

AIDS DRUG ASSISTANCE PROGRAM

2022-23

November Estimate



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I. Program Overview

The California Department of Public Health (CDPH), Center for Infectious Diseases, Office of AIDS (OA) administers the Acquired Immunodeficiency Syndrome (AIDS) Drug Assistance Program (ADAP). ADAP provides access to life-saving medications for eligible California residents living with human immunodeficiency virus (HIV), assistance with costs related to HIV pre-exposure prophylaxis (PrEP) for clients at risk for acquiring HIV, and post-exposure prophylaxis (PEP) for clients possibly exposed to HIV. ADAP services, including support for medications, health insurance premiums, and medical out-of-pocket costs, are provided to five groups of clients:

1. **Medication-only clients** are people living with HIV (PLWH) who do not have private insurance and are not enrolled in Medi-Cal or Medicare. ADAP covers the full cost of prescription medications on the ADAP formulary for these individuals. This group only receives services associated with medication costs.
2. **Medi-Cal Share of Cost (SOC) clients** are PLWH enrolled in Medi-Cal who have a SOC for Medi-Cal services. ADAP covers the SOC for medications for these clients. This group only receives services associated with medication costs.
3. **Private insurance clients** are PLWH who have some form of health insurance including insurance purchased through Covered California, privately purchased health insurance, or employer-based health insurance. This group is sub-divided into three client sub-groups: Covered California clients, non-Covered California clients, and employer-based insurance clients. These groups receive services associated with medication costs, health insurance premiums, and medical out-of-pocket costs.
4. **Medicare Part D clients** are PLWH who are enrolled in Medicare and have purchased Medicare Part D plans for medication coverage. This group receives services associated with medication co-pays, medical out-of-pocket costs, and Medicare Part D health insurance premiums. Qualifying Medicare Part D clients can receive premium assistance with Medigap supplemental insurance policies, which cover medical out-of-pocket costs.
5. **PrEP Assistance Program (PrEP-AP) clients** are HIV-negative individuals who are at risk of HIV infection who have chosen to take PrEP as a way to prevent infection. For insured clients, the PrEP-AP pays for PrEP and PEP related medical out-of-pocket costs and covers the gap between what the client's insurance plan and the manufacturer's co-payment assistance program pays towards medication costs. For uninsured clients, PrEP-AP only provides

assistance with PrEP and PEP-related medical costs as medication is provided free by the manufacturer's medication assistance program.

As a covered entity in the Health Resources & Services Administration (HRSA) 340B Drug Pricing Program, ADAP collects rebates for a majority of prescriptions purchased for ADAP clients. ADAP does not collect rebates for prescriptions purchased for Medi-Cal SOC or PrEP-AP clients. As the primary payer, Medi-Cal has the right to claim mandatory rebate on prescriptions for Medi-Cal SOC clients. In order to ensure duplicate rebate claims are not submitted to manufacturers by both programs, which is prohibited, ADAP does not invoice for rebates on these claims. ADAP also does not collect rebate on medication purchases for PrEP-AP clients because PrEP-AP is separate and distinct from ADAP and is not a 340B covered entity.

Historically, most clients ADAP served were medication-only clients without health insurance because PLWH were unable to purchase affordable health insurance in the private marketplace. With the implementation of the Affordable Care Act, more ADAP clients have been able to access public and private health insurance coverage. To ensure ADAP is the payer of last resort, ADAP clients are screened for Medi-Cal eligibility and potentially eligible clients must apply. Clients who enroll in full-scope Medi-Cal are dis-enrolled from ADAP because these clients have no SOC, no drug co-pays or deductibles, and no premiums. All clients who obtain health coverage through Covered California or other health plans can remain in ADAP's medication program to receive assistance with their drug deductibles and co-pays for medications on the ADAP formulary.

Eligible clients with health insurance can co-enroll in ADAP's health insurance assistance programs for assistance with their insurance premiums and medical out-of-pocket costs, which can only be paid if ADAP pays the client's premium. Helping ADAP clients purchase and maintain comprehensive health insurance is more cost effective than paying the full cost of medications and improves health outcomes by providing access to the full spectrum of medical care beyond the HIV outpatient care and medications available through the Ryan White Program.

II. Estimate Methodology

The ADAP Estimate uses a hybrid forecasting approach to estimate costs and revenue associated with medication and insurance assistance services. OA creates statistical models using conventional time series approaches with subject matter input to inform assumptions. Statistical models are reviewed for accuracy and adjusted, as appropriate, using knowledge-based forecasting. Forecasts are modeled conservatively, with the objective of reducing the risk of underestimating budget needs.

A. Expenditure Forecasts

Program data describing client counts and costs are summarized by month and insurance coverage group and combined with external cost drivers (e.g., inflation rates). Data are then divided into "training" and "testing" datasets to develop and test statistical models for accuracy by comparing predicted to actual values. OA relies mainly on two types of models: Bayesian Structural Time Series (BSTS) models, also known as a dynamic linear models, and Autoregressive Integrated Moving Average (ARIMA) models. These models account for trends in historical program growth, inflation, changes in pharmacy utilization, administrative policies, and seasonal effects.

Separate estimates are created for each insurance coverage group and total projected costs are based on the following drivers:

- Expected number of clients served per month
- Expected cost per client per month

Total costs are estimated by multiplying the expected cost per client by the expected number of clients and using the delta method to estimate levels of certainty. Subject matter experts collaboratively review model estimates, which are combined with knowledge-based estimates when historical data are not available.

B. Revenue Forecasts

Revenue forecasts are estimated based on the results of the expenditure forecasts and the following drivers:

- Expected unit rebate amounts for statutorily required 340B rebates and voluntary rebates from manufacturers
- Historical rebate payment amounts and average time between medication dispense and receipt of rebate payments
- Historical trends in back-billing

Rebate revenue is estimated by quarter to reflect manufacturer agreements and is adjusted to reflect expected implementation of any newly negotiated voluntary rebate terms.

III. Estimate Overview

The 2022-23 ADAP November Estimate provides a revised projection of 2021-22 Local Assistance costs for medication, health insurance, medical out-of-pocket costs, ADAP enrollment sites, and administrative costs, along with projected Local Assistance costs for 2022-23.

Table 1 displays the estimated ADAP Local Assistance budget authority need for 2021-22 (column C) and 2022-23 (column G) and compares that need to the amount reflected in the 2021 Budget Act (columns B and F). The 2018 Budget Act authorized an on-going \$2 million in budget authority to modify and expand PrEP-AP which is also displayed in Table 1.

- 2021-22: OA estimates the ADAP budget authority need will be \$432.3 million (Table 1), \$57.2 million less than reported in the 2021 Budget Act. The 11.7 percent decrease is driven primarily by medication expenditures for medication-only clients, which is projected to be lower than previously estimated (Table 8).
- 2022-23: OA estimates the ADAP budget authority need will be \$420.6 million (Table 1), \$68.9 million less than reported in the 2021 Budget Act. The 14.1 percent decrease is driven by the same factor as listed above (Table 11).

Table 2 displays the estimated ADAP revenue for 2021-22 (column C) and 2022-23 (column G) and compares them to the amount reflected in the 2021 Budget Act (columns B and F).

- 2021-22: OA estimates ADAP revenue will be \$367.6 million (Table 2), \$42.9 million less than reported in the 2021 Budget Act. The 10.5 percent decrease is driven primarily by medication expenditures from medication-only clients and changes to the caseload mix, which is projected to be lower than previously estimated (Table 8).
- 2022-23: OA estimates ADAP revenue will be \$353.3 million (Table 2), \$57.3 million less than reported in the 2021 Budget Act. The 13.9 percent decrease is driven primarily by the same factor as listed above (Table 11).

California Department of Public Health AIDS Drug Assistance Program and PrEP Assistance Program 2022-23 November Estimate Table 1: Local Assistance Budget Authority (In Thousands)								
Local Assistance	2021 Budget Act	Current Year FY 2021-22			2021 Budget Act	Budget Year FY 2022-23		
		2022-23 November Estimate	\$ Change from 2021 Budget Act	% Change from 2021 Budget Act		2022-23 November Estimate	\$ Change from 2021 Budget Act	% Change from 2021 Budget Act
(A)	(B)	(C)	(D) = (C)-(B)	(E) = (D)/(B)	(F)	(G)	(H) = (G)-(F)	(I) = (H)/(F)
Total Funds Requested	\$489,538	\$432,293	-\$57,245	-11.7%	\$489,538	\$420,647	-\$68,891	-14.1%
Federal Trust Fund - Fund 0890	\$105,350	\$108,172	\$2,823	2.7%	\$105,350	\$102,207	-\$3,142	-3.0%
ADAP Rebate Fund - Fund 3080	\$382,189	\$322,121	-\$60,068	-15.7%	\$382,189	\$316,440	-\$65,749	-17.2%
2018 Budget Act - PrEP-AP - Fund 3080	\$2,000	\$2,000	\$0	0.0%	\$2,000	\$2,000	\$0	0.0%
Caseload	35,154	34,743	-411	-1.2%	35,154	33,687	-1,467	-4.2%

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.

2022-23 November Estimate Table 2: ADAP Rebate Fund (Fund 3080) Revenues (In Thousands)								
Local Assistance	2021 Budget Act	Current Year FY 2021-22			2021 Budget Act	Budget Year FY 2022-23		
		2022-23 November Estimate	\$ Change from 2021 Budget Act	% Change from 2021 Budget Act		2022-23 November Estimate	\$ Change from 2021 Budget Act	% Change from 2021 Budget Act
(A)	(B)	(C)	(D) = (C)-(B)	(E) = (D)/(B)	(F)	(G)	(H) = (G)-(F)	(I) = (H)/(F)
Total Revenue Requested	\$410,591	\$367,649	-\$42,941	-10.5%	\$410,591	\$353,322	-\$57,269	-13.9%
ADAP Rebate Fund - Fund 3080	\$402,591	\$359,649	-\$42,941	-10.7%	\$402,591	\$345,322	-\$57,269	-14.2%
Interest Income	\$8,000	\$8,000	\$0	0.0%	\$8,000	\$8,000	\$0	0.0%

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.

IV. Summary of Expenditures and Revenue

A. Expenditure Types

ADAP variable expenditures are broken out into two types: health care expenditures and enrollment expenditures.

- a) Health care expenditures are estimated based on five client groups. Four of the client groups are PLWH: Medication-only clients, Medi-Cal SOC clients, private insurance clients, and Medicare Part D clients. The fifth client group includes persons at risk for HIV who are receiving PrEP and are referred to as PrEP-AP clients. Services that the different client groups receive can include coverage of the following health care expenses: prescription medication costs for drugs on the ADAP formulary (including deductibles, co-pays, and co-insurance), health insurance premiums, and medical out-of-pocket costs (e.g., deductibles and co-pays for physician visits, laboratory tests, etc.). Estimated expenditures by client group are shown in Table 3. A detailed display of caseload and expenditures by client group and service type is in Section VI, Tables 6 – 11.
- b) Enrollment expenditures are estimated based on local ADAP enrollment services: OA allocates funds directly to ADAP and PrEP-AP

enrollment sites based on ADAP and PrEP-AP services provided. These funds may only be used for costs associated with enrolling and maintaining clients in ADAP and PrEP-AP. Enrollment expenditure estimates are adjusted annually through the ADAP Estimate, based on caseload and service projections. Estimated expenditures for enrollment services are shown in Table 3.

TABLE 3: ESTIMATED VARIABLE EXPENDITURES BY CLIENT GROUP		
CLIENT GROUP	EXPENDITURES	
	FY 2021-22	FY 2022-23
Medication-Only	\$296,107,031	\$270,831,264
Medi-Cal SOC	\$1,070,816	\$1,182,264
Private Insurance	\$99,111,239	\$108,944,692
Medicare Part D	\$26,750,023	\$29,225,130
PrEP-AP	\$6,016,207	\$7,083,988
SUBTOTAL	\$429,055,317	\$417,267,338
Admin Costs: ADAP	\$5,529,365	\$5,556,326
Admin Costs: PrEP-AP	\$604,821	\$659,805
Admin Costs: Enrollment	\$7,275,000	\$7,335,000
Health Management Systems (HMS)	-\$12,171,376	-\$12,171,376
TOTAL	\$430,293,127	\$418,647,093
Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.		

B. Revenue and Federal Grants

- a) ADAP Special Funds – ADAP receives both mandatory and voluntary supplemental rebates from drug manufacturers for ADAP medication expenditures. An approximate six-month delay in rebate revenue exists because of the time required for billing the drug manufacturers and receipt of the rebate. 2021-22 revenue projections are based on estimated rebates from estimated and actual medication expenditures from January through December 2021. 2022-23 revenue projections are based on estimated rebates from estimated drug expenditures from January through December 2022.
- b) Federal Funds – ADAP receives federal funds from HRSA through the Ryan White Part B Program.
 - 2021-22: Total federal fund budget authority will be \$108.2 million (Table 1), \$2.8 million (2.7 percent) higher than reported in the 2021 Budget Act. Federal fund budget authority includes the following New Assumptions:
 - 2021 Ryan White Part B Supplemental grant: \$1.9 million
 - 2021 Ryan White Part B grant: \$95 million

- 2021 ADAP Emergency Relief Funds grant (also called ADAP Shortfall Relief grant): \$5.3 million
 - 2020 Ryan White Part B grant (Carryover): \$6 million
 - 2022-23: Total federal fund budget authority is projected to be \$102.2 million (Table 1), \$3.1 million (3 percent) lower than reported in the 2021 Budget Act. Federal fund budget authority includes the following estimated grant funding:
 - 2022 Ryan White Part B grant: \$95 million
 - 2022 Ryan White Part B Supplemental grant: \$1.9 million
 - 2022 ADAP Emergency Relief Funds grant (ADAP Shortfall Relief grant): \$5.3 million
- c) Federal Match – HRSA requires grantees to have HIV-related non-HRSA expenditures. California's HRSA match requirement for the 2021 Ryan White Part B grant year (April 1, 2021 through March 31, 2022) is \$67.2 million. OA meets the match requirement using ADAP Rebate Fund (Fund 3080) expenditures. The 2022 match requirement is anticipated to be communicated late March 2022.

V. Assumptions

Future Fiscal Issues

Impact of the Novel Coronavirus (COVID-19)

Background: On March 4, 2020, California declared a state of emergency over the COVID-19 pandemic. Shortly after, on March 19, 2020, California issued a Shelter-In-Place order. The order has had a tremendous impact on Californians, ranging from a sharp rise in unemployment to possible loss of comprehensive health coverage. The potential impact specifically to ADAP clients can be life threatening. People who have a serious underlying medical condition might be at higher risk for severe illness, including people with compromised immune systems. In order to mitigate against unnecessary COVID-19 exposure, OA took steps to ensure ADAP clients maintain their program eligibility by implementing measures to mitigate the risk of clients falling out of care. Those measures included allowing clients to enroll virtually with their enrollment worker and increasing the number of allowable medication dispenses to reduce the number of trips a client would need to make to the pharmacy. In addition, OA will continue to monitor unemployment rates for potential impacts or shifts in client types, such as a shift from employer-based insurance to medication only. At this time, it is not clear how unemployment will impact ADAP, as the impacts to ADAP from COVID-19 are currently unknown.

On January 28, 2021, Covered California announced it would join President Biden in responding to the COVID-19 pandemic by announcing a special enrollment period to help people obtain coverage. Effective February 1, 2021, through May 15, 2021, anyone uninsured and eligible to enroll in health care coverage through Covered California could sign up. It is unknown what the potential impact of the special enrollment period may be.

On February 2, 2021, President Biden signed the federal mandate Public Charge Executive Order in efforts to remove barriers to the legal immigration system. Although there may be an increased willingness to enroll in Covered California, it is currently unknown what the potential impact of the Public Charge Executive Order may be.

Description of Change: ADAP saw a spike in medication costs in March 2020, following the first COVID-19 Shelter-In-Place orders. This initial spike was followed by a series of smaller magnitude increases and decreases through the end of the calendar year. Following the initial decrease in client caseload after COVID-19 automatic eligibility extensions ended in August 2020, and after accounting for differences in insurance coverage, underlying trends, and seasonal variation, total costs continued to be lower than expected through the end of 2020-21. In

2020-21, cost changes were primarily driven by changes to overall caseload and client changes in insurance coverage (caseload mix), offsetting effects of annual medication price increases. OA is monitoring data and enrollments and will provide updates in future estimates to determine if caseload shifts seen in 2020-21 are transient or longer term.

Discretionary: No

Reason for Adjustment/Change:

- Federal mandate

Fiscal Impact and Fund Source(s): The fiscal impact is unknown at this time. The funds impacted are the Federal Trust Fund (Fund 0890) and ADAP Rebate Fund (Fund 3080).

California Generic Drugs

Background: Senate Bill (SB) 852, California Affordable Drug Manufacturing Act of 2020, was signed by the Governor and chaptered by the Secretary of State on September 28, 2020, as Chapter 207, Statutes of 2020, requiring the California Health and Human Services Agency (CalHHS) to enter into partnerships, in consultation with other state departments as necessary, to increase competition, lower prices, and address shortages in the market for generic prescription drugs. This bill also aims to reduce the cost of prescription drugs for public and private purchasers, taxpayers, consumers, and to increase patient access to affordable drugs.

SB 852 requires CalHHS to report to the Legislature by July 1, 2022, a description of the status of the drugs targeted for manufacture and by July 1, 2023, to report on the feasibility and advantages of directly manufacturing or distributing generic prescription drugs and selling generic prescription drugs at a fair price. CHHSA will have to determine if viable manufacturing or distribution pathways exist for this effort and determine the optimal method of achieving cost savings before it is known how discounts could be received by ADAP.

Description of Change: At this time, it is not clear how or if this bill would affect ADAP. Until the July 2022 and 2023 reports to the Legislature can be reviewed, ADAP will be unable to determine whether discounted pricing achieved by the State is lower than the pricing already received by ADAP through the federal ADAP Crisis Task Force and HRSA 340B Drug Pricing Program.

Discretionary: No

Reason for Adjustment/Change:

- Statutory requirement

Fiscal Impact and Fund Source(s): The fiscal impact is unknown at this time. The funds impacted are the Federal Trust Fund (Fund 0890) and ADAP Rebate Fund (Fund 3080).

Payment of Medicare Part C Premiums (plus Expansion)

Background: ADAP currently pays private health insurance premiums and outpatient medical out-of-pocket costs for ADAP clients co-enrolled in the Office of AIDS Health Insurance Premium Payment Program (OA-HIPP), Medicare Part D Premium Payment Program (MDPP), and the Employer Based Health Insurance Premium Payment Program (EB-HIPP). However, when ADAP clients become eligible for Medicare, they are no longer eligible for OA-HIPP. These clients must enroll in Medicare as ADAP is the payer of last resort. Currently only clients enrolled in a Medicare Part D health plan are eligible to receive insurance premium and outpatient medical out-of-pocket assistance through MDPP. In addition, clients who qualify for MDPP can request Medicare Supplemental (Medigap) Plan premium assistance. Clients who enroll in a Medicare Part C plan currently receive no premium or medical out-of-pocket cost assistance through ADAP.

Medicare Part C, also known as Medicare Advantage, is a bundled insurance plan that includes hospital (Medicare Part A), medical (Medicare Part B) and prescriptions (Medicare Part D). According to HRSA Policy Clarification Notice (PCN) 18-01, Ryan White HIV/AIDS Program grant recipients may use funds to pay premiums and/or cost sharing when the Medicare Part C plan includes prescription drug coverage; or in conjunction with paying for Medicare Part D premiums and cost sharing for plans that do not include prescription drug coverage. ADAP clients who become eligible for Medicare Part C receive no premium assistance which creates inequity amongst ADAP's Medicare population.

Description of Change: Utilize ADAP rebate funds to establish the Medicare Part C Premium Payment Program and pay for Medicare Part C premiums for eligible ADAP clients.

Discretionary: Yes

Reason for Adjustment/Change:

- Encourage more ADAP clients to enroll into comprehensive health coverage, which will result in an overall reduction in ADAP expenditures

- Improve the overall health of people living with HIV in California because clients will have comprehensive hospital coverage
- Continue supporting health insurance coverage for ADAP clients as they become eligible for Medicare
- Align Medicare Part C with other health insurance premium payment programs

Fiscal Impact and Fund Source(s): Fiscal impact is unknown at this time. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Payment of Medicare Part C Medical Out-of-Pocket Costs

Background: In addition to paying private health insurance premiums for ADAP clients co-enrolled in the OA-HIPP, EB-HIPP, and MDPP programs, ADAP also pays for outpatient medical out-of-pocket costs. ADAP proposes to pay for outpatient medical out-of-pocket costs for clients co-enrolled in the Medicare Part C Premium Payment Program.

Health and Safety Code (HSC) Section 120955 (i) states that the department may subsidize, using available federal funds and monies from the ADAP rebate fund, costs associated with a health care service plan or health insurance policy, including medical co-payments and deductibles for outpatient care, and premiums to purchase or maintain health insurance coverage.

Description of Change: Utilize ADAP rebate funds to establish the Medicare Part C Premium Payment Program and pay for Medicare Part C outpatient medical out-of-pocket costs for eligible ADAP clients.

Discretionary: Yes

Reason for Adjustment/Change:

- Establish equitable benefits for ADAP's insurance assistance programs
- Continue supporting health insurance coverage for ADAP clients as they become eligible for Medicare

Fiscal Impact and Fund Source(s): Fiscal impact is unknown at this time. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Medicare Coverage of Extra and Innovative Supplemental Plans

Background: Original Medicare consists of Part A (hospitalization) and Part B (medical insurance). Medicare Part B covers 80 percent of costs that clients incur after meeting the annual deductible. Medicare Supplemental (Medigap) plans assist with the remaining 20 percent of costs.

There are varying levels of coverage for Medicare supplemental plans (A-N), with plans F and G being the most comprehensive. The most comprehensive plans also offer “Extra” or “Innovative” benefits to cover services outside of the base medical coverage. For example, Extra/Innovative plans may cover the costs of hearing aids, vision exams, Silver Sneaker gym memberships, 24/7 nurse consultations, and many other services. Due to various advancements in HIV care and treatment, people living with HIV are living longer. Extra and Innovative plans would be a public health benefit for our aging population by offering services that may mitigate future non-HIV related care; for example, Silver Sneaker gym memberships can decrease social isolation and help improve cardiovascular and bone health.

The MDPP began paying Medicare Part B supplemental medical plan premiums June 1, 2018. Effective July 1, 2020, SB 407 (Chapter 549, Statutes of 2019), requires Extra and Innovative benefits to be separated on all Medicare supplemental billing statements. MDPP currently pays for Medicare Part D premiums, Part B out-of-pocket costs, and the base premium for supplemental plans. Supplemental plans with Extra or Innovative benefits included may have lower total premium costs compared to identical supplemental plans that do not include the additional benefits. Clients are required to cover the nominal costs for Extra or Innovative benefits.

Description of Change: ADAP proposes to pay Medicare Part B supplemental plan premiums including the Extra and Innovative benefits.

Discretionary: Yes

Reason for Adjustment/Change:

- Improve the overall health of people living with HIV in California as additional plan benefits offer a more holistic approach to healthcare
- More plan choices improve access to care
- Continue supporting health insurance coverage for ADAP clients as they become eligible for Medicare

Fiscal Impact and Fund Source(s): Fiscal impact is unknown at this time. The fund impacted is the ADAP Rebate Fund (Fund 3080).

PrEP-AP Navigation and Retention

Background: ADAP received statutory and budgetary authority through the 2016 Budget Act to provide services to HIV-negative persons at risk for acquiring HIV. Statutory authority is codified in HSC Section 120972 and allowed OA to implement the PrEP-AP to assist both insured and uninsured individuals who meet

eligibility requirements. The PrEP-AP provides assistance with PrEP-related and non-occupational PEP-related medical out-of-pocket costs, and access to medications on the PrEP-AP formulary for the prevention of HIV and treatment of sexually transmitted infections.

Description of Change: In 2021, SB 133 added language allowing allocation of ADAP funds to local health departments and community-based organizations to support PrEP and PEP navigation and retention coordinators and related services, to the extent that funds are available. The coordinators will work to increase PrEP and PEP initiation and retention among HIV-negative individuals most vulnerable to contracting HIV by performing activities such as: outreach and education, community messaging, assistance with applying for and retaining health coverage, assistance with enrollment in PrEP and PEP financial assistance programs, care coordination and adherence support, financial assistance for transportation costs, and linkage to behavioral health, substance use, housing, and other social service programs.

Discretionary: No

Reason for Adjustment/Change:

- Legislative requirement

Fiscal Impact and Fund Source(s): Fiscal impact is unknown at this time. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Expansion of Medi-Cal to All Income-Eligible Californians

Background: Over the last decade, the Medi-Cal program has significantly expanded and changed, in large part due to the implementation of the Patient Protection and Affordable Care Act, and the state-led expansions of Medi-Cal coverage to undocumented children, young adults, and older adults over age 50. The Budget builds on those expansions to expand full-scope eligibility to all income-eligible undocumented adults aged 26 through 49.

Description of Change: Beginning no sooner than January 1, 2024, Medi-Cal will be available to all income-eligible Californians and move California to near-universal eligibility for health care coverage. Increasing the number of clients eligible for full-scope Medi-Cal will result in cost savings to ADAP. Existing clients who qualify for this expansion will be disenrolled from ADAP as these clients have no share of cost, no drug co-pays or deductibles, and no premiums.

Discretionary: No

Reason for Adjustment/Change:

- Statutory requirement

Fiscal Impact and Fund Source(s): Fiscal impact is unknown at this time. The funds impacted are the ADAP Rebate Fund (Fund 3080) and Federal Trust Fund (Fund 0890).

New Assumptions**Decrease in Federal Funds: 2021 Ryan White Part B Supplemental Grant**

Background: The Ryan White Part B Supplemental grant develops and/or enhances access to a comprehensive continuum of high-quality care and treatment services for low-income individuals living with HIV. The amount of each award is based on submitted data demonstrating the severity of the HIV epidemic in the applicant's state/territory, co-morbidities, cost of care, and service needs of emerging populations.

The following table displays Ryan White Part B Supplemental grant application amounts, total funds awarded, and total ADAP Local Assistance received per grant budget period.

Grant Budget Period	Application Amount	Total Funds Awarded	Total Local Assistance
2017 (09/30/2017 – 09/29/2018)	\$35,000,000	\$35,000,000	\$25,000,000
2018 (09/30/2018 – 09/29/2019)	\$35,000,000	\$23,765,871	\$17,000,000
2019 (09/30/2019 – 09/29/2020)	\$15,000,000	\$6,375,772	\$4,700,000
2020 (09/30/2020 – 09/29/2021)	\$10,000,000	\$2,628,306	\$2,567,306
2021 (09/30/2021 – 09/29/2022)	\$9,000,000	\$1,941,558	\$1,916,558

Description of Change: On May 10, 2021, OA applied for the competitive 2021 Ryan White Part B Supplemental grant. OA requested the maximum amount of \$9 million, with \$8.9 million specifically for ADAP Local Assistance to be used in 2021-22. On September 1, 2021, OA received the notice of award for the 2021 Ryan White Part B Supplemental grant. The total award was \$1.9 million, most of which is ADAP Local Assistance as displayed in the table above.

Discretionary: Yes

Reason for Adjustment/Change:

- Competitive funding opportunity
- Prior funding does not guarantee that funding will be provided in the future

Fiscal Impact and Fund Source(s): Decrease of \$651,000 in Local Assistance for 2021-22 and 2022-23. The fund impacted is the Federal Trust Fund (Fund 0890).

Decrease in Federal Funds: 2021 Ryan White Part B Grant

Background: The Ryan White Part B grant is the largest of the three federal grants for which ADAP receives funding and is a non-competitive grant. Grant funding is appropriated in five, 12-month budget periods that run from April 1 to March 31. Within the five-year funding cycle, funding from year to year is provided as long as the program remains eligible and submits all reporting requirements timely.

On November 20, 2020, OA applied for the 2021 Ryan White Part B grant, the fifth year of the latest five-year funding cycle. The funding requested in the grant application totaled \$137.1 million, of which \$102.2 million (\$96.2 million in Local Assistance) was requested for the ADAP Branch.

Description of Change: On March 17, 2021, OA received the notice of award for the 2021 Ryan White Part B grant. The total award received was \$135.7 million, of which \$95 million is ADAP Local Assistance.

Discretionary: Yes

Reason for Adjustment/Change:

- Fully leverage federal funding

Fiscal Impact and Fund Source(s): Decrease of \$1.3 million in Local Assistance for 2021-22 and 2022-23. The fund impacted is the Federal Trust Fund (Fund 0890).

Decrease in Federal Funds: 2021 ADAP Emergency Relief Funds Grant (ADAP Shortfall Relief Grant)

Background: The ADAP Emergency Relief Funds grant (ADAP Shortfall Relief grant) is intended for states/territories that demonstrate the need for additional resources to prevent, reduce and/or eliminate ADAP waiting lists through implementation of cost-containment measures. OA's cost-containment measures include maintaining data match agreements to ensure ADAP is the payer of last resort.

On October 26, 2020, OA applied for the maximum amount of \$7 million for the competitive 2021 ADAP Emergency Relief Funds grant (all Local Assistance).

The following table displays the historical grant application amounts for which OA applied, and the total funds awarded per grant budget period:

Table 5: ADAP Emergency Relief Funds (Shortfall Relief) Grant		
Grant Budget Period	Application Amount	Total Funds Awarded
2017 (04/01/2017 – 03/31/2018)	\$9,000,000	\$9,000,000
2018 (04/01/2018 – 03/31/2019)	\$11,000,000	\$11,000,000
2019 (04/01/2019 – 03/31/2020)	\$11,000,000	\$11,000,000
2020 (04/01/2020 – 03/31/2021)	\$10,000,000	\$6,537,311
2021 (04/01/2021 – 03/31/2022)	\$7,000,000	\$5,307,130

Description of Change: On March 12, 2021, OA received the notice of award for the 2021 ADAP Emergency Relief Funds grant in the amount of \$5.3 million (all Local Assistance).

Discretionary: Yes

Reason for Adjustment/Change:

- Competitive funding opportunity
- Prior funding does not guarantee that funding will be provided in the future

Fiscal Impact and Fund Source(s): Decrease of \$1.2 million in Local Assistance for 2021-22 and 2022-23. The fund impacted is the Federal Trust Fund (Fund 0890).

Increase in Federal Funds: 2020 Ryan White Part B Grant Carryover

Background: The Ryan White Part B grant is the largest of the three federal grants for which ADAP receives funding and is a non-competitive grant. Grant funding is appropriated in five, 12-month budget periods that run from April 1 to March 31. Within the five-year funding cycle, funding from year to year is provided as long as the program remains eligible and submits all reporting requirements timely. Funding from the Ryan White Part B grant that is not fully expended by the end of the budget period can be carried over to the next budget period with approval from HRSA.

Description of Change: At the end of August 2021, OA closed out the 2020 Ryan White Part B grant with HRSA and applied for carryover funding. Upon closure of the grant, the amount of unspent funding was determined to be \$6.3 million, of which \$6 million in Local Assistance was requested for the ADAP Branch.

On October 27, 2021, OA received the carryover notice of award in the amount of \$6.3 million, of which \$6 million in Local Assistance is designated for the ADAP Branch. Carryover funding will be spent in 2021-22.

Discretionary: Yes

Reason for Adjustment/Change:

- Fully leverage federal funding

Fiscal Impact and Fund Source(s): Increase of \$6 million in Local Assistance for 2021-22. The fund impacted is the Federal Trust Fund (Fund 0890).

Medi-Cal Expansion: Age 50 and Older Regardless of Immigration Status

Background: The 2021-22 Governor's Budget expanded eligibility for full-scope Medi-Cal benefits to all persons aged 50 years and older, regardless of immigration status. As the federal government only shares in the cost of restricted-scope services, this expansion is primarily funded by State resources.

California law allows eligible citizens and immigrants of any status to apply for comprehensive, or full-scope, Medi-Cal coverage if they are under age 25. Prior to this enactment, persons aged 25 and over with undocumented status could only apply for restricted-scope Medi-Cal.

Historically, only citizens and documented immigrants were eligible to apply for full-scope Medi-Cal. In 2016, the legislature authorized full-scope Medi-Cal coverage to undocumented persons age 18 and under; then, in 2020, this was expanded to ages 19 to 25. This latest budget enhancement adds ongoing funding of full-scope coverage for ages 50 and over.

Description of Change: Increasing the number of clients eligible for full-scope Medi-Cal will result in cost savings to ADAP. Existing clients who qualify for this expansion will be disenrolled from ADAP as these clients have no share of cost, no drug co-pays or deductibles, and no premiums. This change becomes effective May 1, 2022.

Discretionary: No

Reason for Adjustment/Change:

- Statutory requirement

Fiscal Impact and Fund Source(s): Estimated savings for 2021-22 is \$8 million for 1,720 clients. Estimated savings for 2022-23 is \$48.6 million for 1,720 clients.¹ The

¹ Projected costs for 2021-22 and 2022-23 have been reduced from prior estimates (unpublished) to reflect more conservative attrition estimates.

funds impacted are the ADAP Rebate Fund (Fund 3080) and Federal Trust Fund (Fund 0890).

Existing Assumptions

ADAP Pilot Program for Jails

Background: Prior to 2008, 36 local county jails participated in the ADAP to provide medication assistance to qualifying detainees. The program was terminated in 2008 due to the elimination of funding from the State's General Fund. Subsequently, in 2018, HRSA released PCN 18-02, which permitted the use of HRSA funds for individuals who are currently detained in a county jail and are not yet convicted of a crime or are not covered by federal or state health benefits during the period of incarceration. Subsequent to the PCN release, Orange County requested that CDPH provide ADAP services at their county jail. The provision of ADAP support services for those not covered by federal or state health benefits expands outreach to a vulnerable population while ensuring continuity of care as clients navigate the judicial system. Upon incarceration, clients are able to enroll via a certified enrollment worker from the county jail that has been approved as an enrollment site. The enrollment worker confirms the client meets eligibility requirements and ensures that all required documents to substantiate eligibility are submitted. The client and the enrollment worker complete an ADAP application via the ADAP Enrollment System (AES) and upload the required forms into the system. New and existing clients are able to access medication at the jail pharmacy thus maximizing potential adherence to medicinal regimens. Additionally, clients who are scheduled for release can be provided a prescription refill allowing them access to medication as they transfer from incarceration to a more traditional enrollment site.

In response to Orange County's request, OA initiated a pilot program with their county jail. OA, in coordination with the Department of Finance, may consider expanding the pilot program in the future to other interested county jails after careful consideration of the impact to the ADAP Rebate Fund both in the short and long term. The assumption was approved for the Orange County pilot program to continue through 2021-22.

Description of Change: OA requests the ADAP jail pilot program be expanded to other interested county jails (Los Angeles, Marin, Riverside, San Francisco, San Luis Obispo, and Siskiyou) in 2022-23. OA would meet with the interested county jails to understand how the respective county jail operates, and OA would determine if the jail would be suitable to be an ADAP jail enrollment site. Interested county jails would have to submit a new Enrollment Site Application, enter into a contract with OA, be added to the Pharmacy Benefits Manager

Pharmacy Network, and complete the new enrollment worker training prior to enrolling eligible clients.

Discretionary: Yes

Reason for Adjustment/Change:

- HRSA PCN 18-02, which permits the use of funds for individuals who are currently detained in a county jail.
- Treatment and suppression of HIV/AIDS and HIV/AIDS-related opportunistic infections among high-risk individuals
- Effective outreach to underserved populations
- Continuity of care

Fiscal Impact and Fund Source(s): The projected net fiscal impact of Orange County in 2021-22 is \$719,000 (\$1.1 million expenditures minus \$354,000 rebate) from serving 123 eligible clients. For 2022-23, the projected net fiscal impact of Orange County is \$317,000 (\$933,000 expenditures minus \$616,000 rebate) from serving 107 eligible clients. The projected net fiscal impact of the interested counties including Orange County in 2021-22 is \$11.7 million (\$17.4 million expenditures minus \$5.7 million rebate) from serving 1,998 eligible clients. For 2022-23, the projected net fiscal impact of the interested counties including Orange County in 2022-23 is \$5.1 million (\$15.1 million expenditures minus \$10 million rebate) from serving 1,733 eligible clients. The funds impacted are the ADAP Rebate Fund (Fund 3080) and Federal Trust Fund (Fund 0890).

U.S. Preventive Services Task Force (USPSTF) “A” Grade Recommendation on PrEP for Persons at High Risk of HIV Acquisition

Background: On June 11, 2019, the USPSTF issued a final recommendation of an “A” grade for PrEP for persons who are at high risk of HIV acquisition. The USPSTF makes recommendations about the effectiveness of specific preventive care services for patients without obvious related signs or symptoms. The Patient Protection and Affordable Care Act states a medical insurer must cover and may not impose any cost sharing requirement for any evidence-based preventive items or services that have a grade of “A” or “B” in the current USPSTF recommendations. Federal regulations require plans and issuers to provide coverage for new recommended preventive services for plan/policy years beginning on or after the date that is one year from the date the relevant recommendation or guideline is issued. For most insurers, this was implemented January 1, 2021.

With exceptions for certain religious employers, coverage requirements apply to all private plans – including individual, small group, large group, and self-insured plans in which employers contract administrative services to a third-party payer – with the

exception of plans that were in existence prior to March 23, 2010. These plans cannot make significant changes to their coverage (for example, increasing patient cost-sharing, cutting benefits, or reducing employer contributions).

Insured PrEP-AP clients were required to enroll into Gilead's Co-payment Assistance Program to receive co-pay assistance with Truvada® and Descovy® as many health plans did not cover PrEP as a preventative service. In response to USPSTF's recommendation, the PrEP-AP changed its policy and does not require clients to enroll into Gilead's Co-payment Assistance Program as the client's health plan will cover the cost of PrEP effective June 11, 2020, unless the health plan has yet to implement USPSTF's recommendation. If the client's health plan did not implement USPSTF's recommendation, the client will be required to enroll into Gilead's Co-payment Assistance Program. Clients with private insurance enrolled in Gilead's Co-payment Assistance Program are eligible for PrEP medication co-payment assistance of \$7,200 per calendar year. After this threshold has been met, the PrEP-AP provides wrap-around coverage for any remaining PrEP medication co-payments for the remainder of the calendar year.

The elimination of a cost-sharing requirement for PrEP because of the USPSTF's "A" grade recommendation will alleviate some of the financial burden on PrEP-AP for insured clients whose health plan has implemented the USPSTF recommendation.

Description of Change: As of January 1, 2021, all health plans regulated by the Department of Insurance and Department of Managed Health Care implemented the USPTF recommendation. Self-insured employee health benefit plans not regulated by the Department of Insurance or Department of Managed Health Care, and health plans in existence prior to March 23, 2010, are not required to implement this recommendation.

Discretionary: No

Reason for Adjustment/Change:

- USPSTF "A" grade recommendation
- Federal and state legislative requirements

Fiscal Impact and Fund Source(s): Estimated savings for 2021-22 is \$3.3 million for 2,316 fewer insured PrEP-AP clients. Estimated savings for 2022-23 is \$4.3 million for 3,292 fewer insured PrEP-AP clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Discontinued Assumptions

Expansion of PrEP-AP

Why is Change Needed/Reason for Adjustment: Previously approved in the 2021-22 ADAP May Revision Estimate as a Future Fiscal Issue. This assumption will be discontinued as the following enhancements were implemented with the corresponding dates: 1) PrEP medication for insured clients without requiring use of the manufacturer's assistance program if it is not accepted by the client's health plan or pharmacy contracted by the health plan implemented on March 1, 2019; 2) payment of PEP and related medical costs implemented on October 4, 2019; 3) PrEP-AP access for individuals 12 years of age or older implemented on June 4, 2020; and 4) the ability to consider insured individuals as uninsured for confidentiality or safety reasons implemented on June 4, 2020. On June 29, 2020, Governor Newsom approved AB 80 (Chapter 12, Statutes of 2020), which contained trailer bill language amending HSC 120972 to subsidize up to 30 days of PrEP and PEP medications for the prevention of HIV infection, without regard to whether the person was a victim of sexual assault. The passage of the bill eliminates the barrier of having to repackage medication for starter packs. Thus, this eliminates the need for PrEP-AP to pay for PEP and PrEP starter packs regardless if PrEP-AP eligibility requirements are met or if the individual was a victim of sexual assault. PrEP-AP will not be implementing payment of insurance premiums for clients enrolled in the PrEP-AP as cost estimates exceed current budget authority for this expansion.

Decrease in Federal Funds: 2020 Ryan White Part B Grant

Why is Change Needed/Reason for Adjustment: Previously approved in the 2021-22 ADAP May Revision Estimate for use in 2020-21. Since 2020-21 has ended, and the funding has already been expended, this assumption will be discontinued.

Decrease in Federal Funds: 2020 Ryan White Part B Supplemental Grant

Why is Change Needed/Reason for Adjustment: Previously approved in the 2021-22 ADAP May Revision Estimate for use in 2020-21. Since 2020-21 has ended, and the funding has already been expended, this assumption will be discontinued.

Federal Funds: 2020 ADAP Emergency Relief Funds Grant (ADAP Shortfall Relief Grant)

Why is Change Needed/Reason for Adjustment: Previously approved in the 2021-22 ADAP May Revision Estimate for use in 2020-21. Since 2020-21 has ended,

and the funding has already been expended, this assumption will be discontinued.

Increase in Federal Funds: 2019 Ryan White Part B Grant Carryover

Why is Change Needed/Reason for Adjustment: Previously approved in the 2021-22 ADAP May Revision Estimate for use in 2020-21. Since 2020-21 has ended, and the funding has already been expended, this assumption will be discontinued.

VI. Expenditure Details

- A. Tables 6 through 11, starting on the next page, break down caseload and expenditures by client group and service type.

TABLE 6: FY 2021-22 November Estimate Caseload and Variable Expenditures						
CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	11,000	31.7%	\$296,107,031	\$0	\$0	\$296,107,031
Medi-Cal SOC	101	0.3%	\$1,070,816	\$0	\$0	\$1,070,816
Private insurance*	10,872	31.3%	\$22,829,066	\$74,497,460	\$1,784,713	\$99,111,239
Medicare Part D*	7,520	21.6%	\$22,551,159	\$3,929,472	\$269,392	\$26,750,023
PrEP-AP	5,250	15.1%	\$4,680,372	\$0	\$1,335,835	\$6,016,207
SUBTOTAL	34,743	100.0%	\$347,238,444	\$78,426,932	\$3,389,940	\$429,055,317
Admin Costs: ADAP	-	-	\$2,314,733	\$2,105,624	\$1,109,008	\$5,529,365
Admin Costs: PrEP-AP	-	-	\$350,615	\$0	\$254,206	\$604,821
Admin Costs: Enrollment	-	-	\$0	\$0	\$0	\$7,275,000
HMS	-	-	-\$12,171,376	\$0	\$0	-\$12,171,376
TOTAL	34,743	100.0%	\$337,732,416	\$80,532,557	\$4,753,154	\$430,293,127
* Subgroup of 12,160 clients receiving assistance for premium payments and medical-out-of-pocket costs. Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.						

TABLE 7: FY 2021 Budget Act Caseload and Variable Expenditures						
CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	12,452	35.4%	\$333,979,452	\$0	\$0	\$333,979,452
Medi-Cal SOC	114	0.3%	\$1,460,097	\$0	\$0	\$1,460,097
Private insurance*	10,265	29.2%	\$22,183,728	\$84,628,923	\$1,855,904	\$108,668,555
Medicare Part D*	7,555	21.5%	\$19,150,279	\$3,755,386	\$416,447	\$23,322,112
PrEP-AP	4,768	13.6%	\$2,192,298	\$0	\$757,966	\$2,950,264
SUBTOTAL	35,154	100.0%	\$378,965,854	\$88,384,309	\$3,030,317	\$470,380,480
Admin Costs: ADAP	-	-	\$5,692,162	\$1,896,492	\$981,545	\$8,570,200
Admin Costs: PrEP-AP	-	-	\$350,615	\$0	\$217,133	\$567,749
Admin Costs: Enrollment	-	-	\$0	\$0	\$0	\$8,020,000
HMS	-	-	\$0	\$0	\$0	\$0
TOTAL	35,154	100.0%	\$385,008,632	\$90,280,801	\$4,228,996	\$487,538,429
* Subgroup of 12,984 clients receiving assistance for premium payments and medical-out-of-pocket costs. Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.						

TABLE 8: FY 2021-22 - Difference Between November Estimate and 2021 Budget Act						
CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	-1,452	-11.7%	-\$37,872,421	\$0	\$0	-\$37,872,421
Medi-Cal SOC	-13	-11.1%	-\$389,281	\$0	\$0	-\$389,281
Private insurance*	607	5.9%	\$645,338	-\$10,131,463	-\$71,191	-\$9,557,316
Medicare Part D*	-35	-0.5%	\$3,400,880	\$174,086	-\$147,055	\$3,427,912
PrEP-AP	482	10.1%	\$2,488,074	\$0	\$577,869	\$3,065,943
SUBTOTAL	-411	-1.2%	-\$31,727,410	-\$9,957,376	\$359,623	-\$41,325,163
Admin Costs: ADAP	-	-	-\$3,377,429	\$209,132	\$127,463	-\$3,040,835
Admin Costs: PrEP-AP	-	-	\$0	\$0	\$37,072	\$37,072
Admin Costs: Enrollment	-	-	\$0	\$0	\$0	-\$745,000
HMS	-	-	-\$12,171,376	\$0	\$0	-\$12,171,376
TOTAL	-411	-1.2%	-\$47,276,215	-\$9,748,244	\$524,158	-\$57,245,302
* Subgroup decreased 824 clients receiving assistance for premium payments and medical-out-of-pocket costs. Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.						

TABLE 9: FY 2022-23 November Estimate Caseload and Variable Expenditures

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	9,499	28.2%	\$270,831,264	\$0	\$0	\$270,831,264
Medi-Cal SOC	103	0.3%	\$1,182,264	\$0	\$0	\$1,182,264
Private insurance*	10,893	32.3%	\$24,147,460	\$82,787,588	\$2,009,643	\$108,944,692
Medicare Part D*	7,537	22.4%	\$24,330,300	\$4,625,204	\$269,627	\$29,225,130
PrEP-AP	5,656	16.8%	\$5,754,969	\$0	\$1,329,019	\$7,083,988
SUBTOTAL	33,687	100.0%	\$326,246,257	\$87,412,792	\$3,608,289	\$417,267,338
Admin Costs: ADAP	-	-	\$2,049,455	\$2,297,045	\$1,209,827	\$5,556,326
Admin Costs: PrEP-AP	-	-	\$382,490	\$0	\$277,315	\$659,805
Admin Costs: Enrollment	-	-	\$0	\$0	\$0	\$7,335,000
HMS	-	-	-\$12,171,376	\$0	\$0	-\$12,171,376
TOTAL	33,687	100.0%	\$316,506,825	\$89,709,837	\$5,095,431	\$418,647,093

* Subgroup of 12,993 clients receiving assistance for premium payments and medical-out-of-pocket costs. Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.

TABLE 10: FY 2021 Budget Act Caseload and Variable Expenditures

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	12,452	35.4%	\$333,979,452	\$0	\$0	\$333,979,452
Medi-Cal SOC	114	0.3%	\$1,460,097	\$0	\$0	\$1,460,097
Private insurance*	10,265	29.2%	\$22,183,728	\$84,628,923	\$1,855,904	\$108,668,555
Medicare Part D*	7,555	21.5%	\$19,150,279	\$3,755,386	\$416,447	\$23,322,112
PrEP-AP	4,768	13.6%	\$2,192,298	\$0	\$757,966	\$2,950,264
SUBTOTAL	35,154	100.0%	\$378,965,854	\$88,384,309	\$3,030,317	\$470,380,480
Admin Costs: ADAP	-	-	\$5,692,162	\$1,896,492	\$981,545	\$8,570,200
Admin Costs: PrEP-AP	-	-	\$350,615	\$0	\$217,133	\$567,749
Admin Costs: Enrollment	-	-	\$0	\$0	\$0	\$8,020,000
HMS	-	-	\$0	\$0	\$0	\$0
TOTAL	35,154	100.0%	\$385,008,632	\$90,280,801	\$4,228,996	\$487,538,429

* Subgroup of 12,984 clients receiving assistance for premium payments and medical-out-of-pocket costs. Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.

TABLE 11: FY 2022-23 - Difference Between November Estimate and 2021 Budget Act

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	-2,953	-23.7%	-\$63,148,188	\$0	\$0	-\$63,148,188
Medi-Cal SOC	-11	-10.0%	-\$277,833	\$0	\$0	-\$277,833
Private insurance*	628	6.1%	\$1,963,732	-\$1,841,335	\$153,739	\$276,137
Medicare Part D*	-19	-0.2%	\$5,180,021	\$869,818	-\$146,820	\$5,903,018
PrEP-AP	888	18.6%	\$3,562,671	\$0	\$571,053	\$4,133,724
SUBTOTAL	-1,467	-4.2%	-\$52,719,597	-\$971,517	\$577,972	-\$53,113,143
Admin Costs: ADAP	-	-	-\$3,642,708	\$400,552	\$228,281	-\$3,013,874
Admin Costs: PrEP-AP	-	-	\$31,874	\$0	\$60,182	\$92,056
Admin Costs: Enrollment	-	-	\$0	\$0	\$0	-\$685,000
HMS	-	-	-\$12,171,376	\$0	\$0	-\$12,171,376
TOTAL	-1,467	-4.2%	-\$68,501,807	-\$570,965	\$866,435	-\$68,891,337

* Subgroup decreased 9 clients receiving assistance for premium payments and medical-out-of-pocket costs. Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.

a) Medication-Only Clients

1. Medication Expenditures:

- 2021-22: Medication expenditures are projected to be \$296.1 million (Table 6), \$37.9 million lower than reported in the 2021 Budget Act (Table 8). The decrease is driven primarily by Medication-Only client volume, which is projected to be lower than previously estimated.
- 2022-23: Medication expenditures are projected to be \$270.8 million (Table 9), \$63.1 million lower than reported in the 2021 Budget Act (Table 11). The decrease is driven by the same factor as listed above.

2. Health Insurance Premiums: There are no health insurance premium expenditures for medication-only clients.

3. Medical Out-Of-Pocket Costs: There are no medical out-of-pocket cost expenditures for medication-only clients.

b) Medi-Cal SOC Clients

1. Medication Expenditures:

- 2021-22: Medication expenditures are projected to be \$1.1 million (Table 6), \$389,000 lower than reported in the 2021 Budget Act (Table 8). The decrease is driven primarily by Medi-Cal SOC client volume and medication cost per month, which is projected to be lower than previously estimated.
- 2022-23: Medication expenditures are projected to be \$1.2 million (Table 9), \$278,000 lower than reported in the 2021 Budget Act (Table 11). The decrease is driven by the same factors as listed above.

2. Health Insurance Premiums: There are no health insurance premium expenditures for Medi-Cal SOC clients.

3. Medical Out-Of-Pocket Costs: There are no medical out-of-pocket cost expenditures for Medi-Cal SOC clients.

c) Private Insurance Clients

1. Medication Expenditures:

- 2021-22: Medication expenditures are projected at \$22.8 million (Table 6), \$645,000 higher than reported in the 2021 Budget Act (Table 8). The increase is driven primarily by private insurance client volume, which is projected to be higher than previously estimated.
- 2022-23: Medication expenditures are projected at \$24.1 million (Table 9), \$2 million higher than reported in the 2021 Budget Act (Table 11). The increase is driven by the same factor as listed above.

2. Health Insurance Premiums:

- 2021-22: Health insurance premium expenditures are projected at \$74.5 million (Table 6), \$10.1 million lower than reported in the 2021 Budget Act (Table 8). The decrease is driven primarily by the numbers of clients with Exchange plans and monthly premiums, which are projected to be lower than previously estimated.
- 2022-23: Health insurance premium expenditures are projected at \$82.8 million (Table 8), \$1.8 million lower than reported in the 2021 Budget Act (Table 11). The decrease is driven primarily by the same factors as listed above, which is projected to be lower than previously estimated; however, this is anticipated to be off-set by the number of clients with off-Exchange plans.

3. Medical Out-Of-Pocket Costs:

- 2021-22: Medical out-of-pocket costs are projected to be \$1.8 million (Table 6), \$71,000 lower than reported in the 2021 Budget Act (Table 8). The decrease is driven primarily by the cost per Medical Out-Of-Pocket benefit service utilization, which is projected to be lower than previously estimated offset by an increase in client volume.
- 2022-23: Medical out-of-pocket costs are projected to be \$2 million (Table 9), \$154,000 higher than reported in the 2021 Budget Act (Table 11). The increase is driven primarily by the same factor as listed above; however, the increase in client volume will be much higher.

d) Medicare Part D Clients

1. Medication Expenditures:

- 2021-22: Medication expenditures are projected at \$22.6 million (Table 6), \$3.4 million higher than reported in the 2021 Budget Act (Table 8). The increase is driven primarily by Medicare Part D medication cost per month, which is projected to be higher than previously estimated.
- 2022-23: Medication expenditures are projected \$24.3 million (Table 9), \$5.2 million higher than reported in the 2021 Budget Act (Table 11). The increase is driven by the same factor as listed above.

2. Health Insurance Premiums:

- 2021-22: Health insurance premium expenditures are projected at \$3.9 million (Table 6), \$174,000 higher than reported in the 2021 Budget Act (Table 8). The increase is driven primarily by the Medicare Part D client mix reflecting a greater percent of clients with Medigap premiums than previously estimated.
- 2022-23: Health insurance premium expenditures are projected at \$4.6 million (Table 9), \$870,000 higher than reported in the 2021 Budget

Act (Table 11). The increase is driven by the same factor as listed above.

3. Medical Out-Of-Pocket Costs:

- 2021-22: Medical out-of-pocket costs are projected to be \$269,000 (Table 6), \$147,000 lower than reported in the 2021 Budget Act (Table 8). The decrease is driven primarily by lower average prices for Medical Out-of-Pocket costs than previously estimated.
- 2022-23: Medical out-of-pocket costs are projected to be \$270,000 (Table 9), \$147,000 lower than reported in the 2021 Budget Act (Table 11). The decrease is driven by the same factor as listed above.

e) PrEP-AP Clients

1. Medication Expenditures:

- 2021-22: Medication expenditures are projected to be \$4.7 million (Table 6), \$2.5 million higher than reported in the 2021 Budget Act (Table 8). The increase is driven primarily by PrEP-AP client count, which is projected to be higher than previously estimated, which assumed widespread implementation of USPSTF recommendations beginning July 2020. OA has since revised its estimates, anticipating more gradual USPSTF implementation since its January 2021 implementation (see Existing Assumption, "U.S. Preventive Services Task Force's "A" Grade Recommendation on PrEP for Persons at High Risk of HIV Acquisition").
- 2022-23: Medication expenditures are projected to be \$5.8 million (Table 9), \$3.6 million higher than reported in the 2021 Budget Act (Table 11). The increase is driven by the same factor listed above.

2. Health Insurance Premiums: There are no health insurance premium expenditures for PrEP-AP clients.

3. Medical Out-Of-Pocket Costs:

- 2021-22: Medical out-of-pocket costs are projected to be \$1.3 million (Table 6), \$578,000 higher than reported in the 2021 Budget Act (Table 8). The increase is driven primarily by PrEP-AP client volume and service utilization, which are projected to be higher than previously estimated.
- 2022-23: Medical out-of-pocket costs are projected to be \$1.3 million (Table 9), \$571,000 higher than reported in the 2021 Budget Act (Table 11). The increase is driven by the same factors as listed above.

VII. Historical Program Data and Trends

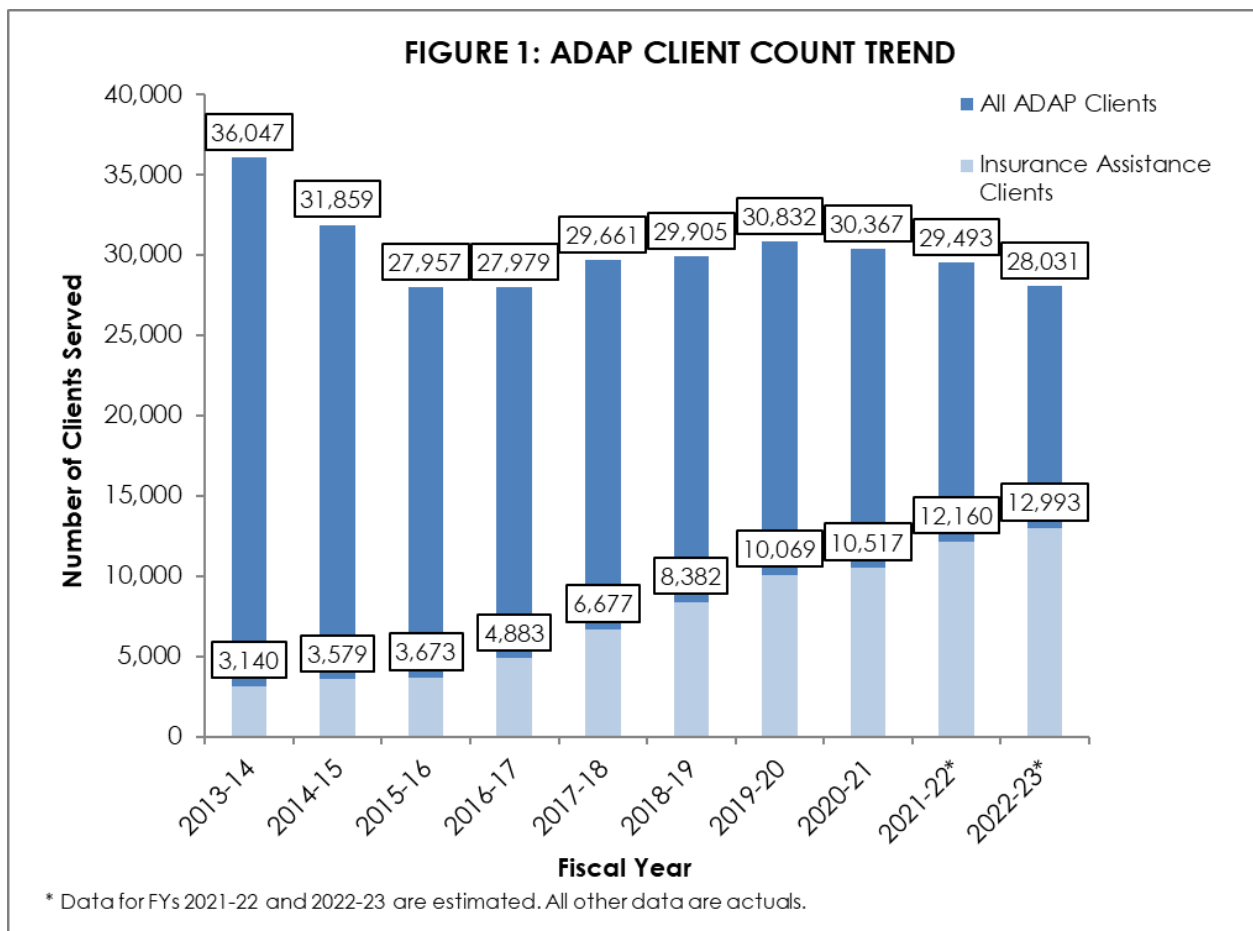
For all figures in this section, data prior to 2021-22 is the observed historical data. Estimates for 2021-22 and 2022-23 are based on the overall projections and include all assumptions.

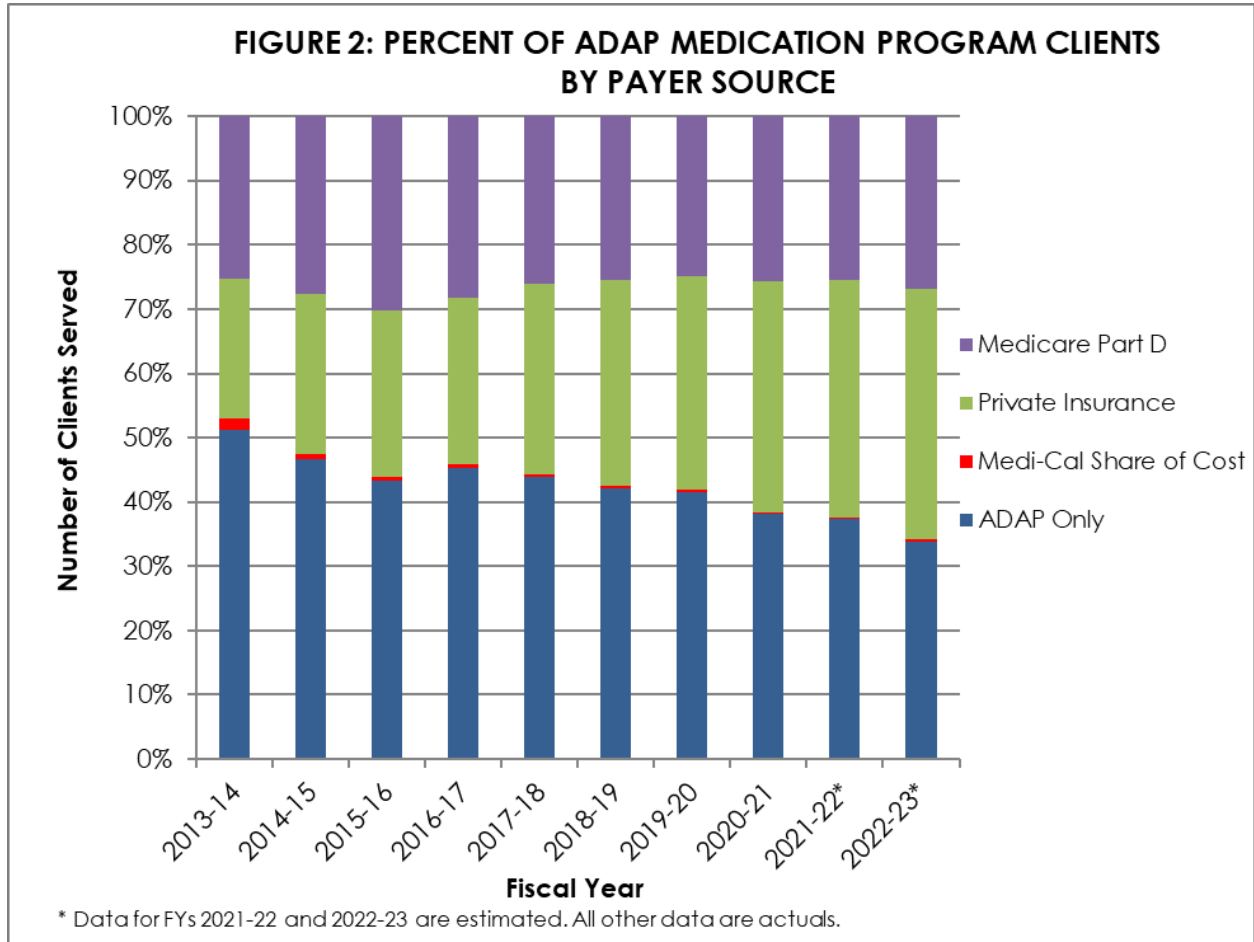
Figure 1 is a summary of client counts in ADAP by fiscal year excluding PrEP-AP clients. The number of ADAP medication program clients who are also receiving insurance assistance is also shown.

Figure 2 shows the proportion of ADAP medication program clients enrolled in the various payer groups by fiscal year.

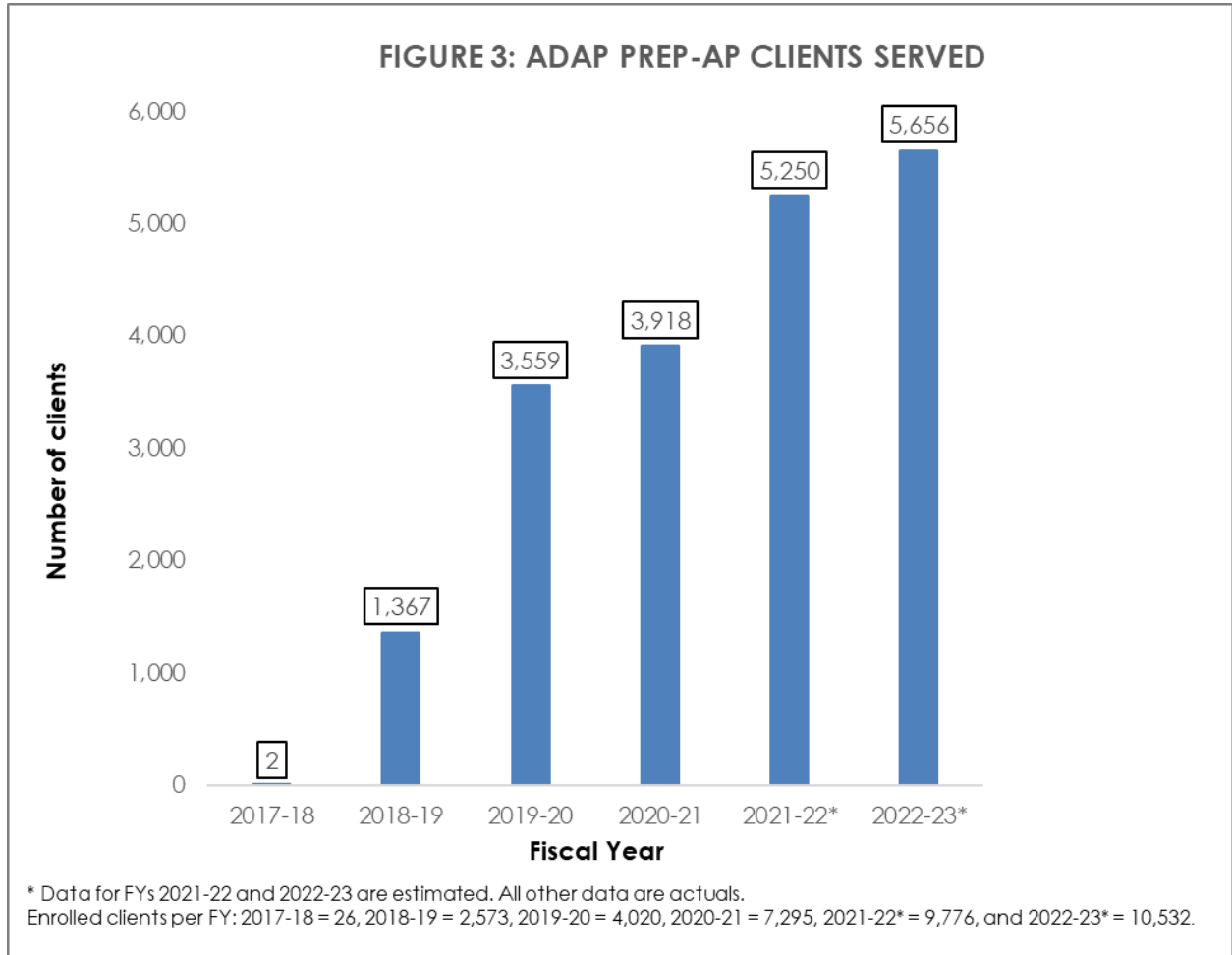
Figure 3 is a summary of client counts in PrEP-AP by fiscal year.

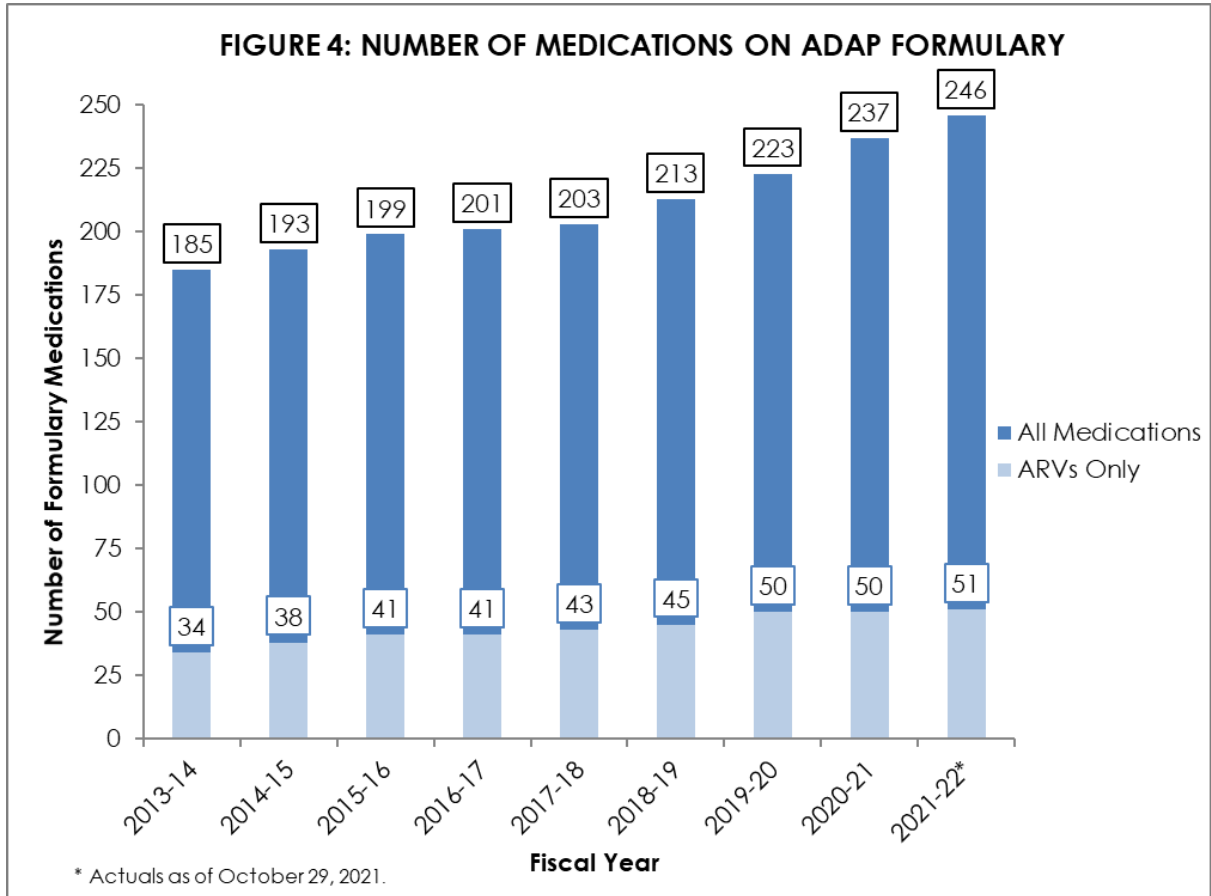
Figure 4 is the number of medications on the ADAP formulary by fiscal year; the number of antiretroviral (ARV) medications is also shown.





Note: In Figures 1 and 2, all client counts represent the number of clients served who incur program costs. Enrolled clients who do not incur program costs are excluded from these counts.





Additions to the ADAP Formulary

The following drug was added to the Formulary on April 28, 2021:

- Bexsero®, non-ARV, meningococcal group B vaccine

The following drugs were added to the Formulary on July 30, 2021:

- Clonazepam (Klonopin®), non-ARV, benzodiazepine
- Duloxetine (Cymbalta®), non-ARV, serotonin and norepinephrine reuptake inhibitors
- Escitalopram (Lexapro®), non-ARV, antidepressant
- Hydroxyzine Pamoate (Vistaril®), non-ARV, antihistamine

The following drugs were added to the Formulary on August 06, 2021:

- Estradiol, non-ARV, estrogen
- Dutasteride, non-ARV, 5-alpha reductase inhibitor
- Finasteride, non-ARV, 5-alpha reductase inhibitor
- Spironolactone, non-ARV, aldosterone receptor antagonist

The following drug was added to the Formulary on October 8, 2021:

- Cabenuva, ARV, extended-release injectable

Deletions from the ADAP Formulary

There are currently no deletions to the ADAP Formulary.

VIII. Current HIV Epidemiology in California

Approximately 137,700 people in California at the end of 2019 had been diagnosed with HIV and reported to OA. However, OA estimates that 13 percent of all PLWH in California are unaware of their infection. Therefore, OA estimates that there were approximately 159,000 PLWH in California as of the end of 2019. Since the epidemic began in 1981, approximately 103,000 Californians diagnosed with HIV have died, with over 1,900 dying in 2019 alone.

Of the approximately 137,700 people living with diagnosed HIV (PLWDH) in California, approximately 37.7 percent are Latinx; 37.2 percent are White; 17.0 percent are Black/African American; 4.2 percent are Asian; 3.4 percent are multi-racial; 0.3 percent are American Indian/Alaskan Native; and 0.2 percent are Native Hawaiian/Pacific Islander. While Latinx and Whites make up the largest percentage of PLWDH in California, the rate of HIV among Blacks/African Americans is substantially higher (984.5 per 100,000 population, versus 347.8 per 100,000 among Whites and 334.9 per 100,000 among Latinx).

Most of California's living HIV cases are attributed to male-to-male sexual transmission (66.6 percent); 8.5 percent of living cases are attributable to high-risk heterosexual contact (defined as contact with a sex partner or partners of the opposite gender who are either known to be HIV infected or known to be someone who injects drugs, has hemophilia, or is a man who has sex with other men); 6.4 percent to men who have sex with men who also inject drugs; 5.6 percent to injection drug use; 1.5 percent to transgender sexual contact; 0.5 percent to perinatal exposure; and 10.9 percent to other or unknown sources including other heterosexual contact.

There are approximately 4,400 new HIV cases reported in California each year, which is a revision from the prior year of approximately 4,700 new HIV cases. One potential driver of the decrease may be the increasing rate of viral suppression among living HIV cases over that time period from around 61 percent in 2015 to over 65 percent in 2019. The number of PLWH in the state is expected to grow by two to three percent each year for the foreseeable future until more progress is made in preventing new HIV infections. This increase is attributed to stable incidence rates and longer survival of those infected primarily due to the effectiveness and availability of treatment.