

AIDS DRUG ASSISTANCE PROGRAM (ADAP)

**Estimate Package
2015-16 May Revision**



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I. Program Overview

The California Department of Public Health (CDPH), Center for Infectious Diseases, Office of AIDS (OA) has two unique programs within the AIDS Drug Assistance Program (ADAP) that provide access to life-saving medications for eligible California residents living with HIV/AIDS:

1. *Medication program*, which pays prescription costs for medications on the ADAP formulary for the following coverage groups (either the full cost of medications or deductibles and co-pays):
 - a. *ADAP-only clients*, for whom ADAP pays 100 percent of the prescription medication cost because these clients do not have a third-party payer;
 - b. *Medi-Cal Share of Cost (SOC) clients*, for whom ADAP pays 100 percent of the prescription drug cost up to the client's Medi-Cal SOC amount;
 - c. *Private insurance clients*, for whom ADAP pays prescription drug deductibles and co-pays; and
 - d. *Medicare Part D clients*, for whom ADAP pays the Medicare Part D drug deductibles and co-pays.
2. *Insurance assistance program(s)*, which pay for private health insurance premiums or Medicare Part D premiums for clients co-enrolled in ADAP. ADAP pays health insurance premiums for eligible clients with one of three different types of health insurance:
 - a. *Non-Covered California private insurance* [OA's Health Insurance Premium Payment (OA-HIPP)/non-Covered California];
 - b. *Private insurance purchased through Covered California* (OA-HIPP/Covered California); and
 - c. *Medicare Part D* (OA/Medicare Part D).

ADAP collects full rebate for prescriptions purchased for all client types listed above except Medi-Cal SOC 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 by both programs to manufacturers, which is prohibited, ADAP does not invoice for rebates on these claims.

Historically, the majority of clients ADAP served were ADAP-only clients without insurance, because people living with HIV/AIDS were unable to purchase affordable health insurance in the private marketplace. However, the health care landscape has changed and more ADAP clients have been able to access public and private insurance coverage due to the Affordable Care Act (ACA). ADAP clients are screened for Medi-Cal eligibility, and potentially eligible clients must apply. Clients who enroll in Medi-Cal Expansion are dis-enrolled from ADAP, because these clients have no SOC and no drug co-pays or deductibles. 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 drugs on the ADAP formulary. Clients with non-employer-based health coverage can co-enroll in ADAP's insurance assistance programs for assistance with their insurance premiums. Assisting clients with purchasing insurance is more cost-effective than paying for the full cost of medications. In addition, assisting clients with purchasing and maintaining insurance coverage improves the overall health of Californians living with HIV/AIDS because clients have comprehensive health insurance and ready 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

This ADAP Estimate for the 2015 May Revision provides revised projections of Current Year (fiscal year [FY] 2014-15) and Budget Year (FY 2015-16) local assistance costs for the medication and insurance assistance programs for ADAP.

Table 1 below shows the estimated ADAP local assistance expenditure need for the Current Year and Budget Year:

- For FY 2014-15, CDPH estimates that ADAP expenditures will be \$352.2 million, which is a \$32.7 million decrease compared to the *2015-16 Governor's Budget*.
- For FY 2015-16, CDPH estimates that ADAP expenditures will be \$389.0 million, which is a \$25.9 million decrease compared to the *2015-16 Governor's Budget*. The decrease in expenditures for both Current and Budget Years is mainly due to a larger number of ADAP clients transitioning to Medi-Cal Expansion than originally expected and fewer ADAP clients accessing hepatitis C treatment than originally predicted.

Table 2, page 4, shows the estimated ADAP rebate fund revenue for Current Year and Budget Year:

- For FY 2014-15, CDPH estimates that ADAP revenue will be \$277.9 million, which is a \$7.6 million increase compared to the FY 2014-15 estimate in the ADAP November 2014 Estimate, mainly due to the overall rebate percentage rate increasing from 70 percent in the *2015-16 Governor's Budget* to 75 percent in this 2015-16 May Revision (based on the last four quarters of actual rebates received).
- For FY 2015-16, CDPH estimates that ADAP revenue will be \$263.2 million, which is a \$2.3 million decrease compared to the FY 2015-16 estimate in the ADAP November 2014 Estimate, mainly due to decreased estimated expenditures. This estimate also factors in the increased rebate percentage rate.

Table 1: Local Assistance AIDS Drug Assistance Program 2015 May Revision (dollars in millions)									
Local Assistance	Current Year FY 2014-15					Budget Year FY 2015-16			
	2014 Budget Act	2015-16 Governor's Budget	2015 May Revision	\$ Change from Governor's Budget to 2015 May Revision	% Change from Governor's Budget to 2015 May Revision	2015-16 Governor's Budget	2015 May Revision	\$ Change from Governor's Budget to 2015 May Revision	% Change from Governor's Budget to 2015 May Revision
Fund:									
Total Funds Requested	\$440.0	\$384.9	\$352.2	-\$32.7	-8.5%	\$415.0	\$389.0	-\$25.9	-6.3%
Federal Funds - Fund 0890	107.8	131.2	135.7	4.5	3.4%	108.1	102.4	-5.7	-5.3%
Rebate Funds - Fund 3080	278.6	247.5	211.3	-36.2	-14.6%	288.6	268.4	-20.2	-7.0%
Reimbursement Funds (SNCP)	53.6	6.2	5.2	-1.0	-16.7%	18.2	18.2	0.0	0.0%
Caseload	37,873	33,791	32,556	-1,235	-3.7%	34,795	33,139	-1,656	-4.8%

Table 2: Rebate Fund Revenues (Fund 3080) 2015 May Revision (dollars in millions)									
Local Assistance	Current Year FY 2014-15					Budget Year FY 2015-16			
	2014 Budget Act	November 2014 Estimate	2015 May Revision	\$ Change from November 2014 Estimate to 2015 May Revision	% Change from November 2014 Estimate to 2015 May Revision	November 2014 Estimate	2015 May Revision	\$ Change from November 2014 Estimate to 2015 May Revision	% Change from November 2014 Estimate to 2015 May Revision
Total Revenue Requested	\$270.8	\$270.3	\$277.9	\$7.6	2.8%	\$265.5	\$263.2	-\$2.3	-0.9%
Rebate Funds - Fund 3080	270.7	270.2	277.8	7.6	2.8%	265.4	263.1	-2.3	-0.9%
Interest Income	0.1	0.1	0.1	0.0	0.0%	0.1	0.1	0.0	0.0%

III. Overall Projections

A. Key influences on ADAP expenditures

- a. FY 2014-15: Compared to the *2015-16 Governor's Budget*, OA estimates that expenditures for the current year have declined by 8.5 percent (Table 1). This decline is due to the following factors.
 - i. Medi-Cal Expansion: A larger number of clients are transitioning to Medi-Cal Expansion than was initially estimated, leading to greater declines in the number of ADAP-only clients.
 - ii. Hepatitis C virus (HCV) treatment: Fewer clients are accessing HCV treatment than was initially estimated.
- b. FY 2015-16: Compared to the *2015-16 Governor's Budget*, OA estimates that expenditures during FY 2015-16 will decline by 6.3 percent, but increase over the revised Current Year. This increase is largely due to the following factors:
 - i. New clients enrolling in ADAP: Covered California and Medi-Cal Expansion had and will continue to have substantial impacts on the number and type of clients receiving ADAP services during FYs 2013-14 and 2014-15 as clients transition out of ADAP or to a different client group within ADAP. However, since these programs will be fully implemented by the end of FY 2014-15, OA expects the number of clients leaving or changing client groups will stabilize and that client caseloads will again increase due to persons being newly diagnosed with HIV. The predicted increases are consistent with historic trends from before the implementation of ACA-related programs.
 - ii. Expanding availability of HCV treatment to all clients: The number of clients accessing HCV treatment during FY 2014-15 has been less than expected, but OA estimates that expanding availability of HCV treatment to all HCV co-infected ADAP clients in FY 2015-16 will lead to increasing program expenditures for these medications.

B. Expenditures

ADAP expenditures are broken out into two program areas: medication expenditures and insurance premium payments.

a. **Medication expenditures**

ADAP's medication program pays prescription costs for medications on the ADAP formulary for four client groups: 1) ADAP-only clients; 2) Medi-Cal SOC clients; 3) private insurance clients; and 4) Medicare Part D clients.

Private insurance and Medicare Part D clients include clients for whom ADAP covers medication deductibles and co-pays. Private insurance clients can include those who have privately-purchased or employer-sponsored health insurance and may or may not be co-enrolled in OA-HIPP. The majority of ADAP private insurance clients are not co-enrolled in OA-HIPP.

- For FY 2014-15, OA estimates that medication expenditures will be \$335.2 million, which is a \$30.9 million decrease compared to the *2015-16 Governor's Budget*.
- For FY 2015-16, OA estimates that medication expenditures will be \$366.4 million, which is a \$25.7 million decrease compared to the *2015-16 Governor's Budget*. The decrease in expenditures for both Current and Budget Years is mainly due to a larger number of ADAP clients

transitioning to Medi-Cal Expansion than originally expected and fewer ADAP clients accessing hepatitis C treatment than originally predicted.

Table 3 below shows the estimated number of clients and total expenditures for medications. The detailed rationale for the projected caseloads, cost per client, and total expenditures is located in appendices A-H; estimates were based on monthly caseload cost per client. Table 3 presented below is an annual summary.

COVERAGE GROUP	FY 2014-15				FY 2015-16			
	CASELOAD		EXPENDITURES		CASELOAD		EXPENDITURES	
	NUMBER	PERCENT	AMOUNT	PERCENT	NUMBER	PERCENT	AMOUNT	PERCENT
ADAP Only	14,166	43.5%	\$295,304,420	88.1%	14,047	42.4%	\$321,595,977	87.8%
Medi-Cal SOC	542	1.7%	\$1,831,535	0.5%	520	1.6%	\$1,838,003	0.5%
Private Insurance	8,521	26.2%	\$19,443,400	5.8%	9,246	27.9%	\$22,883,292	6.2%
Medicare Part D	9,327	28.6%	\$18,625,632	5.6%	9,327	28.1%	\$20,034,773	5.5%
TOTALS	32,556	100.0%	\$335,204,987	100.0%	33,139	100.0%	\$366,352,045	100.0%

b. Insurance premium payments

ADAP pays health insurance premiums for eligible clients with one of three different types of health insurance: 1) non-Covered California private insurance (OA-HIPP/non-Covered California); 2) private insurance purchased through Covered California (OA-HIPP/Covered California); and 3) Medicare Part D (OA/Medicare Part D). OA-HIPP clients are dually enrolled in ADAP; however, ADAP private insurance clients also include those with private employer-sponsored health insurance, for whom ADAP covers medication deductibles and co-pays only, and not premium payments through OA-HIPP.

- For FY 2014-15, OA estimates that insurance premium payment expenditures will be \$12.6 million, which is a \$1.5 million decrease compared to the *2015-16 Governor's Budget*. New enrollments for OA-HIPP have not reached the levels estimated in the *2015-16 Governor's Budget*, and were reduced accordingly for the *2015-16 May Revision*.
- For FY 2015-16, OA estimates that insurance premium payments expenditures will be \$16.5 million, which includes medical out-of-pocket costs (beginning January 2016). This is a \$2.0 million decrease compared to the *2015-16 Governor's Budget*. The reduction in new enrollments in FY 2014-15 leads to a corresponding reduction in FY 2015-16, because FY 2014-15 is the basis for the FY 2015-16 estimate.

Table 4, next page, shows the estimated number of clients and total expenditures for insurance premium payments. The detailed rationale for the projected caseloads, cost per client, and total expenditures are located in appendices A-H.

TABLE 4¹: ESTIMATED ANNUAL CASELOAD AND PREMIUM PAYMENT ASSISTANCE EXPENDITURES BY COVERAGE GROUP

COVERAGE GROUP	FY 2014-15				FY 2015-16			
	CASELOAD		EXPENDITURES		CASELOAD		EXPENDITURES	
	NUMBER	PERCENT	AMOUNT	PERCENT	NUMBER	PERCENT	AMOUNT	PERCENT
OA-HIPP/Non-Covered CA	1,288	37.3%	\$8,857,834	70.1%	1,097	25.8%	\$9,054,375	54.73%
OA-HIPP/Covered CA	1,370	39.6%	\$3,241,865	25.7%	2,328	54.8%	\$6,917,505	41.81%
OA Medicare Part D	797	23.1%	\$539,139	4.3%	821	19.3%	\$571,973	3.46%
TOTALS	3,454	100.0%	\$12,638,838	100.00%	4,246	100.0%	\$16,543,853	100.00%

¹ All premium payment assistance clients are co-enrolled in the ADAP medication program.

c. Fixed expenditures

- i. \$2.0 million for local health jurisdictions (LHJs): Each LHJ allocation is based on the proportion of all ADAP clients the LHJ enrolled during the prior year. These funds may only be used for costs associated with the administration of ADAP enrollment. LHJs determine how to utilize these funds. LHJs may distribute the funds to ADAP enrollment sites, use the funds to support the local ADAP coordinator function, or spend the funds on equipment/supplies necessary for ADAP enrollment.
- ii. Non-approved transaction fees: ADAP pays a reduced transaction fee for transactions between a pharmacy and the pharmacy benefits manager (PBM) that do not result in an ADAP covered transaction (e.g., drug not on the ADAP formulary, refilled too soon, etc.). ADAP will utilize reimbursement funds or supplemental rebate funds for these expenditures as ADAP cannot use RW federal funds or mandatory rebate funds for non-approved transactions. Non-approved transaction fee estimates are \$1,753,461 for FY 2014-15 and \$1,916,392 for FY 2015-16.

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. Therefore, revenue estimates are based on drug expenditures for the last two quarters of the previous FY and the first two quarters of the current FY.
 - For FY 2014-15, OA estimates ADAP rebate revenues will increase by 2.8 percent from \$270.3 million from the ADAP November 2014 Estimate to \$277.9 million in the revised Current Year forecast.
 - For FY 2015-16, OA estimates ADAP rebate revenues will decrease by 0.9 percent from \$265.5 million from the ADAP November 2014 Estimate to \$263.2 million. These estimates account for decreased expenditures and an increase in ADAP’s overall rebate percentage rate.

Based on the average of the most recent four quarters of actual rebates received, the overall rebate percentage rate has increased from 70 percent in the 2015-16 Governor’s Budget to 75 percent in this 2015-16 May Revision.

- b. Reimbursement Funds – The Medi-Cal 1115 Waiver allows the California Department of Health Care Services (DHCS) to use certified public expenditures from various programs, including ADAP, to claim Safety Net Care Pool (SNCP) federal funds. CDPH receives ADAP's portion of the SNCP funds in the form of a reimbursement from DHCS. In FY 2014-15, ADAP is requesting \$5.2 million of the \$53.6 million SNCP funds available for ADAP, based on the *2015-16 Governor's Budget*, due to ADAP's requirement to spend mandatory rebate funds prior to spending federal funds. This amount is a \$1 million decrease from the ADAP November 2014 Estimate of \$6.2 million. DHCS informed OA that after the current Medi-Cal 1115 Waiver expires on October 31, 2015, SNCP reimbursement funds will no longer be available to ADAP. In FY 2015-16, ADAP estimates it will utilize all of the \$18.2 million SNCP funding available for ADAP.
- c. Federal Funds – For FY 2014-15, federal fund revenue increased by \$4.5 million compared to the *2015-16 Governor's Budget* (the Department has sufficient expenditure authority in FY 2014-15 to accommodate the \$4.5 million projected revenue increase; see Table 1 on page 3). On January 13, 2015, the Health Resources and Services Administration (HRSA) issued a Notice of Award (NoA) for \$7,978,533, approving ADAP's request to carryover unspent 2013 RW Part B funds (April 1, 2013 – March 31, 2014) to the 2014 grant year. ADAP utilized these carryover funds prior to the March 31, 2015 grant period end date. The revised Current Year budget also includes a federal fund surplus of \$14.7 million due to the HRSA requirement to spend mandatory rebate funds prior to spending federal funds. OA will submit a carryover request to use these unspent federal funds for ADAP expenditures in the Budget Year.

For FY 2015-16, federal fund revenue is projected to decline by \$5.7 million compared to the *2015-16 Governor's Budget*. In October 2014, ADAP applied for the 2015 ADAP Emergency Relief Funds (ERF) Grant requesting the maximum amount of \$11 million. On March 27, 2015, HRSA issued the NoA for the 2015 ADAP ERF Grant for \$6,441,447, which is a \$4.6 million decrease from what was included in the *2015-16 Governor's Budget*. The budget period is from April 1, 2015 to March 31, 2016; OA will use these funds for ADAP expenditures in the Budget Year.

- d. Match – HRSA requires grantees to have HIV-related non-HRSA expenditures. California's HRSA match requirement for the 2015 Federal RW Part B Grant year (April 1, 2015 – March 31, 2016) is \$65,519,485. OA will meet the match requirement using CDPH OA General Fund Support 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.

A. HCV Drugs (New Assumption)

Consistent with the outcomes of the statewide workgroup to address the state's approach regarding HCV drug policies, ADAP is expanding access to HCV medications to include all HCV co-infected ADAP clients, regardless of liver disease stage. This policy is in alignment with the federal Health and Human Services guidelines for treating HCV co-infection among HIV-infected persons and the revised Department of Veteran Affairs' HCV clinical guidelines, which recommend that all HIV/HCV co-infected patients be treated. HIV co-infection accelerates liver disease progression among HCV-infected persons. Furthermore, HIV/HCV co-infected persons have a more rapid progression to death following liver decompensation, lack of widespread access to liver transplantation, and poorer outcomes following transplantation than HCV mono-infected persons.

During FY 2014-15, several new HCV drugs have become available and have been added to the ADAP formulary, including a co-formulated two-drug combination of ledipasvir/sofosbuvir (Harvoni™) and a four-drug combination of ombitasvir/paritaprevir/ritonavir and dasabuvir co-formulated into two different tablets (Viekira Pak™). National guidelines for treating HCV infection have been updated to include these treatment options.

For the *2015-16 Governor's Budget*, OA estimated that 12 percent of ADAP clients are co-infected with HCV, 32.4 percent of the co-infected clients have F3 or F4 liver disease, and 10 percent of ADAP's co-infected sub-population with F3 or F4 disease would be treated for HCV each FY. However, due to low utilization of the new HCV drugs in FY 2014-15 to date, this revised estimate is based on actual utilization data pro-rated for the remainder of the current FY. Therefore, the FY 2014-15 estimate is based on providing treatment to clients with F3 or F4 disease only, since OA expects that the transition to providing treatment for all co-infected clients will require a ramp-up time period beginning FY 2015-16. The updated estimate for FY 2015-16 is based on the earlier methodology, except that the restriction on treating only patients with F3 or F4 disease was removed, and OA estimates that only 5 percent of ADAP's co-infected sub-population will be treated for HCV each FY; all HCV co-infected ADAP clients were considered eligible for treatment. Additionally, OA expects to implement preferential utilization of lower cost treatment regimens (e.g., Viekira Pak™) among eligible patients when such regimens are equally effective and no medical contraindications to their use exist; this was included in our estimate calculations.

- A. FY 2014-15: OA estimates that 13 clients with F3 or F4 disease will be treated for HCV during FY 2014-15, with an estimated \$1.4 million in program expenditures and \$107,402 in rebate revenue. The estimated net cost is \$1.3 million.
- B. FY 2015-16: OA estimates that access to HCV treatment for all ADAP clients will result in 199 clients being treated with \$9.9 million in program expenditures and \$3.4 million in rebate revenue, for a net cost of \$6.5 million.

TABLE 5: ESTIMATED NUMBER OF CLIENTS RECEIVING HCV TREATMENT AND ASSOCIATED NET COSTS BY FY		
FISCAL YEAR	NUMBER OF CLIENTS TREATED IN FY	NET COST IN FY
2014-15 (estimated)	13	\$1.3 million
2015-16 (estimated)	199	\$6.5 million

B. Reallocate Federal RW Funds to Focus on Linkage to and Retention in Care (New Assumption)

Both in California and nationwide, minority populations are at a greater risk of not being linked to care and treatment shortly after HIV diagnosis and becoming disengaged from medical care and treatment services. Because HIV-infected persons who have an undetectable viral load due to appropriate treatment have a close to zero risk of transmitting HIV to their partner(s), the greater risk of minority populations being untreated leads to health disparities in HIV viral load suppression, survival, and infection rates. In 2012, only 75 percent of HIV-diagnosed African American Californians in care had a suppressed viral load, as compared with 83 percent of Latinos and 88 percent of non-Hispanic Whites. Linking and re-engaging clients in HIV care and treatment services both improves individual health outcomes and prevents new HIV infections.

In FY 2015-16, OA will reallocate the \$1.5 million in RW base funding currently allocated in ADAP to LHJs and/or community-based organizations to support targeted efforts to re-engage HIV-infected minority clients in medical care and treatment. This funding shift is consistent with the President's HIV Care Continuum Initiative and the National HIV/AIDS Strategy goals to improve linkage to and retention in HIV care and treatment services and to improve HIV-related health disparities.

CDPH expects that back-fill of these funds will not be required and that the insurance assistance programs will be funded entirely with special (rebate) funds in FY 2015-16. The \$1.5 million in RW base funding allocated to insurance assistance programs in FY 2013-14 was unspent and is also anticipated to be unspent in FY 2014-15. As a result, this \$1.5 million was included in the carry forward request to HRSA. On January 13, 2015, HRSA issued the NoA for the unspent 2013 RW Part B funds, which included the \$1.5 million. However, approval of this carry forward request does not guarantee approval of future carry forward requests made to HRSA.

C. Covered California (Unchanged Assumption)

This was an Unchanged Assumption in the *2015-16 Governor's Budget*. The following includes updated projections for this Assumption.

The estimates presented here do not include the impact of the policy decision to pay medical out-of-pocket costs, which are presented on page 11. The estimates presented in this assumption are based on what OA projects will occur if the medical out-of-pocket cost policy were not implemented. The overall Estimate includes the impacts of all assumptions.

- a. FY 2014-15: OA estimates a total of 457 clients will newly enroll in OA-HIPP/Covered California in FY 2014-15. This projection is based on Covered California enrollment during FY 2013-14 and the first three months of open enrollment in FY 2015-16. Enrollment of the 457 clients into Covered California in FY 2014-15 is expected to lead to a net savings of \$5.3 million (\$226,104 in premium expenditures, \$694,700 in medication deductibles and co-pays, \$2.6 million in savings due to averted medication expenditures, and \$3.6 million in rebate revenue). This rebate revenue estimate includes rebate for new Covered California clients in FY 2013-14 (due to the usual six-month rebate delay).
- b. FY 2015-16: OA estimates that 205 clients will newly enroll in OA-HIPP/Covered California during FY 2015-16, independent of the impact of paying medical out-of-pocket costs. This projection is based on Covered California enrollment during FYs 2013-14 and 2014-15. New Covered California enrollment in FY 2015-16 is expected to lead to a net savings of \$2.7 million (\$147,761 in premium expenditures, \$329,982 in medication deductibles and co-pays, \$1.3 million in savings due to averted medication expenditures, and \$1.8 million in rebate revenue). This rebate revenue estimate includes rebate for new Covered California clients in FY 2014-15 (due to the usual six-month rebate delay).

D. Payment of Out-Of-Pocket Medical Expenses for all OA-HIPP Clients (Unchanged Assumption)

This was a New Assumption in the *2015-16 Governor's Budget*. The following includes updated projections for this Assumption.

OA estimates that 753 additional clients will enroll in OA-HIPP/Covered California due to payment of medical out-of-pocket costs in FY 2015-16, over and above those who would enroll in OA-HIPP-Covered California even if OA-HIPP did not pay medical out-of-pocket costs, leading to a total of 959 clients newly enrolling in OA-HIPP/Covered California during FY 2015-16 (see Table 6, next page, for a summary of number of new Covered California clients per year for all assumptions). OA projects that 85 percent of these clients will be prior ADAP-only clients, and 15 percent will have been previously enrolled in OA-HIPP in a non-Covered California plan. The medical out-of-pocket projection is based on the Covered California enrollment during FY 2013-14, the enrollment pattern seen in year three of the Pre-existing Condition Insurance (PCIP) and the Low Income Health Program (LIHP) implementation, and previous estimates that 25-33 percent of ADAP clients eligible for Covered California would enroll if medical out-of-pocket costs were covered.

The total fiscal impact of paying medical out-of-pocket costs is based on the costs and savings associated with these 753 additional clients, as well as medical out-of-pocket costs associated with clients who are already enrolled or would choose to enroll in OA-HIPP regardless of coverage of medical out-of-pocket costs. Coverage of medical out-of-pocket costs will lead to a total of \$3.6 million in savings during FY 2015-16 (\$1.1 million in additional premium costs, \$1.8 million in medical out-of-pocket costs, \$1.5 million in additional medication deductibles and co-pays, \$6.2 million savings due to averted medication expenditures, and \$1.8 million in rebate revenue). The full impact of the new Covered California clients in FY 2015-16 will not be realized until FY 2016-17 when the additional rebate revenue is received. Table 6 summarizes the impact of the various assumptions on Covered California client counts.

FY	ASSUMPTIONS INCLUDED	NUMBER OF NEW COVERED CA CLIENTS IN FY	TOTAL NUMBER OF COVERED CA CLIENTS AT END OF FY	NET COST FOR NEW CLIENTS IN EACH FY
2013-14 (actual)	N/A	913	913	N/A
2014-15 (estimated)	ALL	457	1,370	-\$5.3million
2015-16 (estimated)	ALL except medical out-of-pocket costs	205	See below	-\$2.7million
2015-16 (estimated)	Medical out-of-pocket costs	753	See below	-\$0.9 million
2015-16 (estimated)	ALL	959	2,328	-\$3.6million

E. Federal Funding Issue: RW Grant Adjustments (Existing Assumption)

Due to HRSA's requirement to spend available 340B rebate funds prior to spending RW federal funds, ADAP did not spend all of the 2013 RW federal funds by March 31, 2014, and the unspent funds were returned to HRSA. On October 6, 2014, CDPH submitted a carryover request to HRSA for just under \$8 million in unspent 2013 RW Part B funds. On January 13, 2015, HRSA issued a NoA for \$7,978,553 with the budget period ending on March 31, 2015. ADAP used these funds for drug expenditures prior to March 31, 2015.

For FY 2015-16, federal fund revenue decreased by \$5.7 million compared to the *2015-16 Governor's Budget*. In October 2014, ADAP applied for the 2015 ADAP Emergency Relief Funds (ERF) Grant requesting the maximum amount of \$11 million. On March 27, 2015, HRSA issued the NoA for the 2015 ADAP ERF Grant for \$6,441,447, which is a \$4.6 million decrease over what was anticipated in the *2015-16 Governor's Budget*. The budget period is from April 1, 2015 to March 31, 2016; OA will use these funds for ADAP expenditures in the Budget Year.

F. Change in Methodology to New Budget Projection Model (Unchanged Assumption)

There are no changes to this Assumption from the *2015-16 Governor's Budget*.

G. Discontinued Major Assumptions

1. OA-PCIP Implementation

The federal PCIP program ended on April 30, 2014.

2. Impact of LIHP on ADAP

LIHP ended on December 31, 2013.

V. Future Fiscal Issues

1. Potential Savings Due to Cross Match of RW Client Data to Medi-Cal Eligibility Data Systems (MEDS)

To minimize the possibility of paying for medications that should be billed to Medi-Cal or other third-party payers such as Medicare Part D and Covered California, CDPH executed an interagency agreement with DHCS in September 2014 that will allow for a monthly cross match of RW and MEDS client data. OA is currently working with DHCS staff to test and finalize the program that will run the blind match. OA anticipates the monthly cross match will begin by July 1, 2015. Once the monthly match is implemented, to the extent allowable under Medi-Cal, OA will re-coup any prior ADAP expenditures for clients identified with a third-party payer through a pharmacy back-billing process by the ADAP PBM contactor.

2. New HIV Drugs

1. On November 6, 2014, Gilead Sciences Inc. announced that a New Drug Application (NDA) was submitted to the federal Food and Drug Administration (FDA) for a once daily single tablet regimen of elvitegravir(E)/cobicistat(C)/emtricitabine(F)/tenofovir alafenamide intended for use among adult and adolescent treatment-naïve HIV individuals, virologically suppressed patients who switch regimens, and those with renal impairment. Based on the November 6, 2014 NDA date, ADAP estimates possible FDA approval in May 2015.

ADAP is required by state law to add new antiretroviral (ARV) drugs to its formulary within 30 days of receiving federal FDA approval if the new ARV is recommended for addition to the formulary by the ADAP Medical Advisory Committee, the new ARV will not pose a significant cost to the program, and it does not require the removal of another ARV from the formulary. If this drug receives FDA approval, ADAP will monitor pricing and supplemental rebate negotiations closely.

2. On February 6, 2015, the FDA approved Dutrebis, a fixed dose combination tablet containing 150 mg of lamivudine and 300 mg of raltegravir. Dutrebis tablet is approved for use in combination with other ARV products for the treatment of HIV-1 infection. The recommended dosage of Dutrebis is one tablet taken twice daily with or without food.

According to the manufacturer, Merck Pharmaceuticals, Dutrebis will not be made commercially available in the United States at this time, and hence, cannot be added to ADAP's formulary.

3. New HCV Drugs

The following HCV drugs may be approved by the FDA within the next two years:

Daclatasvir

Bristol Myers Squibb submitted a NDA on April 7, 2014 for daclatasvir, a nonstructural protein 5A (NS5A) replication complex inhibitor. Bristol Myers Squibb views the application of daclatasvir as a step toward offering daclatasvir-based regimens to a range of patient types in the United States. On November 26, 2014, Bristol Myers Squibb announced that the FDA issued a Complete Response Letter regarding the NDA for daclatasvir requesting additional data for daclatasvir in combination with other antiviral agents.

Grazoprevir/elbasvir

Merck has completed Phase 2 clinical trials for a fixed dose combination of grazoprevir plus elbasvir (MK-5172/MK-8742) in genotype 1 infected treatment naïve and difficult to treat HCV patients. Phase 3 study of the fixed dose drug is currently in progress and Merck is expected to submit an NDA to the FDA in 2015.

ADAP will monitor for the possible FDA approval of daclatasvir and subsequent pricing if approved. ADAP will also monitor for the possible NDA to be submitted by Merck for grazoprevir/elbasvir.

VI. May Revision Fund Condition Statement

Table 7: Fund Condition Statement (in thousands)				FY 2013-14 Actuals	FY 2014-15 Estimate	FY 2015-16 Estimate
Special Fund 3080: AIDS Drug Assistance Program Rebate Fund						
1	BEGINNING BALANCE			29,494	14,374	79,978
2	Prior Year Adjustment			-54		0
3	Adjusted Beginning Balance			29,440	14,374	79,978
4	REVENUES, TRANSFERS AND OTHER ADJUSTMENTS					
5	Revenues					
6	4163000 Income From Surplus Money Investments (Interest)			36	120	120
7	4171400 Escheat - Unclaimed Checks, Warrants, Bonds, and Coupons			-2,932	0	0
8	4172500 Miscellaneous Revenue			284,483	277,771	263,084
9	Total Revenues, Transfers, and Other Adjustments			281,587	277,891	263,204
Fund 0890 Federal Funds	Total Resources			311,027	292,266	343,182
Fund 3080 Rebate Funds (SNCP) Reimbursement Funds	EXPENDITURES AND EXPENDITURE ADJUSTMENTS					
	Expenditures					
13	8880 FISCAL			4	1	2
14	4265 Department of Public Health					
15	State Operations			1,217	944	1,523
16	ADAP Local Assistance (Drugs)			283,752	200,302	249,885
17	Insurance Assistance Programs (Premiums)			11,679	11,041	18,535
18						
19	Total Expenditures and Expenditure Adjustments			296,653	212,288	269,945
20	FUND BALANCE			14,374	79,978	73,237
Row 6: Interest Actuals for FY 2013-14, Estimated for FYs 2014-15 and 2015-16					120,000	120,000
Fund 3080 Rebate Funds	Miscellaneous Revenue					
	One-time Program Income (LHP-Back-billing)				6,614,863	
	Actual Rebate received July - Sept 2014 from Expenditures for Jan - March 2014				78,433,449	
	Actual Rebate received Oct - Dec 2014 from Expenditures for Apr - June 2014				71,396,517	
	Estimated Rebate to be received Jan - June 2015 from Actual Expenditures from July - Dec 2014 (\$161,768,347 x 75% avg rebate rate)				121,326,261	
	Estimated Rebate to be received Jul - Dec 2015 from Estimated Expenditures for Jan - Jun 2015 (\$167,602,494 x 75% avg rebate rate)					125,701,870
	Estimated Rebate to be received Jan - Jun 2016 from Estimated Expenditures for July - Dec 2015 (\$183,176,023 x 75% avg rebate rate)					137,382,017
	Total Estimated FY 2014-15 Rebate Revenue				277,771,088	
	Total Estimated FY 2015-16 Rebate Revenue					263,083,887

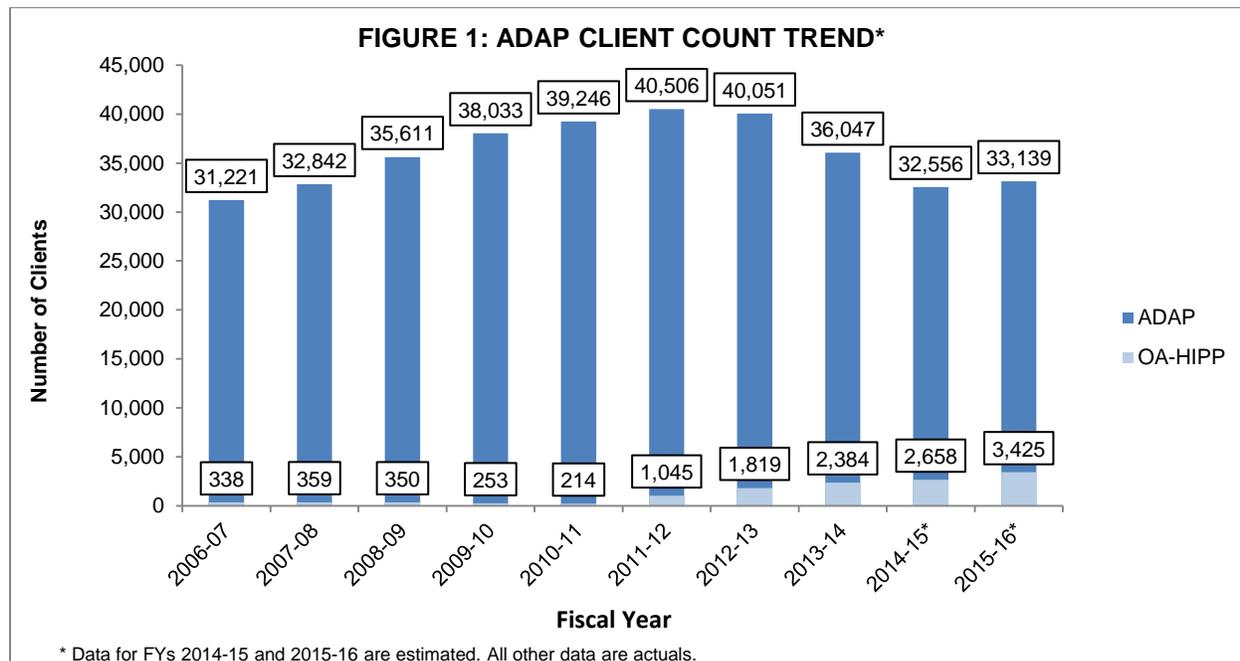
VII. HISTORICAL PROGRAM DATA AND TRENDS

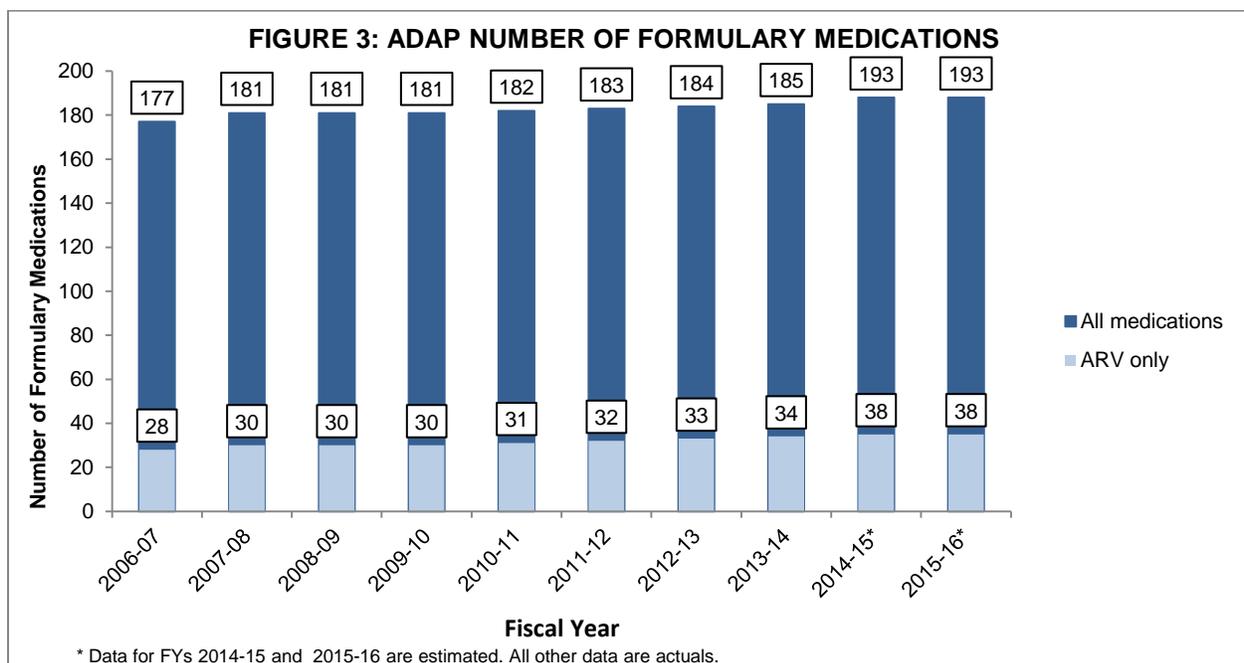
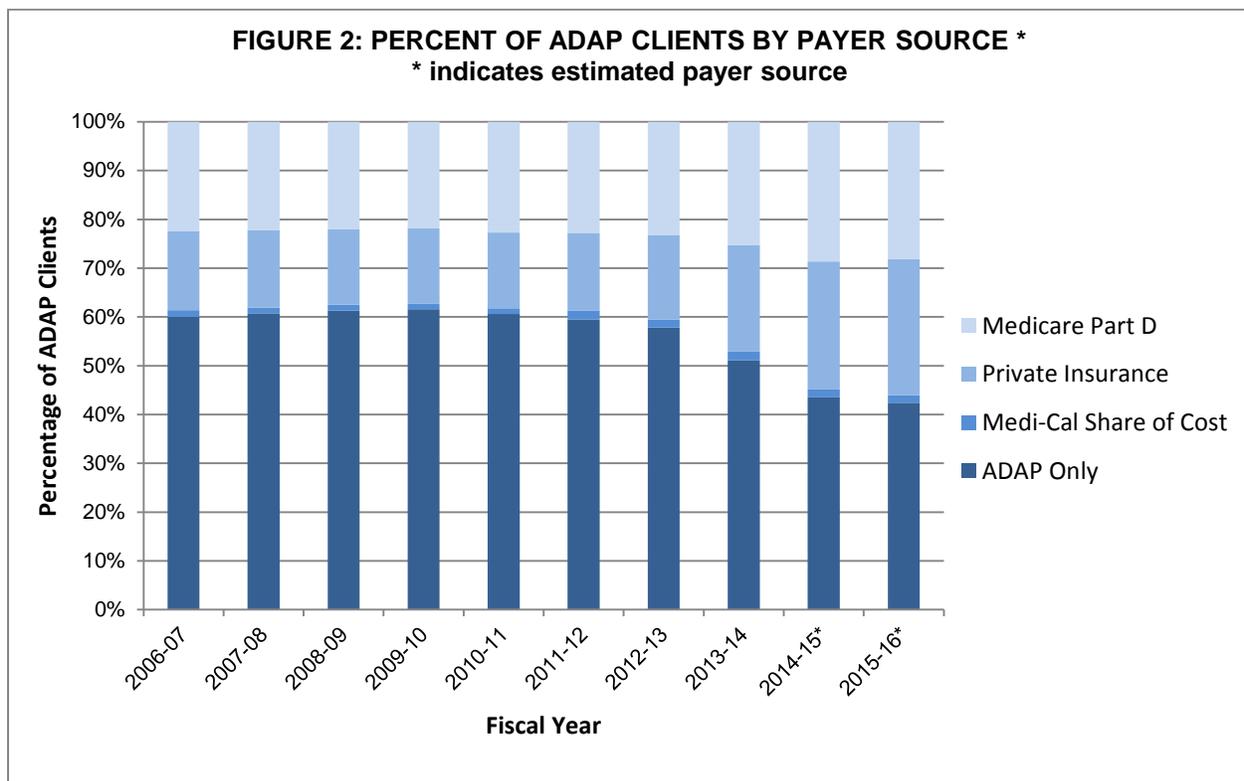
For all figures in this section, the data prior to FY 2014-15 is the observed historical data. Estimates for FYs 2014-15 and 2015-16 are based on the overall projections and include all assumptions. Effective March 2013, all OA-HIPP clients are required to be co-enrolled in ADAP’s medication program. Prior to this date the majority, but not all, OA-HIPP clients were co-enrolled in ADAP’s medication program.

Figure 1 is a summary of total client counts in ADAP by fiscal year; the number of ADAP medication program clients who are co-enrolled in OA-HIPP is also shown. OA-HIPP numbers only include clients with premium assistance for non-Covered California and Covered California plans. Premium assistance for Medicare Part D clients is excluded.

Figure 2 is a summary of the proportion of ADAP clients who are enrolled in the various payer groups by FY.

Figure 3 is the number of medications on the ADAP formulary by FY; the number of ARV medications is also shown.





Co-formulated atazanavir/cobicistat and co-formulated darunavir/cobicistat (ARV medications) were added to the ADAP formulary on February 27, 2015.

Ledipasvir/sofosbuvir tablets (Harvoni®) and ombitasvir/paritaprevir/ritonavir co-formulated tablets co-packaged with dasabuvir tablets (Viekira Pak™) (HCV medications) were added to the ADAP formulary on May 13, 2015.

VIII. Current HIV/AIDS Epidemiology in California

Approximately 121,371 persons were living with HIV in California at the end of 2013 and had been diagnosed and reported to OA. However, the Centers for Disease Control and Prevention (CDC) estimates 14.0 percent of all HIV-infected persons are unaware of their infection. Therefore, OA estimates that there were approximately 141,000 persons living with HIV in California as of the end of 2013.

Persons living with HIV in California are estimated to be 43.0 percent White, 18.0 percent Black/African American, 33.0 percent Hispanic/Latino, 4.0 percent Asian, 0.4 percent American Indian/Alaskan Native, 0.3 percent Native Hawaiian/Pacific Islander, and 1.6 percent multi-racial. While Whites and Hispanics/Latinos make up the largest percentage of persons living with HIV in California, the rate of HIV among Blacks is substantially higher (993 per 100,000 population, versus 349 per 100,000 in Whites and 273 per 100,000 in Hispanics/Latinos).

Based on a CDC algorithm used to estimate the distribution of living cases with respect to mode of HIV exposure, most of California's living HIV cases are attributed to male-to-male sexual transmission (71.4 percent); 11.7 percent of living cases are attributable to sex with high-risk heterosexuals, 8.0 percent to injection drug use, 8.0 percent to men who have sex with men who also inject drugs, 0.6 percent to perinatal exposure, and 0.4 to other or unknown sources.

There are approximately 5,000 new HIV cases reported to OA each year. The number of living HIV/AIDS cases 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. This increase is attributed to stable incidence rates and longer survival of those infected, primarily due to the effectiveness and availability of treatment.

IX. Appendices

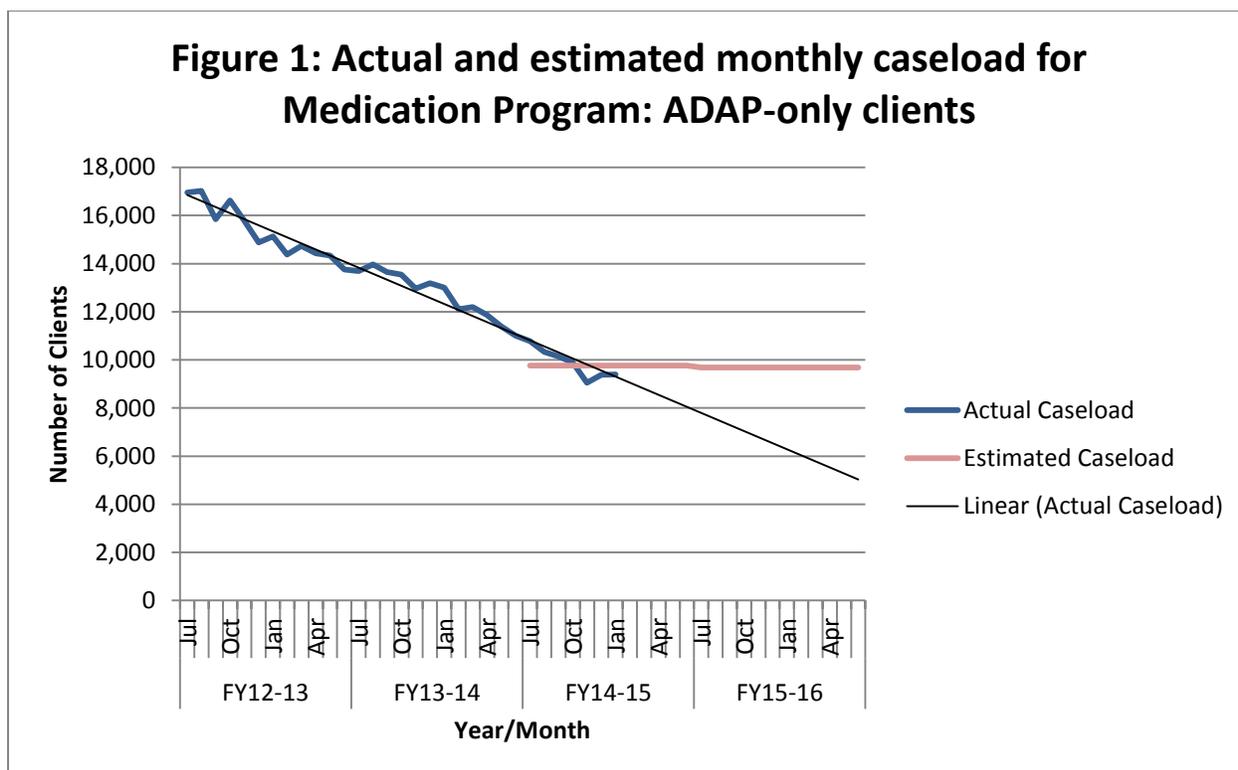
Appendix A: Assumptions and Rationale for Medication Expenditures – ADAP-only

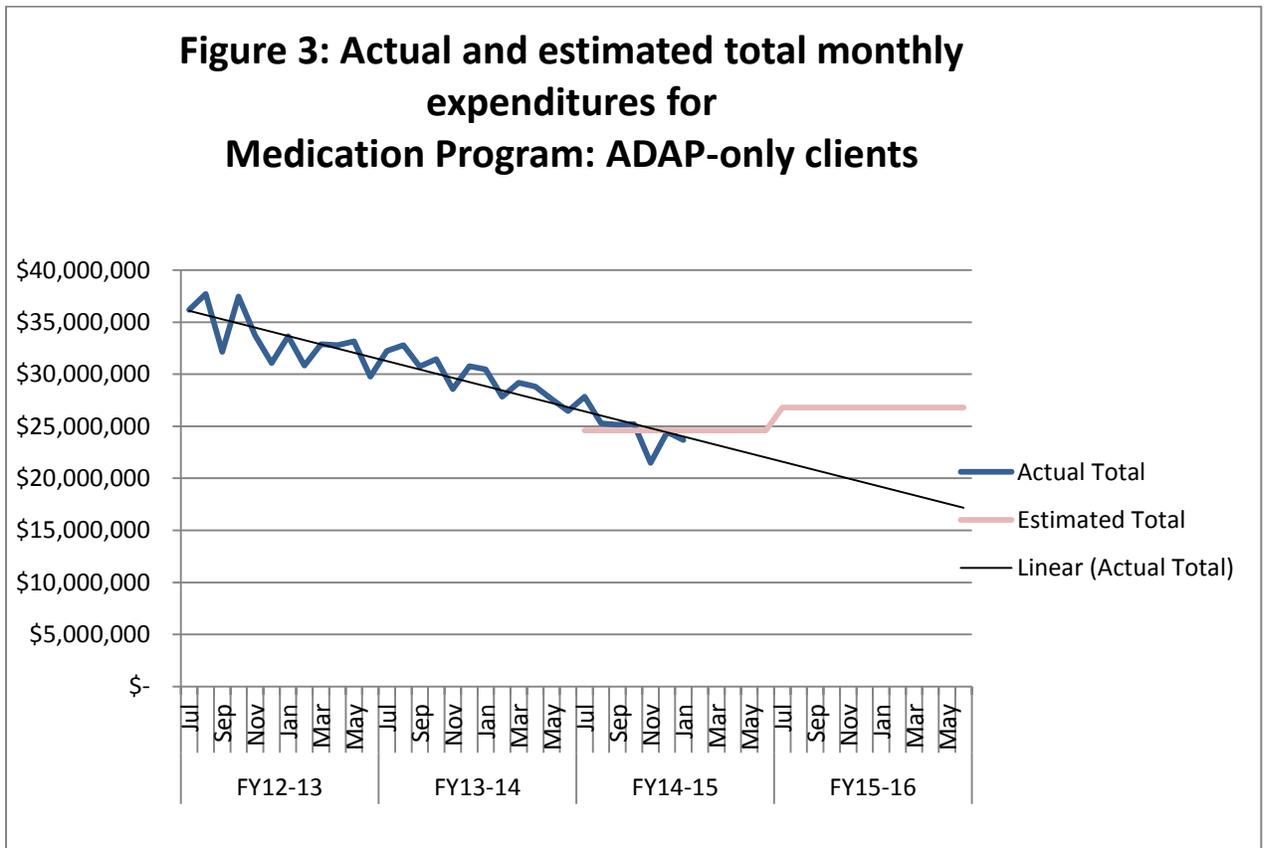
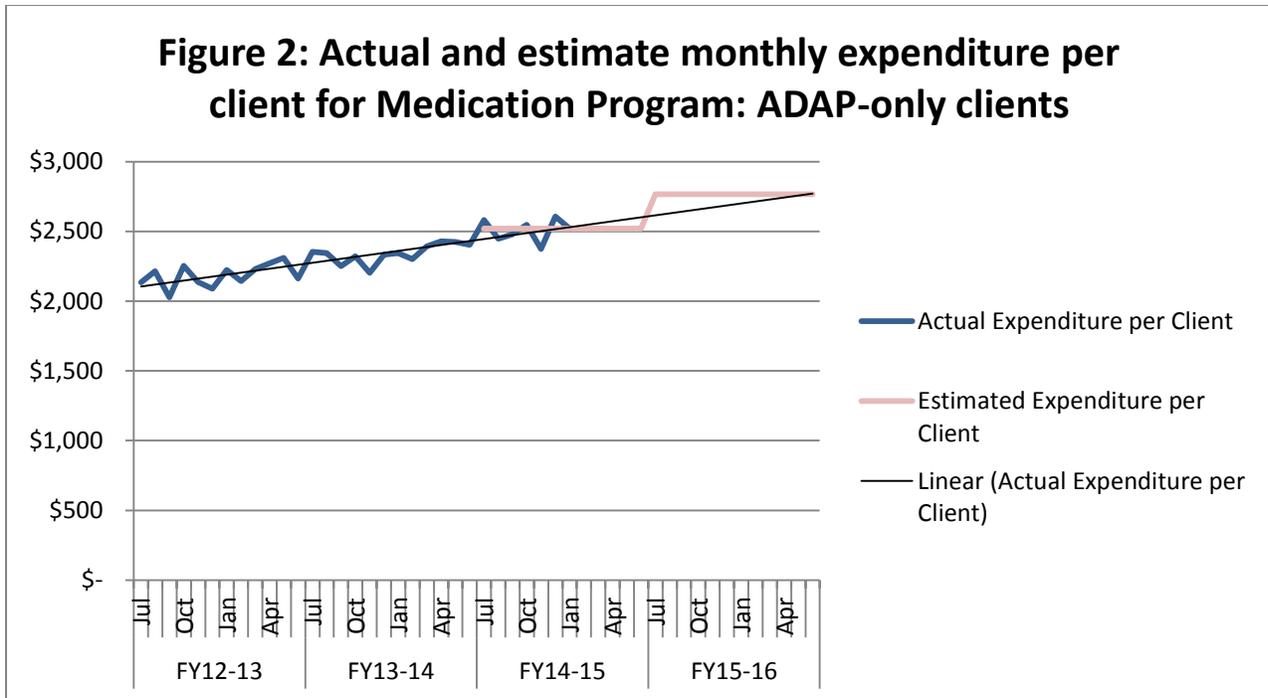
- A. ADAP-only caseload – OA estimates that the average monthly caseload for ADAP-only clients in FY 2014-15 will be 9,763, a decrease of 23.2 percent compared to FY 2013-14. During FY 2015-16, OA estimates the monthly caseload will be 9,681, a decrease of 0.9 percent compared to FY 2014-15. These changes are based on the following:
- a. Historic trends and unchanged assumptions: During FYs 2012-13 and 2013-14, the ADAP-only monthly caseload decreased by an average of 15.3 percent per year compared to the prior year. The caseload during the first seven months of FY 2014-15 decreased by 22.5 percent compared to FY 2013-14. These past trends were primarily driven by LIHP, PCIP, Medi-Cal Expansion, and transition of clients to Covered California. Because the impact of LIHP and PCIP is historical, OA projects the caseload will continue to decline during FY 2014-15 due to ongoing enrollment in Covered California and resolution of the backlog of Medi-Cal Expansion applications. During FY 2015-16, the ADAP-only caseload will likely stabilize primarily due to newly enrolled patients who are not eligible for Medi-Cal Expansion or Covered California.
 - i. Covered California: Based on the number of clients that have moved from ADAP-only to a Covered California private insurance plan during FYs 2013-14 and 2014-15 to date, OA estimates that 267 clients total will move from ADAP-only to Covered California during FY 2014-15. During FY 2015-16, OA estimates that an additional 127 clients will move to Covered California from ADAP-only; this estimate does not include the effect of the new assumption regarding medical out-of-pocket costs.
 - ii. Payment of out-of-pocket medical costs for OA-HIPP clients: Covering out-of-pocket medical costs for OA-HIPP clients will lead to fewer ADAP-only clients, because some eligible ADAP-only clients will choose to enroll in more comprehensive insurance coverage programs, such as those purchased through Covered California. OA estimates that 465 clients will move from ADAP-only to Covered California due to coverage of medical out-of-pocket costs. A total of 592 clients will move from ADAP-only to Covered California during FY 2015-16 due to both the general impact of Covered California as well as covering out-of-pocket medical costs.
 - b. New assumptions.
 - i. HCV drugs: Not applicable (N/A) – this assumption should not impact the ADAP-only caseload.
- B. ADAP-only per client medication expenditures – OA estimates that the average monthly per client expenditures for ADAP-only clients in FY 2014-15 will be \$2,520, an increase of 7.7 percent compared to FY 2013-14. During FY 2015-16, OA estimates the average monthly per client expenditures will be \$2,768, an increase of 9.8 percent compared to FY 2014-15. These changes are based on the following:
- a. Historic trends and unchanged assumptions: During FYs 2012-13 and 2013-14, the ADAP-only average monthly expenditures per client increased by an average of 6.6 percent per year compared to the prior year. The expenditures per client during the first seven months of FY 2014-15 increased by 7.3 percent compared

to the average monthly expenditures per client during FY 2013-14. This trend is largely driven by increasing drug expenditures, and OA expects it will similarly impact FYs 2014-15 and 2015-16.

- i. Covered California: N/A.
 - ii. Payment of out-of-pocket medical costs for OA-HIPP clients: N/A.
- b. New assumptions.
- i. HCV drugs: OA projects that this new assumption will not impact FY 2014-15. For FY 2015-16, OA estimates a total of 100 ADAP-only clients will receive HCV treatment. The corresponding addition to the average monthly per client expenditures for ADAP-only clients will be \$74.

The following figures (Figures 1-3) show the actual ADAP-only caseload and expenditures per client per month during July 2012 through January 2015, along with our estimates for the remainder of the Current Year (FY 2014-15) and Budget Year (FY 2015-16). The linear trend for the actual data is also shown; caseloads are not projected to follow the linear trend due to the impact of the ACA.





Appendix B: Assumptions and Rationale for Medication Expenditures – Private Insurance

- A. Private insurance medication expenditures caseload: OA estimates that the average monthly number of private insurance clients in FY 2014-15 will be 5,258, an increase of 9.0 percent compared to FY 2013-14. During FY 2015-16, OA estimates the number will be 5,706, an increase of 8.5 percent compared to FY 2014-15. These changes are based on the following:
- a. Historic trends and unchanged assumptions: During FYs 2012-13 and 2013-14, the private insurance average monthly caseload had some seasonal variation, but was generally stable. During July 2014-January 2015, the caseload increased by 3.2 percent compared to FY 2013-14. OA believes this trend will continue for the remainder of FY 2014-15, primarily driven by clients transitioning to private health insurance purchased through Covered California.
 - i. Covered California: Based on the number of clients that have enrolled in Covered California during FY 2013-14, OA estimates that 411 clients will be added to the private insurance caseload during FY 2014-15 due to Covered California. These clients will primarily move to private insurance coverage during the Covered California open enrollment period (November 2014-April 2015). During FY 2015-16, OA estimates that an additional 195 clients will be added to the private insurance caseload due to Covered California. This estimate does not include the effect of the new assumption regarding medical out-of-pocket costs.
 - ii. Payment of out-of-pocket medical costs for OA-HIPP clients: Covering out of pocket medical costs for OA-HIPP clients will lead to more private insurance clients as additional eligible clients will choose to enroll in more comprehensive insurance coverage programs during FY 2015-16. OA estimates that 715 clients will enroll in Covered California due to coverage of medical out-of-pocket costs and receive ADAP support for medication costs. OA estimates that a total of 911 clients total will be added to the private insurance caseload due to the overall impact of Covered California and coverage of out-of-pocket medical costs.
 - b. New assumptions.
 - i. HCV drugs: N/A.
- B. Private insurance per client medication expenditures – Overall, OA estimates that the per-client expenditures for private insurance clients will decrease to \$308/month for FY2014-15, a decrease of 2.0 percent compared to FY 2013-14. In FY 2015-16, OA estimates the per-client expenditures for private insurance clients will be \$334/month, an increase of 8.5 percent compared to FY 2014-15. This change is attributable to the following:
- a. Historic trends and unchanged assumptions: During FY 2012-13 the private insurance average monthly medication expenditure per client decreased by an average of 3.6 percent compared to the prior year. However, in FY 2013-14, the average monthly medication expenditure per client increased by 12.2 percent compared to the prior year. The medication expenditure per client during the first seven months of FY 2014-15 decreased by 14.2 percent, but this is due to regular seasonal variation and reflects a short-term trend before medication deductibles are implemented at the first part of the Calendar Year. The slowing trend of decreasing per-client expenditures is largely driven by increasing medication deductibles and co-pays, particularly for Covered California clients as

compared to clients with employer-based insurance or COBRA plans. OA expects this will similarly impact FYs 2014-15 and 2015-16.

- i. Covered California: Covered California out-of-pocket costs are higher than those for OA-HIPP non-Covered California plans. As more clients move to Covered California, these higher medication expenditures will be reflected in higher expenditures per client. OA estimates the average monthly medication expenditure per client will increase \$5 during FY 2014-15 and \$1 during FY 2015-16 due to Covered California clients.
 - ii. Payment of out-of-pocket medical costs for OA-HIPP clients: Covered California medical out-of-pocket costs are higher than those for OA-HIPP-non-Covered California plans. Due to more clients entering Covered California because of coverage of medical out-of-pocket costs, the per client expenditures for private insurance clients will increase \$6/month.
- b. New assumptions.
- i. HCV drugs: OA projects this new assumption will not impact FY 2014-15. In FY 2015-16, OA estimates a total of 46 ADAP private insurance clients will receive HCV treatment. The corresponding total to the average monthly per client expenditures for private insurance clients will be \$8.

The following figures (Figures 4-6) show the actual private insurance caseload and expenditure per client per month during July 2012 through January 2015, along with our estimated numbers for the remainder of the Current Year (FY 2014-15) and Budget Year (FY 2015-16). The linear trend for the actual data is also shown; caseloads are not projected to follow the linear trend due to the impact of the ACA.

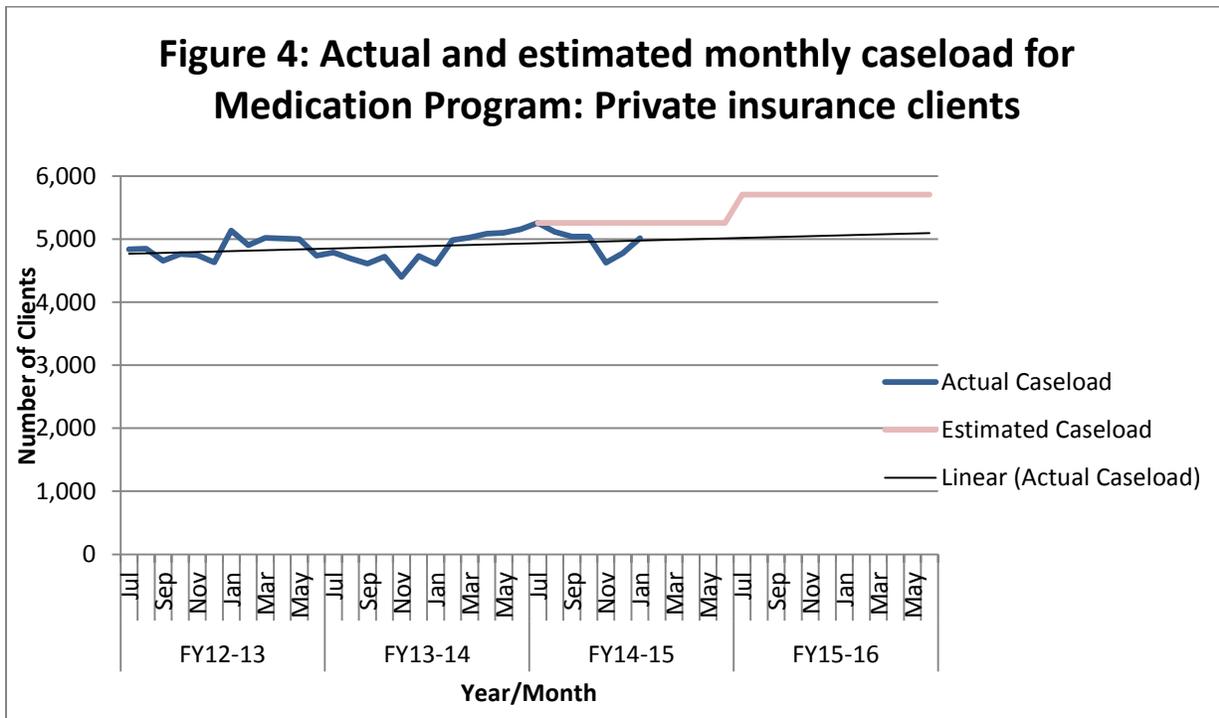


Figure 5: Actual and estimated monthly expenditure per client for Medication Program: Private insurance clients

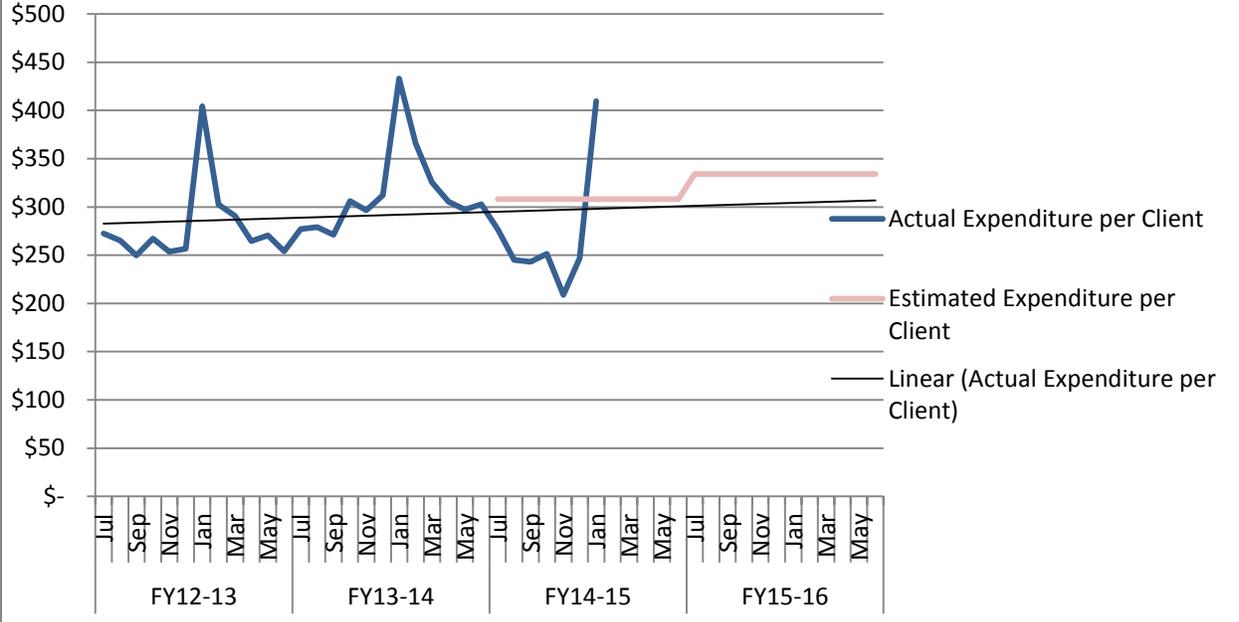
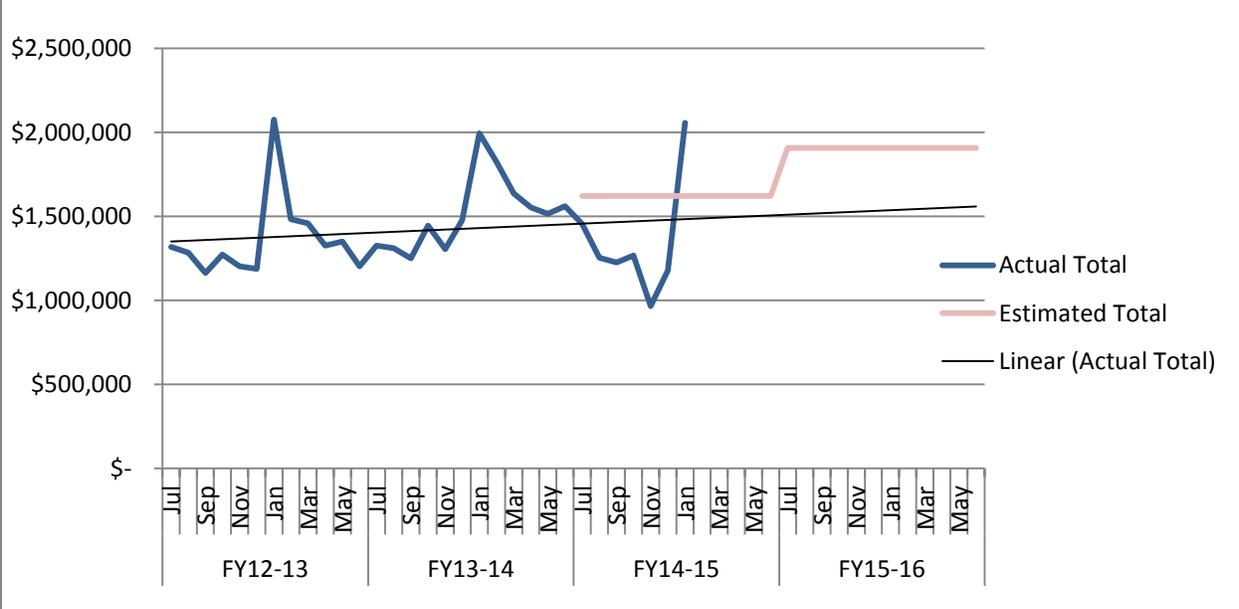


Figure 6: Actual and estimated total monthly expenditures for Medication Program: Private insurance clients



Appendix C: Assumptions and Rationale for Medication Expenditures – Medi-Cal SOC

- A. Medi-Cal SOC caseload – OA estimates that the average monthly number of Medi-Cal SOC clients in FY 2014-15 will be 166, a decrease of 17.9 percent compared to FY 2013-14. During FY 2015-16, OA estimates the number will be 159, a decrease of 4.1 percent compared to FY 2014-15. These changes are based on the following:
- a. Historic trends and unchanged assumptions: During FY 2012-13, the Medi-Cal SOC average monthly caseload was stable compared to the prior year. During FY 2013-14, the average monthly caseload decreased by 11.4 percent compared to the prior year. The caseload during the first seven months of FY 2014-15 decreased by 17.8 percent compared to the average monthly caseload during FY 2013-14. This trend is likely due to Medi-Cal Expansion, as clients who would previously have been given a SOC are now eligible for full Medi-Cal. OA expects this recent trend will disappear by FY 2015-16, as eligible clients with pending Medi-Cal applications are processed and enrolled in that program. In FY 2015-16, OA expects the caseload will continue to decline, although at a much slower rate.
 - i. Covered California: N/A.
 - ii. Payment of out-of-pocket medical costs for OA-HIPP clients: N/A.
 - b. New assumptions.
 - i. HCV drugs: N/A.
- B. Medi-Cal SOC per client medication expenditures – OA estimates the average monthly per client expenditure for Medi-Cal SOC clients in FY 2014-15 will be \$920, an increase of 3.1 percent compared to FY 2013-14. During FY 2015-16, OA estimates the average monthly per-client expenditure will be \$962, an increase of 4.6 percent compared to FY 2014-15. These changes are based on the following:
- a. Historic trends and unchanged assumptions: During FYs 2012-13 and 2013-14, the Medi-Cal SOC average monthly expenditure per client increased 1.7 percent and 3.6 percent, respectively. The expenditure per client during the first seven months of FY 2014-15 decreased by 17.8 percent compared to the average monthly expenditure per client during FY 2013-14. It is unclear what is driving this recent trend; therefore, OA is using prior years to determine the overall estimates until this trend can be more fully evaluated.
 - i. Covered California: N/A.
 - ii. Payment of out-of-pocket medical costs for OA-HIPP clients: N/A.
 - b. New assumptions.
 - i. HCV drugs: OA projects this new assumption will not impact FY 2014-15. For FY 2015-16, OA estimates that a total of three clients will receive HCV treatment. The corresponding increase to the average monthly per client expenditures for Medi-Cal SOC clients will be \$80.

The following figures (Figure 7-9) show the actual Medi-Cal SOC caseload and expenditure per client per month during July 2012 through January 2015, along with our estimated numbers for the remainder of the Current Year (FY 2014-15) and Budget Year (FY 2015-16). The linear trend for the actual data is also shown; caseloads are not projected to follow the linear trend due to the impact of the ACA.

Figure 7: Actual and estimated monthly caseload for Medication Program: Medi-Cal SOC clients

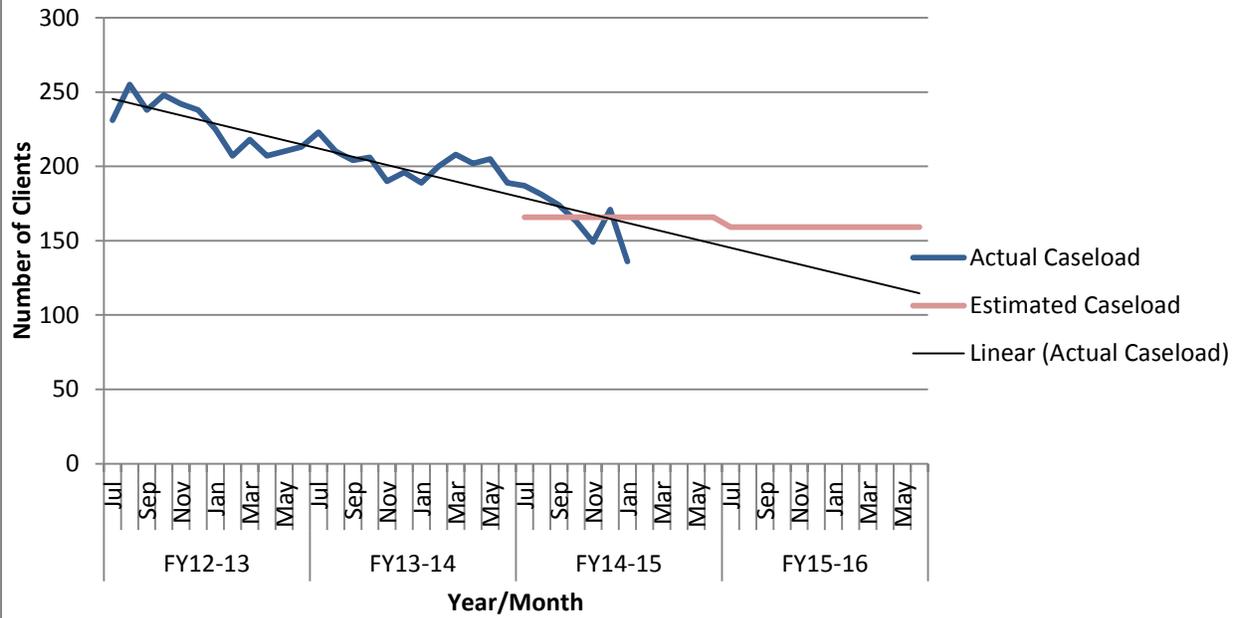


Figure 8: Actual and estimated monthly expenditures per client for Medication Program: Medi-Cal SOC clients

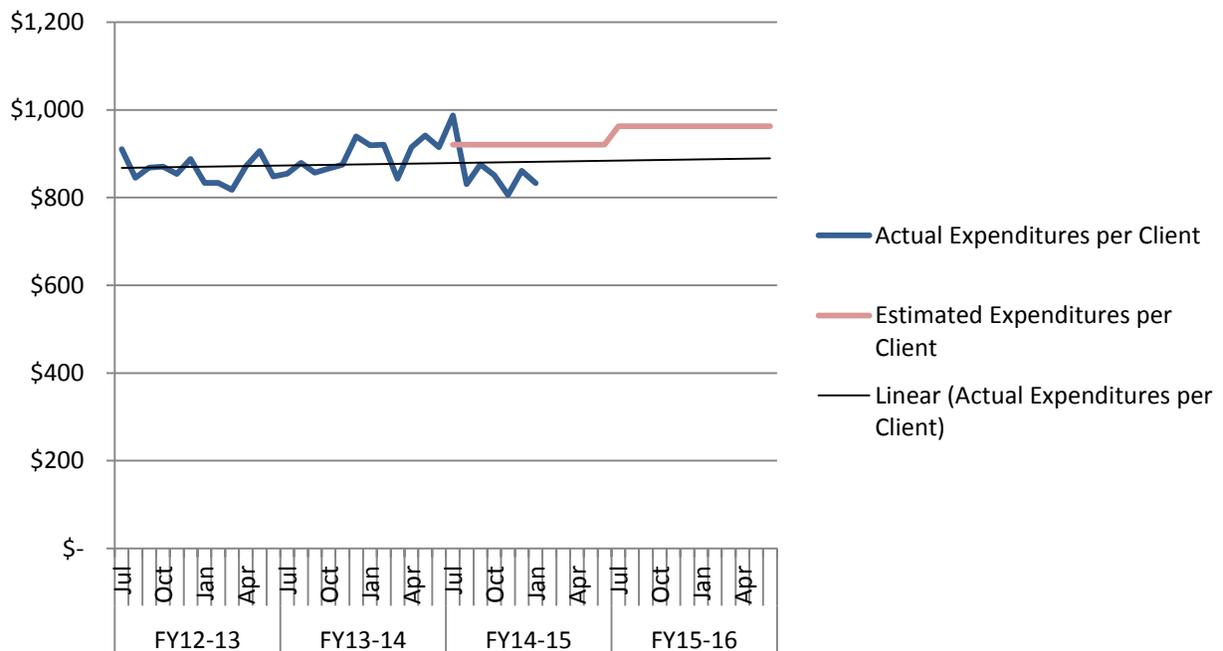
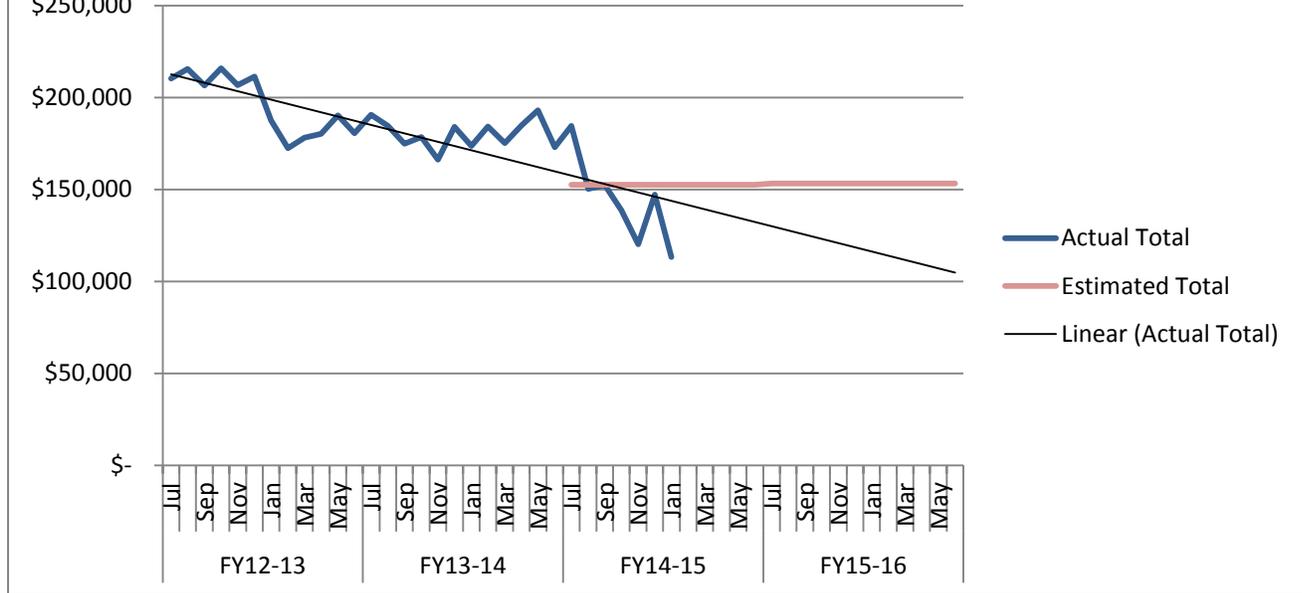


Figure 9: Actual and estimate total monthly expenditures for Medication Program: Medi-Cal SOC clients



Appendix D: Assumptions and Rationale for Medication Expenditures – Medicare Part D

- A. Medicare Part D caseload – Overall, OA estimates that average monthly caseload for clients in the Medicare Part D program in both FYs 2014-15 and 2015-16 will be 4,887, which is a 2.2 percent increase from FY 2013-14. This relative stability is attributable to the following:
- a. Historic trends and unchanged assumptions: During FY 2012-13 the Medicare Part D average monthly caseload increased 3.9 percent compared to the prior year. During FY 2013-14, the average monthly caseload decreased by 1.5 percent compared to the prior year. The caseload during the first seven months of FY 2014-15 declined 8.6 percent, but this is due to normal seasonal variation and does not reflect a long-term trend. Overall, the Medicare Part D caseload has been relatively stable, which OA expects will continue during FY 2015-16. This trend is primarily due to the stability of the aging population of people living with HIV.
 - i. Covered California: N/A.
 - ii. Payment of out-of-pocket medical costs for OA-HIPP clients: N/A.
 - b. New assumptions.
 - i. HCV drugs: N/A.
- B. Medicare Part D per client medication expenditures – OA estimates the average monthly per-client expenditure for Medicare Part D clients in FY 2014-15 will be \$318, an increase of 5.6 percent compared to FY 2013-14. During FY 2015-16, OA estimates the average monthly per-client expenditure will be \$342, an increase of 7.6 percent compared to FY 2014-15. These changes are based on the following:
- a. Historic trends and unchanged assumptions: During FYs 2012-13 and 2013-14, the Medicare Part D average monthly expenditure per client increased 3.8 percent and 5.5 percent, respectively. The expenditure per client during the first seven months of FY 2014-15 decreased by 18.2 percent compared to the average monthly expenditure per client during FY 2013-14. This trend is largely driven by normal seasonal variation and does not reflect a long-term trend. OA projects that the general increasing trend in per-client expenditures seen in FYs 2012-13 and 2013-14 will continue. This trend is primarily due to Medicare Part D plan co-pays and program rules.
 - i. Covered California: N/A.
 - ii. Payment of out-of-pocket medical costs for OA-HIPP clients: N/A.
 - b. New assumptions.
 - i. HCV drugs: OA projects this new assumption will not impact FY 2014-15. In FY 2015-16, OA estimates a total of 50 clients will receive treatment for HCV. The corresponding increase to the average monthly per client expenditures for Medicare Part D clients will be \$7.

The following figures (Figure 10-12) show the actual Medicare Part D caseload and expenditure per client per month during July 2012 through January 2015, along with OA estimates for the remainder of the Current Year (FY 2014-15) and Budget Year (FY 2015-16). The linear trend for the actual data is also shown.

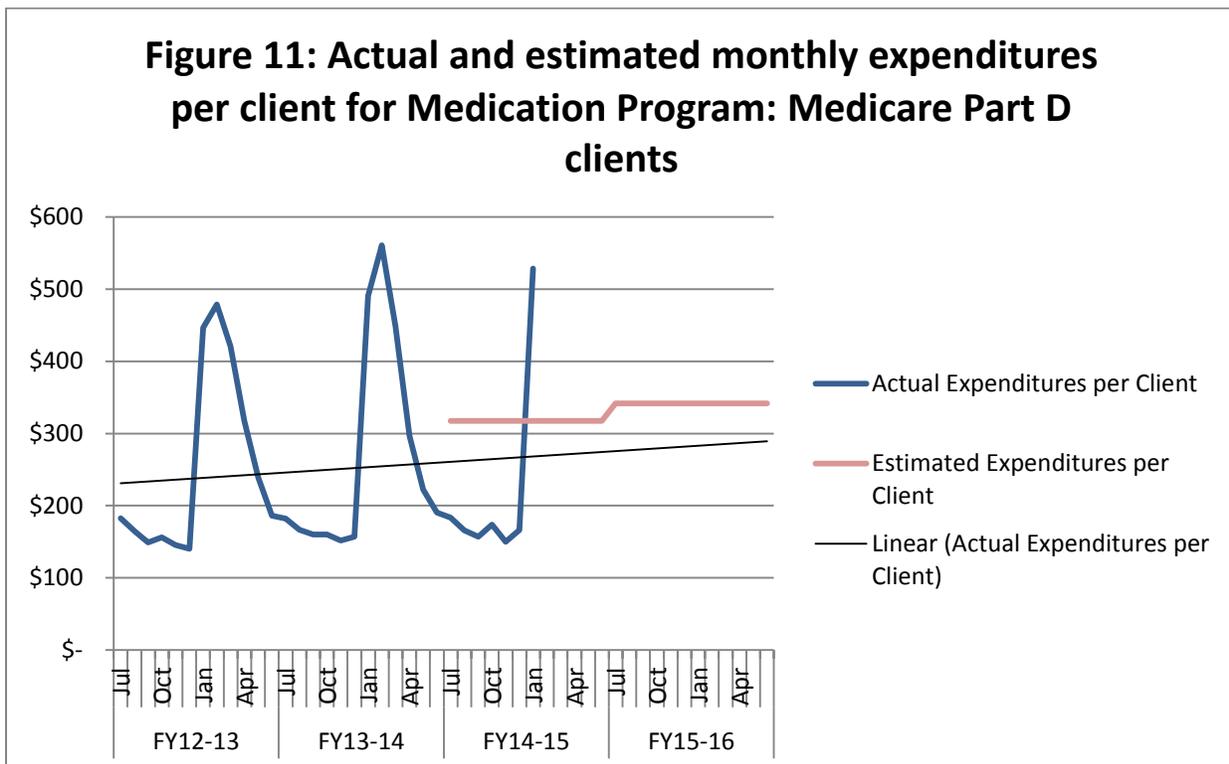
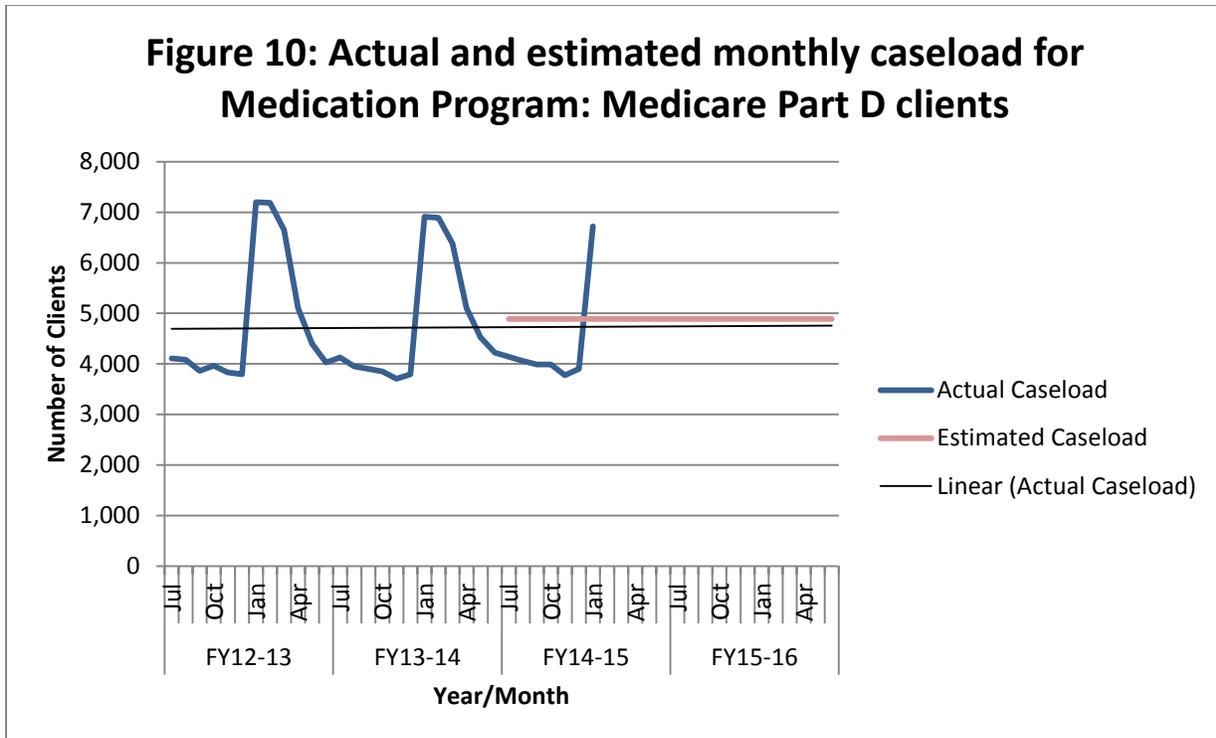
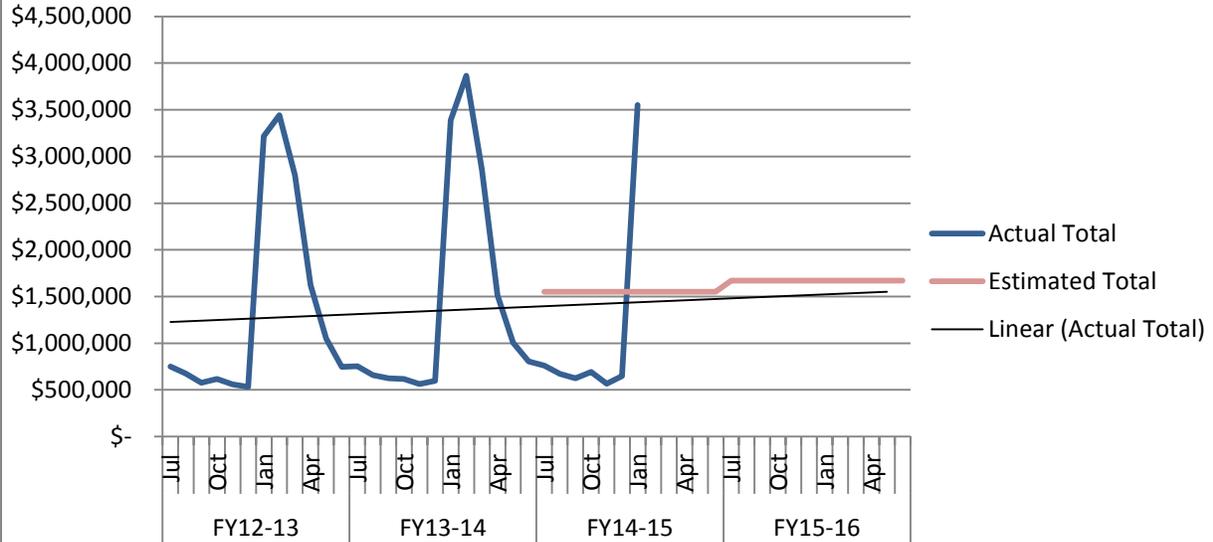


Figure 12: Actual and estimated total monthly expenditures for Medication Program: Medicare Part D clients



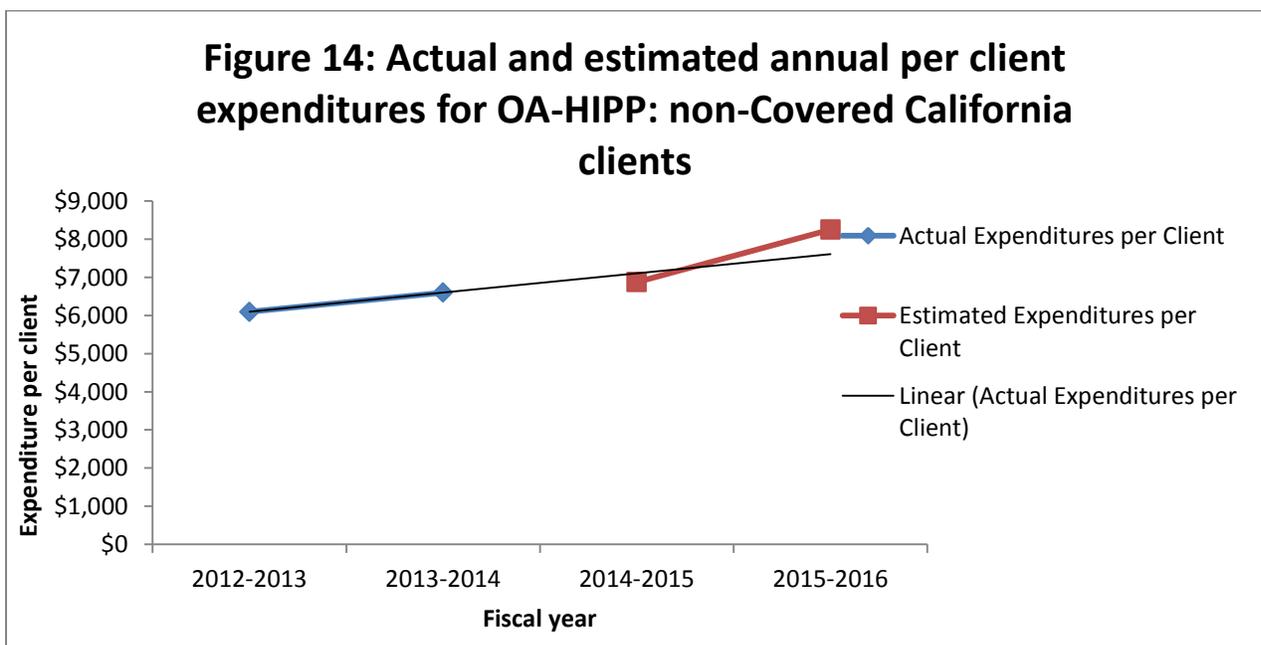
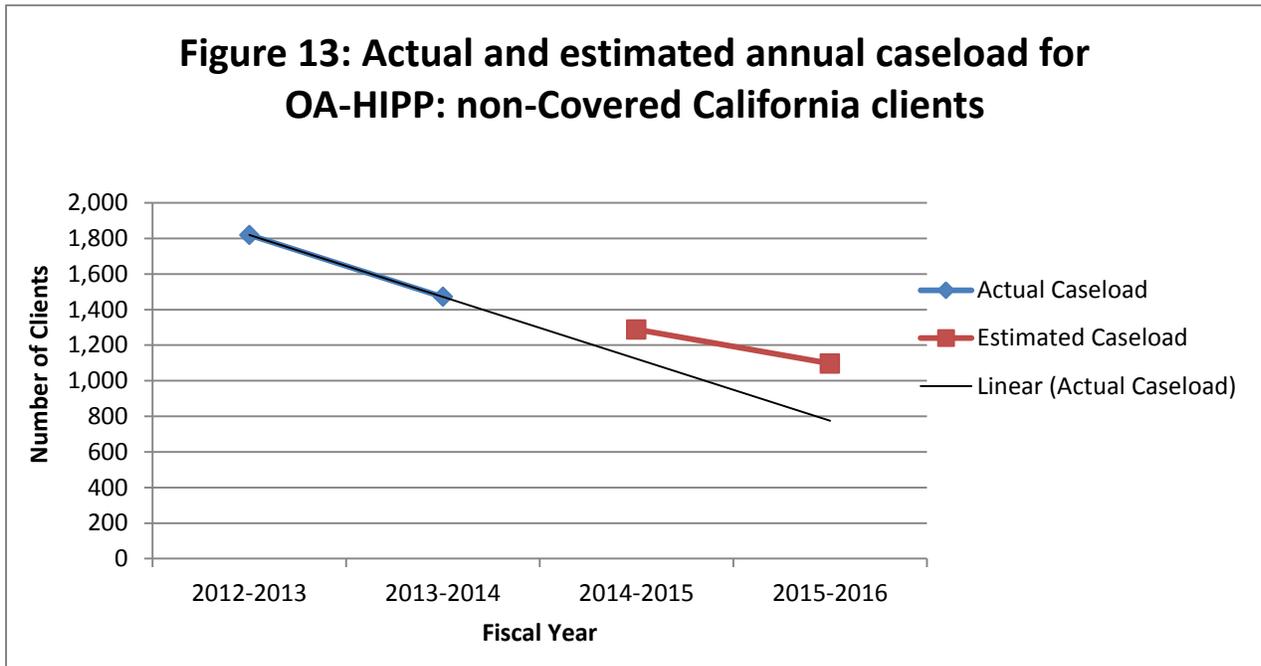
Appendix E: OA-HIPP – Non-Covered California Private Insurance Premium Expenditures

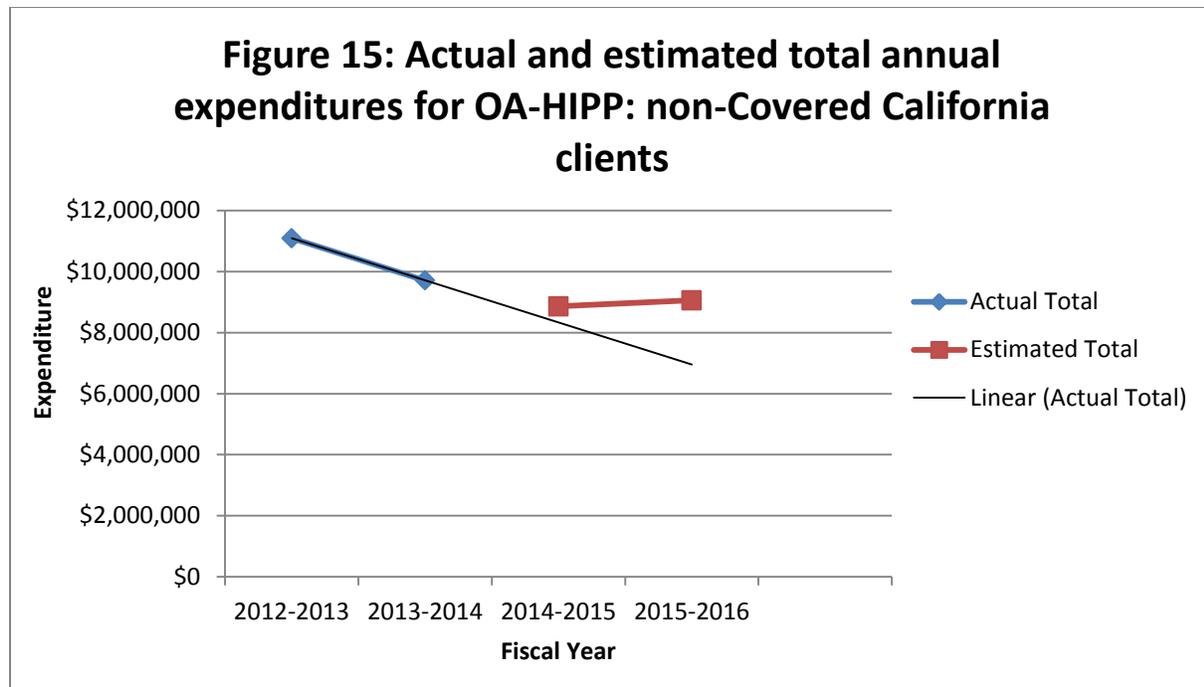
- A. Caseload for non-Covered California private insurance clients – Overall, OA estimates annual¹ caseload for clients in the OA-HIPP non-Covered California program in FY 2014-15 will be 1,288, a decrease of 12.4 percent compared to FY 2013-14. During FY 2015-16, OA estimates the number will be 1,097, a decrease of 14.8 percent compared to FY 2014-15. This change is attributable to the following:
- a. Historical data and unchanged assumptions: During FY 2012-13, the OA-HIPP non-Covered California annual caseload was 1,814, an increase of 74.1 percent compared to the prior year. During FY 2013-14, the annual caseload was 1,471, a decrease of 19.1 percent compared to the prior year. The recent changes in OA-HIPP non-Covered California caseload are due to clients enrolling in Covered California, Medi-Cal Expansion, and other ACA-related programs, such as PCIP or LIHP. OA projects that clients will continue to move out of non-Covered California plans to Covered California plans during FYs 2014-15 and 2015-16.
 - i. Covered California: Covered California will impact the caseload of the OA-HIPP non-Covered California program. OA estimates 91 clients will transition from non-Covered California to Covered California plans during FY 2014-15, and an additional 31 during FY 2015-16. These estimates do not include the impact of the new assumptions.
 - ii. Payment of out-of-pocket medical costs for OA-HIPP clients: N/A. While payment of medical out-of-pocket costs may increase program enrollment in OA-HIPP, OA expects that these clients will enroll in Covered California plans rather than non-Covered California plans.
 - b. New assumptions.
 - i. HCV drugs: N/A.
- B. Expenditure per client for OA-HIPP non-Covered California - Overall, OA estimates that average annual expenditures per client in the OA-HIPP non-Covered California program in FY 2014-15 will be \$6,877, an increase of 4.2 percent compared to FY 2013-14. During FY 2015-16, OA estimates the expenditure will be \$8,254, an increase of 20 percent compared to FY 2014-15. This change is attributable to the following:
- a. Historical data and unchanged assumptions: During FY 2012-13, the OA-HIPP non-Covered California average annual expenditure per client increased 5.9 percent compared to the prior year. During FY 2013-14, the average expenditure per client increased by 8.3 percent compared to the prior year. Overall, this trend reflects a long-term trend that OA expects will continue during FYs 2014-15 and 2015-16. Additionally, OA anticipates the PBM will start electronically paying HIPP premiums in July 2015, which will increase expenditures by \$111/client annually starting in FY 2015-16.
 - i. Covered California: N/A.
 - ii. Payment of out-of-pocket medical costs for OA-HIPP clients: N/A. Covering medical out-of-pocket costs for HIPP clients will increase the incentive for clients to enter HIPP, and also lead to increased program expenditures. OA estimates that coverage of medical out-of-pocket costs will increase per client expenditures by \$977 per client.

¹ All OA-HIPP estimates are based on annual data due to data limitations associated with the premium payment system.

- b. New assumptions.
 - i. HCV drugs: N/A.

The following figures (Figure 13-15) show the actual HIPP non-Covered California caseload and average expenditure per client per year during FYs 2012-13 and 2013-14, along with our estimated numbers for the remainder of the Current Year (FY 2014-15) and Budget Year (FY 2015-16). The linear trend for the actual data is also shown.





Appendix F: OA-HIPP Covered California Premium Expenditures

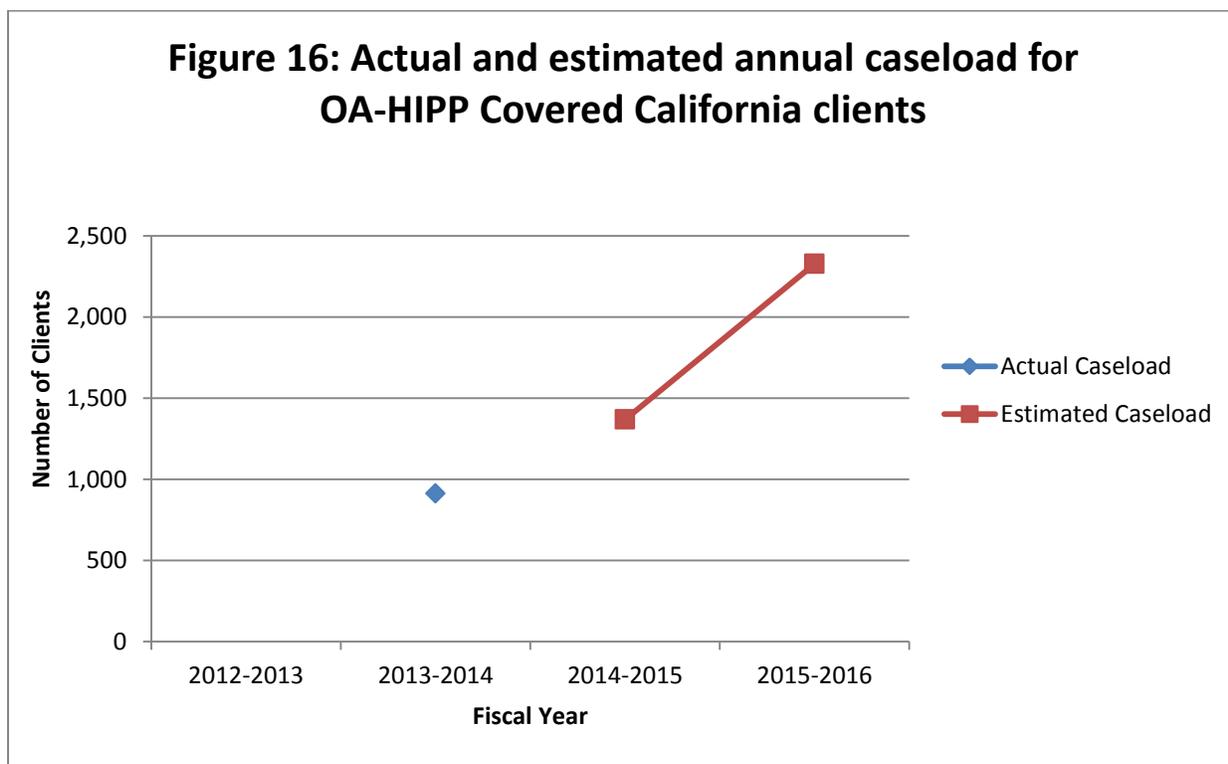
- A. Caseload for OA-HIPP Covered California - Overall, OA estimates that annual² caseload for clients in the OA-HIPP Covered California program in FY 2014-15 will be 1,370, an increase of 50 percent compared to FY 2013-14. During FY 2015-16, OA estimates the number will be 2,328, an increase of 70 percent compared to FY 2014-15. This change is attributable to the following:
- a. Historical data and unchanged assumptions: During FY 2013-14, the annual caseload for OA-HIPP Covered California was 913, the first year that Covered California existed. OA expects the number of OA-HIPP Covered California clients will continue to increase during FYs 2014-15 and 2015-16 due to increased enrollment in Covered California. For these projections, OA assumes that once clients enroll in a Covered California plan, they will stay in the program rather than change to non-Covered California coverage.
 - i. Covered California: OA estimates 457 clients will enroll in the OA-HIPP Covered California program during FY 2014-15, and an additional 205 during FY 2015-16. For FY 2014-15, the second year of Covered California, the projected increase is based on observed enrollment to date in OA-HIPP. For FY 2015-16, the projected increase is based on the recent trend in client enrollments. These estimates are independent of the impact of covering out-of-pocket medical costs, which will have additional impacts on Covered California enrollment during FY 2015-16.
 - ii. Payment of out-of-pocket medical costs for OA-HIPP clients: OA projects payment of medical out-of-pocket costs will increase program enrollment in OA-HIPP Covered California; OA estimates 753 additional clients will enroll in OA-HIPP Covered California in FY 2015-16 due to coverage of out-of-pocket medical costs. The total number of clients expected to enroll in OA-HIPP Covered California during FY 2015-16 is 959.
 - b. New assumptions.
 - i. HCV drugs: N/A.
- B. Expenditure per client for OA-HIP /Covered California - Overall, OA estimates that average annual expenditures per client in OA-HIPP Covered California in FY 2014-15 will be \$2,367, an increase of 14.6 percent compared to FY 2013-14. During FY 2015-16, OA estimates the expenditures will be \$2,971, an increase of 25.5 percent compared to FY 2014-15. Expenditures for FY 2015-16 include both premiums and additional medical out-of-pocket costs. This change is attributable to the following:
- a. Historical data and unchanged assumptions: Covered California started in January 2014 and no data are available for FY 2012-13. During FY 2013-14, the average premium expenditure per client for OA-HIPP Covered California clients was \$2,065. This amount only represents per client expenditures for six months; therefore, OA projects average per client expenditures will increase due to the program now being in effect for all 12 months of the FY. Additionally, Covered California has estimated premium costs will increase 4.2 percent during FY 2014-15; OA has used that percentage to estimate increases in general program expenditures in FYs 2014-15 and 2015-16.
 - i. Covered California: As stated above, the expenditures per client during FY 2013-14 only represents expenditures for 6 months; therefore, OA projects average per client premium costs will increase due to the

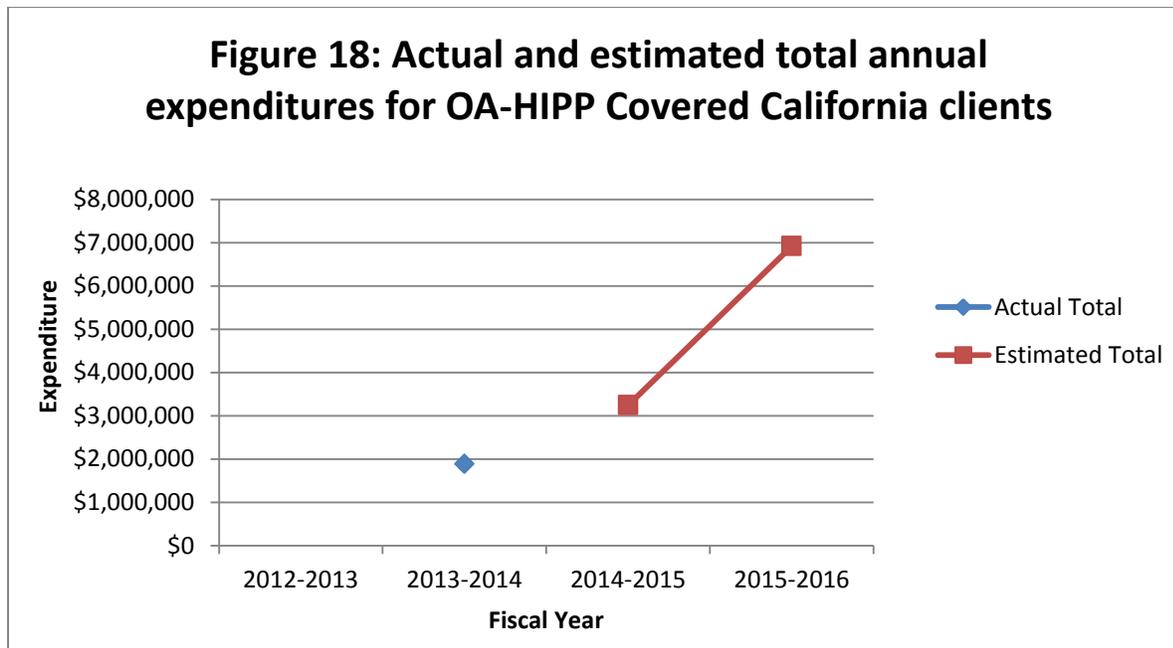
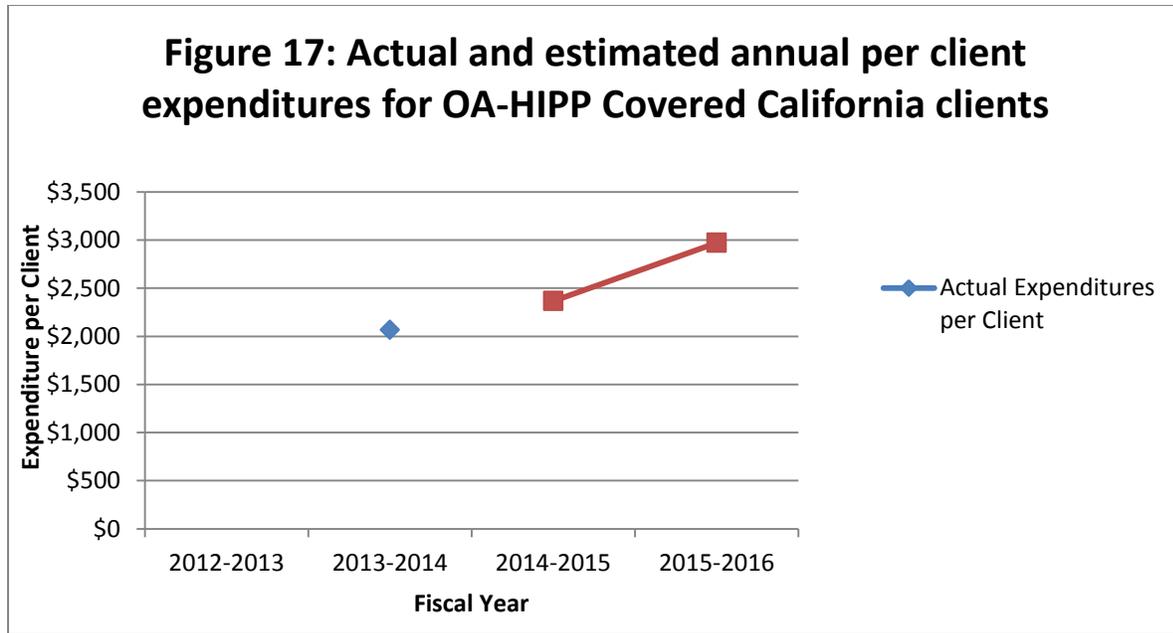
² All OA-HIPP estimates are based on annual data due to data limitations associated with the premium payment system.

program now being in effect for all 12 months of the FY. Additionally, Covered California has estimated that premium costs will increase 4.2 percent during FY 2014-15; OA has used that percentage to estimate increases in general program expenditures in FYs 2014-15 and 2015-16. OA anticipates that the PBM will start electronically paying OA-HIPP premiums in July 2015, which will increase expenditures by \$117 per client during FY 2015-16.

- ii. Payment of out-of-pocket medical costs for OA-HIPP clients: Covering medical out-of-pocket costs for OA-HIPP clients will increase the incentive for clients to enter OA-HIPP, and also lead to increased program expenditures. OA estimates this assumption will increase the annual per client expenditure for OA-HIPP Covered California clients to \$388 in FY 2015-16.
- b. New assumptions.
- i. HCV drugs: N/A.

The following figures (Figure 16-18) show the actual OA-HIPP Covered California caseload and average expenditures per client per year during FYs 2012-13 and 2013-14, along with our estimated numbers for the Current Year (FY 2014-15) and Budget Year (FY 2015-16).





Appendix G: OA-HIPP Health Insurance Premium Expenditures – Medicare Part D

- A. Caseload for OA-HIPP Medicare Part D clients - Overall, OA estimates annual caseload for clients in the OA-HIPP Medicare Part D program in FY 2014-15 will be 797, an increase of 5.4 percent compared to FY 2013-14. During FY 2015-16, OA estimates the number will be 821, an increase of 3 percent compared to FY 2014-15. This change is attributable to the following:
- a. Historical data and unchanged assumptions: During FY 2012-13, the Medicare Part D average annual caseload increased 4.4 percent compared to the prior year. During FY 2013-14, the average annual caseload increased by 2.6 percent compared to the prior year. This trend is primarily due to the aging of the population of persons living with HIV, and will continue in the future.
 - i. Covered California: N/A.
 - ii. Payment of out-of-pocket medical costs for OA-HIPP clients: N/A. Medicare Part D clients are not included in this assumption.
 - b. New assumptions.
 - i. HCV drugs: N/A.
- B. Expenditures per client for OA-HIPP Medicare Part D clients - Overall, OA estimates average annual premium expenditures per client in the OA-HIPP Medicare Part D program in FY 2014-15 will be \$677, an increase of 3 percent compared to FY 2013-14. During FY 2015-16, OA estimates the expenditure will be \$697, an increase of 3 percent compared to FY 2014-15. This change is attributable to the following:
- a. Historical data and unchanged assumptions: OA did not track expenditures for Medicare Part D clients separately from all OA-HIPP clients prior to FY 2013-14. During FY 2013-14, the average annual expenditure per client was \$657. Medicare has estimated that premium costs will increase 3 percent in 2015. OA projects this increase will continue in FY 2015-16.
 - i. Covered California: N/A.
 - ii. Payment of out-of-pocket medical costs for OA-HIPP clients: N/A.
 - b. New assumptions.
 - i. HCV drugs: N/A.

The following figures (Figure 19-21) show the actual OA-HIPP Medicare Part D caseload and expenditures per client per year during FYs 2012-13 and 2013-14, along with our estimated numbers for the Current Year (FY 2014-15) and Budget Year (FY 2015-16). The linear trend for the actual data is also shown.

Figure 19: Actual and estimated annual caseload for OA-HIPP Medicare Part D clients

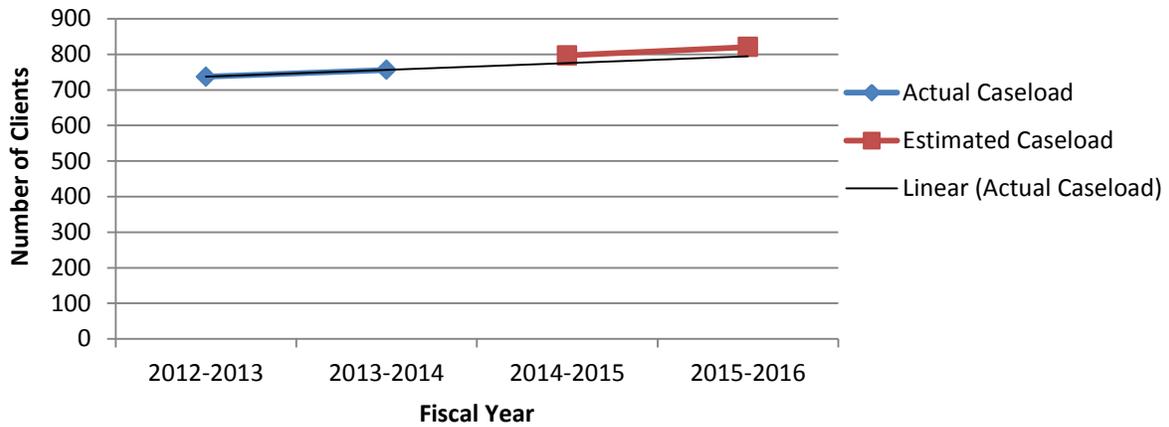


Figure 20: Actual and estimated annual per client expenditures for OA-HIPP Medicare Part D clients

