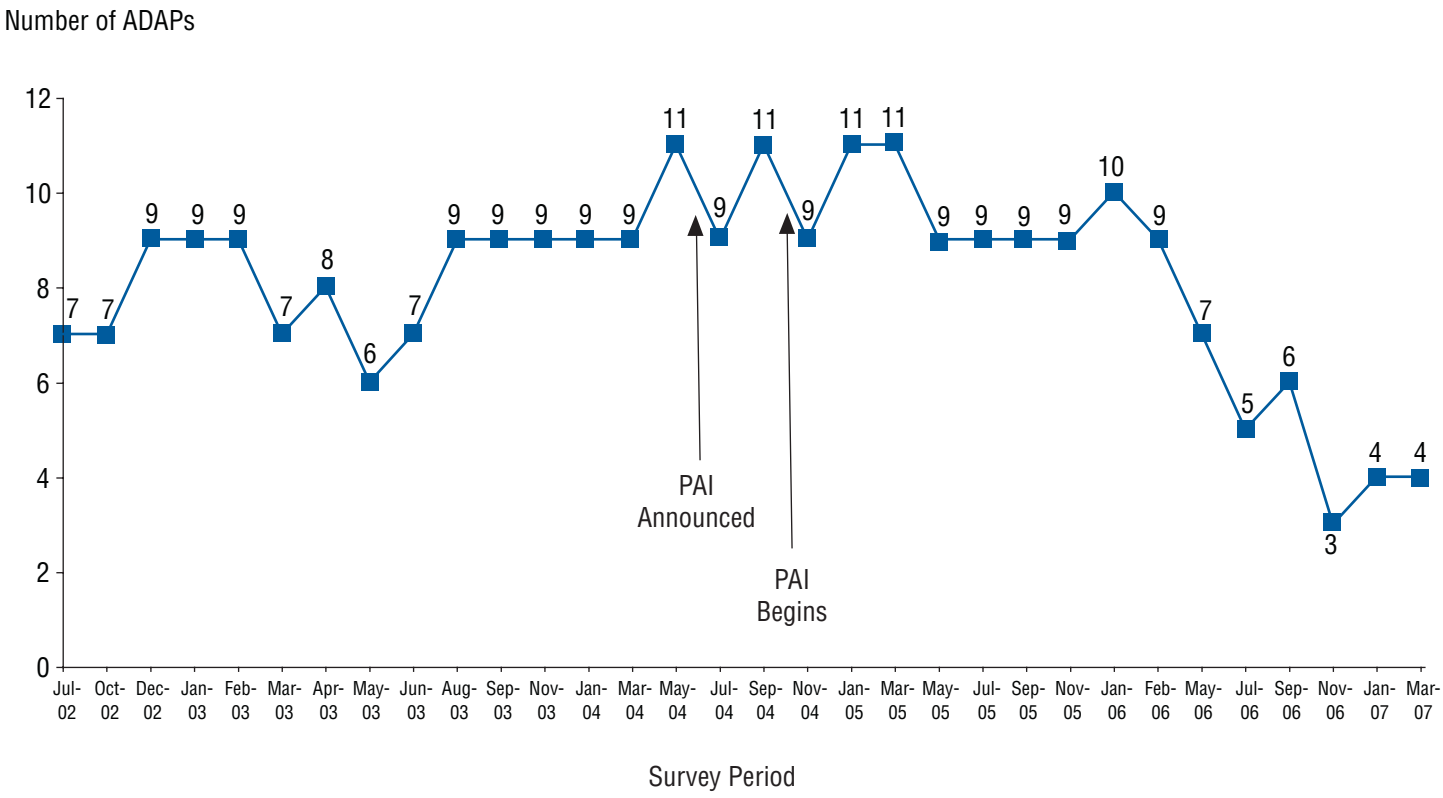
Chart 19
ADAPs with Waiting Lists, March 2007
(571 Individuals in 4 States)



Note: 52 ADAPs reported data. Delaware and Guam did not report data. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006.

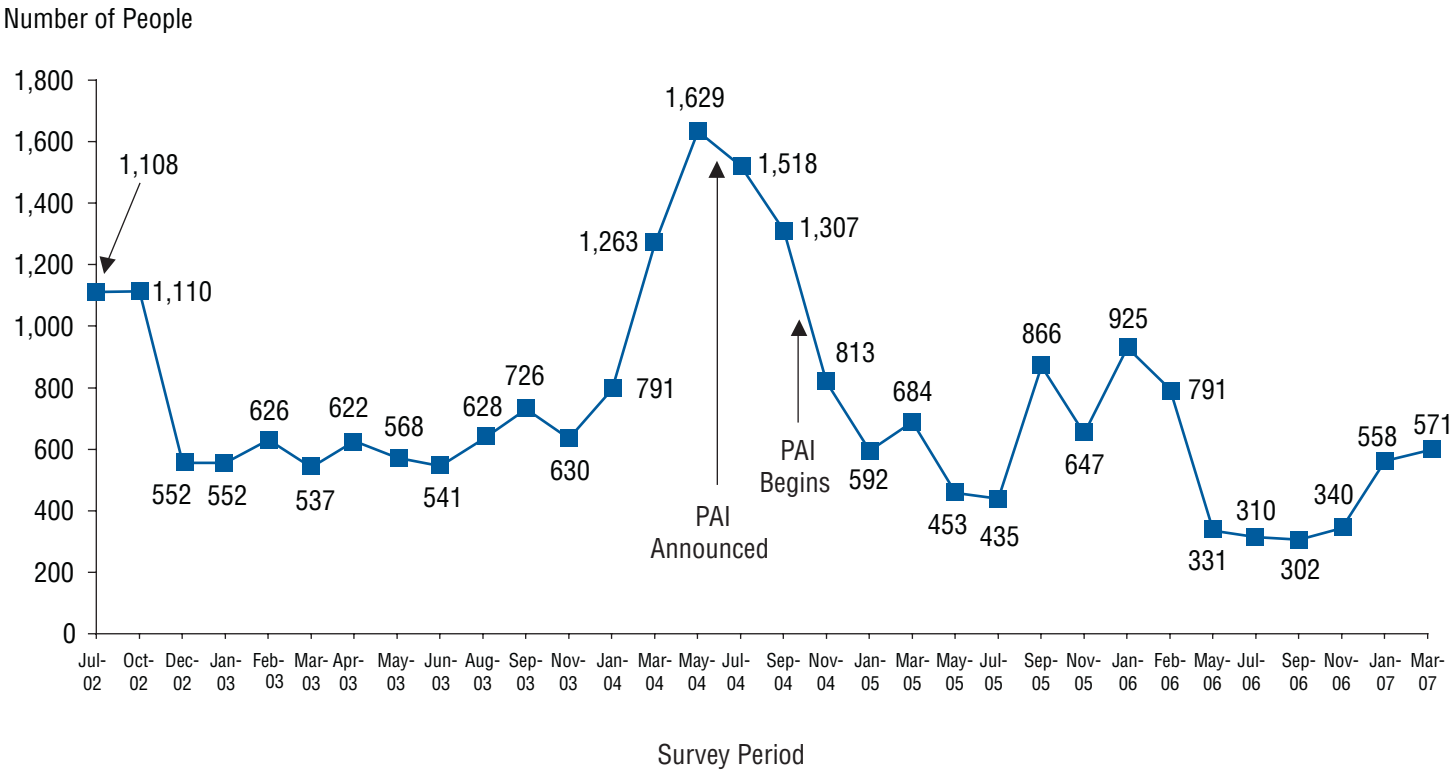
As of March 2007, four jurisdictions had waiting lists in place, totaling 571 individuals with HIV who could not gain access to medications through their state's ADAP, despite meeting its eligibility criteria. Prior to July 2006, two of these states had never implemented an ADAP waiting list. The remaining two states have had an ADAP waiting list for almost two full years (see Appendix XI). In addition to waiting lists, the most visible representation of unmet need for ADAP services, ADAPs have also sought other ways to limit expenditures and some may already have quite limited formularies, lower income eligibility compared to other states, and/or have instituted further restrictions in these and other areas, even if they do not have an active waiting list in place (see Charts 1, 15, 16, 17, 22 and 23 and Appendices VIII, IX, XI, XII).

Chart 20
Number of States with ADAP Waiting Lists by Survey Period, July 2002–March 2007



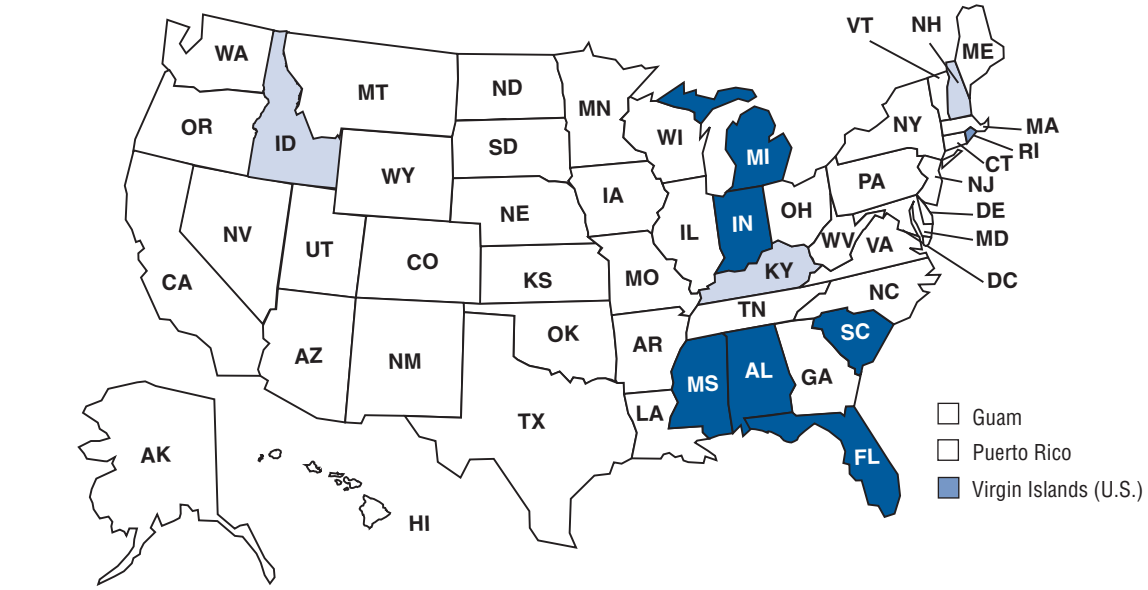
In March 2007, four ADAPs had waiting lists (totaling 571 people). Data from bi-monthly surveys conducted between July 2002 and March 2007 (32 surveys overall) indicate that 20 different states reported having a waiting list in at least one survey period. The number of ADAPs reporting a waiting list ranged from a low of three in November 2006 to as high as 11 in previous periods. As 2006 progressed, the number of states reporting waiting lists and the number of people on waiting lists decreased (see Appendix XI). Previous waiting list states have generally credited this relief largely to the President's ADAP Initiative (PAI), time-limited funds provided to address waiting lists, and to Medicare Part D.

Chart 21
Number of People on ADAP Waiting Lists by Survey Period, July 2002–March 2007



In March 2007, 571 people with HIV were on ADAP waiting lists across the country. 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. Data from bi-monthly surveys conducted between July 2002 and March 2007 (32 surveys overall) indicate that the number of people on waiting lists ranged from a low of 302 to a high of 1,629 with an average of 729 (see Appendix XI). Waiting lists reached their peak in mid-2004 but began to decline soon after, largely due to the introduction of the President's ADAP Initiative (PAI), time-limited funds to address waiting lists, and to increases in state funding; some ADAPs also report that the new Medicare Part D prescription drug benefit helped to alleviate their waiting lists. However, an increase in the number of people on waiting lists has been observed over the past three reporting periods.

Chart 22
ADAPs with Current or Planned Cost-Containment Measures (Other than Waiting Lists), Instituted During Last Year, as of March 2007



Cost-containment measures in place (6 states), as of March 1, 2007

Cost-containment measures in place and anticipate the need to implement additional measures in FY 2007 (2 states), as of March 1, 2007

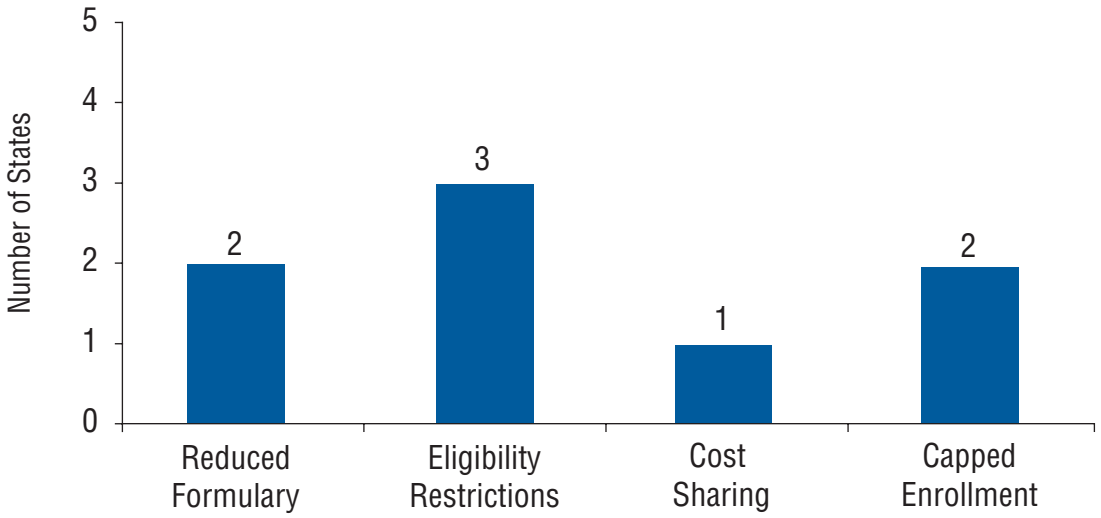
No cost-containment strategies in place but anticipate the need to institute cost-containment strategies in FY 2007 (3 states), as of March 1, 2007

Note: 52 ADAPs reported data. Delaware and Guam did not report data. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006. The ADAP Fiscal Year runs from April 1 through March 31.

In addition to waiting lists, some ADAPs have instituted other measures to contain costs since April 1, 2006. As of March 2007, eight ADAPs implemented cost-containment measures, including two that anticipate instituting an additional measure by the end of ADAP FY 2007 (see Charts 1 and 23). An additional three ADAPs anticipate having to newly institute cost-containment measures during ADAP FY 2007.

In addition to ADAPs that instituted new cost-containment measures over the past fiscal year, many ADAPs have had cost-containment measures in place prior to April 1, 2006. These measures are detailed in Appendix XII.

Chart 23
Number of ADAPs with Cost-Containment Measures (Other than Waiting Lists), Instituted During Last Year, as of March 2007

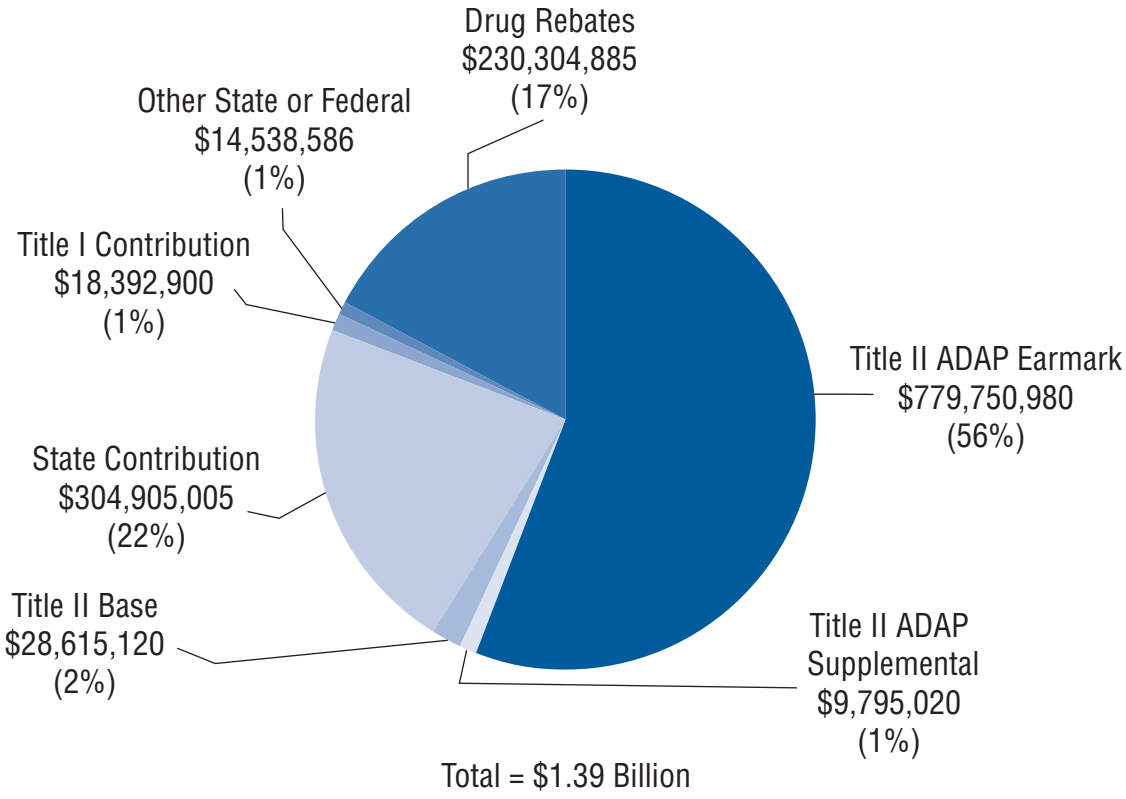


Note: 52 ADAPs reported data. Delaware and Guam did not report data. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006.

As of March 2007, among the states that reported having instituted a cost-containment measure over the past ADAP fiscal year, other than a client waiting list, two reduced the number of drugs on their formularies, three restricted program eligibility, two capped program enrollment, and one implemented cost-sharing for clients.

In addition to ADAPs that instituted these new cost-containment measures over the past fiscal year, many ADAPs have had cost-containment measures in place that are not captured above, including those that are targeted toward specific drugs (e.g., enrollment caps, clinical criteria requirements, and/or prior authorization). These measures and others are detailed in Appendix XII.

Chart 24
National ADAP Budget, by Source, FY 2006



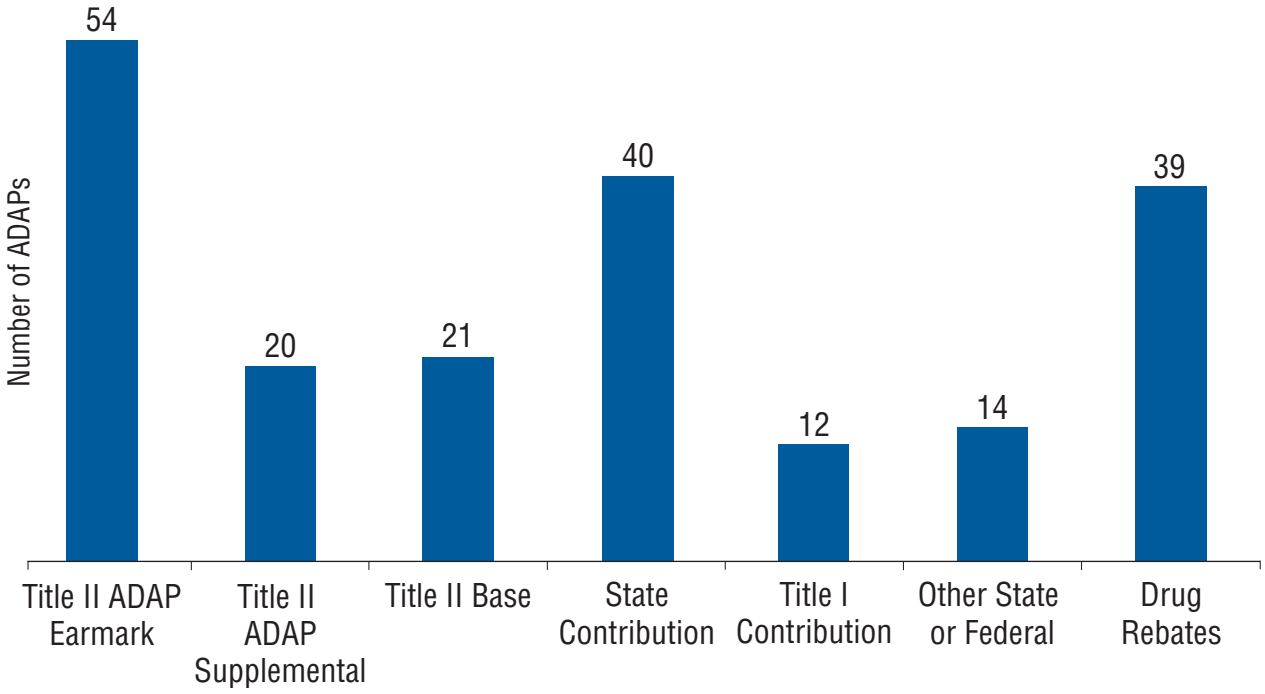
Note: 51 ADAPs reported data. Although Delaware, Guam, and New Mexico did not report, data on their Title II earmark and ADAP supplemental were available and included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006. ADAP supplemental funds are only available for states meeting the required eligibility and matching funds.

In FY 2006, the National ADAP Budget totaled $1.39 billion, up from $1.29 billion in FY 2005 (a seven percent increase). The Title II ADAP earmark (not including the set-aside for the ADAPs supplemental) represented the largest share of the ADAP budget, accounting for $779.8 million, or 56%, of total ADAP funding in FY 2006, a similar share as the prior year (59%). State funding followed at $304.9 million, or 22% (up from 19% last year). Title II base funding, other state and federal funding, and Title II ADAP supplemental grants each represented approximately two percent or less of the total ADAP budget. Title I EMA funding remained at one percent of the overall budget.

Drug rebates account for a growing share of the ADAP budget over time, reaching $230.3 million or 17% of the budget in FY 2006. Rebates are an increasingly important source of revenue for ADAPs. (Note: ADAP Monitoring Reports prior to March 2005 did not include drug rebates as part of the national budget; the current and all prior year budgets have been adjusted to include drug rebates for comparison purposes.)

FY 2006 ADAP budgets range from $97,000 in Guam to approximately $301 million in California (see Appendix XIII).

Chart 25
Number of ADAPs, by Budget Source, FY 2006



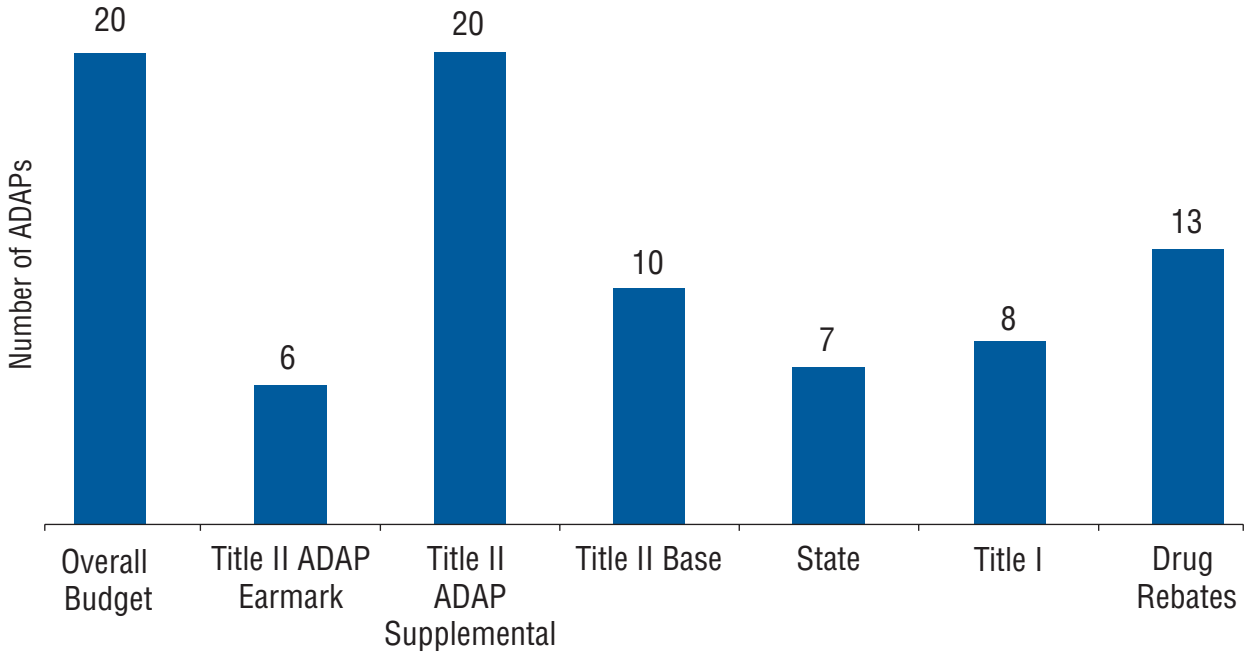
Note: 51 ADAPs reported data. Although Delaware, Guam, and New Mexico did not report, data on their Title II earmark and ADAP supplemental were available and included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006.

By definition, all eligible jurisdictions (54*) 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 2006, two ADAPs reported receiving only ADAP earmark funding. The breakdown of other sources of funding across the country was as follows (among the 51 ADAPs reporting data; see Appendix XIII):

- Title II ADAP Supplemental Treatment Grants: 20 ADAPs received funding, 34 did not
- Title II Base Funds: 21 ADAPs received funding, 30 did not
- State General Revenue Support: 40 ADAPs received funding, 11 did not
- Title I EMA Funds: 12 ADAPs received funding, 39 did not
- Other State/Federal Funds: 14 received funding, 37 did not
- Drug Rebates: 39 ADAPs received funding, 12 did not

*American Samoa, the Marshall Islands, and the Northern Mariana Islands received funding before FY 2006, but HRSA determined they were not eligible for ADAP funding in FY 2006.

Chart 26
Number of ADAPs with Funding Decreases, by Budget Source, FY 2005–FY 2006

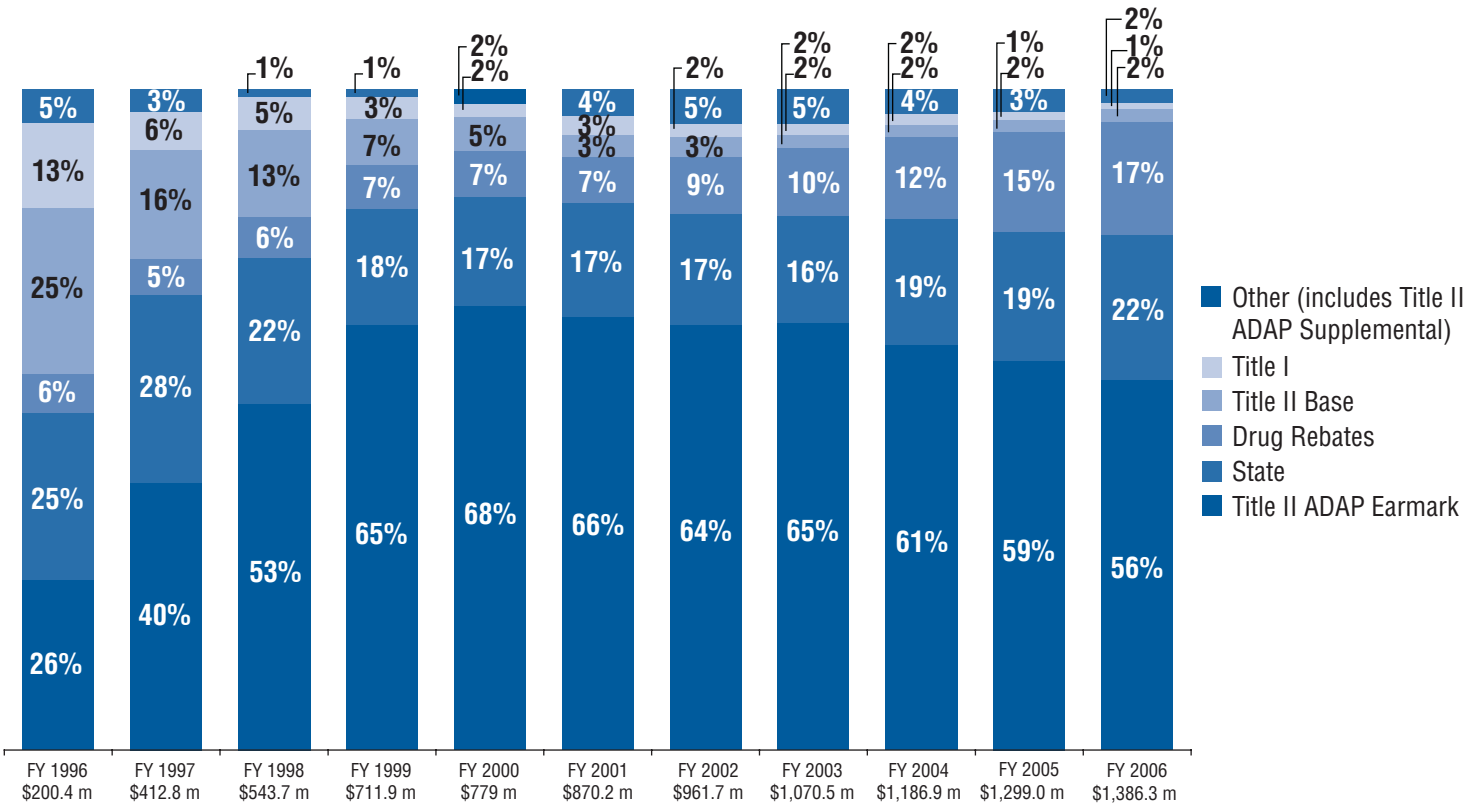


Note: 51 ADAPs reported data. Although Delaware, Guam, and New Mexico did not report, data on their Title II earmark and ADAP supplemental were available and included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006.

Despite a seven percent increase in the National ADAP Budget across all ADAPs between FY 2005 and FY 2006, some ADAPs had decreases either in their overall budget or for specific funding streams, as follows (see Appendices XIV and XV):

- Overall Budget: 34 ADAPs had increases or level funding, 20 had decreases
- Title II ADAP Earmark: 48 ADAPs had increases or level funding; 6 had decreases
- Title II ADAP Supplemental Treatment Grants: all 20 had decreases (see Chart 30 for further detail regarding ADAP Supplemental)
- Title II Base Funds: 15 ADAPs had increases or level funding; 10 had decreases (21 states contributed Title II base funds to the state ADAP in FY 2006 compared to 19 in the previous year)
- State General Revenue Support: 35 ADAPs had increases or level funding, 7 had decreases
- Title I EMA Funds: 5 ADAPs had increases or level funding, 8 had decreases
- Drug Rebates: 30 ADAPs had increases or level funding, 13 had decreases

Chart 27
National ADAP Budget, by Source, FY 1996–FY 2006

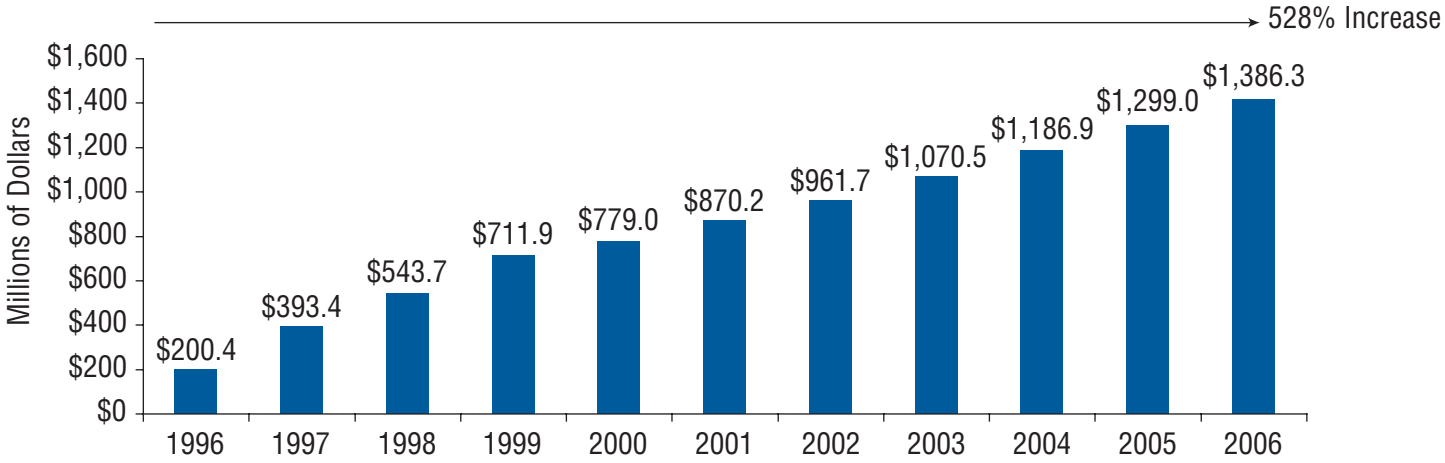


The composition of the National ADAP Budget has changed since FY 1996, the year in which the Title II ADAP earmark began. The earmark has grown significantly as a proportion of the budget, rising from 26% of the budget in FY 1996 to 56% in FY 2006. State funding has declined slightly as a proportion of the national ADAP budget (25% in FY 1996 and 22% in FY 2006), 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 six percent in FY 1996 to 17% in FY 2006, and are now the third largest source of revenue for ADAPs.

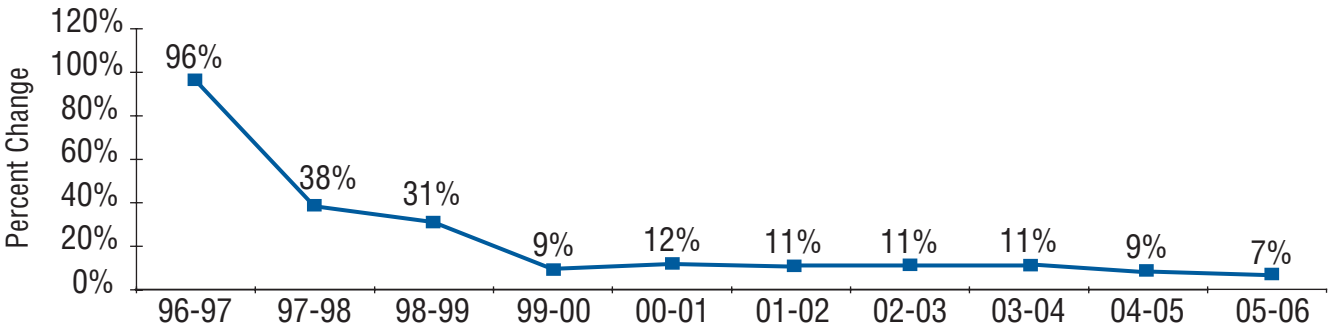
Title II base funding as a proportion of the total ADAP budget has declined markedly, from 25% in FY 1996 to two percent in FY 2006. Title I EMA funding has also decreased significantly over time as a share of the budget (13% in FY 1996 to one percent in FY 2006). Title II base and Title I EMA contributions are the only two funding sources in the National ADAP Budget that were less in amount in FY 2006 than in FY 1996.

Chart 28

The National ADAP Budget, FY 1996–2006



The National ADAP Budget, Rate of Growth, FY 1996–2006

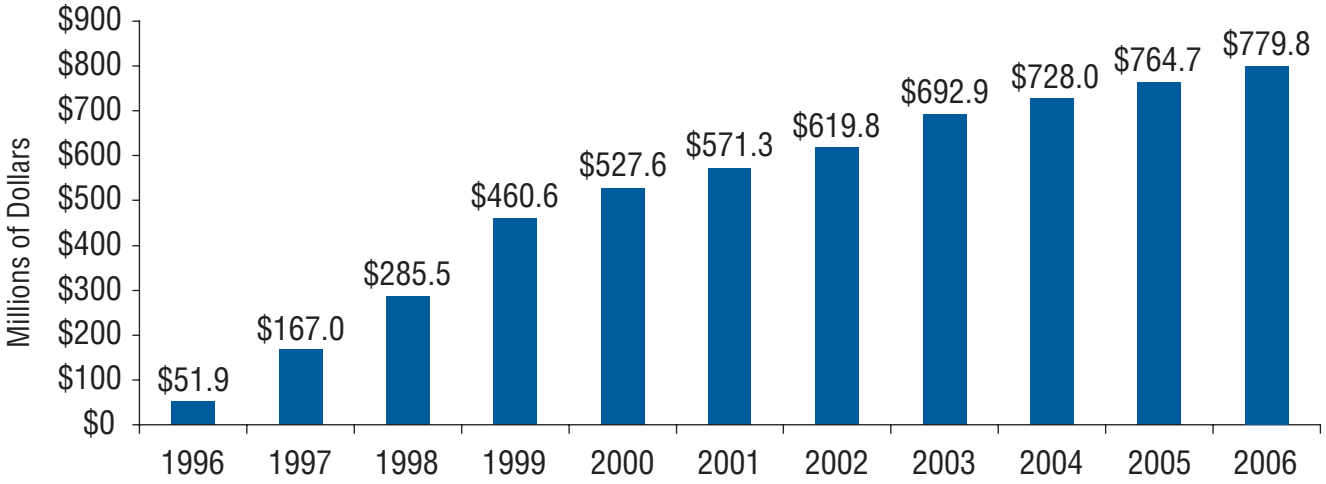


Note: 51 ADAPs reported data. Although Delaware, Guam, and New Mexico did not report, data on their Title II earmark and supplemental were available and included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006. Percentages on the *National ADAP Budget, Rate of Growth* graph represent changes between the two years indicated, not aggregate changes since FY 1996.

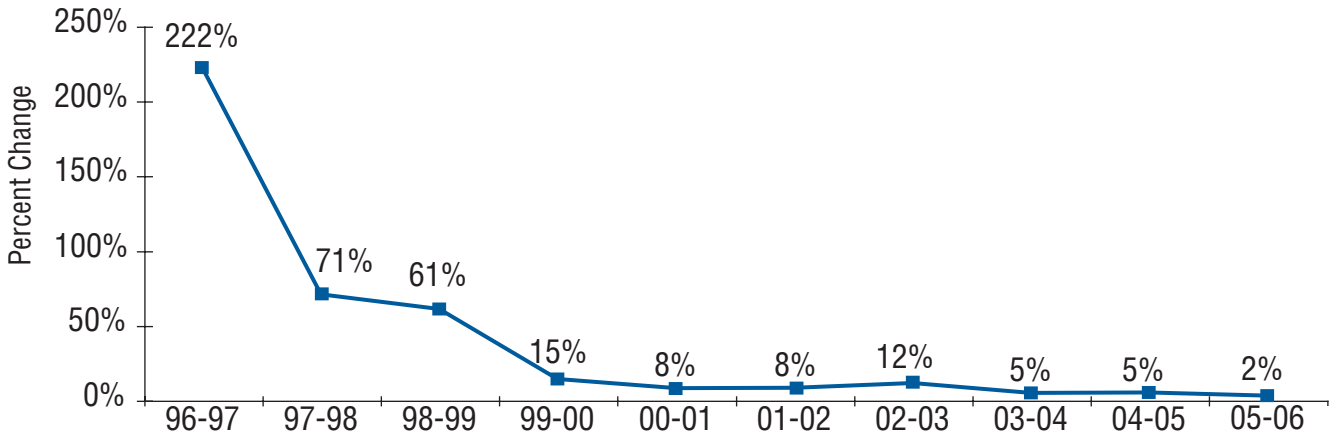
Since FY 1996, the first year of the *National ADAP Monitoring Project* and the year in which highly active antiretroviral therapy (HAART) emerged as the new standard of care, the National ADAP Budget from all sources has grown by more than six-fold (a 528% increase). The budget has grown each year since 1996, but generally at slower rates since the initial growth spurt between 1996 and 1997; since 1999, the annual rate of increase has ranged between seven percent and 12% (see Appendix XIV).

Chart 29

Title II ADAP Earmark, FY 1996–2006



Title II ADAP Earmark, Rate of Growth, FY 1996–2006



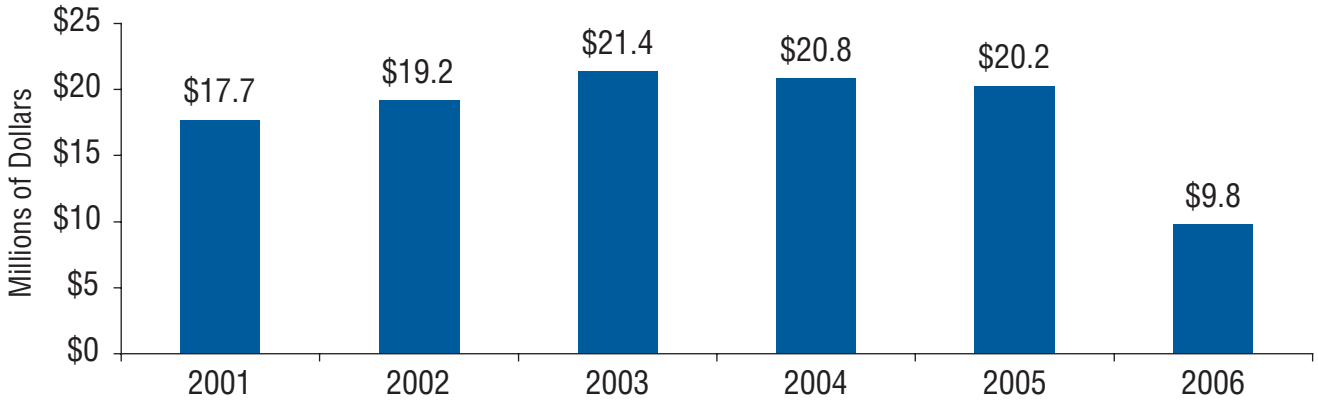
Note: Includes data from 54 ADAPs. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006. Percentages on the *ADAP Earmark, Rate of Growth* graph represent changes between the two years indicated, not aggregate changes since FY 1996. Title II ADAP earmark does not include Title II ADAP supplemental funding set-aside from FY 2001–FY 2006.

The Title II ADAP earmark represents funding appropriated each year by Congress under Title II of Ryan White that is specifically designated for ADAPs. The earmark—the largest component of the National ADAP Budget—increased by $15.1 million (two percent) between FY 2005 and 2006, to $779.8 million. This is the smallest increase since the earmark began.

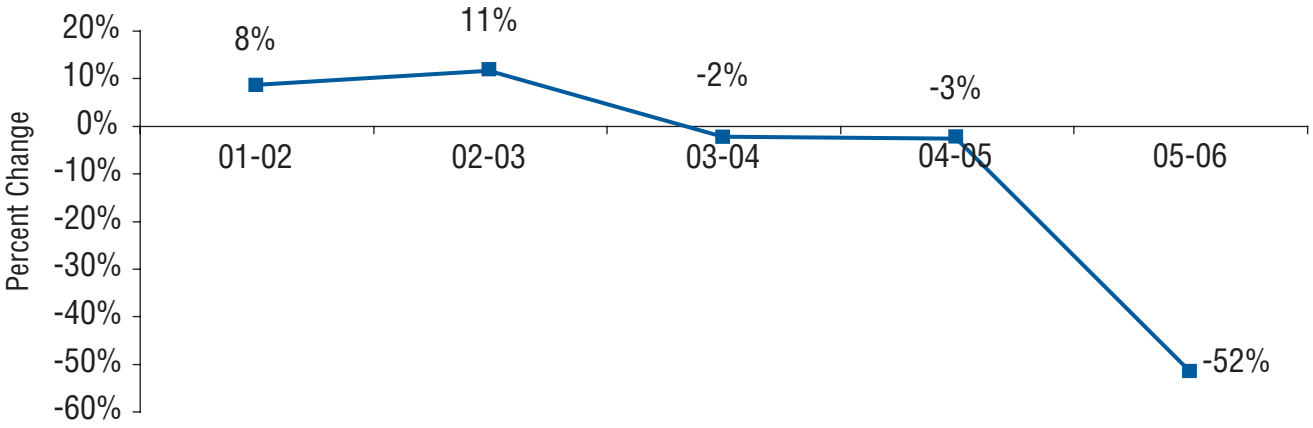
Note: Title II ADAP supplemental awards, a set-aside of the ADAP earmark, are counted separately in this report (see page 5 for description, Chart 30 and Appendices XIII and XV).

Chart 30

Title II ADAP Supplemental Funding, FY 2001–2006



Title II ADAP Supplemental Funding, Rate of Growth, FY 2001–2006

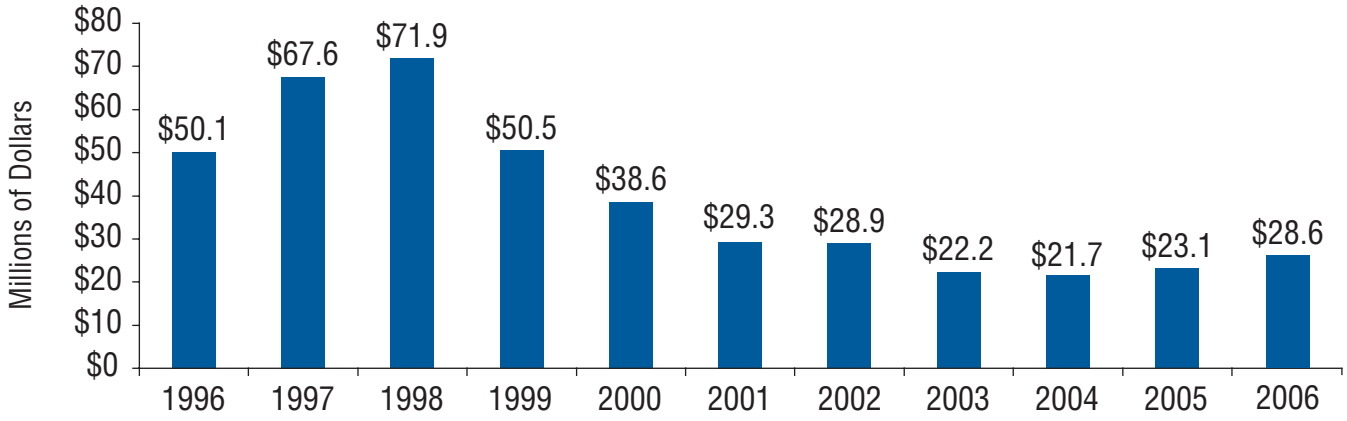


Note: All ADAP supplemental recipient states reported data. Percentages on the *ADAP Supplemental Funding, Rate of Growth* graph represent changes between the two years indicated, not aggregate changes since FY 2001.

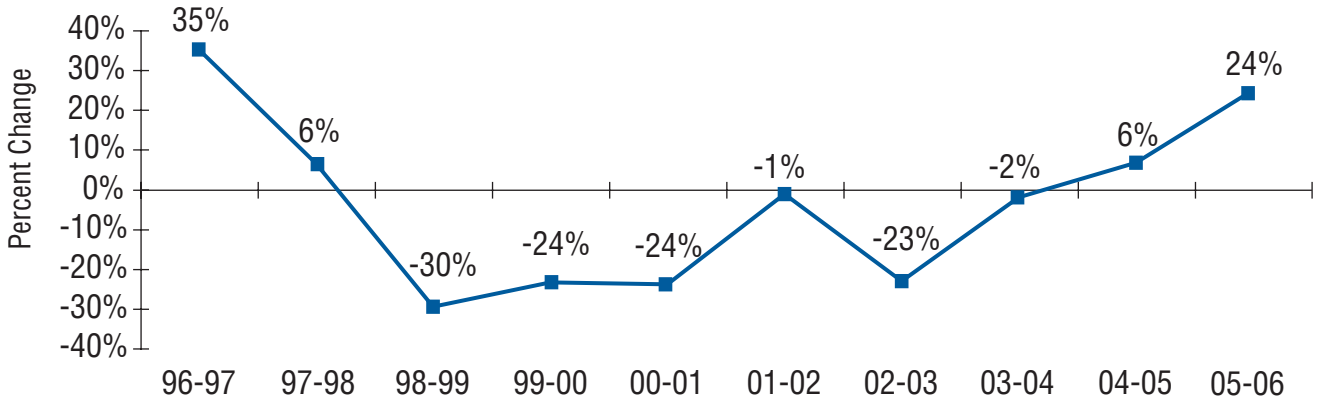
The Title II ADAP supplemental is a set-aside by Congress of three percent (until the most recent reauthorization of Ryan White) of the ADAP earmark. In FY 2006, ADAP supplemental awards were provided to 20 states that met the federal eligibility criteria, applied for funding, and that were able to meet the mandated matching requirement (see page 5 for additional information). However, prior to making grant awards to the 20 states, ADAP supplemental funds were reduced by 52% in order to adjust the ADAP earmark awards in states that would otherwise have received an overall Title II award less than that of the previous year (one of the hold harmless requirements of the Ryan White Program). It should be noted that ADAP supplemental funding was reduced in FY 2004 by two percent and in FY 2005 by four percent for this purpose as well. The 2006 reauthorization of the Ryan White Program raised the percentage allocated to the ADAP supplemental to five percent of the ADAP earmark, beginning in FY 2007. Eligibility for ADAP supplemental funds will be reviewed every funding year rather than linked to the same states throughout the authorization period as under prior law (see Appendices XIII and XV).

Chart 31

Title II Base Funding, FY 1996–2006



Title II Base Funding, Rate of Growth, FY 1996–2006

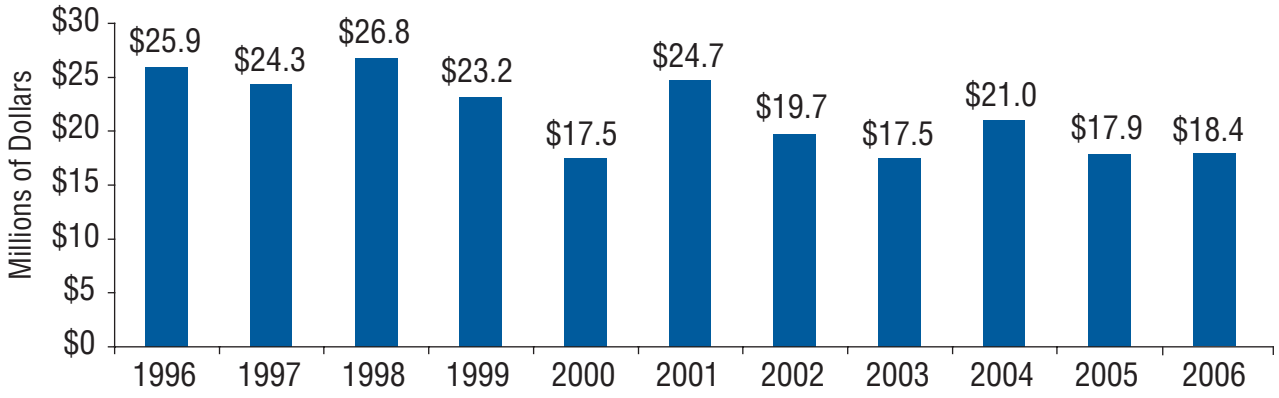


Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data and are not included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006. Percentages on the *Title II Base Funding, Rate of Growth* graph represent changes between the two years indicated, not aggregate changes since FY 1996.

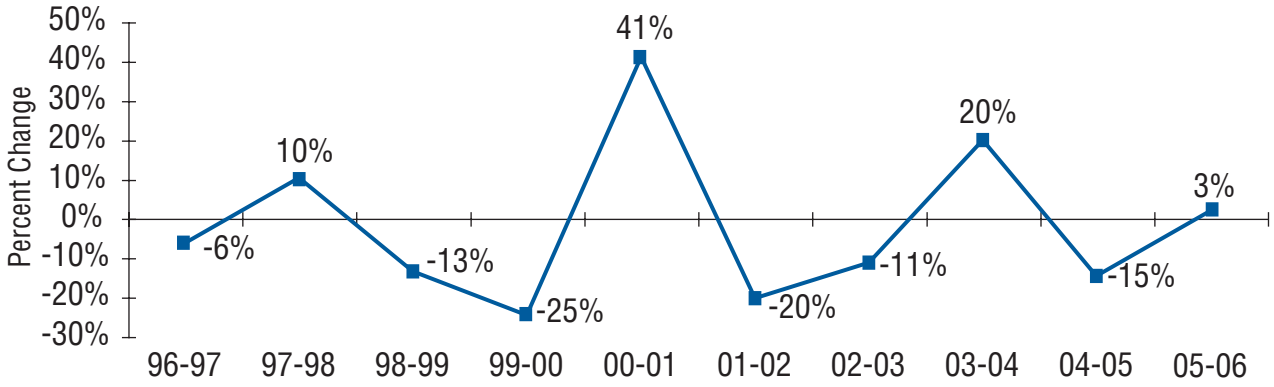
States receive Ryan White Title II base funds (funds through Title II other than those earmarked for ADAP) based on a formula and they are not required to allocate these funds to ADAPs, although many states have historically found this necessary to fill the gap of the ADAP earmark awards and need (see page 5 for description). Title II base funds allocated for ADAP declined each year between FY 1999 and FY 2004, then increased starting in FY 2005, reaching $28.6 million in FY 2006. In FY 2006, 21 states allocated Title II base funds to their ADAP, up from 19 in FY 2005 (Appendices XIII and XV). The amount of Title II base funding allocated by states to their ADAPs is related to several factors, including their overall Title II base award amount and decisions about which allowable services to fund through this mechanism. Title II base funds are intended to cover primary care, mental health, substance abuse treatment, supportive services to maintain clients on HAART and improve their drug adherence, and insurance purchasing and continuation programs; however, when a deficit in ADAP exists, states often must use base funds to fill this gap. In a resource-limited state, this could limit availability of primary and support services.

Chart 32

Title I EMA Funding, FY 1996–2006



Title I EMA Funding, Rate of Growth, FY 1996–2006

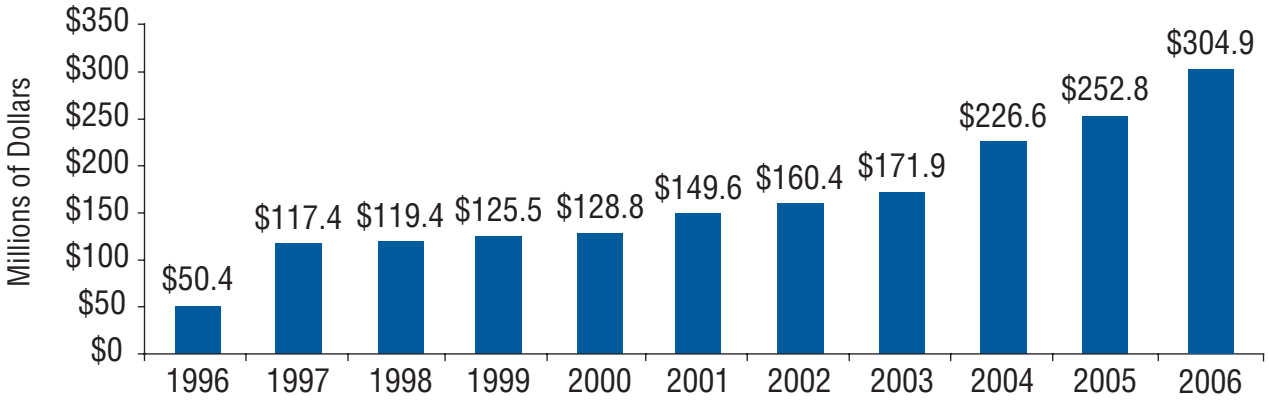


Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data, although they do not have Title I areas within their borders. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006. Percentages on the *Title I EMA Funding, Rate of Growth* graph represent changes between the two years indicated, not aggregate changes since FY 1996.

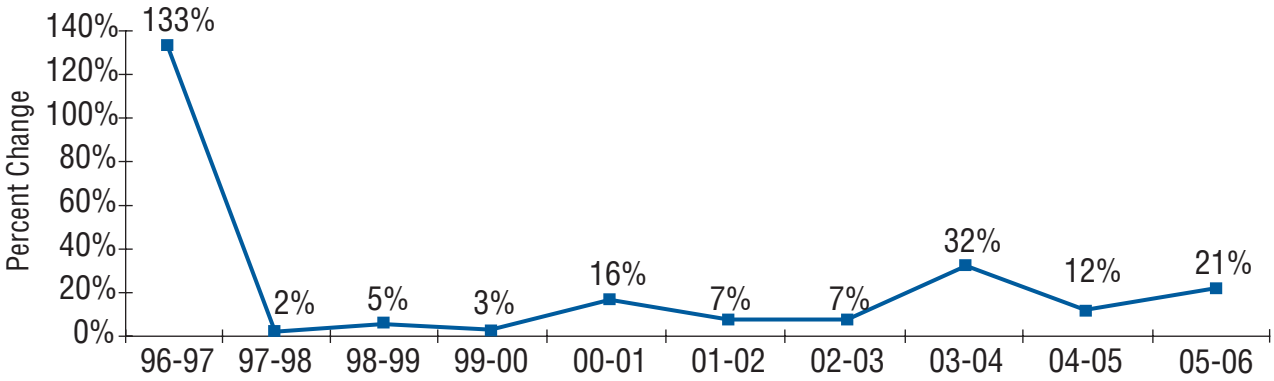
While states make decisions regarding allocation of state general revenue funds (other than matching requirements for ADAP supplemental funding) and Title II base funds to ADAPs, local Ryan White HIV Services Planning Councils make allocation decisions regarding Title I funds. In FY 2006, 12 Title I Eligible Metropolitan Areas (EMAs) contributed a total of $18.4 million to their state's ADAP to purchase medications for clients living within their respective Title I EMA. FY 2006 ADAP contributions from Title I EMAs increased by $0.5 million, or three percent, from FY 2005. These voluntary Title I contributions to ADAPs represented one percent of the National ADAP Budget (see Appendices XIII and XV).

Chart 33

State Funding, FY 1996–2006



State Funding, Rate of Growth, FY 1996–2006

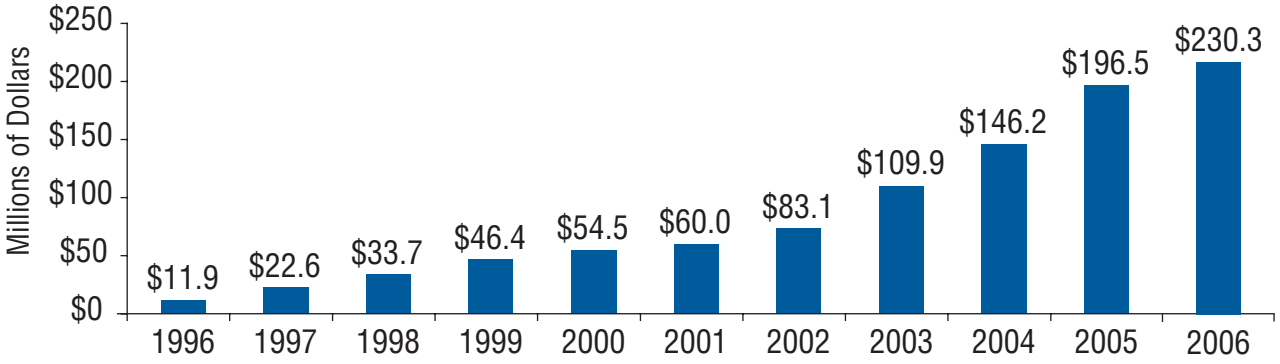


Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data and are not included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006. Percentages on the *State Funding, Rate of Growth* graph represent changes between the two years indicated, not aggregate changes since FY 1996.

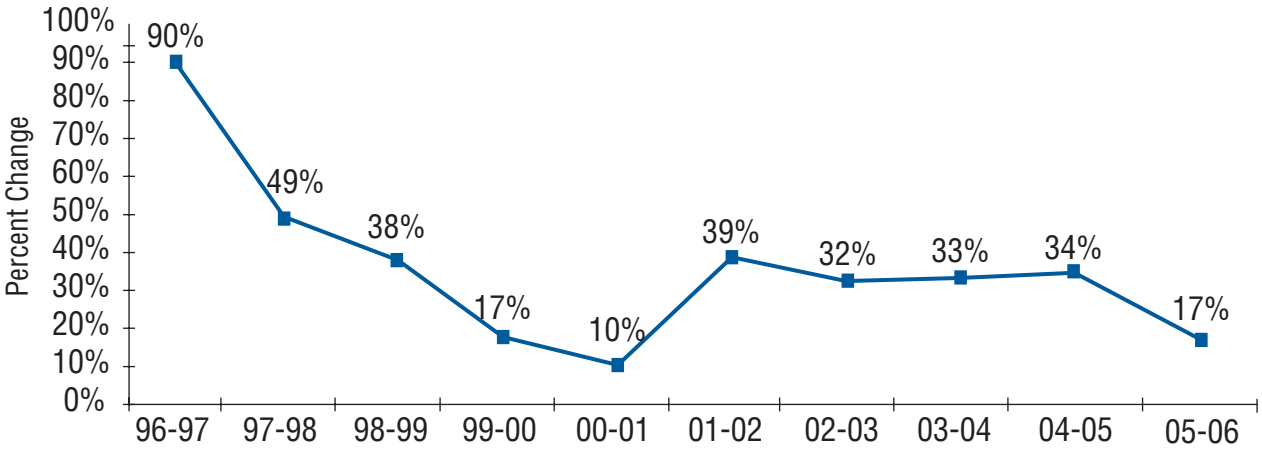
State general revenue funding for ADAPs reached $304.9 million in FY 2006, an increase of $52.1 million, or 21%, over FY 2005 (the largest percentage increase of all national ADAP budget categories). State funding for ADAPs is the second largest component (22%) of the national ADAP budget. Forty states contributed general revenue funds to ADAP in FY 2006, an increase of one over FY 2005 (see Appendices XIII and XV). State funding for ADAPs varies significantly across the country, ranging from those states that do not contribute any state general revenue support to one state that contributes 52% of its budget in state funding (Rhode Island) in FY 2006 (see Appendix XIII). While states that receive ADAP supplemental awards are required to provide a state match, this generally represents a relatively small share of the ADAP budget (less than one percent in FY 2006) (see page 5 for description).

Chart 34

Drug Rebates, FY 1996–2006



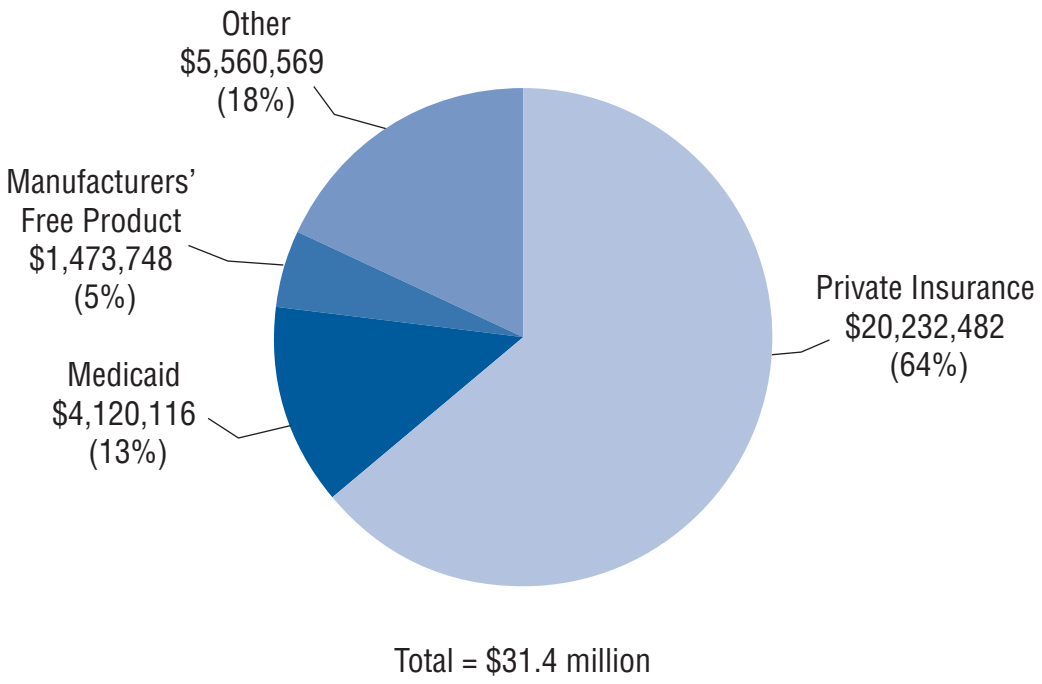
Drug Rebates, Rate of Growth, FY 1996–2006



Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data and are not included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006. Percentages on the *Drug Rebates, Rate of Growth* graph represent changes between the two years indicated, not aggregate changes since FY 1996.

ADAPs estimate receiving manufacturers' drug rebates totaling $230.3 million in FY 2006, an increase of $33.8 million, or 17%, over FY 2005. Funding from rebates is now the third largest component of the ADAP budget (17%), after the federal earmark and state funding (see Appendices XIII and XV). Drug rebates may be voluntary (such as those negotiated with manufacturers and NASTAD's ADAP Crisis Task Force—see page 13 for description), mandated by state law, or mandated and available to ADAPs as 340B entities. The mandated 340B discounts for ADAPs are realized by direct purchase states at the time medications are purchased and are not reflected in estimated rebates (see Chart 36 and Appendix XVII).

Chart 35
Cost Recovery and Other Cost-Saving Mechanisms (Excluding Drug Rebates), FY 2006

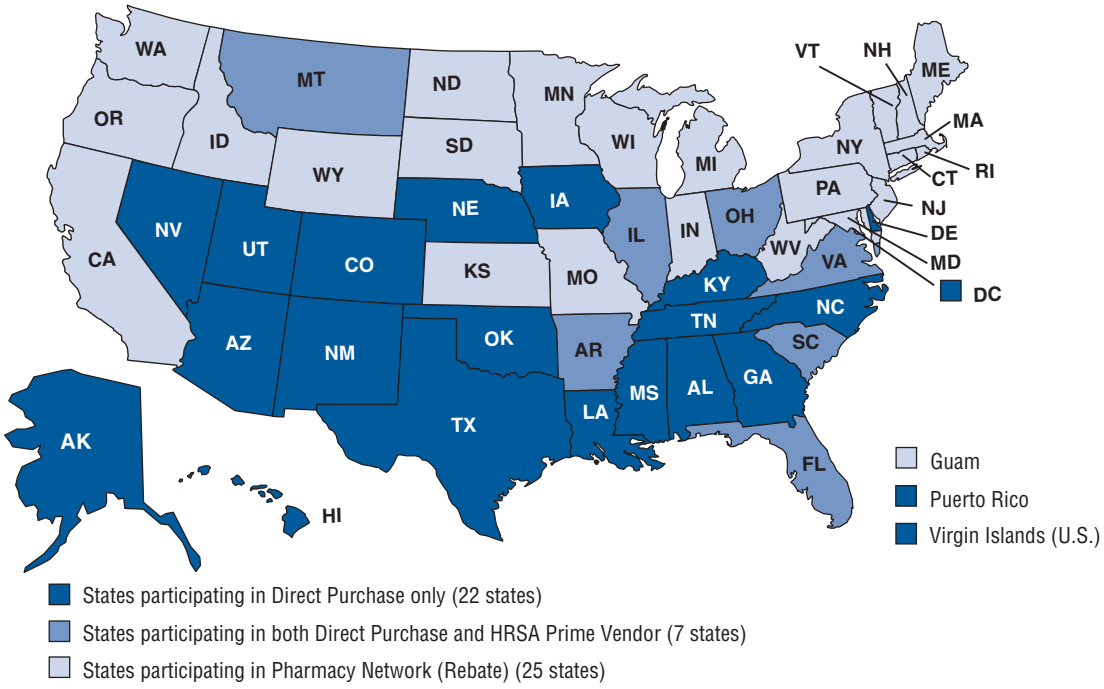


Note: 16 ADAPs reported data. Manufacturers' drug rebates are not included here. Cost recovery and other cost-saving mechanisms are not included in the National ADAP Budget.

Cost recovery represents reimbursement to ADAPs from other entities for medications purchased through the ADAP. Cost recovery from sources other than rebates represented $31.4 million to ADAPs in FY 2006. Private insurance recovery, in which an ADAP receives reimbursement from insurance providers for medications purchased for their clients, represents the primary recovery source, $20.2 million, or 64%, of the total cost recovery in FY 2006.

Insurance recovery from Medicaid represents $4.1 million, or 13% of ADAP cost recovery. Other sources of cost recovery ($5.6 million, or 18%) include income received from other state public assistance programs, cost sharing, and state carryover from previous state fiscal years (see Appendix XVI).

Chart 36
ADAP Drug Purchasing Mechanisms, FY 2006



Notes: Data from 54 ADAPs are included. Although Delaware, Guam, and New Mexico did not report data, their drug purchasing mechanisms are known and included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006.

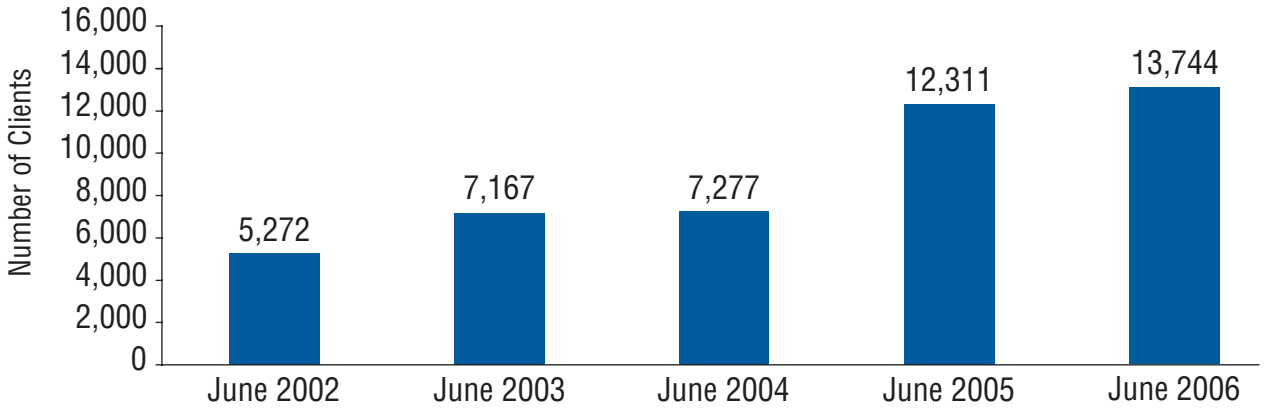
The Section 340B Drug Discount Program, authorized under the Veterans' Health Care Act of 1992, allows certain U.S. Public Health Service covered entities, including ADAPs, to access at least the same drug price discounts as Medicaid. Participation in the program is not mandatory but is strongly encouraged by HRSA, and all but one ADAP (the District of Columbia) participates. States that participate in the program may purchase drugs either directly from wholesalers or through retail pharmacies and then apply to drug manufacturers for rebates. As of June 2006, 29 ADAPs were participating in the direct purchase mechanism and 25 used the rebate or pharmacy network mechanism (see Appendix XVII).

Direct purchase ADAPs may also 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 entities can participate in this program. Seven of the 29 direct purchase ADAPs reported being enrolled in the HRSA prime vendor program in June 2006.

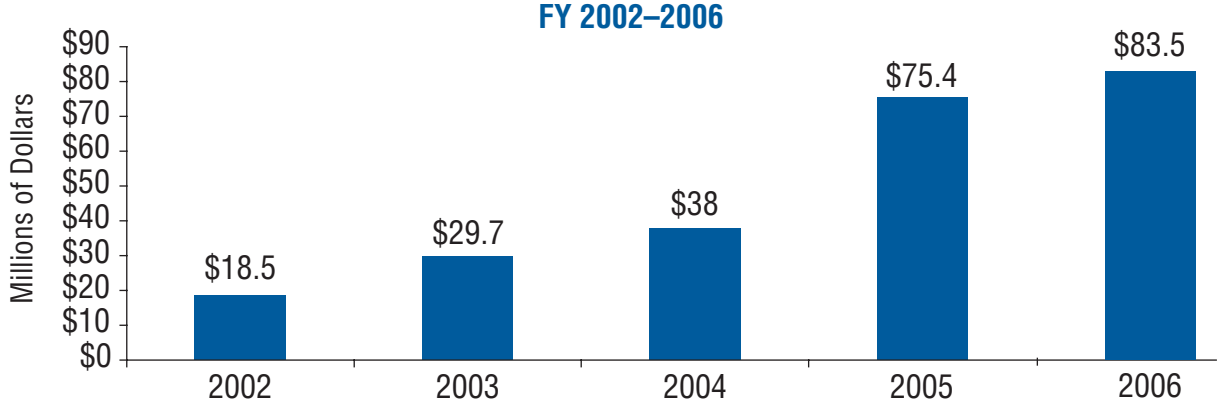
For ADAPs that choose not to participate in the 340B program, HRSA requires them to demonstrate that they are receiving 340B or better prices/rebates through other means. The District of Columbia purchases drugs through the Department of Defense, allowing it to access the Federal Ceiling Price, a lower price only available to certain federal purchasers. States have other options for achieving lower drug prices. For example, several states that participate in the 340B program also have state laws or their own negotiation processes that result in lower prices. In addition, NASTAD's ADAP Crisis Task Force (see page 13 for description), has been successful in negotiating prices lower than 340B ceiling prices for all states; the Task Force estimates that these negotiations have led to an additional $145 million in supplemental rebates/discounts in FY 2006 with a total savings since the Task Force was formed in 2003 of $425 million.

Chart 37

Clients Served in Insurance Purchasing/Maintenance Programs, June 2002–2006



Estimated ADAP Spending on Insurance Purchasing/Maintenance Programs, FY 2002–2006

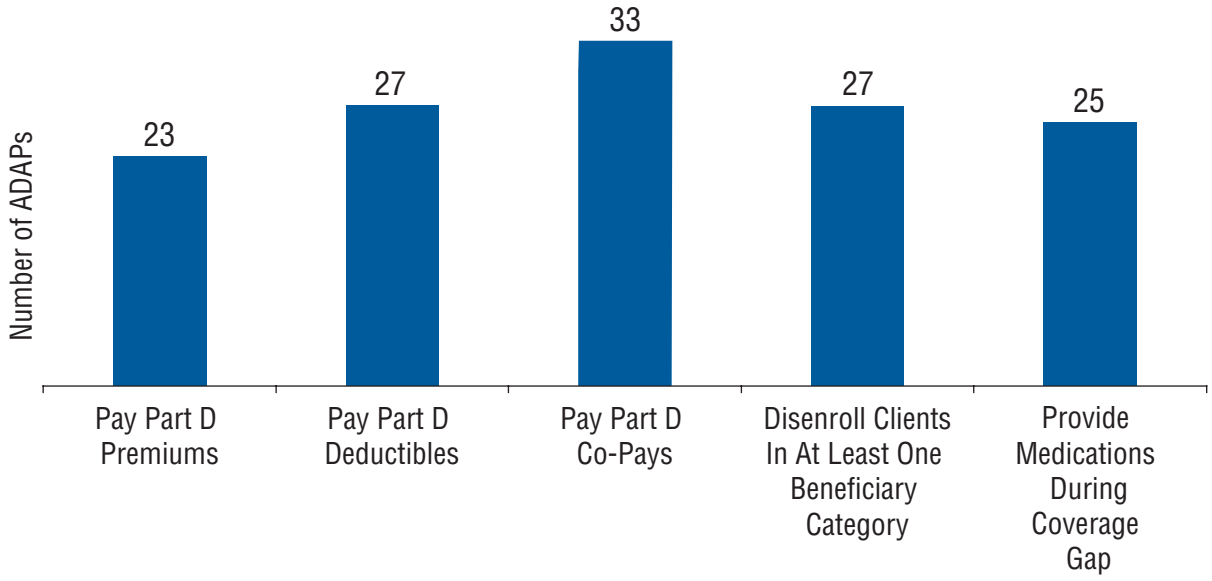


Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data and are not included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006. Health insurance programs include purchasing health insurance and paying insurance premiums, co-payments, and/or deductibles. Client data for June 2002 and 2003 represent clients enrolled; June 2004–2006 data represent clients served. All ADAPs that have reported having insurance purchasing/maintenance programs since 2002 are included.

The Ryan White Program allows states to use ADAP earmark dollars to purchase health insurance and/or pay insurance premiums, co-payments and/or deductibles for individuals eligible for ADAP, provided the insurance has at least comparable or improved formulary benefits to that of the state ADAP. Thirty-one states reported using ADAP funds for this purpose, representing $83.5 million (see Appendix XVIII). In June 2006, an estimated 13,744 ADAP clients were served by these ADAPs under such arrangements, nearly 1,500 more clients than in June 2005 (some of these clients may have also received medications through ADAP). Insurance purchasing and maintenance strategies appear to be cost effective—in June 2006, spending on insurance represented an estimated $395 per capita, less than half of per capita drug expenditures in that month ($991).

Insurance purchasing/maintenance arrangements are playing an increasingly larger role in ADAPs: the number of ADAPs who purchase some form of insurance for clients rose from 29 in 2005 to 31 in 2006; clients served by insurance programs increased by 12% over FY 2005 clients; and FY 2006 expenditures on insurance programs increased by 11% over FY 2005.

Chart 38
ADAP Policies Related to Medicare Part D, as of November 2006



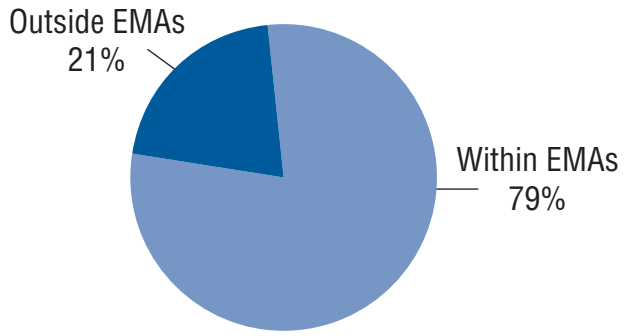
Note: 48 ADAPs reported data.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a new outpatient prescription drug benefit, Part D to the Medicare program effective January 1, 2006. As the payer of last resort, ADAPs were required by HRSA to ensure that all Medicare Part D eligible clients enroll in a Medicare prescription drug plan by May 15, 2006 (or at least ensure that they are not paying for any Medicare-covered prescription drug service for Medicare-eligible ADAP clients). ADAPs are permitted to coordinate with Medicare prescription drug plans and pay for drug plan premiums, deductibles, coinsurance, and co-payments. However, the MMA does not allow ADAP funds (either federal or state) to be applied to *True Out of Pocket Costs* (TrOOP), the costs clients must incur before reaching catastrophic coverage thresholds under Part D. To meet these federal requirements and maintain appropriate medication coverage for their clients, ADAPs began implementing their Part D policies in January 2006.

Twenty-three ADAPs reported paying for Part D premiums for their eligible clients; 27 for Part D deductibles; and 33 for co-payments for at least one eligibility category (dually eligible, full subsidy, partial subsidy and standard). Twenty-five ADAPs are also providing medications to eligible clients once they reach the Part D coverage gap. Clients eligible for both Medicare and Medicaid (dual eligibles) or the full subsidy benefit of Part D were disenrolled from ADAP in 24 states because Part D coverage was considered a comprehensive prescription benefit. Thirteen ADAPs disenrolled full subsidy or standard clients and although some of the clients were enrolled in state pharmaceutical assistance programs, data for all of these clients were not available (see Appendix XIX).

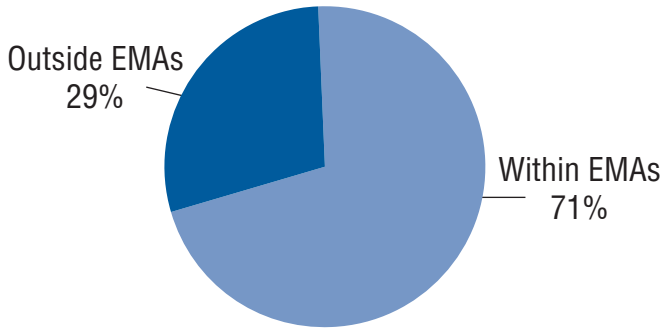
Chart 39

ADAP Clients Served in June 2006 Who Reside within Title I EMAs, in 29 States with EMAs (or portions of EMAs)



Note: EMA clients in Georgia, North Carolina and Wisconsin are not included, nor are clients in any states without EMAs.

ADAP Clients Served in June 2006 Who Reside within Title I EMAs, All States



Note: Delaware, Georgia, New Mexico, North Carolina, and Wisconsin are not included.

Title I of Ryan White 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 people. As of June 2006, there were a total of 51 Title I EMAs in 29 states across the country; five have only a portion of an EMA in their state, with the Title I grantee located in an adjacent state. Most ADAP clients reside in Title I EMAs—79% of clients served in states with Title I EMAs reside in those EMAs. Nationally, 71% of all ADAP clients served reside in a Title I EMA (see Appendix XX). These concentrations continue to reflect the epidemic's 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. It should be noted that the reauthorized Ryan White Program created a second tier of Title I recipients identified as Transitional Grant Areas (TGAs). TGAs are metropolitan areas reporting between 1,000 and 1,999 AIDS cases during the previous five years. Reauthorization also changed the population threshold for both EMAs and TGAs to 50,000 or more.

Appendices

Appendix I

Total Clients Enrolled, Served, Expenditures, and Prescriptions Filled in June 2005 and June 2006

Appendix I

Total Clients Enrolled, Served, Expenditures, and Prescriptions Filled in June 2005 and June 2006

State/Territory	June 2005 Clients Enrolled	June 2006 Clients Enrolled	% Change	June 2005 Clients Served	June 2006 Clients Served	% Change	June 2005 Drug Expenditures	June 2006 Drug Expenditures	% Change	June 2005 Prescriptions Filled	June 2006 Prescriptions Filled	% Change
Alabama	1,100	1,100	0%	915	920	1%	$998,331	$1,032,443	3%	3,898	3,190	-18%
Alaska	37	61	65%	37	49	32%	$37,717	$54,413	44%	94	173	84%
Arizona	998	1,200	20%	918	856	-7%	$862,225	$884,249	3%	3,625	4,330	19%
Arkansas	313	283	-10%	272	198	-27%	$340,433	$164,015	-52%	916	552	-40%
California	23,264	26,505	14%	18,275	17,306	-5%	$21,744,727	$19,889,704	-9%	74,454	71,816	-4%
Colorado	1,464	1,156	-21%	1,045	852	-18%	$908,411	$718,502	-21%	3,301	2,328	-29%
Connecticut	1,594	1,690	6%	1,205	1,339	11%	$1,428,122	$1,598,359	12%	5,367	6,356	18%
Delaware	339	—	—	249	—	—	$145,746	—	—	898	—	—
District of Columbia	1,202	945	-21%	726	563	-22%	$737,223	$481,576	-35%	2,723	1,970	-28%
Florida	13,062	11,258	-14%	8,682	8,267	-5%	$6,034,910	$6,276,117	4%	24,000	19,552	-19%
Georgia	7,877	4,923	-38%	4,162	3,473	-17%	$3,754,677	$3,427,413	-9%	14,783	11,712	-21%
Guam	7	—	—	5	—	—	$8,383	—	—	13	—	—
Hawaii	251	185	-26%	211	144	-32%	$208,132	$160,584	-23%	829	632	-24%
Idaho	89	80	-10%	76	63	-17%	$107,765	$86,202	-20%	200	169	-16%
Illinois	4,811	4,526	-6%	3,459	3,097	-10%	$3,570,547	$3,350,554	-6%	11,757	10,443	-11%
Indiana	79	1,000	1166%	62	1,000	1513%	$73,463	$100,872	37%	216	273	26%
Iowa	312	387	24%	161	315	96%	$106,889	$143,067	34%	535	617	15%
Kansas	426	987	132%	315	294	-7%	$489,310	$334,223	-32%	1,148	735	-36%
Kentucky	581	764	31%	401	574	43%	$438,077	$293,460	-33%	1,334	1,922	44%
Louisiana	1,704	3,596	111%	1,704	1,391	-18%	$955,331	$1,284,521	34%	4,609	3,723	-19%
Maine	70	300	329%	43	93	116%	$83,003	$25,170	-70%	194	308	59%
Maryland	3,093	3,679	19%	2,301	2,558	11%	$2,699,826	$2,877,431	7%	8,457	9,045	7%
Massachusetts	2,685	3,840	43%	2,368	2,665	13%	$587,041	$530,415	-10%	9,945	10,890	10%
Michigan	1,734	1,830	6%	1,337	1,526	14%	$1,589,245	$1,639,116	3%	6,240	7,290	17%
Minnesota	1,258	797	-37%	726	565	-22%	$354,759	$193,206	-46%	322	1,333	314%
Mississippi	1,238	1,031	-17%	772	666	-14%	$693,982	$618,932	-11%	2,427	2,432	0%
Missouri	1,795	1,649	-8%	1,200	1,032	-14%	$1,230,555	$1,252,643	2%	5,374	4,509	-16%
Montana	56	71	27%	49	52	6%	$40,590	$45,683	13%	175	152	-13%
Nebraska	446	246	-45%	265	246	-7%	$141,245	$123,504	-13%	476	393	-17%
Nevada	836	701	-16%	704	416	-41%	$622,725	$450,724	-28%	2,141	1,300	-39%
New Hampshire	375	342	-9%	137	109	-20%	$143,902	$116,138	-19%	689	469	-32%
New Jersey	5,355	5,125	-4%	3,964	4,015	1%	$5,696,256	$5,878,562	3%	22,963	23,633	3%
New Mexico	—	—	—	—	—	—	—	—	—	—	—	—
New York	16,404	16,481	0.5%	12,686	12,467	-2%	$19,743,999	$18,407,214	-7%	60,667	55,427	-9%
North Carolina	2,547	3,367	32%	1,887	2,093	11%	$2,850,842	$1,936,635	-32%	7,264	6,503	-10%

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Total Clients Enrolled, Served, Expenditures, and Prescriptions Filled in June 2005 and June 2006

State/Territory	June 2005 Clients Enrolled	June 2006 Clients Enrolled	% Change	June 2005 Clients Served	June 2006 Clients Served	% Change	June 2005 Drug Expenditures	June 2006 Drug Expenditures	% Change	June 2005 Prescriptions Filled	June 2006 Prescriptions Filled	% Change
North Dakota	45	47	4%	33	25	-24%	$22,232	$22,411	1%	93	77	-17%
Ohio	1,554	2,489	60%	1,371	1,606	17%	$328,962	$1,115,040	239%	5,387	6,195	15%
Oklahoma	755	766	1%	611	583	-5%	$470,647	$399,865	-15%	1,827	1,725	-6%
Oregon	1,041	1,326	27%	1,028	1,312	28%	$272,172	$113,812	-58%	4,287	3,318	-23%
Pennsylvania	5,625	5,705	1%	3,186	3,296	3%	$4,668,522	$4,022,076	-14%	18,593	14,590	-22%
Puerto Rico	3,750	3,834	2%	3,750	3,576	-5%	$4,888,766	$3,124,797	-36%	19,711	9,863	-50%
Rhode Island	—	699	—	—	338	—	—	$267,166	—	—	1,118	—
South Carolina	2,527	2,670	6%	1,793	1,798	0%	$1,350,045	$1,351,515	0%	4,729	5,706	21%
South Dakota	114	120	5%	59	70	19%	$29,653	$43,089	45%	111	154	39%
Tennessee	1,155	2,438	111%	918	2,150	134%	$180,418	$475,660	164%	—	2,242	—
Texas	13,365	13,512	1%	8,802	7,455	-15%	$7,179,803	$6,384,476	-11%	23,798	19,773	-17%
Utah	289	397	37%	225	330	47%	$190,168	$178,596	-6%	1,092	609	-44%
Vermont	176	194	10%	136	101	-26%	$41,446	$64,399	55%	379	306	-19%
Virgin Islands (U.S.)	121	138	14%	57	57	0%	$47,117	$39,168	-17%	171	143	-16%
Virginia	2,816	2,810	0%	1,781	1,477	-17%	$2,003,407	$1,841,255	-8%	6,034	4,665	-23%
Washington	2,734	3,068	12%	1,194	1,940	62%	$769,278	$858,797	12%	5,023	8,426	68%
West Virginia	299	276	-8%	183	118	-36%	$183,236	$101,874	-44%	398	316	-21%
Wisconsin	855	1,198	40%	477	647	36%	$476,363	$486,795	2%	1,912	1,395	-27%
Wyoming	71	64	-10%	47	38	-19%	$62,098	$30,718	-51%	189	106	-44%
Total	**134,694**	**141,856**		**96,970**	**96,121**		**$102,592,722**	**$95,297,158**		**375,768**	**344,904**	
Comparison Total	***134,348***	***141,157***	***5%***	***96,716***	***95,783***	***-1%***	***$102,438,592***	***$95,029,993***	***-7%***	***374,381***	***341,544***	***-9%***

Comparison Totals are based on only those states that reported data in both time periods.

Note: 51 ADAPs reported data in FY 2006. Delaware, Guam, New Mexico and Rhode Island did not report data in at least one of the reporting years and therefore are not included in the comparison total. American Samoa, the Marshall Islands, and the Northern Mariana Islands are also not included in the comparison totals because HRSA determined they were not eligible for ADAP funding in FY 2006.

Appendix II

ADAP Drug Expenditures, by Class, June 2006

Appendix II

ADAP Drug Expenditures, by Class, June 2006

State/Territory	June 2006 Total Expenses	June 2006 NRTI Expenses	NRTI % of Total Expenses	June 2006 NNRTI Expenses	NNRTI % of Total Expenses	June 2006 PI Expenses	PI % of Total Expenses	June 2006 Fusion Inhibitor Expenses	Fusion Inhibitor % of Total Expenses	June 2006 "A1" OI Expenses	"A1" OI % of Total Expenses	June 2006 All Other Rx Expenses	All Other Rx % of Total Expenses
Alabama	$1,032,443	$487,813	47%	$174,823	17%	$304,539	29%	$26,657	3%	$38,611	4%	$0	0%
Alaska*	$54,413	$25,097	46%	$8,899	16%	$15,796	29%	$0	0%	$1,219	2%	$3,402	6%
Arizona	$884,249	$408,635	46%	$73,142	8%	$269,387	30%	$13,968	2%	$21,906	2%	$97,212	11%
Arkansas	$164,015	$89,508	55%	$23,280	14%	$42,439	26%	$1,421	1%	$3,185	2%	$4,183	3%
California	$19,889,704	$9,422,106	47%	$2,104,519	11%	$6,037,291	30%	$179,857	1%	$555,724	3%	$1,590,207	8%
Colorado	$718,502	$389,715	54%	$100,839	14%	$197,995	28%	$10,404	1%	$19,549	3%	$0	0%
Connecticut	$1,598,359	$459,977	29%	$166,096	10%	$442,759	28%	$24,277	2%	$9,786	1%	$495,464	31%
Delaware	—	—	—	—	—	—	—	—	—	—	—	—	—
District of Columbia	$481,576	$238,560	50%	$50,404	10%	$152,061	32%	$10,081	2%	$8,463	2%	$22,008	5%
Florida	$6,276,117	$3,348,699	53%	$618,677	10%	$1,979,395	32%	$75,529	1%	$87,000	1%	$166,817	3%
Georgia	$3,427,413	$1,753,492	51%	$375,935	11%	$1,120,000	33%	$45,731	1%	$132,254	4%	$0	0%
Guam	—	—	—	—	—	—	—	—	—	—	—	—	—
Hawaii	$160,584	$85,837	53%	$20,123	13%	$45,674	28%	$0	0%	$2,322	1%	$6,628	4%
Idaho*	$86,202	$45,467	53%	$11,091	13%	$29,303	34%	$0	0%	$341	0.4%	$0	0%
Illinois	$3,350,554	$1,694,087	51%	$481,878	14%	$568,227	17%	$100,205	3%	$16,852	1%	$489,304	15%
Indiana	$100,872	$43,902	44%	$12,099	12%	$32,903	33%	$6,119	6%	$598	1%	$5,250	5%
Iowa	$143,067	$84,345	59%	$21,240	15%	$36,465	26%	$0	0%	$1,017	1%	$0	0%
Kansas	$334,223	$141,642	42%	$39,439	12%	$119,824	36%	$2,243	1%	$6,493	2%	$24,582	7%
Kentucky	$293,460	$166,659	57%	$32,196	11%	$84,975	29%	$0	0%	$6,198	2%	$3,433	1%
Louisiana**	$1,284,521	$673,459	52%	$166,072	13%	$423,370	33%	$21,621	2%	$0	0%	$0	0%
Maine	$25,170	$13,996	56%	$3,021	12%	$7,557	30%	$215	1%	$117	0.5%	$265	1%
Maryland	$2,877,431	$1,367,307	48%	$257,162	9%	$972,828	34%	$42,283	1%	$58,528	2%	$179,323	6%
Massachusetts	$530,415	$220,321	42%	$64,289	12%	$151,825	29%	$2,097	0%	$18,935	4%	$72,949	14%
Michigan	$1,639,116	$718,558	44%	$176,283	11%	$489,992	30%	$36,134	2%	$17,447	1%	$200,702	12%
Minnesota	$193,206	$88,500	46%	$20,102	10%	$57,567	30%	$0	0%	$4,276	2%	$22,761	12%
Mississippi	$618,932	$320,564	52%	$101,915	16%	$158,699	26%	$14,496	2%	$21,285	3%	$1,973	0.3%
Missouri	$1,252,643	$599,228	48%	$170,307	14%	$363,609	29%	$14,507	1%	$20,590	2%	$84,403	7%
Montana	$45,683	$19,972	44%	$9,935	22%	$13,528	30%	$0	0%	$46	0.1%	$2,203	5%
Nebraska	$123,504	$62,415	51%	$14,484	12%	$42,329	34%	$1,313	1%	$1,568	1%	$1,395	1%
Nevada	$450,724	$236,567	52%	$44,484	10%	$147,103	33%	$4,744	1%	$5,565	1%	$12,262	3%
New Hampshire	$116,138	$37,680	32%	$18,211	16%	$16,300	14%	$0	0%	$795	1%	$43,152	37%
New Jersey	$5,878,562	$2,499,140	43%	$550,280	9%	$1,090,692	19%	$86,481	1%	$132,096	2%	$1,519,873	26%
New Mexico	—	—	—	—	—	—	—	—	—	—	—	—	—
New York	$18,407,214	$8,395,676	46%	$1,950,546	11%	$5,233,370	28%	$307,674	2%	$491,508	3%	$2,028,440	11%
North Carolina	$1,936,635	$1,012,184	52%	$246,552	13%	$557,548	29%	$24,298	1%	$58,132	3%	$37,921	2%

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ADAP Drug Expenditures, by Class, June 2006

State/Territory	June 2006 Total Expenses	June 2006 NRTI Expenses	NRTI % of Total Expenses	June 2006 NNRTI Expenses	NNRTI % of Total Expenses	June 2006 PI Expenses	PI % of Total Expenses	June 2006 Fusion Inhibitor Expenses	Fusion Inhibitor % of Total Expenses	June 2006 "A1" OI Expenses	"A1" OI % of Total Expenses	June 2006 All Other Rx Expenses	All Other Rx % of Total Expenses
North Dakota*	$22,411	$11,820	53%	$5,760	26%	$4,322	19%	$0	0%	$43	0.2%	$466	2%
Ohio	$1,115,040	$232,618	21%	$159,960	14%	$722,450	65%	$0	0%	$0	0%	$13	0.001%
Oklahoma	$399,865	$207,752	52%	$56,798	14%	$109,923	27%	$1,161	0.3%	$11,357	3%	$12,874	3%
Oregon	$113,812	$30,977	27%	$11,618	10%	$22,170	20%	$2,733	2%	$2,339	2%	$43,976	39%
Pennsylvania	$4,022,076	$1,835,571	46%	$485,063	12%	$1,105,373	27%	$89,060	2%	$71,492	2%	$435,517	11%
Puerto Rico	$3,124,797	$1,124,427	36%	$100,732	3%	$1,378,860	44%	$82,206	3%	$350,279	11%	$88,294	3%
Rhode Island	$267,166	$141,983	53%	$45,112	17%	$65,447	24%	$4,013	2%	$2,039	1%	$8,572	3%
South Carolina	$1,351,515	$721,327	53%	$193,114	14%	$370,607	27%	$23,136	2%	$19,041	1%	$24,290	2%
South Dakota***	$43,089	$31,302	73%	$9,877	23%	$0	0%	$0	0%	$1,554	4%	$356	1%
Tennessee	$475,660	$43,832	9%	$269,930	57%	$88,141	19%	$14,389	3%	$57,561	12%	$1,807	0.4%
Texas	$6,384,476	$3,484,875	55%	$697,571	11%	$2,034,245	32%	$69,963	1%	$69,186	1%	$28,637	0.4%
Utah	$178,596	$87,939	49%	$28,532	16%	$57,158	32%	$0	0%	$4,968	3%	$0	0%
Vermont	$64,399	$28,103	44%	$9,184	14%	$17,224	27%	$4,005	6%	$124	0.2%	$5,759	9%
Virgin Islands (U.S.)*	$39,168	$18,115	46%	$6,189	16%	$14,105	36%	$0	0%	$691	2%	$68	0.2%
Virginia	$1,841,255	$1,004,550	55%	$255,048	14%	$482,438	26%	$15,029	1%	$62,372	3%	$21,820	1%
Washington	$858,797	$450,332	52%	$125,173	15%	$207,889	24%	$3,711	0.4%	$18,645	2%	$53,048	6%
West Virginia*	$101,874	$58,549	57%	$23,135	23%	$19,859	19%	$0	0%	$322	0.3%	$0	0%
Wisconsin	$486,795	$245,669	50%	$57,202	12%	$152,789	31%	$8,102	2%	$14,380	3%	$8,653	2%
Wyoming*	$30,718	$15,693	51%	$7,584	25%	$4,738	15%	$0	0%	$872	3%	$1,831	6%
Total	**$95,297,158**	**$44,926,540**	**47%**	**$10,655,901**	**11%**	**$28,063,087**	**30%**	**$1,369,860**	**1%**	**$2,429,669**	**3%**	**$7,852,092**	**8%**

*ADAP does not include fusion inhibitor on its formulary.

**Louisiana is the only state that does not include at least one "A1" OI on its formulary.

***South Dakota does not include fusion inhibitor on its formulary and is the only state that does not include any protease inhibitors.

Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data and are not included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006.

Appendix III

ADAP Prescriptions Filled, by Class, June 2006

Appendix III

ADAP Prescriptions Filled, by Class, June 2006

State/Territory	June 2006 Total Rx	June 2006 NRTI Rx	NRTI % of Total Rx	June 2006 NNRTI Rx	NNRTI % of Total Rx	June 2006 PI Rx	PI % of Total Rx	June 2006 Fusion Inhibitor Rx	Fusion Inhibitor % of Total Rx	June 2006 "A1" OI Rx	"A1" OI % of Total Rx	June 2006 All Other Rx	All Other % of Total Rx
Alabama	3,190	1,341	42%	480	15%	753	24%	14	0.4%	602	19%	0	0%
Alaska*	173	72	42%	27	16%	42	24%	0	0%	16	9%	16	9%
Arizona	4,330	886	20%	315	7%	812	19%	12	0.3%	439	10%	1,866	43%
Arkansas	552	219	40%	91	16%	120	22%	1	0.2%	83	15%	38	7%
California	71,816	21,974	31%	7,076	10%	14,199	20%	171	0.2%	8,142	11%	20,254	28%
Colorado	2,328	961	41%	409	18%	603	26%	9	0.4%	346	15%	0	0%
Connecticut	6,356	1,248	20%	548	9%	999	16%	18	0.3%	162	3%	3,381	53%
Delaware	—	—	—	—	—	—	—	—	—	—	—	—	—
District of Columbia	1,970	740	38%	222	11%	482	24%	5	0.3%	241	12%	280	14%
Florida	19,552	6,478	33%	1,996	10%	6,213	32%	57	0.3%	2,531	13%	2,277	12%
Georgia	11,712	5,639	48%	453	4%	3,114	27%	38	0.3%	2,468	21%	0	0%
Guam	—	—	—	—	—	—	—	—	—	—	—	—	—
Hawaii	632	245	39%	78	12%	126	20%	0	0%	75	12%	108	17%
Idaho*	169	77	46%	27	16%	53	31%	0	0%	12	7%	0	0%
Illinois	10,443	4,438	42%	1,801	17%	1,658	16%	72	1%	234	2%	2,240	21%
Indiana	273	80	29%	29	11%	60	22%	3	1%	20	7%	81	30%
Iowa	617	297	48%	120	19%	150	24%	0	0%	0	0%	50	8%
Kansas	735	262	36%	105	14%	194	26%	1	0.1%	128	17%	45	6%
Kentucky	1,922	781	41%	241	13%	472	25%	0	0%	244	13%	184	10%
Louisiana**	3,723	1,872	50%	645	17%	1,188	32%	18	0.5%	0	0%	0	0%
Maine	308	96	31%	54	18%	89	29%	2	1%	21	7%	46	15%
Maryland	9,045	3,015	33%	802	9%	2,274	25%	44	0.5%	869	10%	2,041	23%
Massachusetts	10,890	1,662	15%	800	7%	906	8%	14	0.1%	190	2%	7,318	67%
Michigan	7,290	1,769	24%	636	9%	1,146	16%	39	1%	208	3%	3,492	48%
Minnesota	1,333	421	32%	110	8%	281	21%	1	0.1%	61	5%	459	34%
Mississippi	2,432	849	35%	392	16%	446	18%	11	0.5%	368	15%	366	15%
Missouri	4,509	1,227	27%	472	10%	708	16%	12	0.3%	337	7%	1,753	39%
Montana	152	55	36%	27	18%	29	19%	0	0%	10	7%	31	20%
Nebraska	393	104	26%	47	12%	102	26%	1	0.3%	19	5%	120	31%
Nevada	1,300	534	41%	163	13%	370	28%	4	0.3%	131	10%	98	8%
New Hampshire	469	87	19%	51	11%	26	6%	0	0%	17	4%	288	61%
New Jersey	23,633	7,877	33%	1,479	6%	2,061	9%	52	0.2%	1,393	6%	10,771	46%
New Mexico	—	—	—	—	—	—	—	—	—	—	—	—	—
New York	55,427	14,689	27%	4,718	9%	8,716	16%	166	0.3%	3,966	7%	23,172	42%
North Carolina	6,503	2,615	40%	957	15%	1,536	24%	17	0.3%	948	15%	430	7%

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Appendix III *(continued)*

ADAP Prescriptions Filled, by Class, June 2006

State/Territory	June 2006 Total Rx	June 2006 NRTI Rx	NRTI % of Total Rx	June 2006 NNRTI Rx	NNRTI % of Total Rx	June 2006 PI Rx	PI % of Total Rx	June 2006 Fusion Inhibitor Rx	Fusion Inhibitor % of Total Rx	June 2006 "A1" OI Rx	"A1" OI % of Total Rx	June 2006 All Other Rx	All Other % of Total Rx
North Dakota*	77	30	39%	15	19%	12	16%	0	0%	4	5%	16	21%
Ohio	6,195	1,922	31%	900	15%	1,199	19%	17	0.3%	555	9%	1,602	26%
Oklahoma	1,725	776	45%	288	17%	422	24%	1	0.1%	176	10%	62	4%
Oregon	3,318	470	14%	274	8%	445	13%	11	0.3%	183	6%	1,935	58%
Pennsylvania	14,590	4,065	28%	1,425	10%	2,389	16%	62	0.4%	1,003	7%	5,646	39%
Puerto Rico	9,863	3,010	31%	387	4%	3,421	35%	77	1%	1,807	18%	1,161	12%
Rhode Island	1,118	432	39%	171	15%	239	21%	5	0.4%	97	9%	174	16%
South Carolina	5,706	2,392	42%	942	17%	1,297	23%	29	1%	574	10%	472	8%
South Dakota***	154	83	54%	33	21%	0	0%	0	0%	21	14%	17	11%
Tennessee	2,242	1,069	48%	0	0%	542	24%	10	0.4%	497	22%	124	6%
Texas	19,773	9,948	50%	2,880	15%	5,611	28%	61	0.3%	1,072	5%	201	1%
Utah	609	273	45%	132	22%	143	23%	0	0%	61	10%	0	0%
Vermont	306	117	38%	46	15%	54	18%	5	2%	20	7%	64	21%
Virgin Islands (U.S.)*	143	64	45%	19	13%	28	20%	0	0%	28	20%	4	3%
Virginia	4,665	1,858	40%	709	15%	1,134	24%	13	0.3%	838	18%	113	2%
Washington	8,426	2,694	32%	908	11%	1,241	15%	9	0.1%	693	8%	2,881	34%
West Virginia*	316	183	58%	61	19%	49	16%	0	0%	23	7%	0	0%
Wisconsin	1,395	564	40%	198	14%	363	26%	5	0.4%	165	12%	100	7%
Wyoming*	106	35	33%	16	15%	5	5%	0	0%	9	8%	41	39%
Total	**344,904**	**112,595**	**33%**	**34,775**	**10%**	**68,522**	**20%**	**1,087**	**0.3%**	**32,107**	**9%**	**95,818**	**28%**

*ADAP does not include fusion inhibitor on its formulary.

**Louisiana is the only state that does not include at least one "A1" OI on its formulary.

***South Dakota does not include fusion inhibitor on its formulary and is the only state that does not include any protease inhibitors.

Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data and are not included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006.

Appendix IV

Race/Ethnicity of ADAP Clients Served, June 2006

Appendix IV

Race/Ethnicity of ADAP Clients Served, June 2006

State/Territory	June 2006 Clients Served	Non-Hispanic Black/African American	Non-Hispanic White	Hispanic	Asian	Native Hawaiian/Pacific Islander	American Indian/Alaskan Native	Multi-Racial	Other	Unknown
Alabama	920	62%	35%	3%	1%	—	<1%	—	—	—
Alaska	49	12%	61%	20%	4%	—	2%	—	—	—
Arizona	856	7%	49%	42%	1%	—	1%	1%	—	—
Arkansas	198	32%	63%	4%	—	1%	—	1%	—	—
California	17,306	11%	40%	41%	3%	<1%	<1%	3%	—	2%
Colorado	852	14%	52%	29%	1%	<1%	2%	1%	—	—
Connecticut	1,339	37%	39%	23%	<1%	—	<1%	—	—	—
Delaware	—	—	—	—	—	—	—	—	—	—
District of Columbia	563	74%	7%	10%	<1%	—	<1%	—	4%	5%
Florida	8,267	44%	25%	30%	<1%	<1%	<1%	<1%	—	—
Georgia	3,473	65%	29%	5%	<1%	—	<1%	1%	—	—
Guam	—	—	—	—	—	—	—	—	—	—
Hawaii	144	1%	52%	12%	19%	14%	—	3%	—	—
Idaho	63	2%	81%	17%	—	—	—	—	—	—
Illinois	3,097	38%	34%	25%	1%	—	—	—	<1%	1%
Indiana	1,000	17%	72%	6%	1%	—	<1%	1%	3%	—
Iowa	315	22%	64%	11%	2%	—	<1%	—	—	—
Kansas	294	24%	55%	19%	1%	—	<1%	<1%	—	—
Kentucky	574	22%	72%	4%	<1%	<1%	<1%	1%	—	<1%
Louisiana	1,391	59%	37%	2%	<1%	<1%	<1%	<1%	—	1%
Maine	93	5%	84%	8%	—	1%	2%	—	—	—
Maryland	2,558	66%	18%	5%	1%	<1%	<1%	9%	—	1%
Massachusetts	2,665	27%	45%	24%	2%	—	<1%	<1%	3%	—
Michigan	1,526	—	—	—	—	—	—	—	—	—
Minnesota	565	25%	54%	13%	2%	<1%	1%	—	2%	3%
Mississippi	666	71%	28%	<1%	<1%	—	<1%	1%	—	—
Missouri	1,032	43%	52%	3%	<1%	<1%	<1%	<1%	—	1%
Montana	52	2%	79%	0%	—	—	19%	—	—	—
Nebraska	246	19%	52%	26%	—	—	1%	—	2%	—
Nevada	416	20%	44%	32%	2%	—	<1%	—	—	1%
New Hampshire	109	19%	62%	16%	—	—	—	3%	—	1%
New Jersey	4,015	48%	23%	26%	1%	<1%	—	—	2%	—
New Mexico	—	—	—	—	—	—	—	—	—	—
New York	12,467	34%	31%	28%	2%	<1%	<1%	—	—	5%
North Carolina	2,093	54%	32%	10%	1%	<1%	1%	—	2%	—

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Race/Ethnicity of ADAP Clients Served, June 2006

State/Territory	June 2006 Clients Served	Non-Hispanic Black/African American	Non-Hispanic White	Hispanic	Asian	Native Hawaiian/Pacific Islander	American Indian/Alaskan Native	Multi-Racial	Other	Unknown
North Dakota	25	12%	80%	0%	—	—	8%	—	—	—
Ohio	1,606	30%	62%	5%	1%	—	<1%	<1%	2%	—
Oklahoma	583	16%	70%	6%	1%	—	7%	—	—	—
Oregon	1,312	7%	73%	14%	1%	<1%	2%	3%	—	—
Pennsylvania	3,296	40%	42%	9%	1%	—	<1%	—	1%	8%
Puerto Rico	3,576	0%	0%	100%	—	—	—	—	—	—
Rhode Island	338	18%	57%	17%	1%	—	2%	2%	4%	—
South Carolina	1,798	66%	29%	4%	<1%	<1%	<1%	—	<1%	<1%
South Dakota	70	19%	71%	0%	1%	—	6%	3%	—	—
Tennessee	2,150	53%	42%	0%	<1%	—	<1%	—	2%	2%
Texas	7,455	29%	32%	37%	1%	—	<1%	—	<1%	1%
Utah	330	8%	66%	24%	<1%	—	2%	—	—	<1%
Vermont	101	8%	83%	5%	1%	—	—	3%	—	—
Virgin Islands (U.S.)	57	61%	7%	32%	—	—	—	—	—	—
Virginia	1,477	54%	29%	8%	1%	—	1%	—	<1%	8%
Washington	1,940	12%	60%	14%	2%	1%	1%	4%	1%	6%
West Virginia	118	8%	91%	0%	2%	—	—	—	—	—
Wisconsin	647	20%	63%	15%	1%	—	2%	—	<1%	<1%
Wyoming	38	8%	68%	16%	—	3%	—	5%	—	—
Total	**96,121**	**33%**	**36%**	**26%**	**1%**	**<1%**	**<1%**	**1%**	**<1%**	**2%**

Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data and are not included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006.

Appendix V

Gender and Age of ADAP Clients Served, June 2006

Appendix V

Gender and Age of ADAP Clients Served, June 2006

State/Territory	June 2006 Clients Served	Gender				Age						
		Male	Female	Transgender	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	920	69%	31%	0%	0%	—	0%	—	—	—	<1%	—
Alaska	49	76%	24%	0%	0%	—	0%	—	—	—	2%	—
Arizona	856	86%	14%	0%	0%	—	0%	2%	—	—	3%	—
Arkansas	198	88%	12%	0%	—	0%	—	2%	—	—	3%	—
California	17,306	90%	9%	<1%	0%	0%	0%	2%	—	41%	2%	<1%
Colorado	852	85%	14%	<1%	0%	0%	<1%	2%	—	—	1%	—
Connecticut	1,339	72%	28%	0%	0%	—	0%	—	—	—	4%	—
Delaware	—	—	—	—	—	—	—	—	—	—	—	—
District of Columbia	563	72%	25%	<1%	3%	—	0%	—	56%	39%	0%	3%
Florida	8,267	71%	28%	<1%	0%	<1%	<1%	2%	—	—	2%	—
Georgia	3,473	76%	24%	<1%	<1%	—	0%	3%	—	—	2%	—
Guam	—	—	—	—	—	—	—	—	—	—	—	—
Hawaii	144	91%	9%	0%	0%	0%	—	0%	—	—	5%	—
Idaho	63	79%	21%	0%	—	—	—	—	—	—	2%	—
Illinois	3,097	83%	17%	0%	<1%	—	—	—	57%	38%	2%	
Indiana	1,000	84%	16%	0%	0%	—	<1%	2%	55%	—	2%	—
Iowa	315	78%	22%	0%	0%	—	<1%	—	—	—	1%	—
Kansas	294	76%	24%	<1%	0%	—	<1%	3%	—	—	1%	—
Kentucky	574	83%	17%	<1%	0%	0%	0%	1%	—	45%	2%	
Louisiana	1,391	75%	25%	<1%	0%	<1%	0%	2%	—	43%	2%	
Maine	93	86%	14%	0%	—	0%	0%	—	—	—	0%	—
Maryland	2,558	64%	36%	0%	0%	<1%	<1%	2%	—	45%	3%	
Massachusetts	2,665	69%	31%	<1%	0%	—	<1%	<1%	50%	—	2%	—
Michigan	1,526	85%	15%	<1%	—	—	—	—	—	—	—	—
Minnesota	565	79%	21%	0%	0%	0%	1%	—	55%	40%	2%	
Mississippi	666	70%	30%	0%	0%	—	<1%	5%	—	—	2%	—
Missouri	1,032	82%	18%	0%	0%	0%	<1%	3%	—	32%	<1%	
Montana	52	83%	17%	0%	—	—	0%	—	—	—	2%	—
Nebraska	246	75%	25%	0%	—	—	0%	—	66%	—	1%	—
Nevada	416	79%	20%	<1%	0%	—	1%	—	—	33%	1%	<1%
New Hampshire	109	66%	33%	1%	—	—	—	2%	—	40%	1%	
New Jersey	4,015	66%	34%	0%	0%	0%	—	—	49%	—	2%	—
New Mexico	—	—	—	—	—	—	—	—	—	—	—	—
New York	12,467	76%	24%	<1%	0%	0%	<1%	—	—	45%	3%	
North Carolina	2,093	70%	30%	0%	0%	0%	0%	—	58%	—	1%	—

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Appendix V *(continued)*

Gender and Age of ADAP Clients Served, June 2006

State/Territory	June 2006 Clients Served	Gender				Age						
		Male	Female	Transgender	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
North Dakota	25	76%	24%	0%	—	—	0%	—	—	—	—	—
Ohio	1,606	83%	16%	<1%	<1%	—	<1%	2%	52%	—	2%	—
Oklahoma	583	85%	15%	0%	0%	—	0%	—	—	—	<1%	—
Oregon	1,312	88%	12%	<1%	0%	0%	0%	3%	—	—	2%	—
Pennsylvania	3,296	78%	22%	0%	<1%	—	<1%	—	47%	48%	3%	
Puerto Rico	3,576	66%	34%	0%	—	—	—	—	—	—	4%	—
Rhode Island	338	81%	19%	0%	<1%	—	0%	<1%	49%	—	2%	—
South Carolina	1,798	70%	30%	<1%	0%	0%	<1%	—	53%	43%	2%	
South Dakota	70	77%	23%	0%	0%	—	0%	1%	—	—	1%	—
Tennessee	2,150	78%	22%	<1%	<1%	—	<1%	—	69%	23%	<1%	<1%
Texas	7,455	79%	21%	0%	0%	—	<1%	—	59%	37%	2%	
Utah	330	88%	12%	0%	0%	—	<1%	—	—	37%	1%	
Vermont	101	82%	18%	0%	0%	—	—	1%	—	—	1%	—
Virgin Islands (U.S.)	57	54%	44%	2%	—	—	—	—	—	—	5%	—
Virginia	1,477	70%	29%	0%	1%	—	<1%	—	56%	38%	2%	<1%
Washington	1,940	87%	13%	<1%	<1%	0%	<1%	1%	54%	43%	2%	
West Virginia	118	81%	19%	0%	0%	—	—	—	—	—	2%	—
Wisconsin	647	85%	14%	<1%	0%	—	<1%	—	53%	44%	2%	
Wyoming	38	76%	24%	0%	—	0%	—	11%	—	—	8%	—
Total	**96,121**	**78%**	**22%**	**<1%**	**<1%**	**<1%**	**<1%**	**2%**	**54%**	**41%**	**2%**	**<1%**

Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data and are not included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006.

Appendix VI

Income Level and Insurance Status of ADAP Clients Served, June 2006

Appendix VI

Income Level and Insurance Status of ADAP Clients Served, June 2006

State/Territory	June 2006 Clients Served	Income Level						Insurance Status				
		≤100% FPL	101-200% FPL	201-300% FPL	301-400% FPL	>400% FPL	Unknown	Medicaid	Medicare	Dually Eligible*	Private Insurance	Uninsured
Alabama	920	53%	36%	11%	0%	0%	0%	1%	2%	0%	2%	95%
Alaska	49	47%	29%	24%	0%	0%	0%	0%	10%	0%	31%	59%
Arizona	856	0%	0%	0%	0%	0%	100%	0%	25%	0%	0%	75%
Arkansas	198	51%	42%	6%	—	0%	1%	4%	15%	5%	8%	68%
California	17,306	97%	1%	1%	1%	0%	0%	1%	7%	7%	19%	64%
Colorado	852	67%	25%	8%	0%	0%	0%	0%	0%	0%	0%	0%
Connecticut	1,339	29%	47%	19%	6%	<1%	0%	—	22%	—	57%	43%
Delaware	—	—	—	—	—	—	—	—	—	—	—	—
District of Columbia	563	72%	18%	5%	1%	0%	4%	—	19%	18%	6%	—
Florida	8,267	52%	35%	12%	1%	0%	0%	1%	2%	0%	—	97%
Georgia	3,473	0%	89%	0%	0%	0%	11%	0%	30%	5%	1%	65%
Guam	—	—	—	—	—	—	—	—	—	—	—	—
Hawaii	144	32%	47%	18%	3%	0%	0%	2%	26%	0%	19%	33%
Idaho	63	35%	65%	0%	—	0%	0%	0%	0%	0%	0%	100%
Illinois	3,097	45%	30%	16%	7%	2%	0%	1%	1%	0%	4%	94%
Indiana	1,000	58%	33%	8%	0%	0%	0%	0%	0%	0%	0%	100%
Iowa	315	61%	39%	0%	0%	0%	0%	4%	12%	—	6%	78%
Kansas	294	72%	21%	7%	0%	0%	0%	2%	3%	3%	16%	80%
Kentucky	574	35%	46%	19%	0%	0%	0%	0%	51%	0%	29%	20%
Louisiana	1,391	0%	100%	0%	0%	0%	0%	—	—	—	—	—
Maine	93	46%	40%	12%	2%	0%	0%	52%	1%	38%	5%	3%
Maryland	2,558	21%	40%	22%	13%	5%	0%	0%	42%	0%	60%	20%
Massachusetts	2,665	45%	21%	14%	11%	8%	0%	25%	27%	10%	58%	8%
Michigan	1,526	30%	39%	15%	9%	3%	4%	0%	15%	0%	29%	50%
Minnesota	565	40%	41%	17%	2%	0%	0%	—	—	—	—	—
Mississippi	666	61%	28%	9%	1%	0%	0%	0%	9%	0%	0%	91%
Missouri	1,032	62%	32%	7%	0%	0%	0%	12%	0%	0%	15%	73%
Montana	52	0%	0%	0%	—	0%	100%	0%	6%	2%	15%	85%
Nebraska	246	0%	100%	0%	—	0%	0%	—	26%	—	—	—
Nevada	416	50%	34%	10%	6%	0%	1%	0%	5%	—	—	95%
New Hampshire	109	48%	37%	10%	—	0%	6%	15%	20%	5%	15%	75%
New Jersey	4,015	45%	24%	18%	9%	4%	0%	0%	5%	0%	27%	73%
New Mexico	—	—	—	—	—	—	—	—	—	—	—	—
New York	12,467	37%	31%	17%	12%	4%	0%	0%	13%	—	15%	85%
North Carolina	2,093	93%	7%	0%	0%	0%	0%	1%	9%	0%	0%	90%

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Appendix VI *(continued)*

Income Level and Insurance Status of ADAP Clients Served, June 2006

State/Territory	June 2006 Clients Served	Income Level						Insurance Status				
		≤100% FPL	101-200% FPL	201-300% FPL	301-400% FPL	>400% FPL	Unknown	Medicaid	Medicare	Dually Eligible*	Private Insurance	Uninsured
North Dakota	25	44%	40%	4%	12%	0%	0%	4%	12%	0%	32%	68%
Ohio	1,606	61%	28%	9%	1%	1%	0%	4%	8%	3%	26%	59%
Oklahoma	583	38%	62%	0%	0%	0%	0%	3%	17%	11%	9%	65%
Oregon	1,312	49%	39%	12%	<1%	0%	0%	0%	32%	1%	100%	0%
Pennsylvania	3,296	13%	35%	22%	3%	<1	27%	0%	0%	0%	26%	74%
Puerto Rico	3,576	80%	20%	0%	—	0%	0%	80%	—	—	—	—
Rhode Island	338	31%	42%	16%	9%	1%	1%	4%	17%	4%	36%	39%
South Carolina	1,798	42%	32%	18%	5%	3%	<1%	0%	—	0%	—	78%
South Dakota	70	37%	50%	13%	0%	0%	0%	—	—	—	—	—
Tennessee	2,150	72%	19%	7%	<1%	1%	1%	—	—	—	—	—
Texas	7,455	75%	19%	6%	0%	0%	0%	8%	10%	1%	1%	99%
Utah	330	39%	33%	21%	7%	0%	<1%	0%	2%	0%	20%	80%
Vermont	101	44%	56%	0%	0%	0%	0%	27%	18%	2%	33%	16%
Virgin Islands (U.S.)	57	0%	26%	51%	23%	0%	0%	—	32%	4%	28%	—
Virginia	1,477	64%	26%	8%	<1%	0%	2%	0%	8%	3%	—	89%
Washington	1,940	34%	36%	24%	5%	0%	<1%	18%	32%	16%	12%	39%
West Virginia	118	51%	36%	14%	0%	0%	0%	25%	39%	10%	7%	35%
Wisconsin	647	38%	38%	23%	0%	0%	1%	0%	3%	0%	35%	62%
Wyoming	38	71%	29%	0%	—	0%	0%	31%	22%	11%	10%	90%
Total	**96,121**	**55%**	**27%**	**10%**	**4%**	**1%**	**2%**	**6%**	**12%**	**3%**	**17%**	**71%**

*Eligible for both Medicaid and Medicare.

Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data and are not included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006. Insurance categories are not mutually exclusive. Insurance status percentages by category are based on the number of clients from ADAPs that reported data for that category.

Appendix VII

ADAP Clients by CD4 Count, Enrolled During 12-Month Period, June 2006

Appendix VII

ADAP Clients by CD4 Count, Enrolled During 12-Month Period, June 2006

State/Territory	Number of Clients	CD4 ≤ 200	CD4 between 201-350	CD4 between 351-500	CD4 > 500
Alabama	—	—	—	—	—
Alaska	—	—	—	—	—
Arizona	—	—	—	—	—
Arkansas	317	30%	23%	20%	27%
California	3,985	32%	24%	18%	25%
Colorado	—	—	—	—	—
Connecticut	—	—	—	—	—
Delaware	—	—	—	—	—
District of Columbia	—	—	—	—	—
Florida	2,347	44%	29%	14%	13%
Georgia	—	—	—	—	—
Guam	—	—	—	—	—
Hawaii	44	32%	30%	14%	25%
Idaho	96	9%	25%	31%	34%
Illinois	3,083	42%	7%	11%	40%
Indiana	196	17%	24%	22%	37%
Iowa	387	17%	31%	21%	31%
Kansas	—	—	—	—	—
Kentucky	283	39%	23%	18%	20%
Louisiana	—	—	—	—	—
Maine	275	18%	24%	18%	41%
Maryland	3,726	27%	33%	12%	29%
Massachusetts	5,259	20%	21%	22%	36%
Michigan	338	36%	23%	16%	25%
Minnesota	444	18%	26%	21%	35%
Mississippi	341	50%	26%	11%	13%
Missouri	—	—	—	—	—
Montana	20	40%	25%	10%	25%
Nebraska	373	16%	21%	21%	42%
Nevada	928	45%	23%	13%	19%
New Hampshire	338	20%	20%	22%	38%
New Jersey	6,935	25%	20%	20%	35%
New Mexico	—	—	—	—	—
New York	11,196	36%	24%	19%	21%
North Carolina	4,074	25%	23%	19%	33%
North Dakota	—	—	—	—	—
Ohio	2,581	24%	21%	20%	36%
Oklahoma	651	20%	20%	20%	39%
Oregon	830	17%	24%	23%	36%
Pennsylvania	—	—	—	—	—
Puerto Rico	—	—	—	—	—
Rhode Island	141	26%	24%	18%	31%
South Carolina	737	44%	25%	12%	19%
South Dakota	—	—	—	—	—
Tennessee	1,282	30%	22%	20%	28%

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Appendix VII *(continued)*

ADAP Clients by CD4 Count, Enrolled During 12-Month Period, June 2006

State/Territory	Number of Clients	CD4 ≤ 200	CD4 between 201-350	CD4 between 351-500	CD4 > 500
Texas	3,400	44%	27%	14%	15%
Utah	78	35%	35%	15%	15%
Vermont	50	34%	24%	24%	18%
Virgin Islands (U.S.)	—	—	—	—	—
Virginia	764	31%	23%	26%	20%
Washington	—	—	—	—	—
West Virginia	48	27%	23%	27%	23%
Wisconsin	881	18%	20%	23%	39%
Wyoming	—	—	—	—	—
Total	**56,428**	**31%**	**23%**	**18%**	**28%**

Note: 34 ADAPs reported data. Data reflect clients enrolled in ADAP over the past 12 months or the most recent 12 months for which data are available. In addition, ADAPs are required to recertify clients two times a year. As a result, these data do not necessarily represent CD4 counts of new clients.

Appendix VIII

ADAP Client Eligibility Requirements by State, as of June 2006

Appendix VIII

ADAP Client Eligibility Requirements by State, as of June 2006

State/Territory	Financial Eligibility as % of FPL (GR=Gross income; NET=Net income)	Medical Eligibility (CD4=CD4 Cell Count; VL = Viral Load)	State Residency Requirement	Asset Limits
Alabama	250% GR	—	Yes (Proof required)	—
Alaska	300% GR	—	Yes	Consistent with the asset limit for Medicaid.
Arizona	300% GR	—	Yes (Proof required)	—
Arkansas	300% GR	CD4<350 or VL>55,000	Yes	—
California	400% GR	—	Yes (Proof required)	—
Colorado	300% GR	—	Yes (Proof required)	First $2,000 of liquid assets (savings, checking account, IRA's, etc.) will not count against the client; first $50,000 of equity in any business the client owns is exempt.
Connecticut	400% NET	—	Yes (Proof required)	—
Delaware	—	—	—	—
District of Columbia	400% GR	—	Yes (Proof required)	Liquid assets can not exceed $5,000.
Florida*	350% GR	—	Yes	$25,000
Georgia	300% GR	CD4<350	Yes (Proof required)	Not to exceed $5,000.
Guam	—	—	—	—
Hawaii	400% GR	—	Yes	$10,000 in liquid assets not including residence, one vehicle, federally recognized retirement accounts.
Idaho	200% GR	—	—	—
Illinois	400% GR	—	Yes (Proof required)	—
Indiana	300% GR	—	Yes	—
Iowa	200% GR	—	Yes (Proof required)	$10,000 resource limit excludes primary residence and personal vehicle.
Kansas	300% NET	—	—	—
Kentucky	300% GR	—	Yes (Proof required)	$10,000
Louisiana	200% GR	—	Yes (Proof required)	$4,000 not including one residence and one vehicle.
Maine	400% GR	—	Yes	
Maryland	500% GR	CD4 (Specifics not reported)	Yes (Proof required)	—
Massachusetts	510% GR	—	Yes	—
Michigan	450% GR	—	Yes	—
Minnesota	300% GR	—	Yes	$25,000 in cash asset.
Mississippi**	400% GR	CD4≤350	Yes (Proof required)	—
Missouri	300% GR	—	Yes	—
Montana	330% GR	—	Yes (Proof required)	—
Nebraska	200% GR	—	Yes (Proof required)	—
Nevada	400% GR	—	Yes (Proof required)	May own one car, a home and additional assets must not exceed $4,000.
New Hampshire	300% GR	If not on ARV, must have CD4 <250 or have a designated OI.	Yes (Proof required)	—
New Jersey	500% GR	—	Yes	—
New Mexico	—	—	—	—
New York	449% GR	—	Yes	$25,000
North Carolina***	125% NET	—	Yes	—

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Appendix VIII *(continued)*

ADAP Client Eligibility Requirements by State, as of June 2006

State/Territory	Financial Eligibility as % of FPL (GR=Gross income; NET=Net income)	Medical Eligibility (CD4=CD4 Cell Count; VL = Viral Load)	State Residency Requirement	Asset Limits
North Dakota	400% NET	—	Yes	—
Ohio	500% GR	—	Yes (Proof required)	—
Oklahoma	200% GR	—	Yes (Proof required)	—
Oregon	200% GR	—	Yes (Proof required)	$10,000, excluding one home, one automobile, personal property/furnishings, and certain retirement accounts.
Pennsylvania	350% GR	—	Yes	—
Puerto Rico	200% NET	—	Yes	—
Rhode Island	400% GR	—	Yes	—
South Carolina	300% GR	—	Yes	—
South Dakota	300% GR	—	Yes	—
Tennessee	300% GR	—	Yes (Proof required)	Household resource values less than or equal to $8,000, as reported by client.
Texas	200% GR	Recent CD4 and VL count needed for each applicant to the program.	Yes (Proof required)	—
Utah	400% GR	—	Yes	$5,000
Vermont	200% NET	—	Yes (Proof required)	—
Virgin Islands (U.S.)	400% GR	—	—	—
Virginia	300% GR	CD4 <500 or detectable VL	—	—
Washington	300% GR	—	Yes (Proof required)	$10,000 excluding one home, one automobile and certain retirement accounts.
West Virginia	250% GR	—	Yes (Proof required)	—
Wisconsin	300% GR	—	Yes (Proof required)	—
Wyoming	200% GR	—	Yes (Proof required)	—
Total		**7**	**47**	16

*Florida changed its income eligibility level from 350% to 300% FPL in March 2007.

**Mississippi changed its medical eligibility level from CD4 350 or less to CD4 less than 350 in March 2007.

***North Carolina changed its income eligibility level from net family income of 125% to gross family income of 200% on November 1, 2006.

Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data and are not included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006.

Appendix IX

ADAP Formulary Coverage by State, as of November 2006

Appendix IX

ADAP Formulary Coverage by State, as of November 2006

State/Territory	Total Number of Drugs on Formulary	NRTIs Covered* (13 Drugs)	PIs Covered** (9 Drugs)	NNRTIs Covered (3 Drugs)	Fusion Inhibitor Covered (1 Drug)	"A1" OI Prophylaxis Covered (29 PHS Recommended Drugs)	Other Medications Covered
Alabama	39 (31)	11 (12)	9	3	1	10 (8)	5
Alaska	73 (72)	13 (12)	9	3	0	22	26
Arizona	92 (96)	13 (12)	9	3	1	14 (16)	52
Arkansas	55	12	9	2	1	14	17 (14)
California	165 (153)	13 (12)	9	3	1	27	112
Colorado	62 (48)	12 (9)	9 (6)	3	1 (0)	16 (13)	21
Connecticut	192 (191)	13 (12)	9	3	1	21	145
Delaware	271 (238)	12	9	3	1	21 (23)	225
District of Columbia	85 (78)	13 (12)	9 (8)	3	1	17	42 (37)
Florida	73 (71)	13 (12)	9	3	1	11	36
Georgia	68 (13)	13 (12)	9	3	1	29 (18)	13
Guam***	19	5	4	2	0	8	0
Hawaii	96 (95)	13 (12)	9	3	1	22	48
Idaho***	42 (41)	12 (11)	7	3	0	16	4
Illinois	90 (86)	13 (12)	9 (8)	3	1	20	44 (45)
Indiana	97	11 (12)	9	3	1	13	60
Iowa	38 (35)	12 (11)	9 (8)	3	1	7 (9)	6 (3)
Kansas***	54	12	9	3	1	12	17
Kentucky	57 (48)	11	9 (7)	3	1 (0)	14 (13)	19 (14)
Louisiana	26	13 (12)	9	3	1	0	0 (1)
Maine	108 (39)	13 (12)	9	3	1	24 (9)	58 (5)
Maryland***	115 (114)	13 (12)	9	3	1	26	63
Massachusetts	open formulary	13 (12)	9	3	1	29	open formulary
Michigan	261 (194)	13 (12)	9	3	1	23	212 (146)
Minnesota	133 (130)	13 (12)	9 (8)	3	1	20	87
Mississippi***	53 (52)	13 (12)	9	2	1	15	13
Missouri	234 (238)	13 (12)	9	3	1	21 (18)	187 (195)
Montana	120 (144)	13 (12)	9	3	1	16 (19)	78 (100)
Nebraska	114	12	9	2	1	15	75 (66)
Nevada***	70 (69)	13 (12)	9	3	1	13	31
New Hampshire	open formulary	13 (12)	9	3	1	29 (27)	open formulary
New Jersey	open formulary	13 (12)	9	3	1	29	open formulary
New Mexico	73 (69)	13 (12)	9	3	1	18	29 (26)
New York	481 (480)	13 (12)	9	3	1	27	428
North Carolina	60 (59)	13 (12)	9	3	1	16	18

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Appendix IX *(continued)*

ADAP Formulary Coverage by State, as of November 2006

State/Territory	Total Number of Drugs on Formulary	NRTIs Covered* (13 Drugs)	PIs Covered** (9 Drugs)	NNRTIs Covered (3 Drugs)	Fusion Inhibitor Covered (1 Drug)	"A1" OI Prophylaxis Covered (29 PHS Recommended Drugs)	Other Medications Covered
North Dakota	96	13	8	3	0	19	53
Ohio	85(86)	13 (12)	9	3	1	14 (15)	45 (46)
Oklahoma	54 (53)	13 (12)	9	3	1	18	10
Oregon***	64(63)	13 (12)	9	3	1	22	16
Pennsylvania***	77(76)	13 (12)	9	3	1	22	29
Puerto Rico***	124	12	8	3	1	23	77
Rhode Island	68 (67)	13 (12)	9	3	1	15	27
South Carolina	57 (55)	12 (11)	8 (9)	3	1	16 (14)	17
South Dakota	52 (44)	12	0	3	0	12	25 (17)
Tennessee	60 (91)	13 (12)	9	3	1	20 (19)	14 (47)
Texas	41	13 (12)	9	3	1	11	4 (5)
Utah	40 (37)	13 (10)	9	3	1	11	3
Vermont	93 (92)	13 (12)	9	3	1	18	49
Virgin Islands (U.S.)***	39 (38)	10	8	3	1 (0)	9	8
Virginia	68	13 (12)	9	3	1	22 (23)	20
Washington***	180 (179)	13 (12)	9	3	1	21	133
West Virginia	38 (33)	12	9 (8)	3	0	9 (6)	5 (4)
Wisconsin	283 (282)	13 (12)	9	3	1	21	236
Wyoming***	82 (80)	13 (12)	9	3	1 (0)	17	39

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

*Atripla is a multi-class combination product that includes efavirenz (NNRTI), emtricitabine (NRTI), and tenofovir disoproxil fumarate (NRTI). For the purposes of the National ADAP Monitoring Project Annual Report, Atripla is included in the NRTI class.

**Agenerase (amprenavir), an additional approved protease inhibitor, is not counted in the formulary totals because the manufacturer discontinued its sale and distribution in capsule form, used for adult dosing, after 2004 and is instead manufacturing fosamprenavir (Lexiva), a "prodrug" of Agenerase (a prodrug is an inactive precursor of a drug, converted into its active form in the body). Some ADAPs may continue to include Agenerase on their formularies, and it still available in pediatric dosing.

Fortovase (saquinavir soft-gel) is no longer marketed by the manufacturer. The *National ADAP Monitoring Project Annual Repor*t counts Fortovase and Invirase (saquinavir hard-gel) as one drug for the purposes of tabulating the number of protease inhibitors covered on an ADAP's formulary.

***State did not provide full formulary data, but did indicate addition of new drugs.

Note: 44 ADAPs reported data. For the states that did not report formulary coverage, last year's information was used. American Samoa, the Marshall Islands and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006.

Appendix X

ADAP Formulary Coverage of Hepatitis C Treatment and Hepatitis A & B Vaccines by State, as of June 2006

Appendix X

ADAP Formulary Coverage of Hepatitis C Treatment and Hepatitis A & B Vaccines by State, as of June 2006

State/Territory	Hepatitis C Treatment	Hepatitis A Vaccine	Hepatitis B Vaccine
Alabama	—	—	—
Alaska	—	Yes	Yes
Arizona	Yes	Yes	Yes
Arkansas	Yes	—	—
California	Yes	Yes	Yes
Colorado	Yes	—	—
Connecticut	Yes	Yes	Yes
Delaware	—	—	—
District of Columbia	Yes	—	—
Florida	Yes	Yes	Yes
Georgia	—	—	—
Guam	—	—	—
Hawaii	Yes	—	—
Idaho	—	—	—
Illinois	—	—	—
Indiana	—	—	—
Iowa	—	—	—
Kansas	—	—	—
Kentucky	—	Yes	Yes
Louisiana	—	—	—
Maine	—	Yes	Yes
Maryland	Yes	—	—
Massachusetts	Yes	Yes	Yes
Michigan	Yes	Yes	Yes
Minnesota	—	—	—
Mississippi	Yes	—	—
Missouri	—	Yes	Yes
Montana	—	—	—
Nebraska	—	—	—
Nevada	Yes	—	—
New Hampshire	—	—	—
New Jersey	Yes	Yes	Yes
New Mexico	—	—	—
New York	Yes	Yes	Yes
North Carolina	—	—	—
North Dakota	—	Yes	Yes
Ohio	Yes	Yes	Yes
Oklahoma	—	—	—
Oregon	—	—	—
Pennsylvania	Yes	Yes	Yes
Puerto Rico	Yes	—	—
Rhode Island	Yes	—	—
South Carolina	Yes	—	—
South Dakota	Yes	Yes	Yes
Tennessee	Yes	—	—

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Appendix X *(continued)*

ADAP Formulary Coverage of Hepatitis C Treatment and Hepatitis A & B Vaccines by State, as of June 2006

State/Territory	Hepatitis C Treatment	Hepatitis A Vaccine	Hepatitis B Vaccine
Texas	—	—	—
Utah	—	—	—
Vermont	—	Yes	Yes
Virgin Islands (U.S.)	—	—	—
Virginia	Yes	Yes	Yes
Washington	Yes	Yes	Yes
West Virginia	—	—	—
Wisconsin	Yes	Yes	Yes
Wyoming	—	Yes	Yes
Total	**25**	**21**	**21**

Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data and are not included. Oklahoma did not respond to question regarding formulary coverage of hepatitis C treatment and Tennessee did not respond to questions regarding formulary coverage of hepatitis A and B vaccines. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding.

Appendix XI

Number of People on ADAP Waiting Lists, by Survey Period and State, July 2002–March 2007

Appendix XI

Number of People on ADAP Waiting Lists, by Survey Period and State, July 2002–March 2007

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	May-05	Jul-05	Sep-05	Nov-05	Jan-06	Feb-06	May-06	Jul-06	Sep-06	Nov-06	Jan-07	Mar-07	# 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	180	143	168	196	285	280	38		6				28	188
Alaska										1			4	9	7	8	12	4	5	1			8	8	12	12			10	10	16	13	19	8
Arizona																																		
Arkansas															3		11	31	30	43	59	55	78	73	89	89	21	4					13	45
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	13	18	26	33	40	36	15						14	19
Illinois																																		
Indiana	30	34	34	34	34	34				47	48	47													9	9	8		33				13	31
Iowa															6	31	46	12	39	47	55												7	34
Kansas																																		
Kentucky	50	62	121	121	121	121	141	141	130	135	165	140	140	123	113	138	191		27	72	80	125	192	217	258	211	188	153					27	136
Louisiana																																		
Maine																																		
Maryland																																		
Massachusetts																																		
Michigan																																		
Minnesota																																		
Mississippi																																		
Missouri																																		
Montana	2	2	8	8	8						4	1	4	4	8	10	14		6	5	4	6	15	12	17	17	20	20	20	22	22	20	26	11
Nebraska			8	8	15	15	29	29	30	36	30	30						15	27	46	61	85	85	92	89	94							19	43
Nevada																																		
New Hampshire																																		
New Jersey																																		
New Mexico																																		
New York																																		

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Number of People on ADAP Waiting Lists, by Survey Period and State, July 2002–March 2007

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	May-05	Jul-05	Sep-05	Nov-05	Jan-06	Feb-06	May-06	Jul-06	Sep-06	Nov-06	Jan-07	Mar-07	# of Periods w/Waiting Lists	Average # of People on Waiting List
North Carolina	**715**	**776**	**150**	**150**	**217**		**50**					**96**	**126**	**449**	**716**	**891**	**524**	**493**	**325**	**325**		**2**	**293**	**13**	**83**								**19**	**337**
North Dakota																																		
Ohio																																		
Oklahoma																																		
Oregon	18	18	9	9	9	145	236	236	220	228	228	24																					12	115
Palau																																		
Pennsylvania																																		
Puerto Rico																														126	75	2	101
Rhode Island																																		
South Carolina																											94	209	308	394	463	5	294
South Dakota	**43**	**43**	**43**	**43**	**43**	**43**	**49**	**49**	**49**	**52**	**50**		**49**	**43**	**23**	**28**	**36**															**16**	**43**
Tennessee																																		
Texas																																		
Utah																	11																1	11
Vermont																																		
Virgin Islands (U.S.)																																		
Virginia																																		
Washington																																		
West Virginia							**9**	**9**	**10**	**12**	**14**	**21**	**28**	**34**	**35**	**35**	**35**	**5**	**1**	**1**	**1**	**1**	**1**	**3**	**43**	**43**	**41**	**39**	**24**				**23**	**19**
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**	**684**	**453**	**435**	**866**	**647**	**925**	**791**	**331**	**310**	**302**	**340**	**558**	**571**		**729**
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**	**9**	**9**	**9**	**9**	**10**	**9**	**7**	**5**	**6**	**3**	**4**	**4**	**20**	

States in **bold** eligible for the President's ADAP Initiative (PAI), announced in June 2004. PAI provided $20 million in one-time funds targeted to individuals on waiting lists in 10 states. States in **bold** began including PAI clients on their waiting lists in May 2005. The initiative ended in September 2006.

Appendix XII

ADAP Programmatic Cost-Containment Measures in Place by State, as of June 2006

Appendix XII

ADAP Programmatic Cost-Containment Measures in Place by State, as of June 2006

State/Territory	Client Cost Sharing	Overall Program Enrollment Cap	Drug Specific Enrollment Cap	Maximum Cost Per Client	Maximum Number of Prescriptions Per Client Per Month	Drug(s) with Clinical Criteria	Drug(s) with Prior Authorization	Drug(s) with Required Resistance Testing***	Other ADAP Program Practices/Restrictions
Alabama	—	Yes (1,100)	Yes (Fuzeon)	—	—	Fuzeon	Fuzeon, Procrit	Fuzeon	—
Alaska	—	—	—	—	—	—	—	—	—
Arizona	—	—	—	—	—	Fuzeon, HEPC treatment, Valcyte	Fuzeon, Valcyte	Fuzeon	—
Arkansas	—	—	Yes (Fuzeon)	—	—	—	Fuzeon	Fuzeon	—
California	—	—	—	—	—	Aptivus, Bupropion, Ciprofloxacin, Fentanyl, Fuzeon, Ketorola, Methadone, Oxandrolone, Paclitaxel, Somatropin	Amikacin, Blemomycin, Cidofovir, Ciprofloxacin, Daunorubicin, Doxorubicin, Enfuvirtide, Epoetin, Fentanyl, Filgrastim, Fomivirsen, Foscarnet, Ganciclovir, Hepatitis A & B vaccine, Interferon, Ketorolac, Lansoprazole, Methadone, Nandrolone, Omeprazole, Paclitaxel, Pegylated Interferon, Ribavirin/Interferon Alfa 2b, Somatropin, testosterone (gel and injectable), Tipranavir, Valacyclovir, Valganciclovir, Vinblastine, Vincristine	Enfuvirtide, Tipranavir	Step therapy for Lansoprazole and Omeprazole
Colorado	—	—	—	—	—	—	—	—	—
Connecticut	—	—	—	—	—	—	Serostim	—	—
Delaware	—	—	—	—	—	—	—	—	—
District of Columbia	—	—	—	—	—	—	—	—	—
Florida	—	—	—	—	—	Deca-Duroblin, Epoetin Alpha, Epogen, Hepatitis A & B vaccine, Magace, Neuprogen, Oxandrin, Procrit, testosterone	Fuzeon	—	—
Georgia	—	—	Yes (Fuzeon)	—	Yes	—	Aptivus, Fuzeon	Aptivus, Fuzeon	—
Guam	—	—	—	—	—	—	—	—	—
Hawaii	—	—	—	—	—	Fuzeon	Fuzeon, HCV medications	Fuzeon	—
Idaho	—	—	—	—	—	—	—	—	—
Illinois	—	—	Yes (Aptivus, Fuzeon, Oral Valcyte)	Yes ($2,000 Per Month)	Yes	—	Aptivus, Fuzeon, Valcyte	Fuzeon	—
Indiana	—	Yes (1,100)	—	—	—	—	—	—	—
Iowa	—	—	—	—	—	—	Fuzeon	—	—
Kansas	—	—	—	—	—	—	Fuzeon	—	—
Kentucky	—	—	—	—	—	—	Prezista	Prezista	—
Louisiana	—	—	—	—	—	Fuzeon	Fuzeon	Fuzeon	—

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Appendix XII *(continued)*

ADAP Programmatic Cost-Containment Measures in Place by State, as of June 2006

State/Territory	Client Cost Sharing	Overall Program Enrollment Cap	Drug Specific Enrollment Cap	Maximum Cost Per Client	Maximum Number of Prescriptions Per Client Per Month	Drug(s) with Clinical Criteria	Drug(s) with Prior Authorization	Drug(s) with Required Resistance Testing***	Other ADAP Program Practices/Restrictions
Maine	—	—	—	—	—	—	Fuzeon	—	—
Maryland	—	—	—	—	—	—	epoetin alfa, filgrastim, Fuzeon, oral ribavirin, oxandrolone, peg interferon alfa 2a & 2b	—	—
Massachusetts	—	—	—	—	—	—	—	—	Program uses insurance purchasing as both a cost containment and primary ADAP service.
Michigan	—	—	—	—	—	—	Fuzeon, Neupogen, Procrit	Fuzeon	Mandatory generics, quantity limits; Step therapy for antidepressants, antihistamines, and proton pump inhibitors.
Minnesota	Yes	—	—	—	—	—	—	—	—
Mississippi	—	—	—	—	—	—	—	—	—
Missouri	—	—	—	—	—	—	—	—	—
Montana	—	*	Yes (Fuzeon, Aptivus)	—	—	Amphotercin B (liquid formulation), Atripla, Cancidas/Vfend, Epogen, Fuzeon, MAOIs (Marplan/Nardil/ Parnate), Neurontin, Prezista, testosterone, Trizivir	Amphotercin B (liquid formulation), Atripla, Cancidas/Vfend, Epogen, Fuzeon, MAOIs (Marplan/Nardil/ Parnate), Neurontin, Prezista, testosterone, Trizivir	—	—
Nebraska	—	—	—	—	—	—	Fuzeon	—	—
Nevada	—	—	—	—	—	Fuzeon	Fuzeon	—	—
New Hampshire	—	—	—	—	—	—	Drugs classified by NH Medicaid as "non-preferred"	—	—
New Jersey	—	—	—	—	—	—	—	—	—
New Mexico	—	—	—	—	—	—	—	—	—
New York	—	—	—	—	—	—	Aptivus, Epogen, Fuzeon, G-csf, Mepron, Neumega, Win Rho	—	—
North Carolina**	—	Yes (4,000)	—	—	—	Fuzeon	Fuzeon	Fuzeon	—
North Dakota	—	—	—	—	—	—	—	—	—
Ohio	—	—	Yes (Fuzeon)	—	—	—	—	—	—
Oklahoma	—	—	Yes (Fuzeon)	Yes ($12,000 Per Year)	—	—	Aptivus, Fuzeon, Prezista	—	—
Oregon	Yes	—	—	—	—	—	—	—	Program uses insurance purchasing as both a cost containment and primary ADAP service.
Pennsylvania	—	—	—	—	—	—	—	—	—

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Appendix XII *(continued)*

ADAP Programmatic Cost-Containment Measures in Place by State, as of June 2006

State/Territory	Client Cost Sharing	Overall Program Enrollment Cap	Drug Specific Enrollment Cap	Maximum Cost Per Client	Maximum Number of Prescriptions Per Client Per Month	Drug(s) with Clinical Criteria	Drug(s) with Prior Authorization	Drug(s) with Required Resistance Testing***	Other ADAP Program Practices/Restrictions
Puerto Rico	—	—	—	—	—	—	Aptivus, Fuzeon	Aptivus, Fuzeon	—
Rhode Island	—	—	—	—	—	—	—	—	—
South Carolina	Yes	—	—	—	—	—	Fuzeon	—	—
South Dakota	—	—	—	Yes ($8,500 Per Year)	—	—	—	—	—
Tennessee	—	—	—	—	—	—	Fuzeon	—	—
Texas	—	—	—	—	—	Each drug has specific criteria; see program guidelines.	—	Fuzeon	—
Utah	—	—	—	—	—	—	—	—	—
Vermont	—	—	Yes (Fuzeon)	—	—	Fuzeon	—	—	—
Virgin Islands (U.S.)	—	—	—	—	—	—	—	—	—
Virginia	—	—	—	—	—	Aptivus, Fuzeon, Prezista	Aptivus, Fuzeon, Prednisone, Prezista, Voriconazole	—	—
Washington	Yes	—	Yes (Fuzeon)	—	—	Fuzeon	Aptivus, Clarithromycin, Fosamprenavir, Fuzeon, Marinol, Norvir, Valtrex, Zofran	Fuzeon	—
West Virginia	—	—	—	—	—	—	—	—	—
Wisconsin	—	—	—	—	—	—	—	—	—
Wyoming	—	—	—	—	—	—	—	—	—
Total	**4**	**3**	**9**	**3**	**2**	**13**	**28**	**14**	**4**

*No specific enrollment cap. Cap is determined based on budget.

**North Carolina has a soft cap for overall program enrollment that is based on available funding and "cost/month/client" analysis.

***ADAPs requiring that a resistance test be performed on a client before the ADAP will cover the cost of the drug(s) listed. The ADAP may or may not pay for the resistance test.

Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data and are not included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006.

Appendix XIII

ADAP Budget, by Source, FY 2006

Appendix XIII

ADAP Budget, by Source, FY 2006

State/Territory	Title II ADAP Earmark	% of Total Budget	Title II ADAP Supplemental*	% of Total Budget	Title II Base	% of Total Budget	State Contribution	% of Total Budget	Title I Contribution	% of Total Budget	Other State or Federal	% of Total Budget	Drug Rebates	% of Total Budget	Total FY 2006 Budget
Alabama	$7,901,465	51%	$397,673	3%	$877,547	6%	$5,991,044	38%	$0	0%	$0	0%	$400,000	3%	$15,567,729
Alaska	$534,924	100%	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%	$534,924
Arizona	$9,623,252	91%	$0	0%	$0	0%	$1,000,000	9%	$0	0%	$0	0%	$0	0%	$10,623,252
Arkansas	$3,598,289	97%	$0	0%	$114,169	3%	$0	0%	$0	0%	$0	0%	$0	0%	$3,712,458
California	$90,235,394	30%	$0	0%	$11,409,607	4%	$107,740,000	36%	$0	0%	$0	0%	$91,935,000	31%	$301,320,001
Colorado	$5,710,273	51%	$282,569	3%	$344,000	3%	$4,366,482	39%	$365,260	3%	$0	0%	$60,000	1%	$11,128,584
Connecticut	$12,158,193	70%	$0	0%	$0	0%	$606,678	4%	$0	0%	$0	0%	$4,500,000	26%	$17,264,871
Delaware	$3,486,482	100%	—	—	—	—	—	—	—	—	—	—	—	—	$3,486,482
District of Columbia**	$15,188,675	100%	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%	$15,188,675
Florida	$88,022,839	87%	$0	0%	$944,245	1%	$10,500,000	10%	$0	0%	$0	0%	$1,891,053	2%	$101,358,137
Georgia	$26,816,477	64%	$1,349,649	3%	$43,676	0.1%	$11,805,339	28%	$1,976,400	5%	$0	0%	$0	0%	$41,991,541
Guam	$92,437	95%	$4,563	5%	—	—	—	—	—	—	—	—	—	—	$97,000
Hawaii	$2,165,333	82%	$0	0%	$0	0%	$440,535	17%	$0	0%	$0	0%	$50,000	2%	$2,655,868
Idaho	$465,496	24%	$22,131	1%	$259,214	13%	$779,300	40%	$0	0%	$0	0%	$418,516	22%	$1,944,657
Illinois	$27,800,193	70%	$0	0%	$0	0%	$12,100,000	30%	$0	0%	$0	0%	$0	0%	$39,900,193
Indiana	$7,305,591	97%	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%	$209,890	3%	$7,515,481
Iowa	$1,430,675	60%	$70,614	3%	$0	0%	$822,606	35%	$0	0%	$3,263	0.1%	$40,000	2%	$2,367,158
Kansas	$2,123,496	52%	$0	0%	$0	0%	$400,000	10%	$205,000	5%	$0	0%	$1,344,291	33%	$4,072,787
Kentucky	$4,558,007	84%	$227,356	4%	$72,274	1%	$250,000	5%	$0	0%	$115,000	2%	$200,000	4%	$5,422,637
Louisiana	$15,931,601	93%	$795,005	5%	$0	0%	$0	0%	$0	0%	$0	0%	$467,200	3%	$17,193,806
Maine	$831,937	88%	$0	0%	$0	0%	$60,000	6%	$0	0%	$0	0%	$53,250	6%	$945,187
Maryland	$27,938,941	64%	$0	0%	$0	0%	$0	0%	$238,351	1%	$5,200,000	12%	$10,000,000	23%	$43,377,292
Massachusetts	$15,560,303	74%	$0	0%	$0	0%	$2,802,358	13%	$790,632	4%	$0	0%	$1,900,000	9%	$21,053,293
Michigan	$11,931,032	59%	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%	$8,200,000	41%	$20,131,032
Minnesota	$3,288,877	73%	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%	$1,200,000	27%	$4,488,877
Mississippi	$6,972,148	87%	$0	0%	$255,713	3%	$750,000	9%	$0	0%	$0	0%	$0	0%	$7,977,861
Missouri	$7,702,126	47%	$0	0%	$550,000	3%	$4,390,224	27%	$920,000	6%	$0	0%	$2,708,563	17%	$16,270,913
Montana	$310,671	56%	$14,146	3%	$154,000	28%	$54,979	10%	$0	0%	$6,579	1%	$16,000	3%	$556,375
Nebraska	$1,185,386	55%	$58,179	3%	$0	0%	$900,000	42%	$0	0%	$0	0%	$18,860	1%	$2,162,425
Nevada	$5,083,984	68%	$0	0%	$374,121	5%	$1,813,437	24%	$0	0%	$137,800	2%	$120,000	2%	$7,529,342
New Hampshire	$778,520	28%	$0	0%	$0	0%	$180,000	7%	$928,695	34%	$447,476	16%	$400,000	15%	$2,734,691
New Jersey	$35,030,826	50%	$0	0%	$0	0%	$9,000,000	13%	$68,000	0.1%	$1,003,019	1%	$25,657,198	36%	$70,759,043
New Mexico	$2,361,780	100%	—	—	—	—	—	—	—	—	—	—	—	—	$2,361,780
New York	$132,808,536	54%	$0	0%	$1,000,135	0.4%	$41,295,245	17%	$11,591,562	5%	$1,896,994	1%	$58,296,000	24%	$246,888,472
North Carolina	$15,068,543	53%	$758,386	3%	$0	0%	$12,120,856	42%	$0	0%	$0	0%	$750,000	3%	$28,697,785

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Appendix XIII *(continued)*

ADAP Budget, by Source, FY 2006

State/Territory	Title II ADAP Earmark	% of Total Budget	Title II ADAP Supplemental*	% of Total Budget	Title II Base	% of Total Budget	State Contribution	% of Total Budget	Title I Contribution	% of Total Budget	Other State or Federal	% of Total Budget	Drug Rebates	% of Total Budget	Total FY 2006 Budget
North Dakota	$120,131	61%	$0	0%	$76,417	39%	$0	0%	$0	0%	$0	0%	$0	0%	$196,548
Ohio	$11,455,538	74%	$0	0%	$0	0%	$3,515,299	23%	$250,000	2%	$52,000	0.3%	$150,000	1%	$15,422,837
Oklahoma	$3,851,706	69%	$193,361	3%	$0	0%	$1,287,340	23%	$0	0%	$160,454	3%	$120,000	2%	$5,612,861
Oregon	$4,406,889	56%	$0	0%	$0	0%	$952,451	12%	$0	0%	$0	0%	$2,520,000	32%	$7,879,340
Pennsylvania	$29,645,030	57%	$0	0%	$0	0%	$14,822,515	29%	$0	0%	$0	0%	$7,282,403	14%	$51,749,948
Puerto Rico	$21,952,293	72%	$1,104,839	4%	$5,830,742	19%	$1,728,396	6%	$0	0%	$0	0%	$0	0%	$30,616,270
Rhode Island	$2,107,383	48%	$0	0%	$20,000	0.5%	$2,280,000	52%	$0	0%	$0	0%	$0	0%	$4,407,383
South Carolina	$13,738,201	85%	$642,369	4%	$0	0%	$800,000	5%	$0	0%	$0	0%	$900,000	6%	$16,080,570
South Dakota	$233,463	59%	$0	0%	$105,517	27%	$0	0%	$0	0%	$0	0%	$59,000	15%	$397,980
Tennessee	$12,777,562	40%	$0	0%	$5,943,875	18%	$8,000,000	25%	$0	0%	$5,294,558	16%	$211,000	1%	$32,226,995
Texas	$55,471,791	59%	$2,767,173	3%	$0	0%	$34,622,983	37%	$652,000	1%	$0	0%	$0	0%	$93,513,947
Utah	$2,225,832	75%	$94,342	3%	$0	0%	$180,000	6%	$0	0%	$136,162	5%	$342,178	11%	$2,978,514
Vermont	$383,059	54%	$0	0%	$0	0%	$0	0%	$0	0%	$60,938	9%	$265,000	37%	$708,997
Virgin Islands (U.S.)	$679,239	76%	$30,574	3%	$25,000	3%	$154,000	17%	$0	0%	$0	0%	$0	0%	$888,813
Virginia	$15,541,487	80%	$746,636	4%	$0	0%	$2,612,200	13%	$0	0%	$0	0%	$600,000	3%	$19,500,323
Washington	$8,280,398	55%	$0	0%	$0	0%	$2,761,238	18%	$407,000	3%	$0	0%	$3,553,845	24%	$15,002,481
West Virginia	$1,446,601	65%	$71,412	3%	$154,868	7%	$188,000	8%	$0	0%	$0	0%	$375,000	17%	$2,235,881
Wisconsin	$3,259,411	48%	$164,043	2%	$0	0%	$464,000	7%	$0	0%	$24,343	0.4%	$2,930,638	43%	$6,842,435
Wyoming	$172,264	23%	$0	0%	$60,000	8%	$367,500	48%	$0	0%	$0	0%	$160,000	21%	$759,764
Total	**$779,750,980**	**56%**	**$9,795,020**	**1%**	**$28,615,120**	**2%**	**$304,905,005**	**22%**	**$18,392,900**	**1%**	**$14,538,586**	**1%**	**$230,304,885**	**17%**	**$1,386,302,496**

*ADAP supplemental awards were provided to 20 states that met the federal eligibility criteria, applied for funding, and were able to meet the mandated matching requirement.

**The District of Columbia purchases drugs through the Department of Defense. Rebates do not apply.

Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data but the federal ADAP earmark and ADAP supplemental award totals are incorporated into the national budget. American Samoa, Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006. Total FY 2006 Budget includes Federal, state, and drug rebate dollars. Cost recovery funds, with the exception of drug rebates, are not included in this total budget.

Appendix XIV

ADAP Budget, FY 2005–FY 2006

Appendix XIV

ADAP Budget, FY 2005 - FY 2006

State/Territory	ADAP FY 2005 Total Budget	ADAP FY 2006 Total Budget	% Change
Alabama	$13,305,055	$15,567,729	17%
Alaska	$517,035	$534,924	3%
American Samoa	$2,360	—	—
Arizona	$10,326,619	$10,623,252	3%
Arkansas	$3,393,643	$3,712,458	9%
California	$264,291,174	$301,320,001	14%
Colorado	$11,425,978	$11,128,584	-3%
Connecticut	$18,401,556	$17,264,871	-6%
Delaware	$3,379,483	$3,486,482	3%
District of Columbia	$14,648,361	$15,188,675	4%
Florida	$99,702,484	$101,358,137	2%
Georgia	$43,205,839	$41,991,541	-3%
Guam	$101,695	$97,000	-5%
Hawaii	$2,668,577	$2,655,868	-0.5%
Idaho	$1,284,073	$1,944,657	51%
Illinois	$37,926,143	$39,900,193	5%
Indiana	$7,242,843	$7,515,481	4%
Iowa	$2,029,657	$2,367,158	17%
Kansas	$3,259,977	$4,072,787	25%
Kentucky	$5,559,691	$5,422,637	-2%
Louisiana	$17,442,981	$17,193,806	-1%
Maine	$1,062,831	$945,187	-11%
Marshall Islands	$2,360	—	—
Maryland	$45,289,205	$43,377,292	-4%
Massachusetts	$21,604,898	$21,053,293	-3%
Michigan	$15,364,472	$20,131,032	31%
Minnesota	$6,080,294	$4,488,877	-26%
Mississippi	$6,495,703	$7,977,861	23%
Missouri	$13,799,516	$16,270,913	18%
Montana	$468,112	$556,375	19%
Nebraska	$1,474,557	$2,162,425	47%
Nevada	$6,996,445	$7,529,342	8%
New Hampshire	$2,718,924	$2,734,691	1%
New Jersey	$64,592,155	$70,759,043	10%
New Mexico	$2,293,895	$2,361,780	3%
New York	$237,916,843	$246,888,472	4%
North Carolina	$30,408,944	$28,697,785	-6%
North Dakota	$259,493	$196,548	-24%
Northern Marianas	$4,720	—	—
Ohio	$16,214,008	$15,422,837	-5%
Oklahoma	$5,474,149	$5,612,861	3%
Oregon	$7,357,790	$7,879,340	7%
Pennsylvania	$42,485,124	$51,749,948	22%
Puerto Rico	$31,716,607	$30,616,270	-3%
Rhode Island	$2,109,545	$2,107,383	-0.1%

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Appendix XIV *(continued)*

ADAP Budget, FY 2005 - FY 2006

State/Territory	ADAP FY 2005 Total Budget	ADAP FY 2006 Total Budget	% Change
South Carolina	$15,087,564	$16,080,570	7%
South Dakota	$471,692	$397,980	-16%
Tennessee	$17,612,899	$32,226,995	83%
Texas	$95,072,995	$93,513,947	-2%
Utah	$2,602,257	$2,978,514	14%
Vermont	$622,594	$708,997	14%
Virgin Islands (U.S.)	$709,945	$888,813	25%
Virginia	$19,844,417	$19,500,323	-2%
Washington	$16,441,895	$15,002,481	-9%
West Virginia	$2,165,992	$2,235,881	3%
Wisconsin	$5,334,712	$6,842,435	28%
Wyoming	$737,418	$759,764	3%
Total	**$1,299,010,193**	**$1,384,002,496**	
Comparison Total	***$1,299,000,753***	***$1,384,002,496***	***7%***

Comparison Totals are based on only those states that reported data in both fiscal years.

Note: 51 ADAPs reported data. Earmark-only funds were utilized for Delaware, Guam, New Mexico, and Rhode Island because their full budget information was not reported in either FY 2005 or FY 2006. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included in the comparison total for FY 2006 because HRSA determined they were not eligible for ADAP funding in FY 2006. ADAP Total Budget includes Federal, state, and drug rebate dollars. Cost recovery funds, with the exception of drug rebate dollars, are not included these total budgets.

Appendix XV

Major FY 2006 Budget Categories Compared with FY 2005

Appendix XV

Major FY 2006 Budget Categories Compared with FY 2005

State/Territory	2005 Title II ADAP Earmark	2006 Title II ADAP Earmark	% Change	2005 Title II ADAP Supplemental	2006 Title II ADAP Supplemental*	% Change	2005 Title II Base Contribution	2006 Title II Base Contribution	% Change	2005 State Contribution	2006 State Contribution	% Change	2005 Title I	2006 Title I	% Change	2005 Est. Drug Rebates	2006 Est. Drug Rebates	% Change
Alabama	$8,474,550	$7,901,465	-7%	$804,633	$397,673	-51%	$1,026,240	$877,547	-14%	$2,999,632	$5,991,044	100%	$0	$0	—	$0	$400,000	—
Alaska	$505,035	$534,924	6%	$0	$0	—	$0	$0	—	$0	$0	—	$0	$0	—	$12,000	$0	—
Arizona	$9,326,619	$9,623,252	3%	$0	$0	—	$0	$0	—	$1,000,000	$1,000,000	0%	$0	$0	—	$0	$0	—
Arkansas	$3,393,643	$3,598,289	6%	$0	$0	—	$0	$114,169	—	$0	$0	—	$0	$0	—	$0	$0	—
California	$90,028,301	$90,235,394	0.2%	$0	$0	—	$11,377,873	$11,409,607	4%	$84,961,250	$107,740,000	27%	$0	$0	—	$77,923,750	$91,935,000	18%
Colorado	$5,706,243	$5,710,273	0.1%	$594,438	$282,569	-52%	$136,000	$344,000	3%	$4,413,606	$4,366,482	-1%	$517,558	$365,260	-29%	$58,133	$60,000	3%
Connecticut	$12,052,389	$12,158,193	1%	$0	$0	—	$0	$0	—	$1,776,352	$606,678	-66%	$0	$0	—	$4,572,815	$4,500,000	-2%
Delaware	$3,379,483	$3,486,482	3%	—	—	—	—	—	—	$40	—	—	—	—	—	—	—	—
District of Columbia**	$14,648,361	$15,188,675	4%	$0	$0	—	$0	$0	—	$0	$0	—	$0	$0	—	$0	$0	—
Florida	$86,648,817	$88,022,839	2%	$0	$0	—	$0	$944,245	—	$9,000,000	$10,500,000	17%	$0	$0	—	$4,053,667	$1,891,053	-53%
Georgia	$26,509,592	$26,816,477	1%	$2,781,061	$1,349,649	-51%	$458,118	$43,676	-90%	$11,305,339	$11,805,339	4%	$1,875,000	$1,976,400	5%	$0	$0	—
Guam	$92,039	$92,437	0.4%	$9,656	$4,563	-53%	—	—	—	—	—	—	—	—	—	—	—	—
Hawaii	$2,161,042	$2,165,333	0.2%	$0	$0	—	$0	$0	—	$440,535	$440,535	0%	$0	$0	—	$67,000	$50,000	-25%
Idaho	$464,915	$465,496	0.1%	$48,773	$22,131	-55%	$217,885	$259,214	19%	$177,500	$779,300	339%	$0	$0	—	$375,000	$418,516	12%
Illinois	$27,326,143	$27,800,193	2%	$0	$0	—	$0	$0	—	$10,100,000	$12,100,000	20%	$0	$0	—	$500,000	$0	—
Indiana	$7,072,843	$7,305,591	3%	$0	$0	—	$0	$0	—	$0	$0	—	$0	$0	—	$170,000	$209,890	24%
Iowa	$1,390,025	$1,430,675	3%	$145,824	$70,614	-52%	$0	$0	—	$375,000	$822,606	119%	$0	$0	—	$45,000	$40,000	-11%
Kansas	$2,123,977	$2,123,496	0%	$0	$0	—	$0	$0	—	$400,000	$400,000	0%	$206,000	$205,000	-0.5%	$530,000	$1,344,291	154%
Kentucky	$4,441,472	$4,558,007	3%	$465,945	$227,356	-51%	$72,274	$72,274	0%	$180,000	$250,000	39%	$0	$0	—	$400,000	$200,000	-50%
Louisiana	$15,670,230	$15,931,601	2%	$1,643,928	$795,005	-52%	$0	$0	—	$0	$0	—	$0	$0	—	$128,823	$467,200	263%
Maine	$832,631	$831,937	-0.1%	$0	$0	—	$0	$0	—	$60,000	$60,000	0%	$0	$0	—	$75,600	$53,250	-30%
Maryland	$27,583,380	$27,938,941	1%	$0	$0	—	$63,034	$0	—	$0	$0	—	$91,803	$238,351	160%	$8,000,000	$10,000,000	25%
Massachusetts	$15,168,804	$15,560,303	3%	$0	$0	—	$0	$0	—	$4,216,175	$2,802,358	-34%	$319,919	$790,632	147%	$1,900,000	$1,900,000	0%
Michigan	$11,764,472	$11,931,032	1%	$0	$0	—	$0	$0	—	$0	$0	—	$0	$0	—	$3,600,000	$8,200,000	128%
Minnesota	$3,155,286	$3,288,877	4%	$0	$0	—	$0	$0	—	$1,150,000	$0	—	$0	$0	—	$1,775,008	$1,200,000	-32%
Mississippi	$5,795,703	$6,972,148	20%	$0	$0	—	$0	$255,713	—	$700,000	$750,000	7%	$0	$0	—	$0	$0	—
Missouri	$7,693,516	$7,702,126	0.1%	$0	$0	—	$550,000	$550,000	0%	$2,096,000	$4,390,224	109%	$1,460,000	$920,000	-37%	$2,000,000	$2,708,563	35%
Montana	$310,671	$310,671	0%	$32,185	$14,146	-56%	$86,469	$154,000	78%	$9,000	$54,979	511%	$0	$0	—	$13,787	$16,000	16%
Nebraska	$1,164,119	$1,185,386	2%	$119,581	$58,179	-51%	$40,857	$0	—	$150,000	$900,000	500%	$0	$0	—	$0	$18,860	—
Nevada	$5,038,545	$5,083,984	1%	$0	$0	—	$0	$374,121	—	$1,565,704	$1,813,437	16%	$252,196	$0	—	$140,000	$120,000	-14%
New Hampshire	$702,308	$778,520	11%	$0	$0	—	$0	$0	—	$180,000	$180,000	0%	$1,290,835	$928,695	-28%	$400,000	$400,000	0%
New Jersey	$35,019,792	$35,030,826	0%	$0	$0	—	$0	$0	—	$9,000,000	$9,000,000	0%	$72,363	$68,000	-6%	$20,500,000	$25,657,198	25%
New Mexico	$2,293,895	$2,361,780	3%	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
New York	$129,645,186	$132,808,536	2%	$0	$0	—	$1,400,000	$1,000,135	-29%	$37,350,000	$41,295,245	11%	$10,955,614	$11,591,562	6%	$55,200,000	$58,296,000	6%
North Carolina	$13,836,529	$15,068,543	9%	$1,451,559	$758,386	-48%	$0	$0	—	$12,120,856	$12,120,856	0%	$0	$0	—	$3,000,000	$750,000	-75%

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Major FY 2006 Budget Categories Compared with FY 2005

State/Territory	2005 Title II ADAP Earmark	2006 Title II ADAP Earmark	% Change	2005 Title II ADAP Supplemental	2006 Title II ADAP Supplemental*	% Change	2005 Title II Base Contribution	2006 Title II Base Contribution	% Change	2005 State Contribution	2006 State Contribution	% Change	2005 Title I	2006 Title I	% Change	2005 Est. Drug Rebates	2006 Est. Drug Rebates	% Change
North Dakota	$106,199	$120,131	13%	$0	$0	—	$72,158	$76,417	6%	$0	$0	—	$0	$0	—	$50,000	$0	—
Ohio	$11,405,756	$11,455,538	0.4%	$0	$0	—	$3,928,799	$0	—	$338,787	$3,515,299	938%	$300,000	$250,000	-17%	$30,000	$150,000	400%
Oklahoma	$3,775,959	$3,851,706	2%	$396,127	$193,361	-51%	$143,070	$0	—	$884,032	$1,287,340	46%	$0	$0	—	$105,000	$120,000	14%
Oregon	$4,380,112	$4,406,889	1%	$0	$0	—	$0	$0	—	$977,678	$952,451	-3%	$0	$0	—	$2,000,000	$2,520,000	26%
Pennsylvania	$29,037,124	$29,645,030	2%	$0	$0	—	$0	$0	—	$13,448,000	$14,822,515	10%	$0	$0	—	$0	$7,282,403	—
Puerto Rico	$23,024,279	$21,952,293	-5%	$2,323,286	$1,104,839	-52%	$2,861,706	$5,830,742	104%	$1,199,828	$1,728,396	44%	$0	$0	—	$0	$0	—
Rhode Island	$2,109,545	$2,107,383	-0.1%	—	$0	—	—	$20,000	—	—	$2,280,000	—	—	$0	—	—	$0	—
South Carolina	$12,673,062	$13,738,201	8%	$1,329,502	$642,369	-52%	$0	$0	—	$500,000	$800,000	60%	$0	$0	—	$585,000	$900,000	54%
South Dakota	$226,558	$233,463	3%	$0	$0	—	$190,134	$105,517	-45%	$0	$0	—	$0	$0	—	$55,000	$59,000	7%
Tennessee	$10,144,000	$12,777,562	26%	$0	$0	—	$0	$5,943,875	—	$0	$8,000,000	—	$0	$0	—	$104,195	$211,000	103%
Texas	$54,812,764	$55,471,791	1%	$5,750,282	$2,767,173	-52%	$0	$0	—	$30,509,949	$34,622,983	13%	$0	$652,000	—	$4,000,000	$0	—
Utah	$2,225,184	$2,225,832	0%	$197,073	$94,342	-52%	$0	$0	—	$180,000	$180,000	0%	$0	$0	—	$0	$342,178	—
Vermont	$382,594	$383,059	0.1%	$0	$0	—	$0	$0	—	$0	$0	—	$0	$0	—	$240,000	$265,000	10%
Virgin Islands (U.S.)	$643,097	$679,239	6%	$66,848	$30,574	-54%	$0	$25,000	—	$0	$154,000	—	$0	$0	—	$0	$0	—
Virginia	$15,188,795	$15,541,487	2%	$1,593,422	$746,636	-53%	$0	$0	—	$2,612,200	$2,612,200	0%	$0	$0	—	$450,000	$600,000	33%
Washington	$8,274,070	$8,280,398	0.1%	$0	$0	—	$115,212	$0	—	$5,587,602	$2,761,238	-51%	$600,000	$407,000	-32%	$1,865,011	$3,553,845	91%
West Virginia	$1,406,545	$1,446,601	3%	$147,557	$71,412	-52%	$300,000	$154,868	-48%	$36,890	$188,000	410%	$0	$0	—	$275,000	$375,000	36%
Wisconsin	$3,263,844	$3,259,411	-0.1%	$342,402	$164,043	-52%	$0	$0	—	$464,000	$464,000	0%	$0	$0	—	$1,123,147	$2,930,638	161%
Wyoming	$169,918	$172,264	1%	$0	$0	—	$50,000	$60,000	20%	$367,500	$367,500	0%	$0	$0	—	$150,000	$160,000	7%
Total	**$764,669,961**	**$779,750,980**	**2%**	**$20,244,082**	**$9,795,020**	**-52%**	**$23,089,829**	**$28,615,120**	**24%**	**$252,833,455**	**$304,905,005**	**21%**	**$17,941,288**	**$18,392,900**	**3%**	**$196,472,936**	**$230,304,885**	**17%**

*ADAP supplemental awards were provided to 20 states that met the federal eligibility criteria, applied for funding, and were able to meet the mandated matching requirement.

**The District of Columbia purchases drugs through the Department of Defense. Rebates do not apply.

Note: 51 ADAPs reported data. Delaware, Guam, and New Mexico did not report data in FY 2006, however their ADAP earmark and ADAP supplemental awards are included in the appropriate budget columns. American Samoa, the Marshall Islands, and the Northern Mariana Islands are included in FY 2005 data because they received ADAP funding; they are not included in FY 2006 data because HRSA determined they were not eligible for ADAP funding in FY 2006. This table does not include the "other state/federal" category ($14,538,586), which is reported in the national budget in Appendices XIII and XIV.

Appendix XVI

Cost Recovery and Other Cost-Saving Mechanisms (Excluding Drug Rebates), FY 2006

Appendix XVI

Cost Recovery and Other Cost-Saving Mechanisms (Excluding Drug Rebates), FY 2006

State/Territory	Private Insurance	Medicaid	Manufacturers' Free Product	Other	Total
Alabama	$0	$150,000	$25,000	$0	$175,000
Alaska	$198,000	$0	$2,015	$0	$200,015
Colorado	$0	$36,000	$60,000	$0	$96,000
Florida	$0	$0	$146,733	$0	$146,733
Michigan	$660,000	$0	$0	$0	$660,000
New Jersey	$3,220,724	$2,500,000	$0	$5,360,569	$11,081,293
New York	$8,500,000	$750,000	$0	$0	$9,250,000
North Carolina	$0	$0	$100,000	$0	$100,000
Oklahoma	$52,000	$0	$40,000	$0	$92,000
Oregon	$0	$0	$0	$150,000	$150,000
Pennsylvania	$7,512,990	$0	$0	$0	$7,512,990
South Carolina	$0	$100,000	$500,000	$0	$600,000
Texas	$0	$0	$560,000	$0	$560,000
Utah	$0	$0	$0	$50,000	$50,000
Virginia	$0	$375,958	$40,000	$0	$415,958
Wisconsin	$88,768	$208,158	$0	$0	$296,926
Total	**$20,232,482**	**$4,120,116**	**$1,473,748**	**$5,560,569**	**$31,386,915**
Number of ADAPs	**7**	**7**	**9**	**3**	**16**

Note: 16 ADAPs reported data.

Appendix XVII

ADAP Drug Purchasing and Prime Vendor Participation, June 2006

Appendix XVII

ADAP Drug Purchasing and Prime Vendor Participation, June 2006

State/Territory	Participates in 340B	Direct Purchase	Pharmacy Network (Rebate)	HRSA Prime Vendor (340B Direct Purchasers Only)
Alabama	Yes	Yes	—	—
Alaska	Yes	Yes	—	—
Arizona	Yes	Yes	—	—
Arkansas	Yes	Yes	—	Yes
California	Yes	—	Yes	—
Colorado	Yes	Yes	—	—
Connecticut	Yes	—	Yes	—
Delaware	Yes	Yes	—	—
District of Columbia	—	Yes	—	—
Florida	Yes	Yes	—	Yes
Georgia	Yes	Yes	—	—
Guam	Yes	—	Yes	—
Hawaii	Yes	Yes	—	—
Idaho	Yes	—	Yes	—
Illinois	Yes	Yes	—	Yes
Indiana	Yes	—	Yes	—
Iowa	Yes	Yes	—	—
Kansas	Yes	—	Yes	—
Kentucky	Yes	Yes	—	—
Louisiana	Yes	Yes	—	—
Maine	Yes	—	Yes	—
Maryland	Yes	—	Yes	—
Massachusetts	Yes	—	Yes	—
Michigan	Yes	—	Yes	—
Minnesota	Yes	—	Yes	—
Mississippi	Yes	Yes	—	—
Missouri	Yes	—	Yes	—
Montana	Yes	Yes	—	Yes
Nebraska	Yes	Yes	—	—
Nevada	Yes	Yes	—	—
New Hampshire	Yes	—	Yes	—
New Jersey	Yes	—	Yes	—
New Mexico	Yes	Yes	—	—
New York	Yes	—	Yes	—
North Carolina	Yes	Yes	—	—
North Dakota	Yes	—	Yes	—
Ohio	Yes	Yes	—	Yes
Oklahoma	Yes	Yes	—	—
Oregon	Yes	—	Yes	—
Pennsylvania	Yes	—	Yes	—
Puerto Rico	Yes	Yes	—	—
Rhode Island	Yes	—	Yes	—
South Carolina	Yes	Yes	—	Yes
South Dakota	Yes	—	Yes	—
Tennessee	Yes	Yes	—	—

(continued on next page)

Appendix XVII *(continued)*

ADAP Drug Purchasing and Prime Vendor Participation, June 2006

State/Territory	Participates in 340B	Direct Purchase	Pharmacy Network (Rebate)	HRSA Prime Vendor (340B Direct Purchasers Only)
Texas	Yes	Yes	—	—
Utah	Yes	Yes	—	—
Vermont	Yes	—	Yes	—
Virgin Islands (U.S.)	Yes	Yes	—	—
Virginia	Yes	Yes	—	Yes
Washington	Yes	—	Yes	—
West Virginia	Yes	—	Yes	—
Wisconsin	Yes	—	Yes	—
Wyoming	Yes	—	Yes	—
Total	**53**	**29**	**25**	**7**

Note: Drug purchasing data from 54 ADAPs are included. Although Delaware, Guam, and New Mexico did not report data, their drug purchasing mechanisms are known and included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006. The 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.

Appendix XVIII

Federal ADAP Funds Used for Insurance Purchasing/ Maintenance and Number of Clients Served Through Insurance Purchasing/Maintenance, 2006

Appendix XVIII

Federal ADAP Funds Used for Insurance Purchasing/Maintenance and Number of Clients Served Through Insurance Purchasing/Maintenance, 2006

State/Territory	FY 2006 Est. Expenditures	June 2006 Expenditures	June 2006 Clients Served
Alabama	$250,000	$5,000	8
Alaska	$75,000	$5,190	25
Arizona	$0	$0	0
Arkansas	$5,200	$4,296	29
California	$22,098,850	$892,789	3,321
Colorado	$860,597	$58,161	93
Connecticut*	$167,000	—	0
Delaware	—	—	—
District of Columbia	$60,000	$1,917	33
Florida	$2,033,729	$169,477	—
Georgia	$0	$0	0
Guam	—	—	—
Hawaii*	$100,000	—	0
Idaho	$0	$0	0
Illinois	$0	$0	0
Indiana	$6,482,700	$338,143	845
Iowa	$215,623	$16,065	112
Kansas	$0	$0	0
Kentucky	$520,000	$34,451	310
Louisiana	$300,000	$25,647	117
Maine	$215,000	$11,000	125
Maryland	$1,800,000	$223,097	359
Massachusetts	$10,471,816	$806,685	1,241
Michigan	$600,000	$47,434	547
Minnesota	$1,891,770	$81,183	511
Mississippi	$0	$0	0
Missouri	$1,052,795	$69,729	229
Montana	$40,934	$2,643	4
Nebraska	$120,000	$3,896	26
Nevada	$0	$0	0
New Hampshire	$250,000	$4,954	26
New Jersey	$2,700,000	$214,491	52
New Mexico	—	—	—
New York	$9,600,000	$931,957	1,400
North Carolina	$0	$0	0
North Dakota	$0	$0	0
Ohio	$816,000	$244,339	748
Oklahoma	$295,621	$20,582	140
Oregon	$3,120,000	$317,132	1,166
Pennsylvania	$0	$0	0
Puerto Rico	$0	$0	0
Rhode Island	$0	$0	0
South Carolina	$1,000,000	$78,743	418
South Dakota	$0	$0	0
Tennessee	$8,543,334	$330,117	297

Appendix XVIII *(continued)*

Federal ADAP Funds Used for Insurance Purchasing/Maintenance and Number of Clients Served Through Insurance Purchasing/Maintenance, 2006

State/Territory	FY 2006 Est. Expenditures	June 2006 Expenditures	June 2006 Clients Served
Texas	$0	$0	0
Utah	$500,000	$2,135.07	56
Vermont	—	$38,283.00	58
Virgin Islands	$37,000	$770.00	1
Virginia	$0	$0	0
Washington	$6,658,218	$131,210.00	1,054
West Virginia	$0	$0	0
Wisconsin	$575,000	$312,025.00	393
Wyoming	$0	$0	0
Total	**$83,456,187**	**$5,423,541**	**13,744**

New states since 2005 reported in **bold.**

"$0" or "0" indicates ADAP does not use ADAP funds for insurance purchasing/maintenance.

*Connecticut and Hawaii use ADAP funds for insurance purchasing/maintenance, but reported $0 expenditures for June 2006.

Note: 51 states reported data. Delaware, Guam, and New Mexico did not report data and are not included. American Samoa, the Marshall Islands, and the Northern Mariana Islands are not included because HRSA determined they were not eligible for ADAP funding in FY 2006.

Appendix XIX

ADAPs and Medicare Part D "Wrap-Around" Policies, as of November 2006

Appendix XIX

ADAPs and Medicare Part D "Wrap-Around" Policies, as of November 2006

State/Territory	Part D Premiums		Part D Deductibles		Part D Co-Pays				Disenrollment from ADAP*				Provide Medications During Coverage Gap**
	Partial Subsidy Clients	Standard Clients	Partial Subsidy Clients	Standard Clients	Dually Eligible Clients	Full Subsidy Clients	Partial Subsidy Clients	Standard Clients	Dually Eligible Clients	Full Subsidy Clients	Partial Subsidy Clients	Standard Clients	
Alabama	—	Yes	Yes	Yes	—	—	—	Yes	Yes	Yes	Yes	—	—
Alaska	Yes	Yes	Yes	Yes	—	—	—	—	—	—	—	—	Yes
Arizona	—	—	—	—	—	—	—	—	Yes	Yes	—	—	—
Arkansas	—	—	—	—	—	—	—	—	—	—	—	—	—
California	—	—	Yes	Yes	Yes	Yes	Yes	Yes	—	—	—	—	Yes
Colorado	—	—	—	—	—	—	—	—	—	—	—	—	—
Connecticut	—	—	Yes	Yes	Yes	Yes	Yes	Yes	—	—	—	—	Yes
Delaware	—	Yes	—	Yes	Yes	Yes	Yes	Yes	—	—	—	—	Yes
District of Columbia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	—	—	—	—	Yes
Florida	—	—	Yes	—	—	—	Yes	Yes	Yes	Yes	—	—	—
Georgia	—	—	—	—	—	—	—	—	Yes	Yes	—	—	—
Guam	—	—	—	—	—	—	—	—	—	—	—	—	—
Hawaii	—	—	—	—	—	—	—	—	Yes	Yes	Yes	—	—
Idaho	—	—	—	—	—	—	—	—	Yes	Yes	Yes	Yes	—
Illinois	—	—	—	—	—	—	—	—	—	Yes	Yes	Yes	—
Indiana	—	—	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Iowa	Yes	—	Yes	—	—	—	Yes	—	Yes	Yes	—	Yes	—
Kansas	—	—	—	—	Yes	Yes	Yes	Yes	Yes	—	—	—	—
Kentucky	—	—	—	—	—	Yes	Yes	Yes	—	—	—	—	Yes
Louisiana	—	—	—	—	—	—	Yes	Yes	—	—	—	—	Yes
Maine	—	Yes	—	Yes	Yes	Yes	Yes	Yes	—	—	—	—	Yes
Maryland	Yes	Yes	Yes	Yes	—	—	Yes	Yes	—	—	—	Yes	Yes
Massachusetts	Yes	Yes	—	—	Yes	Yes	Yes	Yes	—	—	—	—	—
Michigan	Yes	Yes	Yes	Yes	—	—	Yes	Yes	Yes	—	—	—	Yes
Minnesota	Yes	—	Yes	—	Yes	Yes	Yes	—	Yes	Yes	Yes	—	—
Mississippi	—	—	—	—	—	—	—	—	—	—	—	—	—
Missouri	—	—	—	—	—	—	—	—	Yes	Yes	—	—	—
Montana	—	—	—	—	—	—	—	—	Yes	Yes	Yes	—	Yes
Nebraska	Yes	Yes	—	—	—	Yes	Yes	Yes	Yes	—	—	—	—
Nevada	Yes	Yes	—	—	Yes	Yes	Yes	Yes	—	—	—	—	—
New Hampshire	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	—	—	—	—	Yes
New Jersey	—	Yes	—	Yes	—	—	—	Yes	—	—	—	Yes	Yes
New Mexico	—	—	—	—	—	—	—	—	—	—	—	—	—
New York	Yes	Yes	Yes	Yes	—	Yes	Yes	Yes	—	—	—	—	Yes
North Carolina	—	—	—	—	—	—	—	—	Yes	Yes	—	—	—

(continued on next page)

ADAPs and Medicare Part D "Wrap-Around" Policies, as of November 2006

State/Territory	Part D Premiums		Part D Deductibles		Part D Co-Pays				Disenrollment from ADAP*				Provide Medications During Coverage Gap**
	Partial Subsidy Clients	Standard Clients	Partial Subsidy Clients	Standard Clients	Dually Eligible Clients	Full Subsidy Clients	Partial Subsidy Clients	Standard Clients	Dually Eligible Clients	Full Subsidy Clients	Partial Subsidy Clients	Standard Clients	
North Dakota	—	—	—	—	—	—	—	—	—	—	—	—	—
Ohio	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	—	—	—	—	—
Oklahoma	—	—	Yes	—	Yes	Yes	Yes	—	Yes	Yes	—	—	Yes
Oregon	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	—	—	—	—	—
Pennsylvania	—	—	Yes	—	Yes	Yes	Yes	—	Yes	—	—	—	Yes
Puerto Rico	—	—	—	—	—	—	—	—	—	—	—	—	—
Rhode Island	—	—	—	—	—	—	—	—	—	—	—	—	—
South Carolina	—	—	—	—	—	—	—	—	Yes	Yes	—	—	—
South Dakota	—	—	—	—	Yes	—	—	—	—	—	—	—	—
Tennessee	—	—	—	—	—	—	—	—	Yes	Yes	Yes	Yes	—
Texas	—	—	—	—	—	—	—	—	Yes	Yes	—	—	—
Virgin Islands (U.S.)	—	Yes	—	Yes	—	—	—	Yes	Yes	—	—	Yes	Yes
Utah	Yes	Yes	Yes	Yes	—	—	Yes	Yes	—	—	Yes	Yes	Yes
Vermont	—	Yes	—	Yes	Yes	Yes	—	Yes	—	—	—	—	Yes
Virginia	—	—	—	—	—	—	—	—	Yes	Yes	—	—	Yes
Washington	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	—	—	—	—	Yes
West Virginia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	—	—	—	—	Yes
Wisconsin	—	—	Yes	Yes	—	—	Yes	Yes	Yes	Yes	—	—	Yes
Wyoming	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	—	—	—	—	Yes
Total	**17**	**21**	**22**	**22**	**20**	**22**	**28**	**28**	**23**	**19**	**9**	**9**	**25**

"—" Signifies that the ADAP has not determined a policy, the ADAP did not report its policy, or the ADAP reported "No."

*Clients receiving any portion of Medicare Part D subsidy were disenrolled from ADAP because the benefit provided them comprehensive care. In many instances, when standard clients were disenrolled from ADAP, they were consequently enrolled in other state pharmaceutical assistance programs (SPAP).

**Once a client reaches the coverage gap (or "doughnut hole") in their Part D plan, the client will revert back to ADAP to receive all medications available through the ADAP formulary.

Note: 48 ADAPs reported data.

Appendix XX

ADAP Clients Served Who Reside in Title I EMAs, June 2006

Appendix XX

ADAP Clients Served Who Reside in Title I EMAs, June 2006

State/Territory	June 2006 Clients Served	June 2006 Number of Clients Served Who Reside Within EMAs	% of Clients Served in June 2006 Who Reside Within EMAs
Alabama	920	NA	NA
Alaska	49	NA	NA
Arizona	856	606	71%
Arkansas	198	NA	NA
California	17,306	16,098	93%
Colorado	852	648	76%
Connecticut	1,339	1,177	88%
Delaware	—	—	—
District of Columbia	563	563	100%
Florida	8,267	6,355	77%
Georgia	3,473	—	—
Guam	—	NA	—
Hawaii	144	NA	NA
Idaho	63	NA	NA
Illinois	3,097	2,608	84%
Indiana	1,000	NA	NA
Iowa	315	NA	NA
Kansas*	294	88	30%
Kentucky	574	NA	NA
Louisiana	1,391	517	37%
Maine	93	NA	NA
Maryland	2,558	2,302	90%
Massachusetts	2,665	2,087	78%
Michigan	1,526	822	54%
Minnesota	565	509	90%
Mississippi	666	NA	NA
Missouri	1,032	868	84%
Montana	52	NA	NA
Nebraska	246	NA	NA
Nevada	416	310	75%
New Hampshire*	109	84	77%
New Jersey	4,015	3,392	84%
New Mexico	—	NA	—
New York	12,467	10,543	85%
North Carolina*	2,093	—	—
North Dakota	25	NA	NA
Ohio	1,606	416	26%
Oklahoma	583	NA	NA
Oregon	1,312	873	67%
Pennsylvania	3,296	1,787	54%
Puerto Rico	3,576	2,746	77%
Rhode Island	338	NA	NA
South Carolina	1,798	NA	NA
South Dakota	70	NA	NA
Tennessee	2,150	NA	NA

(continued on next page)

Appendix XX *(continued)*

ADAP Clients Served Who Reside in Title I EMAs, June 2006

State/Territory	June 2006 Clients Served	June 2006 Number of Clients Served Who Reside Within EMAs	% of Clients Served in June 2006 Who Reside Within EMAs
Texas	7,455	5,740	77%
Utah	330	NA	NA
Vermont	101	NA	NA
Virgin Islands	57	NA	NA
Virginia	1,477	827	56%
Washington	1,940	1,431	74%
West Virginia*	118	8	7%
Wisconsin*	647	—	—
Wyoming	38	NA	NA
Total	**96,121**	**63,405**	
Comparison Total for States with EMAs	***80,428***	***63,405***	***79%***
Comparison Total for All States	***89,908***	***63,405***	***71%***

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

States in **bold** have EMAs or a portion of an EMA within the state. NA indicates not applicable - no EMA within the state.

Note: Comparison Total for states with EMAs does not include Georgia, North Carolina, and Wisconsin nor any states without EMAs. Comparison total for all states does not include Delaware, Georgia, New Mexico, North Carolina, and Wisconsin.

Appendix XXI

HIV/AIDS Medications

Appendix XXI

HIV/AIDS Medications

FDA-Approved Antiretroviral Medications	
GENERIC NAME	**BRAND NAME**
NRTIs	
abacavir	Ziagen
abacavir, zidovudine, and lamivudine	Trizivir
abacavir/lamivudine	Epzicom
didanosine, ddI, dideoxyinosine	Videx
efavirenz, emtricitabine, tenofovir disoproxil fumarate	Atripla*
FTC, emtricitabine	Emtriva
lamivudine and zidovudine	Combivir
lamivudine, 3TC	Epivir
stavudine, d4T	Zerit
tenofovir disoproxil fumarate	Viread
tenofovir disoproxil/emtricitabine	Truvada
zalcitabine, ddC, dideoxycytidine	Hivid
zidovudine, AZT, azidothymidine, ZDV	Retrovir
NNRTIs	
delavirdine, DLV	Rescriptor
efavirenz	Sustiva
nevirapine, BI-RG-587	Viramune
Protease Inhibitors	
amprenavir	Agenerase**
atazanavir sulfate	Reyataz
darunavir	Prezista
Fosamprenavir Calcium	Lexiva
indinavir, IDV, MK-639	Crixivan
lopinavir and ritonavir	Kaletra
nelfinavir mesylate, NFV	Viracept
ritonavir, ABT-538	Norvir
saquinavir	Fortovase***
saquinavir mesylate, SQV	Invirase
tipranavir	Aptivus
Fusion Inhibitors	
enfuvirtide, T-20	Fuzeon

*Atripla is a multi-class combination product that includes efavirenz (NNRTI), emtricitabine (NRTI), and tenofovir disoproxil fumarate (NRTI). For the purposes of the National ADAP Monitoring Project Annual Report, Atripla is included in the NRTI class.

**The manufacturer of Agenerase (amprenavir) discontinued the sale and distribution of the drug in capsule form, used for adult dosing, after 2004 and is instead manufacturing fosamprenavir (Lexiva), a "prodrug" of Agenerase (a prodrug is an inactive precursor of a drug, converted into its active form in the body). Agenerase is still available in pediatric dosing.

***Fortovase (saquinavir soft-gel) is no longer marketed.

Source: FDA, "Drugs Used in the Treatment of HIV Infection": http://www.fda.gov/oashi/aids/virals.html.

"A1" Medications for the Prevention & Treatment of Opportunistic Infections (Highly Recommended)*			
GENERIC NAME	**BRAND NAME**	**PREVENTION**	**TREATMENT**
acyclovir	Zovirax	X	X
amphotericin B	Fungizone	X	X
azithromycin	Zithromax	X	
cidofovir	Vistide	X	X
clarithromycin	Biaxin	X	X
clindamycin	Cleocin		X
famciclovir	Famvir	X	X
fluconazole	Diflucan	X	X
flucytosine	Ancobon		X
fomivirsen	Vitravene	X	X
foscarnet	Foscavir	X	X
ganciclovir	Cytovene	X	X
Isoniazid (INH)	Lanizid, Nydrazid		X
itraconazole	Sporonox	X	X
leucovorin calcium	Wellcovorin	X	X
peginterferon alfa-2a	PEG-Intron		X
pentamidine	Nebupent		X
pentavalent antimony	—		X
prednisone	Deltasone, Liquid Pred, Metocorten, Orasone, Panasol, Prednicen-M, Sterapred		X
probenecid	—	X	
pyrazinamide (PZA)	—		X
pyrimethamine	Daraprim, Fansidar	X	X
ribavirin	Virazole, Rebetol, Copegus		X
rifabutin	Mycobutin		X
rifampin (RIF)	Rifadin, Rimactane		X
sulfadiazine (oral generic)	Microsulfon	X	X
trimethoprim-sulfamethoxazole (TMP/SMX)	Bactrim, Septra	X	X
valacyclovir	Valtrex		X
valganciclovir	Valcyte		X

* "A" = "should always be offered"; "1" = "evidence from at least one properly randomized, controlled trial"

Sources: CDC, "Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus." *MMWR 2002*; 51(No. RR08):1-46; CDC, "Treating Opportunistic Infections Among HIV-Infected Adults and Adolescents." *MMWR 2004*; 53(No. RR15):1-112. Available at: http://aidsinfo.nih.gov/Guidelines/GuidelineDetail.aspx?MenuItem=Guidelines&Search=Off&GuidelineID=14&ClassID=4.

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