

# ADAP

Working  
Group

An AIDS Drug  
Assistance Program  
Advocacy Coalition

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AIDS Alliance for Children,  
Youth & Families  
AIDS Foundation of Chicago  
AIDS Project Los Angeles  
AIDS Treatment Data Network  
American Academy of HIV Medicine  
Association of Nurses in AIDS Care  
Bayer HealthCare  
Boehringer Ingelheim  
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Broward Log Cabin Club of Florida  
Cities Advocating Emergency AIDS  
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Florida AIDS Action  
Gilead Sciences  
Glaxo Smith Kline  
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Los Angeles Gay & Lesbian Center  
Merck & Co.  
National AIDS Treatment  
Advocacy Project  
National Association of  
People With AIDS  
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Project Inform  
Schering-Plough Corporation  
Title II Community AIDS  
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2/03

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## Introduction to the ADAP Budget Projection Model, Fiscal Year 2004

*The ADAP Working Group is a unique ad hoc coalition of HIV/AIDS community-based organizations, biotechnology, pharmacy and pharmaceutical research companies. Our mission is to ensure adequate access to HIV/AIDS-related therapies through the AIDS Drug Assistance Program (ADAP), funded under Title II of the Ryan White CARE Act.*

The ADAP Working Group believes that the enclosed budget projection provides an accurate representation of the cost of providing a basic standard of HIV/AIDS care to those on ADAP in Fiscal Year 2004, which runs April 1, 2004 - March 31, 2005. It also addresses the funding crisis in the CURRENT FY '03 program year.

The cost of treating a person with AIDS on Medicaid can be upwards of \$40,000 a year\*. In fiscal 2004, adequate HIV disease treatment (including HAART and HIV related conditions) per person on ADAP will average less than \$13,000 for the year. Without adequate ADAP funding, uninsured and underinsured people with HIV will have to wait until they are sick and disabled in order to qualify for Medicaid and receive the full HIV/AIDS treatment that could have prevented their illness progression to "full blown" AIDS. This is clearly unsound health care policy.

The impact of multi-drug anti-HIV therapy has been well publicized over the past few years. The many incremental gains in the prevention and treatment of opportunistic infections have also made a significant contribution to extending and improving the lives of people with AIDS. The stunning drop in US deaths from AIDS since 1995 is a testament to these facts. The adoption of the US Public Health Service guidelines on the use of antiretroviral therapy has further improved the standard of care for people with HIV and AIDS.

The ADAP Working Group believes that it is ethically unacceptable to deny access to available treatments to HIV+ Americans. Nor can we afford to deny optimum HIV and AIDS treatment to all those that could benefit from it. The ADAP population is particularly vulnerable, often depending on a fractured system of care and on other vital Ryan White services. They should not have to decline into complete physical disability to receive the HIV/AIDS treatments they need.

The following summarizes the ADAP Budget Projections:

### FY 2003

Projected ADAP budget need for <b>FY 2003</b> :	\$1,244,138,232
Base budget (from FY 2002):	\$ 986,713,470
Projected Increase in Need <b>FY 2003</b>	\$ 257,424,762
Expected State Share Increase (20% of Need)	\$ 36,419,652**
Federal Increase Approved for <b>FY 2003</b>	\$ 75,326,500
Current projected <b>FY 2003</b> shortfall:	<b>(\$ 145,678,610)</b>

To address the **FY 2003** Shortfall we project the need for an  
**"EMERGENCY SUPPLEMENTAL APPROPRIATION"** of: **+\$145,678,610**

### FY 2004

Projected ADAP budget need for <b>FY 2004</b> :	\$1,415,488,767
Projected base budget for <b>FY 2004</b> :	\$1,062,039,970
Current projected ADAP shortfall for <b>FY 2004</b>	<b>(\$ 353,448,797)</b>

To address the FY 2004 increased demand we project needs as follows:

<b>Federal Share (80%***):</b>	<b>+\$282,759,038</b>
State Share (20%***):	+\$ 70,689,759 **

\*Source: Connors, Medicaid Working Group (data from Community Medical Alliance, Santa Barbara, CA, 1993). The inflation-adjusted annual cost of treating advanced AIDS, based on this data, would be \$58,049.

\*\*The Model assumes a 20% State match of the annual increase in need (\$36,419,652 in FY2003, and \$70,689,759 in FY04). The actual amounts may vary, dependent upon State legislative ADAP budget actions during calendar 2003 and 2004.

\*\*\*This percentage is derived from referencing Congressional Report Language. The historical ADAP budget data shows funding ratios of 74% Federal funds and 26% State funds. The current projection avoids artificially inflating the Federal share by projecting a 20% state match of the total increase in need for each year (see footnote \*\*, above). However, we recognize in reality economic recession related State Budget deficits may affect actual funding outcomes and totals.

## Projection Methods

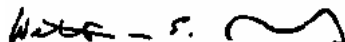
A computer model, developed by respected pharmacoeconomists, was used to estimate the cost of providing the standard of care to these utilizing ADAP clients on a month-by-month basis out to March 31, 2005. The same model has been utilized by the ADAP Working Group to project ADAP need for the past seven years.

The model uses real world information about the immune system status of ADAP clients to project the need for preventive and acute treatment with outpatient drugs. The expected incidence of illness is based on an analysis of data from the Multicenter AIDS Cohort Study (MACS) by Bacellar et al (Journal of Infectious Disease 1994;170). The same model has predicted individual state ADAP expenditures within 5% of the actual totals. A total of 22 states have utilized this model for fiscal projection purposes.

The model makes assumptions about antiretroviral therapy as described in the new NIH/PHS Guidelines. In addition to their basis in the new NIH/PHS Guidelines, these projections mirror current trends in State ADAPs.

The model cannot anticipate all of the changes and refinements in the HIV standard of care that may occur within the timeframe of this projection. The ADAP Working Group will update the projection model whenever new and validated information that impacts the model becomes available.

The attached slide series provide more details on the methodology and the results.



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**FY 2003 (April 2003 – March 2004) and FY 2004 (April 2004 – March 2005)**

**Base Case Assumptions**

- Starting population (June 02) = 84,378
- Monthly growth = 635 (low = 600, high = 670)
- CD4 distribution = national ADAP totals (<50, 9.0%; 50-99, 9.0%; 100-149, 9.0%; 150-199, 11.8%; 200-299, 13.6%; 300+, 50.4%)
- Clinical Trial/EAP/Other source adjustment rate = 95%
- Prophylaxis only = 10% (background rate for those on therapy is based on FL: Of the remaining 90%: 3% mono, 5% dual, 73% triple, 15% quad, 4% quint and higher; average ARVs per regimen = 3.12)
- Antiretroviral use based on PA ADAP (June 2001)
- ARV cost = AWP (October 01, 2002) – 23.9%
- Inflation rate for OIs, and other drugs = 4.6% per year (CPI for medical care)
- Inflation rate for ART = 1.3% per year (CPI for all items)
- Other costs (PMPM): Hyperlipidemia \$5.48, insulin resistance \$2.77, cardiovascular \$5.32, gastrointestinal \$11.58, and anti-diarrheals \$1.44 (total: \$26.60 PMPM)

**Assumptions Based on New Developments in Treatment**

- **Fusion Inhibitors:** Fuzeon, the fusion inhibitor furthest along in development, is expected to receive FDA approval by the end of first quarter of 2003 (calendar year). Since the Ryan White CARE Act fiscal year begins April 1, 2003 of the calendar year, it is assumed that access to Fuzeon begins at that point. In the model, Fuzeon utilization is based on publicly reported available drug supply as production ramps up to reach 15,000 available slots globally by the end of 2003. Assuming ADAP covers 20% of the people currently in treatment, the available Fuzeon slots will be 2,496 by the end of FY03 and 4,536 by the end of FY 04.
- **Hepatitis C Treatment:** Assume that 38% of all patients are coinfecting with HIV and Hepatitis C and 4% are treated. The cost of pegulated interferon is estimated to be \$24,500 per year for an entire course. It is assumed that 50% of patients discontinue treatment after three months due to lack of efficacy. For 2003, an adjustment is made for uptake of a new product.
- **Waiting Lists:** Assumes that 1200 patients will be on waitlists in 2003.
- **Health Insurance Continuation Plans:** Results from FY2000 to FY2002 are used to project the enrollment and total cost of the insurance programs for 2003.

The following slides illustrate the methods used, the results are projected (in additional detail) and provide additional information.

This entire document is available electronically – contact us for electronic copies or web site locations.