AIDS DRUG ASSISTANCE PROGRAM (ADAP)

Fiscal Year 2018-19

May Revision Estimate

Karen L. Smith, MD, MPH
Director and State Public Health Officer

California Department of Public Health

California Department of Public Health

Table of Contents

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 HIV, and will be providing assistance with covering costs related to HIV pre-exposure prophylaxis (PrEP) for clients at risk for acquiring 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 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. Currently, employer-based insurance clients only receive medication services, but it is projected they will be offered health insurance premium and medical out-of-pocket cost services starting in June 2018.
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 and Medicare Part D health insurance premiums. Starting in the spring of 2018, qualifying Medicare Part D clients will have the option for premium assistance with Medigap supplemental insurance policies, which cover medical out-of-pocket costs, or for those without a Medigap policy, assistance with their Medicare Part B medical out-of-pocket costs.
5. **PrEP 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. Phase 1, for the uninsured population, was implemented in April 2018, while Phase 2, for the insured population, is projected to be implemented in June 2018. For insured clients, the PrEP Assistance Program (PrEP-AP) will pay for PrEP-related medical out-of-pocket costs and will cover the gap between what the client's insurance plan and the manufacture's co-payment assistance program will pay towards medication costs. For uninsured clients, the PrEP-AP will only provide assistance with PrEP-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 rebate for a majority of prescriptions purchased for ADAP clients. ADAP does not collect rebate for prescriptions purchased for Medi-Cal SOC, nor PrEP-AP, clients. As the primary payer, Medi-Cal has the right to claim federal 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. CDPH also does not collect rebate on medication purchases for PrEP-AP clients because the 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 potentially eligible clients must apply. Clients who enroll in full-scope Medi-Cal are disenrolled 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. 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 (RW) system.

II. Estimate Overview

The ADAP Estimate for the 2018-19 May Revision provides a revised projection of Current Year [Fiscal Year (FY) 2017-18] local assistance costs for the medication and health insurance programs for ADAP, along with projected local assistance costs for Budget Year (FY 2018-19).

Table 1, page 4, shows the estimated ADAP local assistance expenditure need for the Current Year, and compares it to the amount reflected in the 2018-19 Governor's Budget.

- For FY 2017-18, CDPH estimates that ADAP expenditures will be $392 million, which is a $6.2 million decrease in expenditures compared to the 2018-19 Governor's Budget.

- For FY 2018-19, CDPH estimates that ADAP expenditures will be $432.1 million, which is a $2.3 million decrease in expenditures compared to the 2018-19 Governor's Budget.

Table 2, page 4, shows the estimated ADAP revenue for Current Year and Budget Year and compares them to the amount reflected in the 2018-19 Governor's Budget.

- For FY 2017-18, CDPH estimates ADAP revenue will be $314.1 million, which is a $14.2 million decrease compared to the 2018-19 Governor's Budget. The decrease is primarily due to actual medication expenditures from July through December 2017 being lower than projected in the 2018-19 Governor's Budget.

- For FY 2018-19, CDPH estimates ADAP revenue will be $326.5 million, which is a $22.5 million increase compared to the 2018-19 Governor's Budget. The increase is primarily due to projected medication expenditures from January through December 2018 being higher than projected in the 2018-19 Governor's Budget.

California Department of Public Health
AIDS Drug Assistance Program
2018-19 May Revision Estimate
Table 1: Local Assistance
(dollars in millions)

Local Assistance	2018-19 Governor's Budget	Current Year FY 2017-18			2018-19 Governor's Budget	Budget Year FY 2018-19		
		2018-19 May Revision Estimate	$ Change from 2018-19 Governor's Budget	% Change from 2018-19 Governor's Budget		2018-19 May Revision Estimate	$ Change from 2018-19 Governor's Budget	% Change from 2018-19 Governor's Budget
Fund:								
Total Funds Requested	**$398.1**	**$392.0**	**-$6.2**	**-1.5%**	**$434.4**	**$432.1**	**-$2.3**	**-0.5%**
Federal Funds - Fund 0890	$111.4	$111.4	$0.0	0.0%	$132.4	$132.4	$0.0	0.0%
Rebate Funds - Fund 3080	$286.7	$280.5	-$6.2	-2.2%	$302.0	$299.6	-$2.3	-0.8%
Caseload	29,896	28,597	-1,299	-4.3%	32,438	30,864	-1,574	-4.9%

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

Table 2: Rebate Fund Revenues (Fund 3080)
2018-19 May Revision Estimate
(dollars in millions)

Local Assistance	2018-19 Governor's Budget	Current Year FY 2017-18			2018-19 Governor's Budget	Budget Year FY 2018-19		
		2018-19 May Revision Estimate	$ Change from 2018-19 Governor's Budget	% Change from 2018-19 Governor's Budget		2018-19 May Revision Estimate	$ Change from 2018-19 Governor's Budget	% Change from 2018-19 Governor's Budget
Total Revenue Requested	**$328.3**	**$314.1**	**-$14.2**	**-4.3%**	**$304.0**	**$326.5**	**$22.5**	**7.4%**
Rebate Funds - Fund 3080	$326.6	$312.1	-$14.5	-4.4%	$302.3	$324.5	$22.2	7.3%
Interest Income	$1.8	$2.0	$0.3	14.3%	$1.8	$2.0	$0.3	14.3%

III. Overview Projections

A. Key influences on ADAP expenditures

a) FY 2017-18: Compared to the 2018-19 Governor's Budget, CDPH estimates that expenditures during FY 2017-18 will decrease by 1.5 percent. The decrease is primarily due to a projected decrease in caseload.

b) FY 2018-19: Compared to the 2018-19 Governor's Budget, CDPH estimates that expenditures during FY 2018-19 will decrease by 0.5 percent. The decrease is primarily due to a projected decrease in caseload.

B. Expenditures

ADAP expenditures are broken out into two types: 1) variable expenditures consisting of health care expenditures and, starting in FY 2018-19, enrollment expenditures (see Unchanged Assumption #2 on page 12) and 2) fixed 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. The services the different client groups receive can include coverage of the following health care expenses: prescription medication costs for medications 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.). Expenditures are also shown by these different services for each client group. Estimated expenditures by client group are shown in Table 3. A detailed discussion of caseload and expenditures by client group and service type is in Section V on page 14.
- Local ADAP enrollment services: beginning in FY 2016-17, CDPH 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. Starting in FY 2018-19, CDPH will be moving to a model in which the total amount of funds for ADAP services performed is adjusted annually through the Estimate process based on caseload and estimated services to be performed (see Unchanged Assumption #2 on page 12). Using this methodology, CDPH estimates $6.8 million in enrollment costs in FY 2018-19, a decrease of $1.1 million from the 2018-19 Governor's Budget. The decrease is due to a lower estimate

of client enrollment. A description of the reimbursement methodology is included in Section V (B) on page 18.

TABLE 3: ESTIMATED EXPENDITURES BY CLIENT GROUP

CLIENT GROUP	EXPENDITURES	
	FY 2017-18	FY 2018-19
Medication-Only	$315,706,847	$338,933,509
Medi-Cal SOC	$1,000,515	$1,000,515
Private Insurance	$45,906,517	$61,117,792
Medicare Part D+	$20,475,511	$22,879,604
PrEP	$863,193	$1,304,313
SUBTOTAL	**$383,952,583**	**$425,235,733**
Enrollment Costs	$8,000,000	$6,840,000
TOTAL	**$391,952,583**	**$432,075,733**

+ Expenditures for Medicare Part D clients include Part D premiums, Part D medication co-pays, Part B medical out-of-pocket expenses, and Medigap premiums.

b) Fixed Expenditures

- Local ADAP enrollment services: As described above on page 5, in the 2018-19 Governor's Budget, a fixed amount of $8.0 million was allocated for local ADAP enrollment services in FY 2017-18. Starting in FY 2018-19, enrollment costs will be considered variable expenditures.
- Access, Adherence, and Navigation Program (formerly ADAP Case Management): In FY 2017-18 and FY 2018-19, CDPH will be allocating funds to ADAP enrollment sites identified as having a large number of medication-only clients to provide navigation services to comprehensive health coverage and to provide assistance with achieving and maintaining viral suppression. CDPH estimates allocating approximately $1.2 million for Access, Adherence, and Navigation in FY 2017-18 and $2.3 million in FY 2018-19. See Existing Assumption #1 on page 10.
- Pharmacy Quality Incentive Program (QIP): In FY 2018-19, ADAP will allocate approximately $2.3 million to pharmacies in the ADAP network that provide specific care and prevention measures identified by CDPH with the goal of improving health outcomes and reducing overall state costs.

C. Revenue

a) ADAP Special Funds - ADAP receives both mandatory and voluntary supplemental rebates from drug manufacturers for ADAP drug expenditures. A six-month delay in rebate revenue exists because of the time required for billing the drug manufacturers and receipt of the rebate. FY 2017-18 revenue estimates are based on estimated rebates for actual expenditures from January through December 2017. FY 2018-19 revenue estimates are based on estimated rebates from estimated drug expenditures from January through December 2018.

- For FY 2017-18, CDPH estimates ADAP rebate revenue will decrease by 4.3 percent from $328.3 million in the 2018-19 Governor's Budget to $314.1 million in the revised Current Year forecast. The decrease is primarily due to actual medication expenditures from July through December 2017 being lower than projected in the 2018-19 Governor's Budget.

- For FY 2018-19, CDPH estimates ADAP rebate revenue will increase by 7.4 percent from $304 million in the 2018-19 Governor's Budget to $326.5 million in the revised Budget Year forecast. The increase is primarily due to projected medication expenditures from January 2018 through December 2018 being higher than projected in the 2018-19 Governor's Budget.

b) Federal Funds – for FY 2017-18, total federal fund expenditure authority will not change from the existing $111.4 million established in the 2018-19 Governor's Budget. Federal fund expenditure authority includes: the 2017 ADAP Earmark funds in the amount of $77.4 million, 2017 RW Part B Supplemental grant in the amount of $25 million, and the 2017 ADAP Emergency Relief Fund grant in the amount of $9 million. Additionally, ADAP received $3.9 million in carryover of unspent 2016 RW Part B HIV Care grant funding, which will be utilized for ADAP in FY 2017-18.

For FY 2018-19, total federal fund expenditure authority will not change from the existing $132.4 million established in the 2018-19 Governor's Budget. Federal fund expenditure authority includes: 2018 ADAP Earmark funds in the amount of $96.4 million, for which CDPH will receive split Notice of Awards with the first received on April 6, 2018, and the second expected in June 2018; estimated 2018 RW Part B Supplemental grant funding in the amount of $25 million; and 2018 ADAP Emergency Relief Fund grant funding in the amount of $11 million, for which CDPH will receive split Notice of Awards with the first received on March 16, 2018, and the second tentatively expected in June 2018.

c) Match – the Health Resources and Services Administration (HRSA) requires grantees to have HIV-related non-HRSA expenditures. California's HRSA match requirement for the 2018 Federal RW Part B grant year (April 1, 2018 through March 31, 2019) is anticipated to be approximately $68.1 million. ADAP will confirm the exact match requirement when the second Notice of Award is received for the RW Part B grant, expected in June 2018. CDPH will meet the match requirement using CDPH's OA General Fund State Operations expenditures and Local Assistance expenditures for OA's HIV Surveillance and Prevention Programs, as well as HIV-related expenditures from the California Department of Corrections and Rehabilitation.

IV. Assumption Projections

Below, we summarize the projected impact for each of the major fiscal assumptions.

New Assumptions/Premises

1. ADAP Special Fund State Operations Cost Adjustments

   The FY 2018-19 Governor's Budget includes State Operations expenditure authority, of $7.1 million for FY 2017-18, which included a one-time expenditure authority increase to staff the ADAP Call and Data Processing Center, and to contract for development and implementation of the new interim ADAP Enrollment System (AES) after ADAP eligibility and enrollment functions were taken in-house due to the former enrollment benefits manager not meeting contract deliverables. In FY 2018-19, the Governor's Budget proposed $5.7 million in State Operations expenditure authority, which includes expenditure authority requested through the ADAP Eligibility and Enrollment Budget Change Proposal (BCP) for ongoing ADAP Call and Data Processing Center staffing, a voice over IP service contract for the ADAP Call Center, and informatics contractors to conduct data management and data transfers.

   The interim AES was built as a basic, interim solution while a permanent IT solution could be identified via the Project Approval Lifecycle (PAL) process. The California Department of Technology (CDT) and CDPH Information Technology Services Division (ITSD) are currently working collaboratively to evaluate a long-term IT solution for the ADAP enrollment benefits system.

   CDPH is requesting an ADAP Special Fund State Operations expenditure adjustment to reflect an increase of $1.6 million for FY 2017-18 and $4.4 million in FY 2018-19. For FY 2017-18, the $1.6 million consists of: 1) a contract for $275,000 to address CDPH-specific findings from a risk assessment that took place from December 1, 2016 through January 31, 2017, after security concerns were identified with the former enrollment benefits manager, 2) a contract amendment totaling $1 million to extend contractor staffing resources covering the time period January 1, 2018 to June 30, 2018, to add functionality to the AES necessary to facilitate various program enhancements, including the PrEP-AP (see Existing Assumption #2 on page 11) and adding functionality to extend insurance premiums and medical out-of-pocket benefits to individuals with employer based insurance and Medicare Part B and/or Medigap policies (see Unchanged Assumption #1 on page 12), 3) $209,000 for a consultant to assist ITSD with the PAL process, 4) $9,000 in CDT staff costs for PAL process oversight, and 5) $85,000 in ITSD staff costs for PAL project management. For FY 2018-19, the $4.4 million consists of: 1) $2.1 million for the final six months of the original contact and a contract amendment covering contractor staffing resources assigned to developing and

maintaining the AES from July 1, 2018 to December 31, 2018, 2) $700,000 for ongoing application development requirements based on project needs from January 1, 2019 to June 30, 2019, 3) $1.1 million for AES maintenance and operations from January 1, 2019 to June 30, 2019, 4) $41,000 for a consultant to assist ITSD with the PAL process, 5) $27,000 in CDT staffing costs for PAL process oversight, 6) $56,000 in CDT independent project oversight consulting costs, 7) $228,000 in ITSD staffing costs for PAL project management, and 8) $120,000 for a consultant to assist ITSD with independent verification and validation that the PAL process was completed as specified.

Existing Assumptions/Premises

1. Access, Adherence, and Navigation Program

   ADAP included projected cost savings and expenditures related to providing enhanced services to medication-only clients and clients who are not virally suppressed through outreach performed through the Access, Adherence, and Navigation Program in the FY 2018-19 Governor's Budget. ADAP selected the top 19 sites with the largest medication-only clients to offer participation in the Access, Adherence, and Navigation Program. By providing outreach, ADAP will be able to transition more medication-only clients to comprehensive health coverage and provide clients who are not virally suppressed with resources to help assist in achieving and maintaining viral suppression.

   Of the 19 ADAP enrollment sites invited to participate in the Access, Adherence, and Navigation Program, nine enrollment sites declined due to a variety of reasons including lack of capacity, financial disincentive due to reduced reimbursement rates from private insurance plans compared to higher reimbursement rates received for some Part A RW funded outpatient ambulatory health services, lack of infrastructure to bill for clients with private insurance, and concern over barriers to enrolling clients in off-exchange health insurance plans who are not eligible to purchase insurance through Covered California. As a result of the reduced number of participating enrollment sites, ADAP redirected $1.1 million of the $2.3 million in RW Part B federal funding formerly planned for ADAP enrollment sites (page 6 in the FY 2018-19 November Estimate) instead to pay for medications. ADAP is also adjusting the projected cost savings because of the reduced number of clients that transitioned to private insurance, due to the reduced number of enrollment sites participating in the Access, Adherence, and Navigation Program.

   In FY 2017-18, due to first year implementation and ramp up, ADAP expects a cost of $805,000 ($557,000 in drug expenditure savings, $158,000 in added premium payments, $4,000 medical out-of-pockets costs, and $1.2 million for enrollment site payments for Access, Adherence, and Navigation services) for navigating 40 medication-only clients to private insurance, compared to the $21.2 million in net savings from navigating an estimated 1,512 clients projected in the FY 2018-19 Governor's Budget. In FY 2018-19, ADAP projects net savings of $3.3 million

($8 million in drug expenditure savings, $2.3 million in added premium payments, $77,000 medical out-of-pocket costs, and $2.3 million for enrollment site payments for Access, Adherence, and Navigation services) from navigating an estimated 499 medication-only clients to private insurance, compared to $21.8 million in net savings from navigating an estimated 1,540 clients projected in the FY 2018-19 Governor's Budget.

2. PrEP Assistance Program (PrEP-AP)

The PrEP-AP will provide assistance with: 1) costs for PrEP-related medical services for uninsured individuals who are enrolled in a drug manufacturer's PrEP medication assistance program; and 2) for insured individuals, (a) the cost of medication copays, coinsurance, and deductibles for the prevention of HIV infection after the individual's insurance is applied and, if eligible, after the drug manufacturer's medication assistance program's contributions are applied; and b) medical copays, coinsurance, and deductibles for PrEP-related medical services. Phase 1, for the uninsured population, was implemented in April 2018, while Phase 2, for the insured population, is projected to be implemented in June 2018.

ADAP will incur local assistance PrEP-AP related expenses in FY 2017-18 of: 1) $30,000 to pay for one-time modifications made to the Medical Benefits Manager (MBM) IT platform to accommodate the PrEP-AP, in addition to the $355,000 communicated in the FY 2018-19 Governor's Budget, 2) $46,000 to display PrEP-AP clinical provider information on the PleasePrEPMe.org website to make it easier for prospective clients to locate a contracted clinical provider, 3) $217,000 toward the Pharmacy Benefits Management (PBM) platform to add PrEP-AP client types to ensure accurate pharmacy claim adjudication and coordination of benefits at the pharmacy point-of-sale, and 4) $171,000 for ongoing administrative and operation costs related to enhancing the scope of the PBM call center to accommodate the PrEP-AP, ongoing PrEP-AP formulary maintenance, modification and maintenance of the PBM website to integrate the PrEP-AP, and ongoing enforcement of prior authorization policies on restricted medications on the PrEP Assistance Program formulary. There will be additional PrEP-AP related expenses in FY 2018-19 of: 1) $245,000 for ongoing PBM administrative and operation costs, and 2) $59,000 to display PrEP-AP clinical provider information on the PleasePrEPME.org website.

In FY 2017-18, CDPH anticipates adding 250 clients to the PrEP-AP (83 fewer clients than the 333 projected in the 2018-19 Governor's Budget), resulting in $863,000 in PrEP-related expenditures ($10,000 in medication costs, $35,000 in medical expenses, and $819,000 in total implementation costs and costs for ongoing contracts and administration).

In FY 2018-19, CDPH estimates 1,450 clients will receive PrEP-AP services (83 fewer clients than 1,533 projected in the 2018-19 Governor's Budget), resulting in

$1.3 million in PrEP-related expenditures ($283,000 in medication costs, $718,000 in medical expenses, and $304,000 in costs for ongoing contracts and administration).

Unchanged Assumptions/Premises

1. Payment of Out-of-Pocket Medical Expenses for All OA Health Insurance Premium Payment (OA-HIPP) Clients

   CDPH currently pays private health insurance premiums and outpatient medical out of pocket costs for ADAP clients co-enrolled in OA-HIPP.

   The 2016 Budget Act included funding authority to allow OA-HIPP to pay health insurance premiums and medical out-of-pocket costs for all ADAP clients with health insurance, including those with employer based insurance. Through the 2017 Budget Act, ADAP clarified that it would extend OA-HIPP services to include payment of outpatient medical out-of-pocket costs or Medigap policies to clients co-enrolled in the Medicare Part D Premium Payment Program.

   CDPH expects to start enrolling individuals with employer based insurance into OA-HIPP in June 2018, and expects to be able to pay for Medicare Part B outpatient medical out-of-pocket costs and/or Medigap policies (which cover medical out-of-pocket costs) for clients enrolled in the Medicare Part D Premium Assistance Program in June 2018.

   For FY 2017-18, CDPH projects 97 clients with employer-based insurance will enroll in OA-HIPP, resulting in $246,000 in expenditures ($45,000 toward insurance premiums, $2,000 toward medical out-of-pocket costs, and $199,000 toward implementation costs). CDPH projects 276 clients will enroll in FY 2018-19, resulting in $968,000 in expenditures ($924,000 toward insurance premiums and $44,000 toward medical out-of-pocket costs).

   For FY 2017-18, CDPH projects 42 clients co-enrolled in the Medicare Part D Premium Assistance Program will receive benefits associated with Medicare Part B medical out-of-costs and/or Medigap premiums, resulting in $93,000 in expenditures ($12,000 in medical out-of-pocket costs and $81,000 toward implementation costs). For FY 2018-19, ADAP projects 267 clients will receive benefits associated with Medicare Part B medical out-of-pocket costs and/or Medigap premiums, resulting in $432,000 in expenditures.

2. Increase in Funding to ADAP Enrollment Sites

   The 2017 Budget Act included a one-time legislative augmentation of an additional $4 million for enrollment sites, for a total of $8 million in FY 2017-18. In order to allocate the additional one-time funding included in the legislative augmentation,

CDPH worked with a stakeholder group to refine the existing reimbursement model to include additional services that are currently being performed by ADAP Enrollment Workers. Moving forward, as proposed in the 2018-19 Governor's Budget and starting in FY 2018-19, CDPH will evaluate caseload and ADAP services performed by enrollment sites and will adjust reimbursements annually through the Estimate. For FY 2018-19, the reimbursement model will be similar to the model developed in conjunction with stakeholders for allocating one-time funding received through the legislative augmentation for FY 2017-18. See Section (V)(B) starting on page 18 for more details on the reimbursement model.

CDPH is in the process of developing metrics to monitor enrollment site performance and to ensure that this on-going increase in funding to ADAP enrollment sites results in improved client health outcomes and more clients transitioning to comprehensive health coverage. CDPH will work with stakeholders to finalize proposed metrics.

For FY 2018-19, ADAP projects enrollment costs of $6.8 million, a decrease of $1.1 million from the 2018-19 Governor's Budget. This decrease is due to a lower estimate of client enrollment. This proposal is expected to be cost neutral because CDPH expects at least 249 ADAP clients will transition to private insurance, resulting in $2.8 million in reduced medication expenditures.

Discontinued Major Assumptions

There are no Discontinued Major Assumptions.

V. Expenditure Details

A. A detailed breakdown of caseload and expenditures by client group and service type is shown below in Tables 4 and 5.

TABLE 4: ESTIMATED ANNUAL CASELOAD AND EXPENDITURES BY CLIENT GROUP AND SERVICE TYPE, FY 2017-18

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE				
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	ADDITIONAL ADMIN COSTS	TOTAL EXPENDITURE
Medication-Only	12,652	44.2%	$314,902,156	$0	$0	$804,691	$315,706,847
Medi-Cal SOC	162	0.6%	$997,733	$0	$0	$2,782	$1,000,515
Private insurance*	8,023	28.1%	$15,182,909	$28,231,012	$1,148,156	$1,344,441	$45,906,517
Medicare Part D*	7,510	26.3%	$19,441,397	$888,592	$12,101	$133,421	$20,475,511
PrEP	250	0.9%	$9,797	$0	$34,778	$818,618	$863,193
SUBTOTAL	**28,597**	**100.0%**	**$350,533,992**	**$29,119,603**	**$1,195,035**	**$3,103,953**	**$383,952,583**
Enrollment Costs	0	0.0%	$0	$0	$0	$8,000,000	$8,000,000
TOTAL	**28,597**	**100.0%**	**$350,533,992**	**$29,119,603**	**$1,195,035**	**$11,103,953**	**$391,952,583**

*** Subgroup of 6,268 clients receiving assistance for premium payments and medical-out-of-pocket costs.**

+ Medical out-of-pocket costs for Medicare Part D clients include Medigap premiums and Medicare Part B medical out-of-pocket expenses.

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

TABLE 5: ESTIMATED ANNUAL CASELOAD AND EXPENDITURES BY CLIENT GROUP AND SERVICE TYPE, FY 2018-19

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE				
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	ADDITIONAL ADMIN COSTS	TOTAL EXPENDITURE
Medication-Only	12,938	41.9%	$338,128,817	$0	$0	$804,691	$338,933,509
Medi-Cal SOC	162	0.5%	$997,733	$0	$0	$2,782	$1,000,515
Private insurance*	8,804	28.5%	$18,431,864	$40,698,533	$1,941,964	$45,431	$61,117,792
Medicare Part D*	7,510	24.3%	$21,132,799	$1,263,083	$431,626	$52,096	$22,879,604
PrEP	1,450	4.7%	$282,724	$0	$717,598	$303,991	$1,304,313
SUBTOTAL	**30,864**	**100.0%**	**$378,973,938**	**$41,961,616**	**$3,091,188**	**$1,208,991**	**$425,235,733**
Enrollment Costs	0	0.0%	$0	$0	$0	$6,840,000	$6,840,000
TOTAL	**30,864**	**100.0%**	**$378,973,938**	**$41,961,616**	**$3,091,188**	**$8,048,991**	**$432,075,733**

*** Subgroup of 7,286 clients receiving assistance for premium payments and medical-out-of-pocket costs.**

+ Medical out-of-pocket costs for Medicare Part D clients include Medigap premiums and Medicare Part B medical out-of-pocket expenses.

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 FY 2017-18, CDPH estimates medication expenditures for medication-only clients will be $314.9 million, which is a $3.9 million increase compared to the 2018-19 Governor's Budget. The increase in expenditures is primarily due to decreased medication savings from fewer clients transitioning to private insurance as a result of reduced enrollment site participation in the Access, Adherence, and Navigation Program (See Existing Assumption #1 on page 10) and higher medication costs.
   - For FY 2018-19, CDPH estimates medication expenditures for medication-only clients will be $338.1 million, which is a $16.2 million increase from the 2018-19 Governor's Budget. This increase is due to fewer than expected ADAP only clients navigating to private insurance as a result of reduced enrollment site participation in the Access, Adherence, and Navigation Program, higher medication costs, and an increase in Californians living with HIV.
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 receives services associated with medication costs.

1. Medication Expenditures
   - For FY 2017-18, CDPH estimates medication expenditures for Medi-Cal SOC clients will be $1.0 million, which is a $77,000 decrease compared to the 2018-19 Governor's Budget. The decrease in expenditures is due to fewer clients coded as Medi-Cal SOC accessing medications in ADAP as a result of a monthly match with the Department of Health Care Services, which identifies full-scope Medi-Cal clients who are disenrolled from ADAP.
   - For FY 2018-19, CDPH estimates medication expenditures for Medi-Cal SOC clients will also be $1.0 million, which is also a $77,000 decrease compared to the 2018-19 Governor's Budget. As in FY 2017-18, the decrease in expenditures is due to fewer clients coded as Medi-Cal SOC accessing medications in ADAP as a result of a monthly match with the Department of Health Care Services, which identifies full-scope Medi-Cal clients who are disenrolled from ADAP.
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. Currently, employer-based insurance clients only receive medication services, but it is expected they will be offered health insurance premium and medical out-of-pocket cost services starting in June 2018.

1. Medication Expenditures
   - For FY 2017-18, CDPH estimates medication expenditures for all private insurance clients will be $15.2 million, which is a $2.4 million decrease compared to the 2018-19 Governor's Budget. The decrease in expenditures is due to fewer clients transitioning to private insurance as a result of reduced enrollment site participation in the initial year of the Access, Adherence, and Navigation Program.
   - For FY 2018-19, CDPH estimates medication expenditures for all private insurance clients will be $18.4 million, which is a $5.0 million decrease compared to the 2018-19 Governor's Budget. This decrease is due to fewer clients than expected transitioning to private insurance as a result of the reduced enrollment site participation in the second year of the Access, Adherence, and Navigation Program.
2. Health Insurance Premiums
   - For FY 2017-18, CDPH estimates health insurance premium payment expenditures for all private insurance clients will be $28.2 million, which is a $3.4 million decrease compared to the 2018-19 Governor's Budget. Again, this decrease is due to the same reason as above with an offset for higher premiums.
   - For FY 2018-19, CDPH estimates health insurance premium payment expenditures will be $40.7 million, which is a $3.9 million decrease compared to the 2018-19 Governor's Budget. This decrease is due to the same client transition as above and the increase in premiums.
3. Medical Out-Of-Pocket Costs
   - For FY 2017-18, CDPH estimates medical out-of-pocket costs for all private insurance clients will be $1.1 million, which is a $483,000 decrease from the 2018-19 Governor's Budget. Fewer clients than previously anticipated are utilizing this benefit.
   - For FY 2018-19, CDPH estimates medical out-of-pocket costs will be $1.9 million, which is a $1.1 million decrease from the 2018-19 Governor's Budget. Fewer clients than previously anticipated are expected to use this benefit in FY 2017-18.

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 and Medicare Part D health insurance premiums. Starting in June 2018, CDPH expects Medicare Part D Premium Payment Program clients will also be eligible for coverage of Medigap supplemental insurance premiums (which cover medical out-of-pocket costs for Medicare Part B) and/or assistance with Medicare Part B outpatient medical out-of-pocket costs.

1. Medication Expenditures
   - For FY 2017-18, CDPH estimates medication expenditures for Medicare Part D clients will be $19.4 million, which is a $692,000 decrease from the 2018-19 Governor's Budget. The decrease in expenditures is due to fewer than anticipated clients with Medicare Part D plans in the medication assistance program. This decrease is offset by higher than anticipated deductibles and co-insurance.
   - For FY 2018-19, CDPH estimates medication expenditures for Medicare Part D clients will be $21.1 million, which is a $941,000 decrease from the 2018-19 Governor's Budget. This decrease is due to the same reason above for medication expenditures only.
2. Health Insurance Premiums
   - For FY 2017-18, CDPH estimates Medicare Part D premium payment expenditures will be $889,000, which is a $114,000 increase from the 2018-19 Governor's Budget. This slight change is due to both an increase in monthly premium payments and an increase in Medicare Part D clients for whom ADAP pays Medicare Part D premiums.
   - For FY 2018-19, CDPH estimates Medicare Part D premium payment expenditures will be $1.3 million, which is a $298,000 increase from the 2018-19 Governor's Budget. This increase is due to the same reasons as above.
3. Medical Out-Of-Pocket Costs
   - For FY 2017-18, CDPH estimates medical out-of-pocket costs will be $12,000, which is a $900 decrease from the 2018-19 Governor's Budget. This decrease is due to slightly lower than previously projected monthly costs for paying Medicare Part B medical out-of-pocket costs, including premiums for Medigap policies, for this client group.
   - For FY 2018-19, CDPH estimates medical out-of-pocket costs will be $432,000, which is a $51,000 decrease from the 2018-19 Governor's Budget. This decrease is due to the same reason as above.

e. PrEP clients

This client group includes HIV-negative persons at risk for acquiring HIV who are taking PrEP. For insured clients, the PrEP-AP will cover 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 will receive benefits related only to PrEP-related medical costs, as they will receive free drug from the manufacturer's free drug program. Phase 1, for the uninsured population, was implemented in April 2018, while Phase 2, for the insured population, is expected to be implemented in June 2018 (Existing Assumption #2 on page 11).

1. Medication Expenditures:
   - For FY 2017-18, CDPH estimates medication expenditures for the PrEP-AP will be $10,000, which is a $6,000 increase compared to the FY 2018-19 Governor's Budget. This increase is primarily due to projected drug expenditures associated with treatment of sexually transmitted infections (STIs), offset by a decrease in clients.
   - For FY 2018-19, CDPH estimates medication expenditures will be $283,000, which is a $163,000 increase from the 2018-19 Governor's Budget. This increase is due to full year implementation for this type of service.
2. Health Insurance Premiums: Health insurance premium coverage is not included in the PrEP-AP.
3. Medical Out-Of-Pocket Costs
   - For FY 2017-18, CDPH estimates medical out-of-pocket costs will be $35,000 for PrEP clients, which is a $123,000 decrease compared to the 2018-19 Governor's Budget. This decrease is primarily due to projected lower costs associated with the finalized negotiated fee schedule for medical services associated with this benefit.
   - For FY 2018-19, CDPH estimates medical out-of-pocket costs will be $718,000 for PrEP-AP clients, which is a $1.3 million decrease from the 2018-19 Governor's Budget. This decrease is due to the same reason as above offset by a full year implementation for this type of service.

B. ADAP Enrollment Services

a. For FY 2017-18, the reimbursement methodology is unchanged from the 2018-19 Governor's Budget, a fixed amount of $8.0 million was allocated for local ADAP enrollment services in FY 2017-18.
b. For FY 2018-19, the reimbursement methodology is unchanged from the 2018-19 Governor's Budget and will become a variable cost. CDPH updated projected enrollment numbers below, resulting in an estimate of $6.8 million in enrollment costs in FY 2018-19.
   1. New Medication Enrollment
      - CDPH estimates 3,000 clients will enroll into ADAP at some point throughout the fiscal year, which is a 1,000 client decrease compared to the 2018-19 Governor's Budget. The number of clients projected to enroll is larger than the ADAP caseload projection used when projecting expenditures. This is because expenditure projections take into

consideration the number of clients served, where some clients may enroll and never receive ADAP services.

2. Bi-annual Self-Verification
   - CDPH estimates 33,000 clients will recertify into ADAP at some point throughout the fiscal year, which is a 3,000 client decrease compared to the 2018-19 Governor's Budget. The number of clients projected to recertify is larger than the ADAP caseload projection for the same reason provided above.
3. ADAP Annual Re-Enrollment
   - CDPH estimates 33,000 clients will recertify into ADAP at some point throughout the fiscal year, which is a 3,000 client decrease compared to the 2018-19 Governor's Budget. The number of clients projected to recertify is larger than the ADAP caseload projection for the same reason provided above.
4. New Insurance Assistance Enrollment
   - CDPH estimates 1,200 clients will newly enroll into one of the two CDPH insurance assistance programs, which is a 1,200 client decrease compared to the 2018-19 Governor's Budget. This number is tied directly to expenditure/caseload projections.
5. Insurance Assistance Annual Re-Enrollment
   - CDPH estimates 6,300 existing clients enrolled in CDPH's insurance assistance programs will re-enroll during the fiscal year, which is a 1,600 client decrease compared to the 2018-19 Governor's Budget. This number is tied directly to expenditure/caseload projections.
6. New PrEP Enrollment
   - CDPH estimates 1,200 existing clients enroll into the PrEP Assistance Program during the fiscal year, which is a 333 client decrease compared to the 2018-19 Governor's Budget. This number is tied directly to caseload projections described in Existing Assumption #2 on page 11.
7. PrEP Re-Enrollment
   - CDPH estimates that 750 clients will re-enroll into the PrEP Assistance Program during the fiscal year due to implementation beginning in early 2018, which is a 650 client decrease compared to the 2018-19 Governor's Budget.
8. Paid Insurance Assistance Medical Out-of-Pocket Claims
   - As stated in the 2018-19 Governor's Budget, CDPH will no longer be reimbursing enrollment workers for this service in FY 2018-19. OA's MBM has a contract in place with a medical claims clearinghouse to streamline the medical out-of-pocket benefit process. As such, this work will no longer be performed by ADAP enrollment workers.
9. Paid PrEP Related Medical Out-of-Pocket Claims
   - As stated in the 2018-19 Governor's Budget, CDPH will not be reimbursing enrollment workers for this service. OA's MBM has a contract in place with a medical claims clearinghouse to streamline the medical out-of-pocket benefit process.

VI. Future Fiscal Issues

1. New HIV Drugs

The following HIV drug has received federal Food and Drug Administration (FDA) approval:

- Ibalizumab
  On March 6, 2018, the FDA approved ibalizumab (Trogarzo®), an HIV-1 inhibitor and long-acting monoclonal antibody for multi-drug resistant HIV-1 infection that is to be administered intravenously once every 14 days by a trained medical professional and used in combination with other antiretroviral (ARV) medications. The drug is indicated for adult patients who have tried multiple treatment options with current available therapies but whose HIV infections cannot otherwise be successfully treated, including those with multidrug-resistant HIV. Ibalizumab has not yet been classified by the federal Health and Human Services Agency as a new class of ARV. CDPH is working with the ADAP Crisis Task Force to negotiate the best possible price for this medication.

The following HIV drugs may receive FDA approval in the next year:

- Doravirine/lamivudine/tenofovir disoproxil fumarate
  This is a fixed-dose single tablet regimen combining an investigational non-nucleoside reverse transcriptase inhibitor (doravirine) and two nucleoside analog reverse transcriptase inhibitors (lamivudine and tenofovir disoproxil fumarate). On January 8, 2018, a New Drug Application (NDA) was submitted to the FDA for doravirine/lamivudine/tenofovir disoproxil fumarate for treatment of HIV-1 infected patients. The FDA has set a target action date of October 23, 2018.

- Darunavir/cobicistat/emtricitabine/tenofovir alafenmaide
  This new HIV drug combines a protease inhibitor (darunavir), a pharmacokinetic enhancer (cobicistat), a nucleoside reverse transcriptase inhibitor (emtricitabine), and a nucleotide reverse transcriptase inhibitor (tenofovir alafenamide). On September 25, 2017, Janssen Research and Development LLC announced the submission of an NDA for this once-daily single-tablet regimen for the treatment of HIV-1 infected adults. No FDA target action date has been set yet.

- Doravirine
  This is an investigational non-nucleoside reverse transcriptase inhibitor for use in the treatment of HIV-1 infection in combination with other ARV drugs. On January 8, 2018, the manufacturer, Merck Inc., announced that the FDA accepted an NDA for this once-daily tablet for the treatment of HIV-1 in treatment naïve adults. The FDA has set a target action date of October 23, 2018.

If doravirine/lamivudine/tenofovir disoproxil fumarate,

darunavir/cobicistate/emtricitabine/tenofovir alafenamide, and/or doravirine receive FDA approval and the ADAP Medical Advisory Committee recommends their addition to the ADAP formulary, OA will monitor pricing and supplemental rebates. If OA is able to determine that the drugs do not represent a significant cost increase to the program, ADAP will move forward with adding these drugs to the ADAP formulary.

2. Potential Increase in Federal Funds: 2018 ADAP Emergency Relief Funds (ERF) Grant

   In September 2017, HRSA released the funding opportunity announcement for the 2018 ADAP ERF supplemental grant. This award is intended for states/territories that demonstrate the need for additional resources to prevent, reduce, and/or eliminate ADAP waiting lists, including through implementation of cost-containment measures. California's cost-containment measures include scaling up the effort to encourage medication-only clients to enroll in comprehensive health coverage and OA's insurance assistance programs, and maintaining data sharing agreements to ensure ADAP is the payer of last resort.

   In November 2017, ADAP applied to HRSA for the maximum amount of $11 million for the competitive 2018 ADAP ERF grant. CDPH will receive split Notice of Awards with the first received on March 16, 2018, in the amount of $5.5 million, and the second tentatively expected in June 2018.

   The table below shows historically how much CDPH applied for through the ADAP ERF grant and how much was received:

ADAP Emergency Relief Funds		
Budget Period	**Funds Applied For**	**Funds Received**
2011 (8/01/2011 - 7/31/2012)	$3,000,000	$2,574,357
2012 (8/01/2012 - 9/29/2013)	$10,246,371	$10,141,268
2013 (9/30/2013 - 3/31/2014)	$10,761,268	$10,761,268
2014 (4/01/2014 - 3/31/2015)	$11,000,000	$11,000,000
2015 (4/01/2015 - 3/31/2016)	$11,000,000	$6,441,447
2016 (4/01/2016 - 3/31/2017)	$11,000,000	$10,991,645
2017 (4/01/2017 - 3/31/2018)	$9,000,000	$9,000,000
2018 (4/01/2018 - 3/31/2019)	$11,000,000	TBD

3. Potential Increase in Federal Funds: 2018 RW Part B Supplemental Grant

   In March 2018, HRSA released the funding opportunity announcement for the 2018 RW Part B Supplemental Grant. HRSA anticipates that approximately

$170.0 million will be available nationwide in 2018 RW Part B Supplemental funds. CDPH anticipates HRSA will award funds in September 2018. If awarded, these funds will be spent in the Budget Year.

The table below shows historically the amount of Ryan White Part B Supplemental Grant funding that CDPH applied for for use in the ADAP program and how much was received:

ADAP RW Part B Supplemental Funds		
Budget Period	**Funds Applied For**	**Funds Received**
2010 (09/30/2010 - 09/29/2011)	$3,700,000	$2,659,865
2011 (09/30/2011 - 09/29/2012)	$2,659,865	$1,376,784
2012 (09/30/2012 - 09/29/2013)	$2,659,865	$2,129,954
2013 (09/30/2013 - 09/29/2014)	$4,213,927	$1,738,531
2014 (09/30/2014 - 09/29/2015)	$2,000,000	$2,000,000
2015 (09/30/2015 – 09/29/2016)	$10,000,000	$10,000,000
2016 (09/30/2016 – 09/29/2017)	$10,000,000+	$10,000,000+
2017 (09/30/2017 – 09/29/2018)	$25,000,000*	$25,000,000*
+An additional $8.7 million for HIV Care core medical and support services was received. Total supplemental funds received were $18.7 million. *An additional $10.0 million for HIV Care core medical and support services was received. Total supplemental funds received were $35.0 million.		

VII. Fund Condition Statement

Table 7: Fund Condition Statement[1]
(in thousands)

	Special Fund 3080: AIDS Drug Assistance Program Rebate Fund		FY 2016-17 Actuals	FY 2017-18 Estimate	FY 2018-19 Estimate
1	BEGINNING BALANCE		221,109	260,803	285,526
2	Prior Year Adjustment		162	0	0
3	Adjusted Beginning Balance		221,271	260,803	285,526
4	REVENUES, TRANSFERS AND OTHER ADJUSTMENTS				
5	Revenues				
6	4163000 Income From Surplus Money Investments (Interest)		1,729	2,000	2,000
7	4171400 Escheat - Unclaimed Checks, Warrants, Bonds, and Coupons		16	0	0
8	4172500 Miscellaneous Revenue		249,767	312,099	324,462
9	Total Revenues, Transfers, and Other Adjustments		251,512	314,099	326,462
10	Total Resources		472,783	574,902	611,988
11	EXPENDITURES AND EXPENDITURE ADJUSTMENTS				
12	Expenditures				
13	8880	FI$Cal	1	2	0
14	4265	Department of Public Health			
15		State Operations	6,849	8,764	10,050
16		Medication Local Assistance	186,399	248,405	254,526
17		Insurance Local Assistance	18,691	32,125	45,112
18	9892	Supplemental Pension Payment	0	0	61
19	9900	Statewide General Administrative Expenditures	40	80	152
20	Total Expenditures and Expenditure Adjustments		211,980	289,376	309,901
21	**FUND BALANCE**		**260,803**	**285,526**	**302,087**

Row 6: Interest Actuals for FY 2016-17, Estimated for FYs 2017-18 and 2018-19	1,728,992	2,000,000	2,000,000
Miscellaneous Revenue			
Estimated Rebates received July - Sept 2017 for Actual Expenditures from Jan - March 2017		84,938,724	
Estimated Rebates received Oct - Dec 2017 for Actual Expenditures from Apr - June 2017		85,053,523	
Estimated Rebates received Jan - June 2018 for Actual Expenditures from July - Dec 2017		142,107,008	
Estimated Rebates to be received Jul - Dec 2018 for Estimated Expenditures from Jan - Jun 2018			163,119,046
Estimated Rebate to be received Jan - Jun 2019 for Estimated Expenditures from July - Dec 2018			161,343,087
Total Estimated FY 2017-18 Rebate Revenue		312,099,255	
Total Estimated FY 2018-19 Rebate Revenue			324,462,132

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

VIII. Historical Program Data and Trends

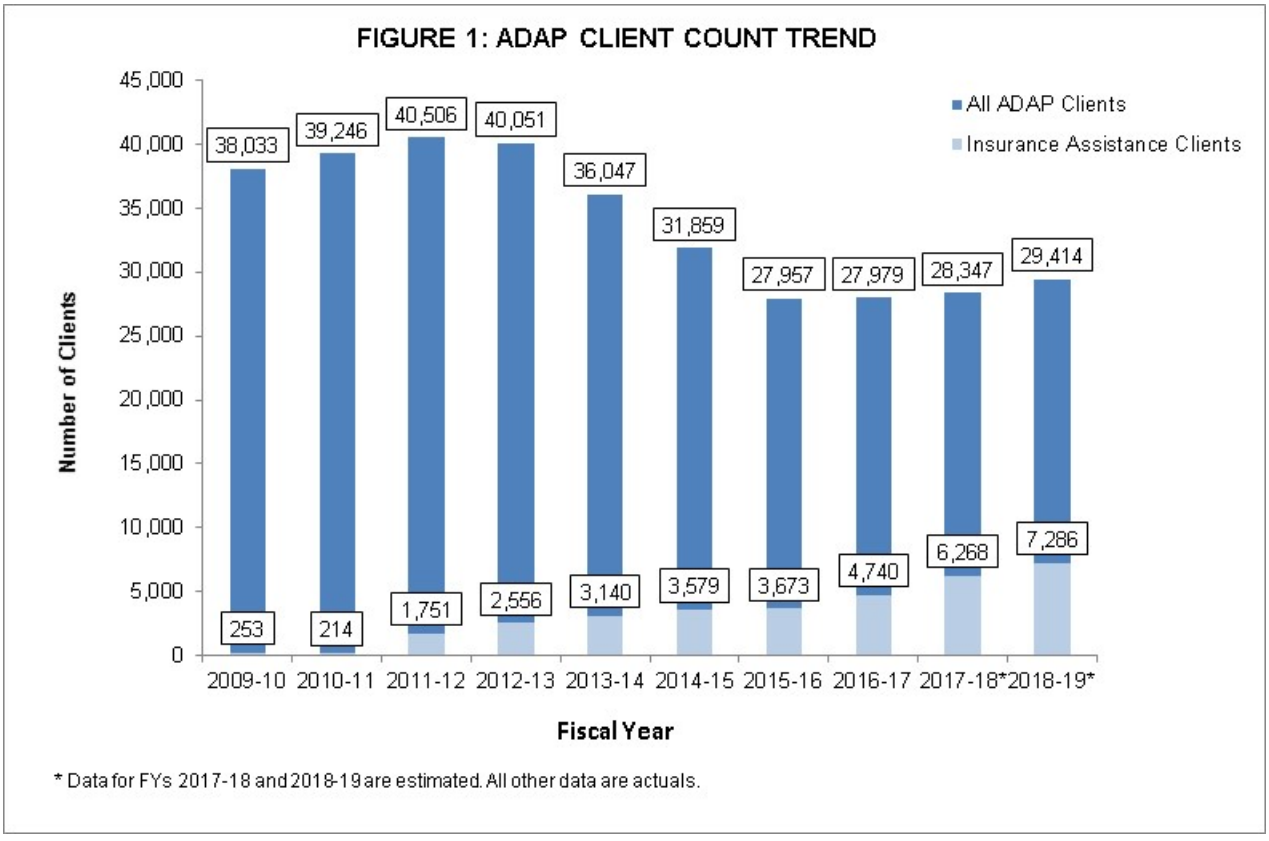
For all figures in this section, the data prior to FY 2017-18 is the observed historical data. Estimates for FY 2017-18 and 2018-19 are based on the overall projections and include all assumptions.

Figure 1 is a summary of total client counts in ADAP by FY, excluding PrEP 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 FY.

Figure 3 is a summary of estimated client counts in the PrEP Assistance Program by FY.

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



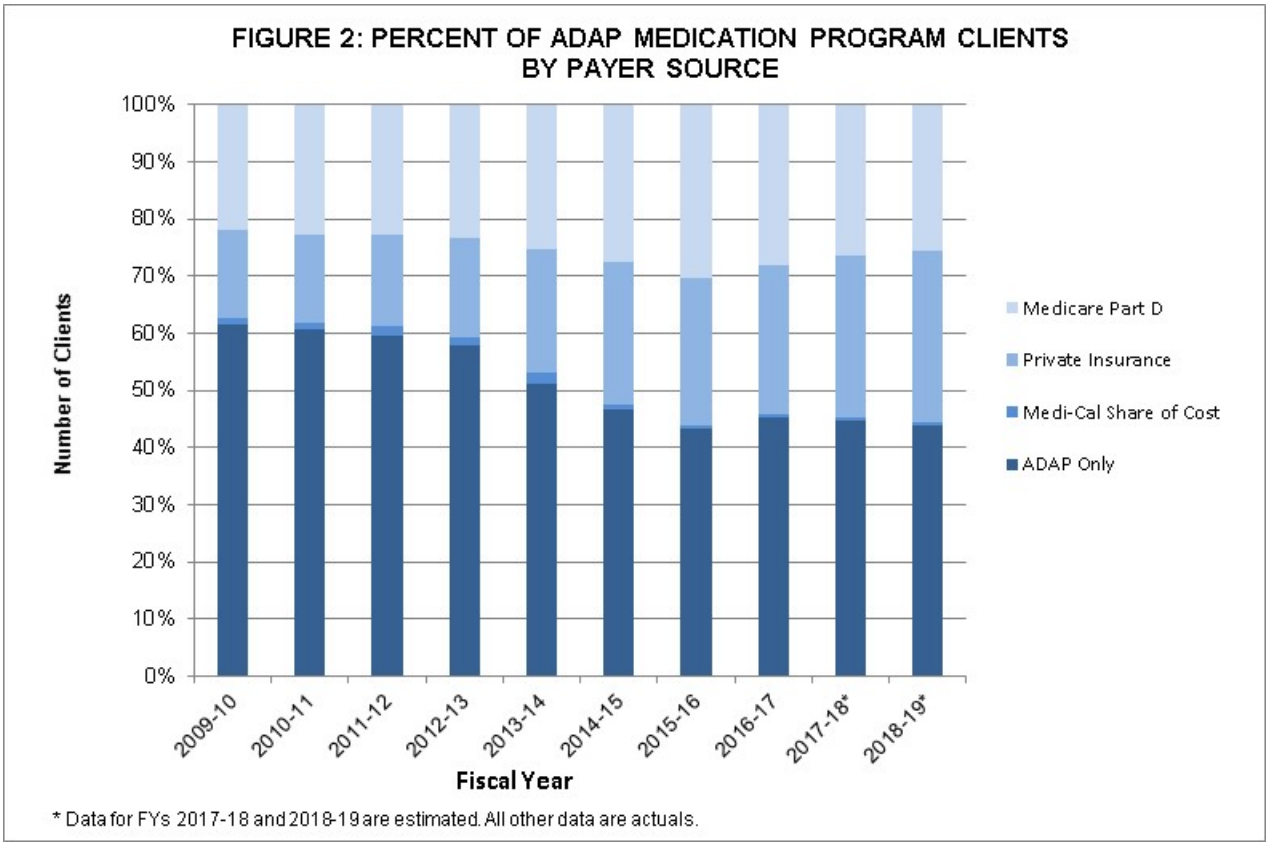
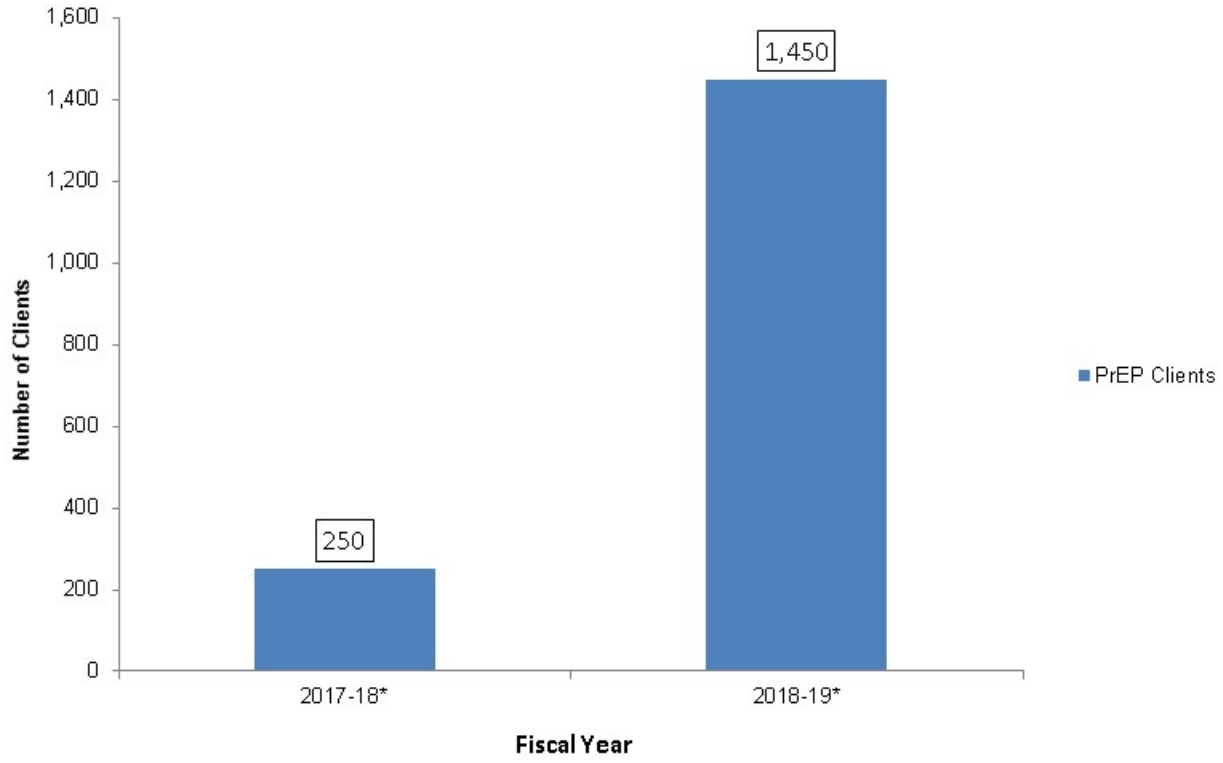


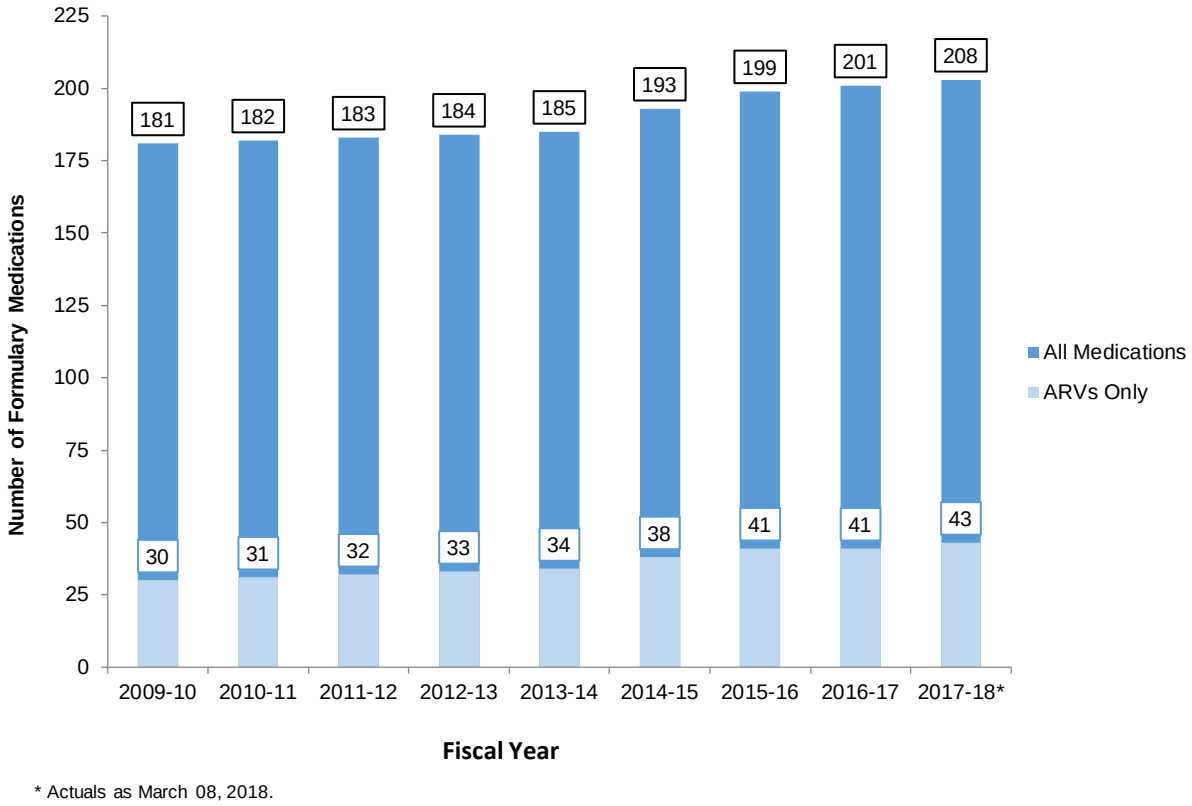
FIGURE 2: PERCENT OF ADAP MEDICATION PROGRAM CLIENTS BY PAYER SOURCE
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Number of Clients
2009-10
2010-11
2011-12
2012-13
2013-14
2014-15
2015-16
2016-17
2017-18*
2018-19*
Fiscal Year
Medicare Part D
Private Insurance
Medi-Cal Share of Cost
ADAP Only
* Data for FYs 2017-18 and 2018-19 are estimated. All other data are actuals.

FIGURE 3: ADAP PREP CLIENT TREND



* Data for FYs 2017-18 and 2018-19 are estimated, and represent 0.9% and 4.7% of total caseload, respectively.

FIGURE 4: NUMBER OF MEDICATIONS ON ADAP FORMULARY



* Actuals as March 08, 2018.

- Bictegravir/emtricitabine/tenofovir alafenamide (Biktarvy®), a once-daily, single tablet complete treatment regime for treatment of HIV-1 infected patients who are treatment naïve, was added to the ADAP formulary on March 7, 2018.
- Sofosbuvir/velpatasvir/voxilaprevir (Vosevi™), a once-daily, single tablet regimen for direct acting antiviral experienced chronic hepatitis C virus infected patients with genotypes 1 through 6 who have had previous treatment failure, was added to the ADAP formulary on March 23, 2018.
- Gemifloxicin, gentamicin, ceftriaxone, and cefixime (four separate medications) for treatment of sexually transmitted infections were added to the ADAP formulary on March 23, 2018.

IX. Current HIV Epidemiology in California

Approximately 132,000 PLWH in California at the end of 2016 had been diagnosed 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 151,000 PLWH in California as of the end of 2016. Since the epidemic began in 1981, approximately 100,000 Californians diagnosed with HIV have died, with over 1,700 dying in 2016 alone.

Of PLWH in California, approximately 40.3 percent are White; 35.3 percent are Hispanic/Latino; 17.5 percent are Black/African American; 3.9 percent are Asian; 2.5 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/Latinos make up the largest percentage of PLWH in California, the rate of HIV among Blacks/African Americans is substantially higher (1,023 per 100,000 population, versus 352 per 100,000 among Whites, and 303 per 100,000 among Hispanics/Latinos).

Most of California's living HIV cases are attributed to male-to-male sexual transmission (66.7 percent); 8.8 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); 7.0 percent to men who have sex with men who also inject drugs; 6.0 percent to injection drug use; 0.6 percent to perinatal exposure; and 11.0 percent to other or unknown sources, including other heterosexual contact.

There are approximately 5,000 new HIV cases reported in California each year. The number of PLWH in the state is expected to grow by approximately 3.0 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.