

AIDS DRUG ASSISTANCE PROGRAM

2021-22

November Estimate



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I. Program Overview

The California Department of Public Health (CDPH), Center for Infectious Diseases, Office of AIDS (OA), AIDS Drug Assistance Program (ADAP) provides access to life-saving medications for eligible California residents living with human immunodeficiency viruses (HIV) and provides assistance with covering costs related to HIV pre-exposure prophylaxis (PrEP) for clients at risk for acquiring HIV and pre-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; therefore, this group is subdivided 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 have the option for premium assistance with Medigap supplemental insurance policies which cover medical out-of-pocket costs.
5. **PrEP Assistance Program (PrEP-AP) clients** are individuals who are at risk for but, not infected with HIV and 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 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 nor 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, the majority of clients ADAP served were medication-only clients without health insurance because PLWH were unable to purchase affordable health insurance in the private marketplace. However, with the implementation of the Affordable Care Act (ACA), more ADAP clients have been able to access public and private health insurance coverage. ADAP clients are screened for Medi-Cal eligibility and potential 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 for if ADAP pays the client's premium. Assisting clients with purchasing health insurance is more cost effective than paying the full cost of medications. In addition, assisting clients with purchasing and maintaining health insurance coverage improves the overall health of Californians living with HIV because clients have comprehensive health insurance and access to the full spectrum of medical care rather than only HIV outpatient care and medications through the Ryan White system.

II. Estimate Overview

The 2021-22 ADAP November Estimate provides a revised projection of 2020-21, 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 2021-22.

Table 1, page 4, displays the estimated ADAP Local Assistance budget authority need for 2020-21 and compares it to the amount reflected in the 2020 Budget Act.

- For 2020-21, OA estimates the ADAP budget authority need will be \$467.3 million, which is a \$29 million increase in budget authority compared to the 2020 Budget Act. The net increase is primarily due to an increase in projected medication expenditures (see key influences on ADAP expenditures on page 4 for more detail).
- For 2021-22, OA estimates the ADAP budget authority need will be \$503.5 million, which is a \$65.1 million increase in budget authority compared to the 2020 Budget Act. The net increase is primarily due to an increase in projected medication expenditures and insurance premium expenditures (see key influences on ADAP expenditures on page 4 for more detail).

Table 2, page 4, displays the estimated ADAP revenue for 2020-21 and 2021-22 and compares them to the amount reflected in the 2020 Budget Act.

- For 2020-21, OA estimates ADAP revenue will be \$431.1 million, which is a \$83.2 million increase compared to the 2020 Budget Act. The increase is primarily due to a projected increase in medication expenditures (see revenue on page 6 for more detail). In 2020-21, the ADAP Rebate Fund transferred a repayable \$100 million loan to the General Fund per AB 89 Chapter 7, which amended the 2020 Budget Act. The projected net balance of revenue for 2020-21 will be \$331.1 million.
- For 2021-22, OA estimates ADAP revenue will be \$449.8 million, which is a \$101.8 million increase compared to the 2020 Budget Act. The increase is primarily due to a projected increase in medication expenditures (see revenue on page 6 for more detail).

California Department of Public Health AIDS Drug Assistance Program and PrEP Assistance Program 2021-22 November Estimate Table 1: Local Assistance Budget Authority (In Thousands)								
Local Assistance	2020 Budget Act	Current Year FY 2020-21			2020 Budget Act	Budget Year FY 2021-22		
		2021-22 November Estimate	\$ Change from 2020 Budget Act	% Change from 2020 Budget Act		2021-22 November Estimate	\$ Change from 2020 Budget Act	% Change from 2020 Budget Act
Total Funds Requested	\$438,340	\$467,334	\$28,995	6.6%	\$438,340	\$503,466	\$65,126	14.9%
Federal Trust Fund - Fund 0890	\$108,796	\$109,140	\$344	0.3%	\$108,796	\$105,350	-\$3,447	-3.2%
ADAP Rebate Fund - Fund 3080	\$329,543	\$358,194	\$28,651	8.7%	\$329,543	\$398,116	\$68,573	20.8%
Caseload	36,523	34,733	-1,790	-4.9%	36,523	35,164	-1,359	-3.7%

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

2021-22 November Estimate Table 2: ADAP Rebate Fund (Fund 3080) Revenues (In Thousands)								
Local Assistance	2020 Budget Act	Current Year FY 2020-21			2020 Budget Act	Budget Year FY 2021-22		
		2021-22 November Estimate	\$ Change from 2020 Budget Act	% Change from 2020 Budget Act		2021-22 November Estimate	\$ Change from 2020 Budget Act	% Change from 2020 Budget Act
Total Revenue Requested	\$347,923	\$431,085	\$83,162	23.9%	\$347,923	\$449,764	\$101,841	29.3%
ADAP Rebate Fund - Fund 3080	\$339,923	\$423,085	\$83,162	24.5%	\$339,923	\$441,764	\$101,841	30.0%
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.

III. Overview Projections

A. Key influences on ADAP Expenditures

- a) 2020-21: Compared to the 2020 Budget Act, OA estimates that 2020-21 expenditures will net increase by 6.6 percent. The net increase is primarily due to an increase in projected medication expenditures from medication-only clients. There are smaller expenditure increases in administration costs and insurance premium expenditures, but the smaller increases in administration costs and insurance premiums are offset by a decrease in medical out-of-pocket costs from lower utilization of services than previously projected in the prior estimate. See the expenditure detail section on page 18.
- b) 2021-22: Compared to the 2020 Budget Act, OA estimates that 2021-22 expenditures will net increase by 14.9 percent. The net increase is primarily due to projected medication expenditures from medication-only clients and insurance premium expenditures from private insurance clients. A small increase in administration costs are offset by a decrease in medical out-of-pocket costs from lower utilization of services than previously projected in the prior estimate and a small projected decrease in enrollment site expenditures. See expenditure detail section on page 18.

B. Expenditure Types

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

a) Health Care and Enrollment Expenditures (Variable Expenditures)

- 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 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 V on page 18.
- Local ADAP enrollment services: Beginning in 2016-17, OA began allocating funds directly to ADAP enrollment sites based on ADAP services provided at each site. These funds may only be used for costs associated with enrolling and maintaining clients in ADAP. The total amount of funds for ADAP services performed is adjusted annually through the ADAP Estimate based on caseload and estimated services to be performed. Estimated expenditures for enrollment services are shown in Table 3.

CLIENT GROUP	EXPENDITURES	
	FY 2020-21	FY 2021-22
Medication-Only	\$342,103,793	\$356,480,156
Medi-Cal SOC	\$1,116,065	\$1,158,425
Private Insurance	\$88,775,907	\$107,608,168
Medicare Part D	\$24,421,933	\$26,652,684
PrEP-AP	\$4,136,501	\$4,151,355
SUBTOTAL	\$460,554,199	\$496,050,788
Enrollment Costs	\$6,780,000	\$7,415,000
TOTAL	\$467,334,199	\$503,465,788

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

C. Revenue

- 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. 2020-21 revenue projections are based on estimated rebates from estimated and actual medication expenditures from January through December 2020. 2021-22 revenue projections are based on estimated rebates from estimated drug expenditures from January through December 2021.
- For 2020-21, OA estimates ADAP rebate revenue will increase by 23.9 percent from \$347.9 million in the 2020 Budget Act to \$431.1 million in the revised current year forecast. The increase is primarily due to an increase in projected medication expenditures from medication-only clients and Medicare Part D clients.
 - For 2021-22, OA estimates ADAP rebate revenue will increase by 29.3 percent from \$347.9 million in the 2020 Budget Act to \$449.8 million in the revised budget year forecast. Similar to above, the increase is primarily due to an increase in projected medication expenditures from medication-only clients and Medicare Part D clients.
- b) Federal Funds – for 2020-21, total federal fund budget authority will increase by \$344,000 to \$109.1 million from the existing \$108.8 million established in the 2020 Budget Act. Federal fund budget authority includes: the 2020 Ryan White Part B grant (ADAP Earmark) in the amount of \$96.2 million (see New Assumption #2 on page 12), the 2020 Ryan White Part B Supplemental grant in the amount of \$2.6 million (see New Assumption #3 on page 13), the 2020 ADAP Emergency Relief Funds grant (also called ADAP Shortfall Relief grant) in the amount of \$6.5 million (see Unchanged Assumption #1 on page 15), and the 2019 Ryan White Part B grant carryover in the amount of \$3.8 million (see New Assumption #4 on page 14).
- c) For 2021-22, total federal fund budget authority will decrease by \$3.4 million to \$105.4 million compared to the \$108.8 million established in the 2020 Budget Act. Federal fund budget authority includes: estimated 2021 Ryan White Part B grant (ADAP Earmark) in the amount of \$96.2 million, estimated 2021 Ryan White Part B Supplemental grant funding in the amount of \$2.6 million, and the estimated 2021 ADAP Emergency Relief Funds grant funding in the amount of \$6.5 million.

Match – the Health Resources and Services Administration (HRSA) requires grantees to have HIV-related non-HRSA expenditures.

California's HRSA match requirement for the 2020 Ryan White Part B grant year (April 1, 2020 through March 31, 2021) is \$67.9 million. OA will meet the match requirement using General Fund State Operations and Local Assistance expenditures from OA's HIV Surveillance and Prevention Programs as well as HIV-related expenditures from the California Department of Corrections and Rehabilitation.

IV. Assumptions

Future Fiscal Issues

Expansion of Pre-Exposure Prophylaxis (PrEP) Assistance Program (PrEP-AP)

Background: The 2018 Budget Act included \$2 million ongoing to support proposals to modify the PrEP-AP by expanding eligibility and accessibility to the PrEP-AP pursuant to Health and Safety Code (HSC) 120972 and authorized through Assembly Bill 1810 (Chapter 34, Statutes of 2018). Approved enhancements include: 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, 2) payment of PEP and related medical costs, 3) payment for PEP and PrEP starter packs, regardless of whether PrEP-AP eligibility requirements are met, 4) PrEP-AP access for individuals 12 years of age or older, 5) the ability to consider insured individuals as uninsured for confidentiality or safety reasons, 6) up to 28 days of PEP medication for victims of sexual assault regardless of whether PrEP-AP eligibility requirements are met and 7) payment of insurance premiums for clients enrolled in the PrEP-AP if it will result in cost-savings to the state. OA is pursuing a phased implementation strategy and has worked with stakeholders to prioritize implementation of enhancements to the PrEP-AP approved in the 2018 Budget Act. OA projects implementation of all enhancements will take place over the next few years and is dependent on timely execution of contracts and the ability of vendors to meet critical milestones.

Description of Change: Enhancements one, two, four, five, and six have been implemented. On June 29, 2020, Governor Newsom approved Assembly Bill 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. OA is in the process of implementing enhancement three and expects completion in 2021. Enhancement seven is addressed with the elimination of cost sharing for PrEP due to the U.S. Preventive Services Task Force's "A" Grade Recommendation (see New Assumption #1 on page 11).

Discretionary: No

Reason for Adjustment/Change:

- Change to HSC Section 120972.
- Passage of Assembly Bill 80.

Fiscal Impact and Fund Source(s): OA does not project a need for additional budget authority beyond the \$2 million for 2020-21 or 2021-22 at this time. OA is continually monitoring costs for the PrEP-AP expansion and will provide future updates if projected costs cannot be absorbed within the existing \$2 million budget authority. The fund impacted is the AIDS Drug Assistance Program (ADAP) Rebate Fund (Fund 3080).

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 Policy Clarification Notice (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.

Description of Change: Subsequent to the PCN release, Orange County requested that CDPH provide ADAP services at their county jail. In response to Orange County's request, OA has initiated a pilot program with their county jail and will extend the pilot program in fiscal year 2021-22 to other interested county jails if this Assumption is approved. The total cost of the pilot in 2020-21 is approximately \$666,000, serving 216 participants. The cost of the pilot is absorbable. If this assumption is not approved, the Orange County pilot program will be terminated for fiscal year 2021-22. 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 will be able to enroll via a certified enrollment worker from the county jail that has been approved as an enrollment site. The enrollment worker will have to confirm the client meets eligibility requirements and warrant that all required documents to substantiate eligibility are submitted. The client and the enrollment worker must complete an ADAP application via the ADAP Enrollment System (AES) and upload the required forms into the system. New and existing clients will be 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.

Discretionary: Yes

Reason for Adjustment/Change:

- HRSA's Policy Notice 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): Estimated costs for 2020-21 are \$666,000 for 216 clients. For 2021-22, costs and clients are unknown at this time due to the uncertainty of other counties participating. The fund impacted is the ADAP Rebate Fund (Fund 3080).

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 March 19, 2020, California issued a stay at home order. The order, although since lifted, 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 exposure, OA has taken steps to ensure ADAP clients maintain their program eligibility by implementing measures to mitigate the risk of clients falling out of care. Those measures include 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.

Description of Change: Currently the impacts to ADAP from COVID-19 are unknown. OA is monitoring data and enrollments and will provide updates in future estimates if any potential impacts become clearer.

Discretionary: No

Reason for Adjustment/Change: N/A.

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: On January 13, 2020, Senator Pan introduced SB 852, California Affordable Drug Manufacturing Act of 2020. This bill would require the California Health and Human Services Agency 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.

Description of Change: SB-852 was signed by the Governor and chaptered by the Secretary of State on September 28, 2020, Chapter 207, Statutes of 2020. It is not clear how or if this would affect ADAP, as ADAP would need to know generic drug pricing for specific medications to make a determination as to whether discounted pricing achieved by the State are lower than the pricing already received by ADAP through the ADAP Crisis Task Force and 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).

New Assumptions**U.S. Preventive Services Task Force’s “A” Grade Recommendation on PrEP for Persons at High Risk of HIV Acquisition**

Background: On June 11, 2019, the United States Preventive Services Task Force (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 date will be January 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 those plans that maintain “grandfathered” status. In order to have been classified as “grandfathered,” plans must have been in existence prior to March 23, 2010, and cannot make significant changes to their coverage (for example, increasing patient cost-sharing, cutting benefits or reducing employer contributions).

Insured PrEP-AP clients were previously 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 has 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 has yet to 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.

Description of Change: 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. OA reached out to several large health plans regarding USPSTF's recommendation and their associated go live date information is listed below:

- Blue Shield of California - Renewing group plans, will have this benefit added as of July 1, 2020. Clients with individual and family plans will have this benefit added effective January 1, 2021.
- Kaiser Permanente - Go live July 1, 2020, with \$0 cost share for Affordable Care Act compliant plans, which includes both Covered California and individual and family off exchange plans.
- Health Net - As individual members or groups re-new health coverage after June 11, 2020, this benefit will be added. All members should have this added benefit by January 1, 2021.

While several health plans will implement the recommendation July 1, 2020, other health plans are not implementing until January 1, 2021.

Discretionary: No

Reason for Adjustment/Change:

- USPSTF "A" grade recommendation.
- Federal and State legislative requirements.

Fiscal Impact and Fund Source(s): Estimated savings for 2020-21 is \$1.1 million from an estimated 1,665 insured PrEP-AP clients. Estimated savings for 2021-22 is \$3.1 million from an estimated 2,409 insured PrEP-AP clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Decrease in Federal Funds: 2020 Ryan White Part B Grant

Background: The Ryan White Part B grant is the largest of the three federal grants that ADAP receives funding for and unlike the other two grants 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 timely on all reporting requirements. The grant is shared between OA's HIV Care Branch and ADAP Branch and is broken into three main sub-components: Base, MAI, and ADAP Earmark. Funding for Base and MAI is utilized by the HIV Care Branch and ADAP Earmark funding is utilized by the ADAP Branch.

In November 2019, OA applied for the 2020 Ryan White Part B grant, the fourth year of the latest five-year funding cycle. The funding requested in the grant application totaled \$139 million of which \$104.1 million was requested for the ADAP Branch and \$34.9 million was requested for the HIV Care Branch.

Description of Change: In March 2020, OA received the notice of award for the 2020 Ryan White Part B grant. The total award received was \$137.2 million, \$1.8 million below what OA applied for. The ADAP Branch received \$102.2 million, a reduction of \$1.9 million in funding (\$1.3 million in Local Assistance and \$600,000 in State Operations), and the HIV Care Branch received \$35 million, an increase of \$100,000 in funding. The \$100,000 increase figure stated is rounded. The actual figure is \$104,849 and is broken down \$62,754 State Operations and \$42,095 Local Assistance. The \$100,000 increase for the HIV Care Branch has no bearing on figures reported in the Estimate and does not affect the ADAP Branch.

Discretionary: Yes

Reason for Adjustment/Change:

- Unanticipated funding change.

Fiscal Impact and Fund Source(s): Decrease of \$1.3 million in Local Assistance for 2020-21 and 2021-22. The fund impacted is the Federal Trust Fund (Fund 0890).

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

Background: In March 2020, HRSA released a notice of funding opportunity for the 2020 Ryan White Part B Supplemental Grant. Approximately \$60 million has been made available nationwide through the 2020 Ryan White Part B Supplemental grant, but the ceiling amount that each applicant can apply for is \$10 million. The purpose of the Ryan White Part B Supplemental grant is to develop and/or enhance 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 grant is shared between OA's HIV Care Branch and ADAP Branch.

The table below displays Ryan White Part B Supplemental grant funds applied for and funds received by grant budget period.

Table 5: Ryan White Part B Supplemental Funds		
Grant Budget Period	Application(s)	Funds Received
2016 (09/30/2016 – 09/29/2017)	\$18,700,000	\$18,700,000*
2017 (09/30/2017 – 09/29/2018)	\$35,000,000	\$35,000,000**
2018 (09/30/2018 – 09/29/2019)	\$35,000,000	\$23,766,000***
2019 (09/30/2019 – 09/29/2020)	\$15,000,000	\$6,376,000****
2020 (09/30/2020 – 09/29/2021)	\$10,000,000	\$2,628,306*****
<p>*Includes \$8.7 million for HIV Care Branch and \$10 million for ADAP.</p> <p>**Includes \$10 million for HIV Care Branch and \$25 million for ADAP.</p> <p>***Includes \$6.8 million for HIV Care Branch and \$17 million for ADAP.</p> <p>****Includes \$1.7 million for HIV Care Branch and \$4.7 million for ADAP.</p> <p>*****Includes \$61,000 for HIV Care Branch and \$2.5 million for ADAP.</p>		

Description of Change: In May 2020, OA applied for the competitive 2020 Ryan White Part B Supplemental grant. OA requested the maximum amount of \$10 million with \$7.5 million specifically for ADAP to be used in 2020-21. On August 21, 2020, OA received the notice of award for the 2020 Ryan White Part B Supplemental grant in the amount of \$2.6 million, which is \$7.4 million less than what was applied for. \$61,000 will go to the HIV Care Branch and \$2.5 million will go to the ADAP Branch for medication expenditures.

Discretionary: Yes

Reason for Adjustment/Change:

- The Ryan White Part B Supplemental grant is a competitive funding opportunity.
- Prior funding does not guarantee that funding will be provided in the future.

Fiscal Impact and Fund Source(s): Decrease of \$2.1 million Local Assistance in 2020-21 and 2021-22. The fund impacted is the Federal Trust Fund (Fund 0890).

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

Background: The Ryan White Part B grant is the largest of the three federal grants that ADAP receives funding for and unlike the other two grants 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 timely on all reporting requirements. The grant is shared between OA's HIV Care Branch and ADAP Branch and is broken into three main sub-components: Base, Minority AIDS Initiative (MAI), and ADAP Earmark. Funding for Base and MAI is utilized by the HIV Care Branch and ADAP Earmark funding is utilized by the ADAP Branch.

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. OA can generally determine how carryover funding is utilized with the exception of MAI funding, which must be utilized solely by the HIV Care Branch. Carryover funding from the Base and the ADAP Earmark are always utilized by the ADAP Branch due to administrative limitations that prevent the HIV Care Branch from timely utilization of carryover funds as carryover funding must be expended by March 31 of any given year.

On August 28, 2020, OA finalized closing the 2019 Ryan White Part B grant with HRSA and applied for carryover funding. Upon closure of the grant there remained \$3.9 million in unspent funding, of which ADAP Branch applied for in carryover \$3.8 million and the HIV Care Branch applied for \$96,000.

Description of Change: On November 23, 2020, OA received a notice of award for the full \$3.9 million that was requested in unspent funding. ADAP Branch's portion of this award is \$3.8 million.

Discretionary: Yes

Reason for Adjustment/Change:

- Fully leverage federal funding.

Fiscal Impact and Fund Source(s): Increase of \$3.8 million Local Assistance in FY 2020-21. The fund impacted is the Federal Trust Fund (Fund 0890).

Unchanged Assumptions/Premises

Decrease in Federal Funds: 2020 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 November 4, 2019, OA applied for the maximum amount of \$10 million for the competitive 2020 ADAP Emergency Relief Funds grant, which is \$1 million less than in prior years. On February

21, 2020, OA received the notice of award for the 2020 ADAP Emergency Relief Funds grant in the amount of \$6.5 million.

The table below displays the historical amount OA applied for and the amount that was received:

Table 4: ADAP Emergency Relief Funds (Shortfall Relief) Grant		
Grant Budget Period	Application(s)	Funds Received
2016 (04/01/2016 – 03/31/2017)	\$11,000,000	\$10,991,645
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

Description of Change: No change from the 2020-21 May Revision Estimate

Discretionary: Yes

Reason for Adjustment/Change:

- The ADAP Emergency Relief Funds grant is a competitive funding opportunity.
- Prior funding does not guarantee that funding will be provided in the future.

Fiscal Impact and Fund Source(s): Decrease of \$4.5 million in Local Assistance in 2020-21 (adjustment made in 2020-21 May Revision Estimate). The fund impacted is the Federal Trust Fund (Fund 0890).

Discontinued Assumptions/Premises

Access, Adherence, and Navigation (AAN) Program

Why is Change Needed/Reason for Adjustment: On March 31, 2020, the six contracts representing nine AAN sites ended. Additionally, the funding for the AAN pilot program ended; therefore, this assumption will be discontinued. As last reported in the 2020-21 May Revision, OA will bring AAN functions in-house in order to navigate uninsured individuals to comprehensive health coverage and to support ADAP clients with achieving and maintaining viral suppression statewide. This effort is currently being implemented.

ADAP Special Fund State Operations Cost Adjustment - Interim ADAP Enrollment System (AES)/Project Approval Lifecycle (PAL)

Why is Change Needed/Reason for Adjustment: Previously approved in the 2019-20 November Estimate for use in 2019-20. Since 2019-20 has ended and the funding has already been expended, this assumption will be discontinued. The enhancements identified via the PAL process were completed making the interim AES the permanent IT solution. A budget change proposal was included in the 2020-21 Governor's Budget for ongoing budget authority for Maintenance and Operations and was approved. Funding is included in the 2020 Budget Act.

Decrease in Federal Funds: 2019 Ryan White Part B Grant

Why is Change Needed/Reason for Adjustment: Previously approved in the 2020-21 ADAP November Estimate for use in 2019-20. Since 2019-20 has ended and the funding has already been expended, this assumption will be discontinued.

Decrease in Federal Funds: 2019 Ryan White Part B Supplemental Grant

Why is Change Needed/Reason for Adjustment: Previously approved in the 2020-21 ADAP November Estimate for use in 2019-20. Since 2019-20 has ended and the funding has already been expended, this assumption will be discontinued.

Federal Funds: 2019 ADAP Emergency Relief Funds Grant (ADAP Shortfall Relief Grant)

Why is Change Needed/Reason for Adjustment: Previously approved in the 2020-21 ADAP November Estimate for use in 2019-20. Since 2019-20 has ended and the funding has already been expended, this assumption will be discontinued.

Increase in Federal Funds: 2018 Ryan White Part B Grant Carryover

Why is Change Needed/Reason for Adjustment: Previously approved in the 2020-21 ADAP November Estimate for use in 2019-20. Since 2019-20 has ended and the funding has already been expended, this assumption will be discontinued.

New HIV Drug

Why is Change Needed/Reason for Adjustment: Previously approved in the 2019-20 ADAP May Revision Estimate, ibalizumab (Trogarzo™) was added to the ADAP formulary on May 3, 2019. Since this drug has been approved and added to the ADAP formulary, this assumption will be discontinued.

V. Expenditure Details

A. A detailed breakdown of caseload and expenditures by client group and service type is displayed below in Tables 6 through 11.

TABLE 6: FY 2020-21 - November Estimate Caseload and Variable Expenditures							
CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE				
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	ADDITIONAL ADMIN COSTS	TOTAL EXPENDITURE
Medication-Only	13,105	37.7%	\$340,881,795	\$0	\$0	\$1,221,998	\$342,103,793
Medi-Cal SOC	104	0.3%	\$1,106,344	\$0	\$0	\$9,720	\$1,116,065
Private insurance*	10,479	30.2%	\$20,452,775	\$64,860,660	\$1,778,894	\$1,683,578	\$88,775,907
Medicare Part D*	7,720	22.2%	\$19,516,929	\$3,281,378	\$383,408	\$1,240,218	\$24,421,933
PrEP-AP	3,325	9.6%	\$263,431	\$0	\$1,326,955	\$2,546,115	\$4,136,501
SUBTOTAL	34,733	100.0%	\$382,221,274	\$68,142,038	\$3,489,257	\$6,701,630	\$460,554,199
Enrollment Site Costs	0	0.0%	\$0	\$0	\$0	\$6,780,000	\$6,780,000
TOTAL	34,733	100.0%	\$382,221,274	\$68,142,038	\$3,489,257	\$13,481,630	\$467,334,199

* Subgroup of 12,005 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: 2020 Budget Act Caseload and Variable Expenditures							
CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE				
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	ADDITIONAL ADMIN COSTS	TOTAL EXPENDITURE
Medication-Only	12,185	33.4%	\$308,722,375	\$0	\$0	\$39,850	\$308,762,225
Medi-Cal SOC	144	0.4%	\$1,209,146	\$0	\$0	\$470	\$1,209,616
Private insurance*	10,705	29.3%	\$21,125,768	\$61,319,291	\$3,191,524	\$1,438,961	\$87,075,544
Medicare Part D*	7,627	20.9%	\$17,905,053	\$4,605,683	\$741,166	\$1,025,291	\$24,277,192
PrEP-AP	5,863	16.1%	\$3,626,475	\$0	\$2,017,760	\$3,088,196	\$8,732,431
SUBTOTAL	36,523	100.0%	\$352,588,816	\$65,924,973	\$5,950,450	\$5,592,768	\$430,057,008
Enrollment Site Costs	0	0.0%	\$0	\$0	\$0	\$8,282,500	\$8,282,500
TOTAL	36,523	100.0%	\$352,588,816	\$65,924,973	\$5,950,450	\$13,875,268	\$438,339,508

* Subgroup of 11,425 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 2020-21 - Difference Between November Estimate and 2020 Budget Act							
CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE				
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	ADDITIONAL ADMIN COSTS	TOTAL EXPENDITURE
Medication-Only	920	7.6%	\$32,159,420	\$0	\$0	\$1,182,148	\$33,341,568
Medi-Cal SOC	-40	-27.5%	-\$102,801	\$0	\$0	\$9,250	-\$93,551
Private insurance*	-226	-2.1%	-\$672,993	\$3,541,369	-\$1,412,630	\$244,617	\$1,700,363
Medicare Part D*	92	1.2%	\$1,611,877	-\$1,324,305	-\$357,758	\$214,928	\$144,741
PrEP-AP	-2,538	-43.3%	-\$3,363,044	\$0	-\$690,804	-\$542,081	-\$4,595,930
SUBTOTAL	-1,790	-4.9%	\$29,632,458	\$2,217,064	-\$2,461,193	\$1,108,862	\$30,497,191
Enrollment Site Costs	0	0.0%	\$0	\$0	\$0	-\$1,502,500	-\$1,502,500
TOTAL	-1,790	-4.9%	\$29,632,458	\$2,217,064	-\$2,461,193	-\$393,638	\$28,994,691

* Subgroup increased 580 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 2021-22 - November Estimate Caseload and Variable Expenditures

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE				
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	ADDITIONAL ADMIN COSTS	TOTAL EXPENDITURE
Medication-Only	13,142	37.4%	\$355,255,595	\$0	\$0	\$1,224,561	\$356,480,156
Medi-Cal SOC	108	0.3%	\$1,148,384	\$0	\$0	\$10,041	\$1,158,425
Private insurance*	10,717	30.5%	\$21,016,850	\$82,827,977	\$1,914,084	\$1,849,256	\$107,608,168
Medicare Part D*	7,767	22.1%	\$20,491,534	\$4,283,559	\$537,252	\$1,340,340	\$26,652,684
PrEP-AP	3,430	9.8%	\$188,582	\$0	\$1,367,012	\$2,595,762	\$4,151,355
SUBTOTAL	35,164	100.0%	\$398,100,945	\$87,111,536	\$3,818,348	\$7,019,960	\$496,050,788
Enrollment Site Costs	0	0.0%	\$0	\$0	\$0	\$7,415,000	\$7,415,000
TOTAL	35,164	100.0%	\$398,100,945	\$87,111,536	\$3,818,348	\$14,434,960	\$503,465,788

* Subgroup of 14,413 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: 2020 Budget Act Caseload and Variable Expenditures

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE				
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	ADDITIONAL ADMIN COSTS	TOTAL EXPENDITURE
Medication-Only	12,185	33.4%	\$308,722,375	\$0	\$0	\$39,850	\$308,762,225
Medi-Cal SOC	144	0.4%	\$1,209,146	\$0	\$0	\$470	\$1,209,616
Private insurance*	10,705	29.3%	\$21,125,768	\$61,319,291	\$3,191,524	\$1,438,961	\$87,075,544
Medicare Part D*	7,627	20.9%	\$17,905,053	\$4,605,683	\$741,166	\$1,025,291	\$24,277,192
PrEP-AP	5,863	16.1%	\$3,626,475	\$0	\$2,017,760	\$3,088,196	\$8,732,431
SUBTOTAL	36,523	100.0%	\$352,588,816	\$65,924,973	\$5,950,450	\$5,592,768	\$430,057,008
Enrollment Site Costs	0	0.0%	\$0	\$0	\$0	\$8,282,500	\$8,282,500
TOTAL	36,523	100.0%	\$352,588,816	\$65,924,973	\$5,950,450	\$13,875,268	\$438,339,508

* Subgroup of 11,425 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 2020-21 - Difference Between November Estimate and 2020 Budget Act

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE				
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	ADDITIONAL ADMIN COSTS	TOTAL EXPENDITURE
Medication-Only	957	7.9%	\$46,533,220	\$0	\$0	\$1,184,711	\$47,717,931
Medi-Cal SOC	-36	-25.0%	-\$60,762	\$0	\$0	\$9,571	-\$51,191
Private insurance*	12	0.1%	-\$108,918	\$21,508,686	-\$1,277,440	\$410,295	\$20,532,624
Medicare Part D*	140	1.8%	\$2,586,482	-\$322,124	-\$203,915	\$315,049	\$2,375,492
PrEP-AP	-2,433	-41.5%	-\$3,437,893	\$0	-\$650,748	-\$492,434	-\$4,581,075
SUBTOTAL	-1,360	-3.7%	\$45,512,129	\$21,186,562	-\$2,132,102	\$1,427,192	\$65,993,781
Enrollment Site Costs	0	0.0%	\$0	\$0	\$0	-\$867,500	-\$867,500
TOTAL	-1,360	-3.7%	\$45,512,129	\$21,186,562	-\$2,132,102	\$559,692	\$65,126,281

* Subgroup increased 2,988 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

This client group includes individuals who do not have private insurance and are not enrolled in Medi-Cal or Medicare Part D. ADAP covers the full cost of prescription medications for these individuals for medications on the ADAP formulary. This group only receives services associated with medication costs.

1. Medication Expenditures:

- For 2020-21, OA estimates medication expenditures for medication-only clients will be \$340.9 million, which is a \$32.2 million increase compared to the 2020 Budget Act. The increase in expenditures is due to a much higher increase in average clients per month and higher average medication costs per month than previously projected.
 - For 2021-22, OA estimates medication expenditures for medication-only clients will be \$355.3 million, which is a \$46.5 million increase compared to the 2020 Budget Act. The increase in expenditures is due to the same reasons 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

This client group includes individuals enrolled in Medi-Cal who have a SOC for Medi-Cal services. This group only receives services associated with medication costs.

1. Medication Expenditures:

- For 2020-21, OA estimates medication expenditures for Medi-Cal SOC clients will be \$1.1 million, which is a \$103,000 decrease compared to the 2020 Budget Act. The decrease in expenditures is due to a slightly lower average caseload per month and lower average medication costs per month.
 - For 2021-22, OA estimates medication expenditures for Medi-Cal SOC clients will be \$1.2 million, which is a \$61,000 decrease compared to the 2020 Budget Act. The decrease in expenditures is due to the same reasons 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

This client group includes individuals who have some form of health insurance including insurance purchased through Covered California, privately purchased

health insurance, or employer-based health insurance; therefore, 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.

1. Medication Expenditures:

- For 2020-21, OA estimates medication expenditures for all private insurance clients will be \$20.5 million, which is a \$673,000 decrease compared to the 2020 Budget Act. The decrease in expenditures is due to a slight decrease in average clients per month and average medication costs per month.
- For 2021-22, OA estimates medication expenditures for all private insurance clients will be \$21.0 million, which is a \$109,000 decrease compared to the 2020 Budget Act. The small decrease in expenditures is due to a slight decrease in average medication costs per month.

2. Health Insurance Premiums:

- For 2020-21, OA estimates health insurance premium payment expenditures for all private insurance clients will be \$64.9 million, which is a \$3.5 million increase compared to the 2020 Budget Act. The increase in expenditures is due to a much higher increase in average clients per month, but offset by reduced average premium costs for Covered California and non-Covered California clients per month.
- For 2021-22, OA estimates health insurance premium payment expenditures for all private insurance clients will be \$82.8 million, which is a \$21.5 million increase compared to the 2020 Budget Act. The increase in expenditures is due to the same reasons listed above.

3. Medical Out-Of-Pocket Costs:

- For 2020-21 OA estimates medical out-of-pocket costs for all private insurance clients will be \$1.8 million, which is a \$1.4 million decrease compared to the 2020 Budget Act. The decrease in expenditures is due to lower than projected average service utilization per month and lower average costs per service per month.
- For 2021-22, OA estimates medical out-of-pocket costs for all private insurance clients will be \$1.9 million, which is a \$1.3 million decrease compared to the 2020 Budget Act. The decrease in expenditures is due to the same reasons listed above.

d. Medicare Part D clients

This client group includes individuals who are enrolled in Medicare and have purchased Medicare Part D plans for medication coverage. This group receives services associated with medication costs, medical out-of-pocket costs, Medicare Part D health insurance premiums and assistance with Medigap premiums, which cover medical out-of-pocket costs.

1. Medication Expenditures:

- For 2020-21, OA estimates medication expenditures for Medicare Part D clients will be \$19.5 million, which is a \$1.6 million increase compared to the 2020 Budget Act. The increase in expenditures is due to a slight increase in average clients per month and higher average medication costs per month than previously projected.
 - For 2021-22, OA estimates medication expenditures for Medicare Part D clients will be \$20.5 million, which is a \$2.6 million increase compared to the 2020 Budget Act. The increase in expenditures is due to the same reasons listed above.
2. Health Insurance Premiums:
- For 2020-21, OA estimates Medicare Part D premium payment expenditures will be \$3.3 million, which is a \$1.3 million decrease compared to the 2020 Budget Act. The decrease in expenditures is primarily due to a decrease in average clients per month for both Medicare Part D and Medigap premiums and lower than anticipated Medicare Part D average premium costs per month.
 - For 2021-22, OA estimates Medicare Part D premium payment expenditures will be \$4.3 million, which is a \$322,000 decrease compared to the 2020 Budget Act. The smaller decrease in expenditures is due to an increase in average clients per month for both Medicare Part D and Medigap premiums combined with a decrease in average Medicare Part D premium costs per month offset by an increase in average Medigap premium costs per month.
3. Medical Out-Of-Pocket Costs:
- For 2020-21, OA estimates medical out-of-pocket costs for Medicare Part D clients will be \$383,000, which is a \$358,000 decrease compared to the 2020 Budget Act. The decrease in expenditures is primarily due to lower than projected average service utilization per month and lower average costs per service per month.
 - For 2021-22, OA estimates medical out-of-pocket costs for Medicare Part D clients will be \$537,000, which is a \$204,000 decrease compared to the 2020 Budget Act. The smaller decrease in expenditures is due to comparable average caseload per month, but lower average costs per service per month.
- e. PrEP-AP clients

This client group includes HIV-negative persons at risk for acquiring HIV who are taking PrEP and for clients possibly exposed to HIV who are taking PEP. For insured clients, PrEP-AP covers the gap between what the client's health insurance plan and the manufacturer's medication co-payment assistance program will pay towards medication costs, along with any PrEP-related medical out-of-pocket costs. Clients without health insurance receive benefits related only to PrEP-related medical costs as PrEP medication is received free from the manufacturer's medication assistance program.

1. Medication Expenditures:

- For 2020-21, OA estimates medication expenditures for PrEP-AP clients will be \$263,000, which is a \$3.4 million decrease compared to the 2020 Budget Act. The decrease in expenditures is primarily due to a decrease in average clients per month and average medication costs per month for insured clients per the USPSTF's recommendations (see New Assumption #1) as insurance plans cover the majority of the costs.
 - For 2021-22, OA estimates medication expenditures for PrEP-AP clients will be \$189,000, which is a \$3.4 million decrease compared to the 2020 Budget Act. The decrease in expenditures is due to the same reasons listed above.
2. Health Insurance Premiums: There are no health insurance premium expenditures for PrEP-AP clients.
 3. Medical Out-Of-Pocket Costs:
 - For 2020-21, OA estimates medical out-of-pocket costs for PrEP-AP clients will be \$1.3 million, which is a \$691,000 decrease compared to the 2020 Budget Act. The decrease in expenditures is primarily due to lower than projected average service utilization per month and lower average costs per service per month, especially for uninsured clients.
 - For 2021-22, OA estimates medical out-of-pocket costs for PrEP-AP clients will be \$1.4 million, which is a \$651,000 decrease compared to the 2020 Budget Act. The decrease in expenditures is due to the same reasons listed above.

VI. Historical Program Data and Trends

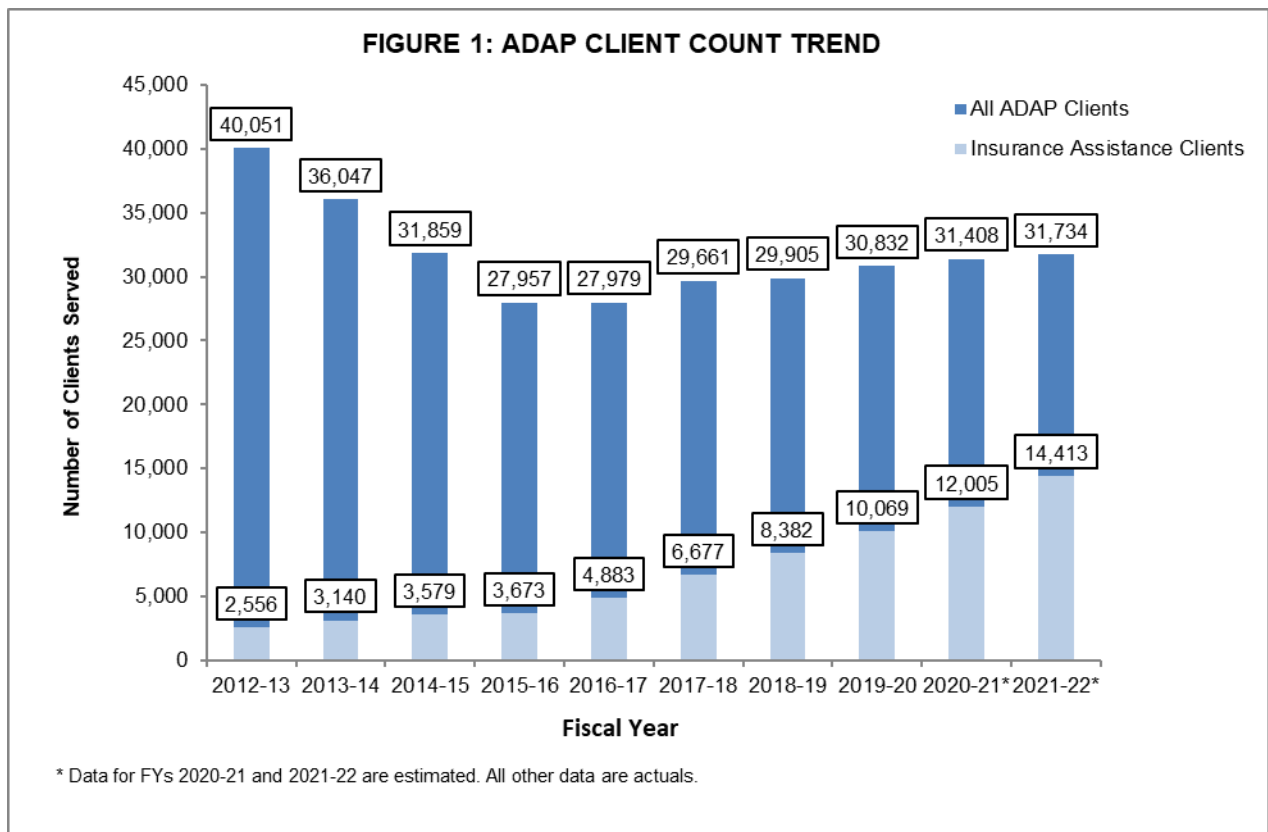
For all figures in this section, data prior to 2020-21 is the observed historical data. Estimates for 2020-21 and 2021-22 are based on the overall projections and include all assumptions.

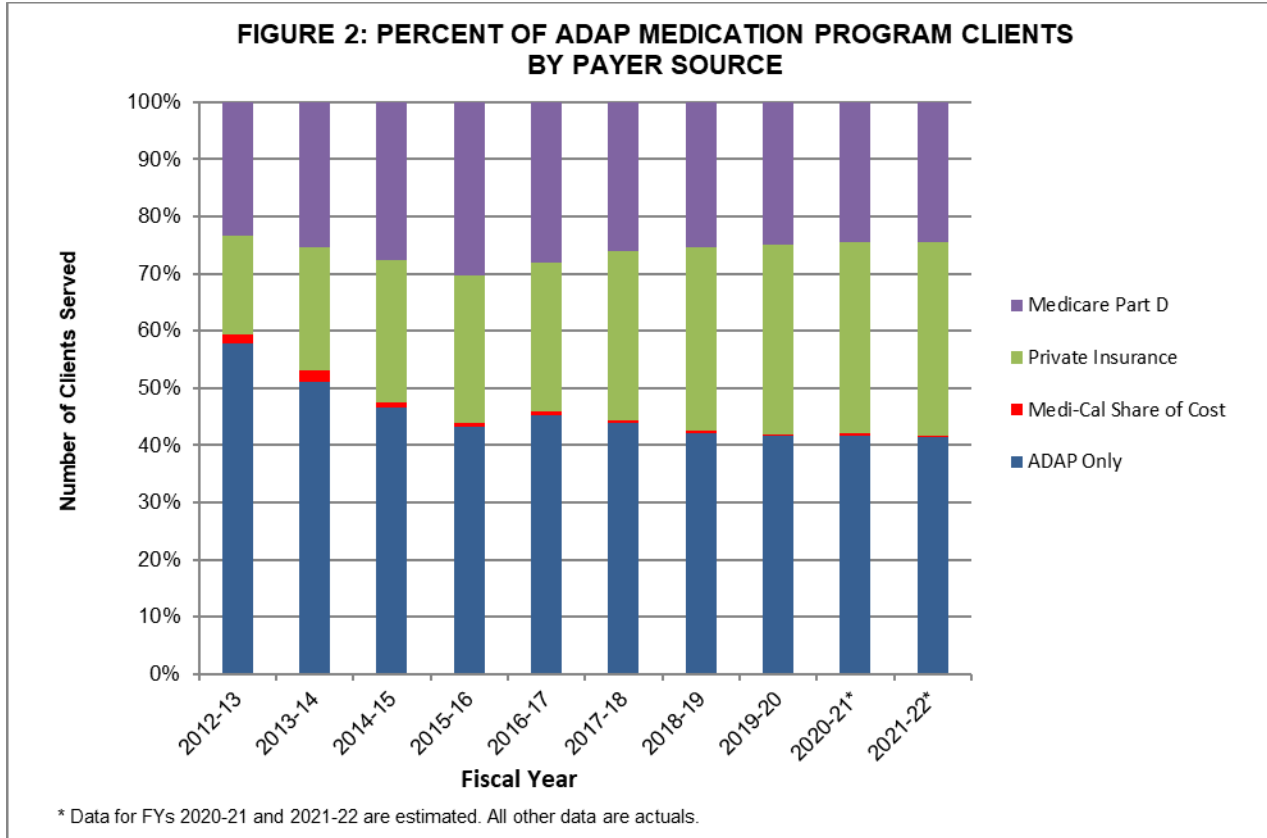
Figure 1 is a summary of client counts in ADAP by fiscal year excluding PrEP-AP clients. The number of ADAP medication program clients who are also receiving insurance assistance is also shown.

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

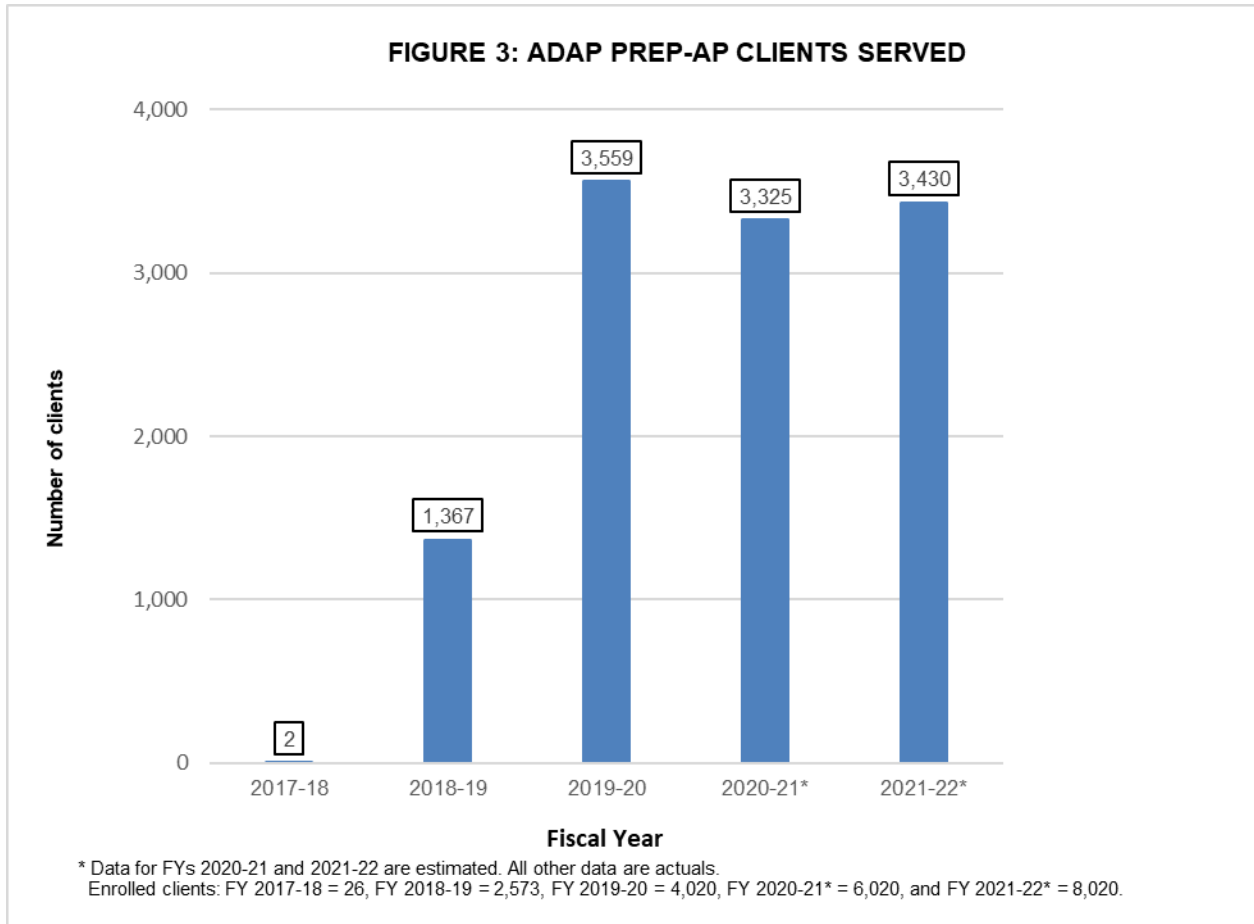
Figure 3 is a summary of client counts in PrEP-AP by fiscal year.

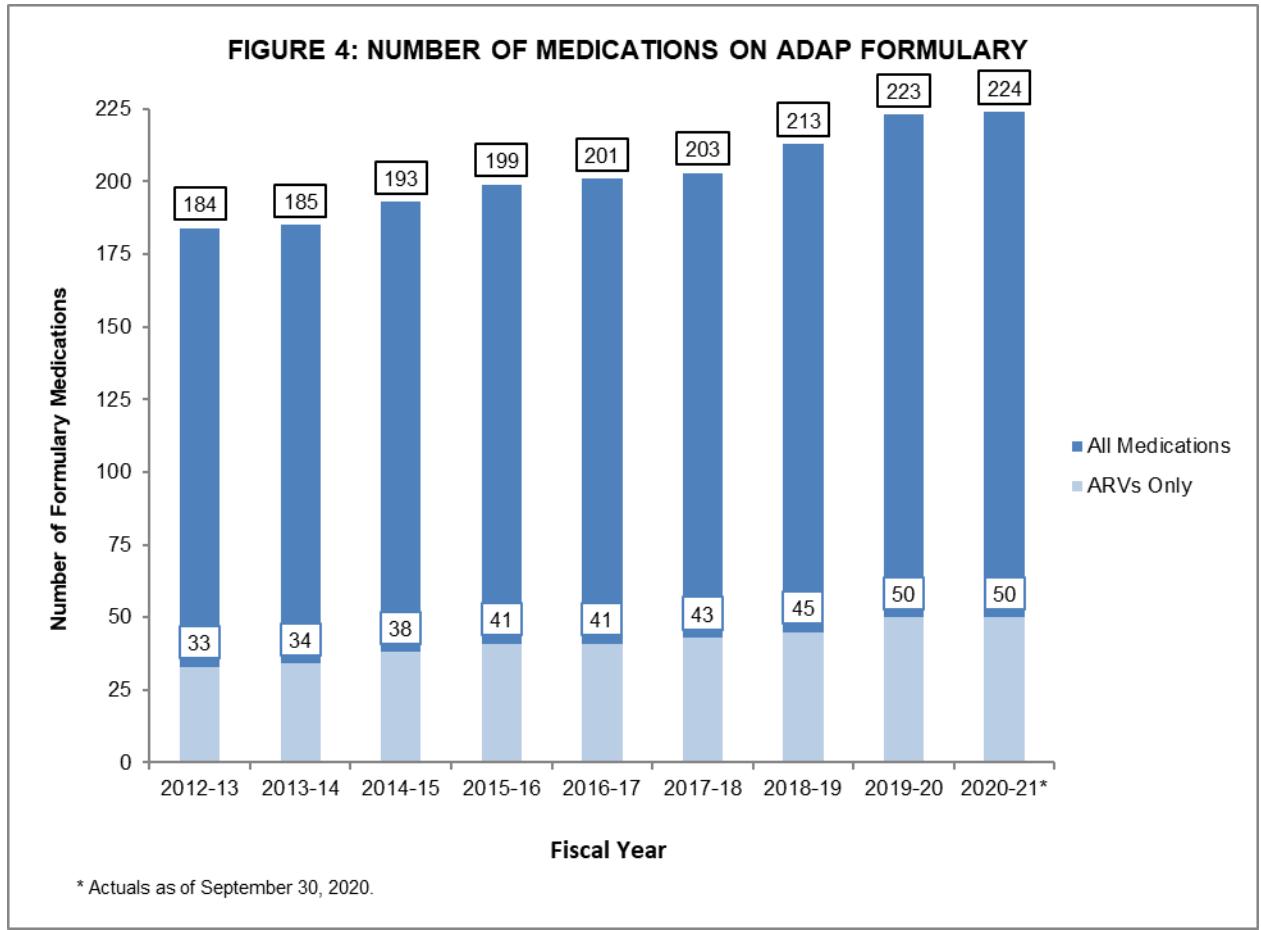
Figure 4 is the number of medications on the ADAP formulary by fiscal year; the number of ARV medications is also shown.





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

- Tesamorelin for injection (Egrifta SV™), non-ARV, growth hormone modifier, was added to the formulary on May 26, 2020.
- Osteltamivir (Tamiflu™), non-ARV, neuraminidase inhibitor, was added to the formulary on July 29, 2020.
- Lamivudine/tenofovir disoproxil fumarate (Temixys™), ARV, was added to the formulary on September 10, 2020.
- Fostemsavir (Rukobia™), ARV, was added to the formulary on September 22, 2020.

Deletions from the ADAP Formulary

- Stavudine (Zerit™), ARV, was deleted from the formulary on June 3, 2020.
- Indinavir (Crixivan™), ARV, was deleted from the formulary on June 5, 2020.
- Rosiglitazone (Avandia™), non-ARV, antidiabetic, was deleted from the formulary on September 10, 2020.

- Clofazimine (Lamprene™), non-ARV, antibiotic, was deleted from the formulary on September 10, 2020.
- Trimetrexate (Neutrexin™), non-ARV, antibiotic, was deleted from the formulary on September 10, 2020.

VII. Current HIV Epidemiology in California

Approximately 136,500 people in California at the end of 2018 had been diagnosed with HIV and reported to OA. However, OA estimates that 12 percent of all PLWH in California are unaware of their infection. Therefore, OA estimates that there were approximately 157,000 PLWH in California as of the end of 2018. Since the epidemic began in 1981, approximately 100,000 Californians diagnosed with HIV have died, with over 1,800 dying in 2018 alone.

Of the approximately 136,500 people living with diagnosed HIV (PLWDH) in California, approximately 38.1 percent are White; 36.9 percent are Hispanic/Latinx; 17.1 percent are Black/African American; 4.1 percent are Asian; 3.2 percent are multi-racial; 0.3 percent are American Indian/Alaskan Native; and 0.2 percent are Native Hawaiian/Pacific Islander. While Whites and Hispanics/Latinxs make up the largest percentage of PLWDH in California, the rate of HIV among Blacks/African Americans is substantially higher (1,028 per 100,000 population, versus 340 per 100,000 among Whites and 323 per 100,000 among Hispanics/Latinxs).

Most of California's living HIV cases are attributed to male-to-male sexual transmission (66.7 percent); 8.6 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); 6.5 percent to men who have sex with men who also inject drugs; 5.7 percent to injection drug use; 1.4 percent to transgender sexual contact; 0.5 percent to perinatal exposure; and 10.6 percent to other or unknown sources including other heterosexual contact.

There are approximately 4,700 new HIV cases reported in California each year, which is a revision from the prior year of approximately 4,800 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 57 percent in 2014 to over 64 percent in 2018. The number of PLWH in the state is expected to grow by approximately three percent each year for the next two years and it is expected that this trend will continue 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.