

AIDS DRUG ASSISTANCE PROGRAM (ADAP)

**November 2014
Estimate Package**

**For
Fiscal Years
2014-15 and 2015-16**



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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 drugs on the ADAP formulary for the following coverage groups (either the full cost of medications or co-pays and deductibles):
 - a. ADAP-only clients, for whom ADAP pays 100 percent of the prescription drug cost because these clients do not have a third-party payer;
 - b. Medi-Cal Share of Cost clients, for whom ADAP pays 100 percent of the prescription drug cost up to the client's share of cost amount;
 - c. Private insurance clients, for whom ADAP pays prescription drug co-pays and deductibles; and
 - d. Medicare Part D clients, for whom ADAP pays the Medicare Part D drug co-pays and deductibles.
2. Insurance Assistance Programs, 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 Share of Cost clients. As the primary payer, Medi-Cal has the right to claim federal mandatory rebate on prescriptions for Medi-Cal Share of Cost 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. ADAP clients are screened for Medi-Cal Expansion eligibility, and potentially eligible clients must apply. Clients who enroll in Medi-Cal Expansion are dis-enrolled from ADAP, because these clients have no share of cost and no drug co-pays or deductibles. Clients who enroll in health coverage available through Covered California or other health coverage can remain in ADAP's medication program to receive assistance with their drug co-pays and deductibles 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 continuum of care, rather than only HIV outpatient care and medications through the Ryan White system.

II. Estimate Overview

The ADAP Estimate provides a revised projection of current year [Fiscal Year (FY) 2014-15] Local Assistance costs for the medication and insurance assistance programs, along with projected costs for the budget year (FY 2015-16) Local Assistance budget for ADAP.

Table 1 below shows the estimated Local Assistance expenditure need for ADAP in the Current Year, FY 2014-15, and Budget Year, FY 2015-16, and compares them against the amount reflected in the 2014 Budget Act.

For FY 2014-15, CDPH estimates ADAP expenditures will be \$384.9 million, which is a \$55.1 million decrease compared to the 2014 Budget Act.

For FY 2015-16, CDPH estimates ADAP expenditures will be \$415.0 million, which is a \$25.0 million decrease compared to the 2014 Budget Act.

Table 2 below shows the estimated ADAP rebate fund revenue for Current Year and Budget Year and compares them to the amount reflected in the 2014 Budget Act.

California Department of Public Health						
AIDS Drug Assistance Program						
November Estimate						
Table 1: Local Assistance						
(dollars in millions)						
	Current Year			Budget Year		
	FY 2014-15			FY 2015-16		
	2014-15 Budget Act	November Estimate	Percent Change	2014-15 Budget Act	Governor's Budget	Percent Change
Total Funds Requested	\$440.0	\$384.9	-12.5%	\$440.0	\$415.0	-5.7%
Federal Funds - Fund 0890	107.8	131.2	21.7%	107.8	108.1	0.3%
Rebate Funds - Fund 3080	278.6	247.5	-11.2%	278.6	288.6	3.6%
Reimbursement Funds (SNCP)	53.6	6.2	-88.4%	53.6	18.2	-66.1%
Caseload	37,873	33,791	-10.8%	37,873	34,795	-8.1%

Table 2: Rebate Fund Revenues Overview ¹						
(dollars in millions)						
	Current Year			Budget Year		
	FY 2014-15			FY 2015-16		
	2014-15 Budget Act	November Estimate	Percent Change	2014-15 Budget Act	Governor's Budget	Percent Change
Total Requested	\$270.8	\$270.3	-0.2%	\$270.8	\$265.5	-2.0%
Rebate Funds - Fund 3080	270.7	270.2	-0.2%	270.7	265.4	-2.0%
Interest Income	0.1	0.1	0.0%	0.1	0.1	0.0%

¹ The revenue figures above are based on the most current and accurate information, which differ from the figures reflected in 2015-16 Governor's Budget fund condition statement.

III. Overall Projections

A. Key influences on ADAP expenditures

- a. FY 2014-15: Compared with the 2014 Budget Act, estimated expenditures for the current year have declined by 12.5 percent (Table 1, page 3). This decline is due to the following factors:
 - i. Covered California: A larger number of clients enrolled in Covered California during FY 2013-14 (913 clients) than was initially predicted. OA projects that the same number of clients will enroll during FY 2014-15. Medication expenditures for these clients have declined, because now ADAP only pays co-pays and deductibles, rather than the full cost, for medications on ADAP's formulary.
 - ii. 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.
 - iii. Hepatitis C virus treatment: Fewer clients are predicted to access hepatitis C virus treatment than was initially estimated, which results in the need to closely monitor federal funding amounts.

Several new hepatitis C drugs have recently been approved by the federal Food and Drug Administration (FDA) that provide a potential cure for the disease. The Governor's Budget sets aside \$300 million over two fiscal years for various state entities to account for the fiscal impact of high-cost drugs, such as those for hepatitis C, while exploring options to contain costs.

- b. FY 2015-16: Compared to the 2014 Budget Act, OA estimates that expenditures during FY 2015-16 will decline by 5.7 percent, but increase over the revised current year. This increase is due to 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, because these programs will be fully implemented by the end of FY 2014-15, OA expects that 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.

B. Expenditures

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

a. **Medication Expenditures**

For FY 2014-15, OA estimates medication expenditures will be \$366.1 million, which is a \$54.6 million decrease compared to the 2014 Budget Act. For FY 2015-16, OA estimates medication expenditures will be \$392.1 million, which is a \$28.4 million decrease compared to the 2014 Budget Act.

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

insurance clients enrolled in ADAP's medication program are not co-enrolled in ADAP's insurance assistance programs.

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 are located in appendices A-H; projections 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	15,275	45.2%	\$323,234,873	88.3%	15,500	44.5%	\$344,424,077	87.8%
Medi-Cal SOC	606	1.8%	\$2,091,940	0.6%	581	1.7%	\$2,117,683	0.5%
Private Insurance	8,787	26.0%	\$22,462,224	6.1%	9,591	27.6%	\$26,071,340	6.6%
Medicare Part D	9,123	27.0%	\$18,359,096	5.0%	9,123	26.2%	\$19,530,843	5.0%
TOTALS	33,791	100.0%	\$366,148,133	100.0%	34,795	100.0%	\$392,143,944	100.0%

b. Insurance Assistance Expenditures

ADAP pays health insurance premiums for eligible clients with one of three different types of health insurance:

1. Non-Covered California private insurance;
2. Private insurance purchased through Covered California; and
3. Medicare Part D.

These clients must be dually enrolled in ADAP's medication program as well as the insurance assistance program; however, private insurance clients enrolled in ADAP's medication program also include those with private employer-sponsored health insurance, for whom ADAP covers medication co-pays and deductibles only, and not premium payments through ADAP's insurance assistance programs.

For FY 2014-15, OA estimates that insurance assistance expenditures will be \$14.1 million, which is a \$1.3 million decrease compared to the 2014 Budget Act. This estimate for the current year only includes premium payment expenditures. For FY 2015-16, OA estimates that insurance assistance expenditures will be \$18.5 million, which includes premium and medical out-of-pocket costs. This is a \$3.1 million increase compared to the 2014 Budget Act.

Table 4, page 6 shows the estimated number of clients and the total expenditures for insurance assistance. The detailed rationale for the projected caseloads, cost per-client, and total expenditures are located in appendices A-H, beginning on page 17.

TABLE 4: ESTIMATED ANNUAL TOTAL CASELOAD AND EXPENDITURES BY COVERAGE GROUP
FOR INSURANCE ASSISTANCE

COVERAGE GROUP	FY 2014-15				FY 2015-16			
	ANNUAL CASELOAD		EXPENDITURES		ANNUAL CASELOAD		EXPENDITURES	
	NUMBER	PERCENT	AMOUNT	PERCENT	NUMBER	PERCENT	AMOUNT	PERCENT
OA-HIPP/Non-Covered California	1,288	32.9%	\$9,003,240	63.90%	1,097	21.8%	\$8,921,980	48.14%
OA-HIPP/Covered California	1,826	46.7%	\$4,535,307	32.19%	3,104	61.8%	\$9,027,661	48.71%
OA Medicare Part D	797	20.4%	\$551,966	3.92%	821	15.6%	\$585,184	3.00%
TOTALS	3,911	100.0%	\$14,090,513	100.00%	5,021	100.0%	\$18,534,825	100.00%

c. Fixed Expenditures (costs do not fluctuate with caseload)

- i. \$2.0 million for local health jurisdictions: Each local health jurisdiction allocation is based on the proportion of all ADAP clients the local health jurisdiction enrolled during the prior year. These funds may only be used for costs associated with the administration of ADAP enrollment. However, the local health jurisdictions determine how to utilize these funds. Local health jurisdictions 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: OA pays a reduced transaction fee for transactions between a pharmacy and the pharmacy benefits manager that does not result in an ADAP covered transaction (e.g., drug not on the ADAP formulary, refilled too soon, etc.). OA utilizes reimbursement funds for these expenditures as OA cannot use Ryan White federal funds or rebate funds for non-approved transactions. Non-approved transaction fee estimates are \$1,915,325 for FY 2014-15 and \$2,051,309 for FY 2015-16.

C. Revenue

- a. ADAP Special Funds: ADAP receives both mandatory and voluntary supplemental rebates from drug manufacturers for ADAP medication 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 medication expenditures for the last two quarters of the previous FY and the first two quarters of the current FY. OA estimates that ADAP rebate revenues will decrease by 0.2 percent from \$270.8 million in the 2014 Budget Act to \$270.3 million in the revised current year forecast. For FY 2015-16, rebate revenue is expected to decrease by 2.0 percent to \$265.5 million when compared to the 2014 Budget Act. These estimates account for decreased expenditures and the following increases in rebate revenue:

- Based on the average of the most recent four quarters of actual rebates received, the overall rebate percentage rate increased from 67 percent in the 2014 May Revision to 70 percent in the 2014 November Estimate.
- In addition, ADAP received payment of \$6.6 million in July 2014 from two counties' Low Income Health Programs for drugs dispensed to ADAP clients who were later identified as being enrolled in the Low Income Health Program

at the time the drugs were dispensed. The medications should have been purchased by the Low Income Health Programs, given the clients were enrolled in their local Low Income Health Program and Ryan White is the payer of last resort. Per the federal Health Resources and Services Administration, these funds must be identified as program income and must be expended prior to utilizing grant funds. The Low Income Health Program ended on December 31, 2013 and no further funding adjustments are expected.

- b. Reimbursement Funds: The Medi-Cal 1115 Waiver allows the California Department of Health Care Services to use certified public expenditures from various programs, including ADAP, to claim Safety Net Care Pool federal funds. CDPH receives ADAP's portion of the Safety Net Care Pool funds in the form of a reimbursement. In FY 2014-15, ADAP is requesting \$6.2 million of the \$53.6 million Safety Net Care Pool funds available for ADAP, based on the FY 2014 Budget Act, due to ADAP's requirement to spend mandatory rebate funds prior to spending federal funds. However, after the current Medi-Cal 1115 Waiver expires on October 31, 2015, Safety Net Care Pool reimbursement funds are not expected to be available for these purposes. Therefore, the amount of federal Safety Net Care Pool reimbursement funds available in state FY 2015-16 for ADAP is \$18.2 million (a \$35.5 million decrease when compared to the 2014 Budget Act). Due to an increase in projected expenditures for FY 2015-16 of \$30.1 million when compared to FY 2014-15, as well as the FY 2015-16 federal fund decrease of \$23 million when compared to FY 2014-15, ADAP will need to utilize all of the \$18.2 million Safety Net Care Pool funding available from the Department of Health Care Services in FY 2015-16.
- c. Federal Funds: For FY 2014-15, federal fund revenue increased by \$23.4 million compared to the 2014 Budget Act. ADAP received \$11.9 million in additional ADAP Supplemental funds and ADAP Emergency Relief Funds. The revised current year budget includes a federal fund surplus of \$11.2 million due to the Health Resources and Services Administration's requirement to spend mandatory rebate funds prior to spending federal funds. OA will submit a carryover request to use these funds for ADAP expenditures in the budget year. In addition, starting in FY 2014-15, ADAP will utilize 25 percent (\$23.8 million) of the federal fund ADAP Earmark allocations each year, beginning in current year, for expenditures during April 1 through June 30.

The federal Ryan White budget year is April 1 through March 31. Historically, ADAP would align the federal fund expenditures with the State FY by delaying spending the new federal grant funds from April 1 to July 1 of each year and utilizing ADAP Special Funds for those three months. This 25 percent accelerated movement of federal funds for three months will allow ADAP to utilize the full 12 months of federal fund expenditures in lieu of nine, thereby decreasing the amount of unused federal funds.

For FY 2015-16, ADAP anticipates federal fund revenue will increase by \$0.3 million from the 2014 Budget Act. In September 2014, ADAP received the 2014 Part B Supplemental Award for \$2 million. In October 2014, ADAP applied for the 2015 ADAP Emergency Relief Funds Grant and requested the maximum amount of \$11 million.

IV. Assumption Projections

Below, we summarize the projections for each of the major fiscal assumptions. Projections were developed sequentially; the effect of one assumption was determined before addressing the effects of the subsequent assumptions. The assumptions are presented here in the order in which they were built in to the model. Any modifications to an earlier assumption changes the projections for subsequent assumptions.

A. Change in Methodology to New Budget Projection Model (Existing Assumption)

For the 2015-16 Governor's Budget, OA adopted a new budget projection model, an expenditure per-client per-month model. Similar to Department of Public Health's other three Estimates, this will provide greater transparency of the costs, different caseload categories, and trends associated with different client groups within ADAP. OA is no longer using the linear regression model due to the inability of that approach to correctly account for changing trends in client load due to the impact of the Affordable Care Act (see Figure 1). The new model is expected to increase the accuracy of the estimated annual expenditures. The model has two input variables, monthly clients served and expenditures per-client per-month. These variables are calculated for four distinct client groups for medication expenditures (ADAP only, Medi-Cal Share of Cost, private insurance, and Medicare Part D), and for three client groups for insurance assistance expenditures (OA-HIPP Covered California, OA-HIPP Non-Covered California, and OA-Medicare Part D). The total estimated expenditures are a sum of the products of the client count and expenditures per-client for each group.

The initial expenditure projection model was developed based on historic trends for each of the client groups, which includes such factors as routine increases in client counts due to new diagnoses and increasing medication or premium expenditures due to inflation. The effect of Medi-Cal Expansion was also included in the initial model, since all Medi-Cal Expansion-eligible clients have either transitioned to Medi-Cal Expansion or are in the process of doing so; moving forward, Medi-Cal Expansion will primarily impact the number of new clients initially enrolling in ADAP, rather than a transition of current ADAP clients to Medi-Cal Expansion.

B. Covered California (Unchanged Assumption)

OA projects that during FY 2014-15, Covered California will have impacts on both medication expenditures and insurance assistance expenditures due to the movement of clients from ADAP-only medication coverage to comprehensive health insurance plans. 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 9. These estimates are based on what OA projects will occur if the medical out-of-pocket cost policy were not implemented. Administrative fees for ADAP's Pharmacy Benefits Manager to electronically process insurance premium payments for ADAP's Insurance Assistance clients starting in early 2015 are included in this assumption. These estimates include the new Covered California clients that OA projects will join the program during FYs 2014-15 and 2015-16, but not the Covered California clients who started accessing ADAP during FY 2013-14, which are included in the base model. Due to the six-month delay in rebate, no rebate revenue is included in this assumption for FY 2014-15.

1. FY 2014-15: OA estimates a total of 913 clients will newly enroll in OA-HIPP-Covered California. This projection is based on Covered California enrollment during FY 2013-14 and the enrollment pattern seen in year two of the Pre-existing Condition Insurance Plan and the Low Income Health Program implementation. Enrollment of the 913 clients into Covered California in FY 2014-15 is expected to lead to a net

- savings of \$3.6 million (\$450,649 in premium costs, \$1.6 million in medication deductibles and co-pays, and \$5.7 million in savings due to averted medication expenditures). This estimate includes one-time estimated start-up and on-going transaction costs for ADAP's Pharmacy Benefits Manager to electronically process OA-HIPP premium payments.
2. FY 2015-16: OA estimates that 567 additional clients will newly enroll in OA-HIPP Covered California, independent of the impact of paying medical out-of-pocket costs. This projection is based on Covered California enrollment during FY 2013-14 and the enrollment pattern seen in year three of the Pre-existing Condition Insurance Plan and the Low-Income Health Program implementation. New Covered California enrollment in FY 2015-16 is expected to lead to a net savings of \$2.6 million (\$408,553 in premium costs, \$1.0 million in medication deductibles and co-pays, and \$4.1 million in savings due to averted medication expenditures during FY 2015-16).
- C. Addition of Hepatitis C Virus Drugs Simeprevir and Sofosbuvir to the ADAP Formulary (Existing Assumption)
- OA estimates that 12 percent of ADAP clients are co-infected with hepatitis C virus, 32.4 percent of the co-infected clients have stage F3 or F4 liver disease, and 10 percent of ADAP's co-infected sub-population with stage F3 or F4 disease will be treated for hepatitis C virus each FY.
1. FY 2014-15: OA estimates that 69 clients will be treated for hepatitis C virus during FY 2014-15, with an estimated \$4.5 million in program expenditures and \$927,959 in rebate revenue. The estimated net cost is \$3.5 million.
 2. FY 2015-16: OA estimates that 135 clients will be treated for hepatitis C virus during FY 2015-16, with an estimated \$8.5 million in program expenditures and \$2.7 million in rebate revenue. The estimated net cost is \$5.8 million.

- D. Payment of Out-Of-Pocket Medical Costs for OA-HIPP Clients (New Assumption)
- In June 2014, the Administration and the Legislature approved a proposal to pay for out-of-pocket medical expenses for all OA-HIPP clients. Due to the time necessary to complete the Request for Proposal process, OA anticipates payment of out-of-pocket medical expenses to begin in January 2016. Developing and implementing the administrative capacity to pay out-of-pocket medical expenses, in addition to premiums for eligible OA-HIPP clients, will remove the financial disincentive currently present for ADAP-only clients to obtain private health insurance. Additional ADAP-only clients enrolling in private insurance coverage results in an overall reduction in ADAP expenditures, more comprehensive access to healthcare services, and improved health outcomes for those enrolled.

Payment of out-of-pocket medical costs will have impacts on both medication expenditures and insurance assistance expenditures. OA projects that more ADAP-only clients will purchase insurance through Covered California, if ADAP pays their medical out-of-pocket costs, rather than if clients remain responsible for their own medical out-of-pocket costs. As a result, ADAP will have fewer clients for whom the program is paying for the full cost of medications, and more clients for whom the program is paying for only part of the cost of medications.

OA estimates 711 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 ADAP did not pay medical out-of-pocket costs, leading to a total of 1,287 clients newly enrolling in OA-HIPP Covered California during

FY 2015-16 (see Table 4a below for a summary of number of Covered California clients per year per all assumptions). OA projects that 85 percent of these clients will be 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 Covered California enrollment during FY 2013-14, the enrollment pattern seen in year three of the Pre-existing Condition Insurance Plan and Low Income Health Program 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 711 additional clients, as well as medical out-of-pocket costs associated with clients who are in or would enroll in OA-HIPP regardless of coverage of medical out-of-pocket costs. Coverage of medical out-of-pocket costs will lead to \$3.1 million in savings during FY 2015-16 (\$357,060 in additional premium costs, \$1.8 million in medical out-of-pocket costs, \$921,103 in additional medication deductibles and co-pays, and \$6.2 million savings due to averted medication expenditures). Table 4a summarizes the impact of the various assumptions on Covered California client counts.

The estimated savings are lower than the estimate provided to the legislature in the spring of 2014 due to higher levels of Covered California enrollment than expected during FY 2013-14. In the 2014 May Revision ADAP Estimate, OA estimated that 227 ADAP clients would enroll in Covered California in FY 2013-14, but 913 clients actually did enroll in Covered California. Of these clients, approximately 66 percent were newly entering the OA-HIPP program. As a result, OA estimates that a substantially higher number of clients will already be enrolled in OA-HIPP Covered California at the start of FY 2015-16, when coverage of medical out-of-pocket will start.

FISCAL YEAR	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	913	1,826	-\$3.6 million
2015-16 (estimated)	ALL except medical out-of-pocket costs	567	See below	-\$2.6 million
2015-16 (estimated)	Medical out-of-pocket costs	711	See below	-\$3.1 million
2015-16 (estimated)	ALL	1,278	3,104	-\$5.8million

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

In May and June 2014, ADAP received additional supplemental Ryan White funds totaling approximately \$11.9 million. ADAP will use these funds for drug expenditures in the current year. In September 2014, ADAP was awarded the maximum amount of \$2 million for the

Competitive 2014 Ryan White Part B Supplemental Grant. ADAP will use these funds for drug expenditures in the budget year.

F. Discontinued Major Assumptions

1. OA- Pre-existing Condition Insurance Plan Implementation
The federal Pre-existing Condition Insurance Plan ended on April 30, 2014.
2. Impact of the Low Income Health Program on ADAP
The Low Income Health Program ended on December 31, 2013.

Future Fiscal Issues

1. Potential Savings Due to Cross Match of Ryan White Client Data with the Medi-Cal Eligibility Data Systems

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 the Department of Health Care Services in September 2014 that will allow for a monthly cross match of Ryan White and Medi-Cal Eligibility Data Systems client data. OA will work with staff from the Department of Health Care Services to develop the program that will run the blind match. 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 Pharmacy Benefits Manager contactor.

2. Carry Forward Request for Unspent Ryan White Federal Grant Funds

On November 16, 2012, the Health Resources and Services Administration released a policy letter stating that due to regulations that govern federally funded grants, including Part B and ADAP awards, grantees are required to spend 340B rebate funds prior to drawing down federal Ryan White grant funds. Due to available 340B rebate funds, ADAP did not spend all of the available 2013 Ryan White federal funds by March 31, 2014; \$8.0 million was left unspent and CDPH has submitted a carry-over request to the Health Resources and Services Administration for these funds. If the request is approved, OA will use the funds for ADAP drug expenditures in the current year.

3. Potential Increase in Federal Funds: 2015 ADAP Emergency Relief Funds

In October 2014, CDPH applied for the maximum amount of \$11 million for the competitive 2015 ADAP Emergency Relief Funds supplemental grant. If awarded, ADAP will use these funds for drug expenditures in the budget year.

4. New HIV Drugs

Two drug manufacturers currently have New Drug Applications for antiretrovirals at various stages of review with the FDA. This may result in two new antiretroviral drugs/drug combinations becoming available on the market before the end of FY 2014-15. As required by law, ADAP must add a new antiretroviral to the formulary within 30 days of FDA approval if its addition does not represent a cost increase to the program and the drug has been recommended for addition by the ADAP Medical Advisory Committee.

1. Darunavir with cobicistat

Janssen Research and Development, LLC (Janssen) submitted a New Drug Application on April 1, 2014. This is a once-daily fixed-dose antiretroviral combination tablet

containing darunavir (a protease inhibitor developed by Janssen) with cobicistat, the pharmacokinetic boosting agent developed by Gilead.

2. Atazanavir with cobicistat

Bristol Myers Squibb submitted a New Drug Application on April 4, 2014. This is a fixed-dose combination of atazanavir sulfate, a protease inhibitor, and cobicistat, the pharmacokinetic boosting agent developed by Gilead.

Elvitegravir, manufactured by Gilead Sciences Inc., is an antiretroviral medication that is in the integrase inhibitor class and will offer another once-daily dosing integrase inhibitor option. Although elvitegravir received FDA approval on September 24, 2014, the drug manufacturer is not currently selling this drug as a stand-alone pill and it is therefore not available to the public at this time.

5. New Hepatitis C Virus Drugs

Two new hepatitis C virus drugs have been approved by the FDA.

1. Ledipasvir with sofosbuvir

Gilead submitted a New Drug Application on April 7, 2014 for a fixed dose combination tablet indicated for treatment of genotype 1 hepatitis C virus. This fixed dose combination is intended to be taken for a period of eight, twelve, or twenty-four weeks depending on patient population, and eliminates the need for interferon or ribavirin. The FDA approved this drug on October 10, 2014. This drug provides a slightly higher cure rate of up to 99 percent and, because it is used without interferon and ribavirin, has fewer side effects than regimens currently on the ADAP formulary. Ledipasvir with sofosbuvir is estimated to be cost neutral and in November 2014 was recommended for addition to the ADAP formulary by the ADAP Medical Advisory Committee. ADAP will work with the Medical Advisory Committee to develop appropriate medical access criteria for this new drug.

2. Ombitasvir/paritaprevir/ritonavir tablets; dasabuvir tablets

On April 21, 2014, AbbVie submitted a New Drug Application for an investigational, interferon-free therapy consisting of a fixed dose combination of ombitasvir/paritaprevir/ritonavir tablets and dasabuvir tablets for genotype 1 hepatitis C virus-infected adult patients. The FDA granted the regimen a Breakthrough Therapy designation in May 2013, and on June 13, 2014 AbbVie announced that the FDA had granted priority review status to the New Drug Application. The FDA approved this drug combination regimen on December 19, 2014. ADAP will monitor drug pricing and rebate negotiations. If this regimen is recommended for addition to the ADAP formulary by the ADAP Medical Advisory Committee, ADAP will work with the Committee to develop appropriate medical access criteria for this new regimen.

One drug manufacturer currently has a New Drug Application under review with the FDA that could result in a new hepatitis C virus drug becoming available on the market before the end of calendar year 2015.

Daclatasvir

Bristol Myers Squibb submitted a New Drug Application on April 7, 2014 for daclatasvir, a nonstructural protein 5A replication complex inhibitor. The data submitted in the New Drug Application requested approval for the use of daclatasvir plus asunaprevir in patients with hepatitis C virus genotype 1b, and also for use of this compound in combination with other agents for multiple genotypes. The FDA granted priority review status and set a target review date of November 30, 2014 under the Prescription Drug User Fee Act. However, on October 7, 2014, Bristol Myers Squibb withdrew the New Drug Application for asunaprevir and indicated they would continue to pursue FDA

approval of daclatasvir and plan to submit additional data for daclatasvir to the FDA.
Therefore, the target review date of November 30, 2014 no longer applies.

6. Potential Loss of Rebate Revenue: Renegotiated Supplemental Rebate Agreements

The ADAP Crisis Task Force, a national-level negotiating body that represents all ADAPs in the country, met in July 2014 with each of the major antiretroviral drug manufacturers to renegotiate voluntary supplemental rebate agreements. All seven antiretroviral manufacturers have agreed to a one-year extension to the terms of the existing rebate agreements, to December 30, 2015.

V. Fund Condition Statement²

Table 5: AIDS Drug Assistance Program				FY 2013-14	FY 2014-15	FY 2015-16
Special Fund 3080 AIDS Drug Assistance Program Rebate Fund				Actuals	Estimate	Estimate
1	BEGINNING BALANCE			29,494	14,374	36,228
2	Prior Year Adjustment			-54		0
3	Adjusted Beginning Balance			29,440	14,374	36,228
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		
8	4172500 Miscellaneous Revenue			284,483	270,173	265,402
9	Total Revenues, Transfers, and Other Adjustments			281,587	270,293	265,522
Fund 0890 Federal Funds	Total Resources			311,027	284,667	301,750
Fund 3080 Rebate Funds (SNCP) Reimbursement Funds	EXPENDITURES AND EXPENDITURE ADJUSTMENTS					
	Expenditures					
12	8880	FISCAL		4	1	2
13	4265	Department of Public Health				
14		State Operations		1,217	944	1,523
15		ADAP Local Assistance (Medications)		283,752	235,120	270,105
16		Insurance Assistance Programs (Premiums)		11,679	12,375	18,535
17						
18	Total Expenditures and Expenditure Adjustments			296,653	248,439	290,165
19	FUND BALANCE			14,374	36,228	11,585
	Row 6: Interest Actuals for FY 2013-14, Estimated for FYs 2014-15 and 2015-16				120,000	120,000
	Miscellaneous Revenue					
	Program Income (LHP-Back-billing)				6,614,863	
	Actual Rebate received as of Jul - Sept 10, 2014 from Expenditures for Jan - Mar 2014				71,790,464	
Fund 3080 Rebate Funds	Estimated Rebates to be received Oct - Dec 2014 from Actual Expenditures from April - June 2014 (\$80,879,142 x 70% avg rebate rate)				63,615,400	
	Estimated Rebates to be received Jan - Jun 2015 from Estimated Expenditures from July - Dec 2014 (\$183,074,067 x 70% avg rebate rate)				128,151,847	
	Estimated Rebate to be received Jul - Dec 2015 from Estimated Expenditures for Jan - Jun 2015 (\$183,074,067 x 70% avg rebate rate)					128,151,847
	Estimated Rebate to be received Jan - Jun 2016 from Estimated Expenditures for July - Dec 2015 (\$196,071,972 x 70% avg rebate rate)					137,250,380
	Total Estimated FY 2014-15 Rebate Revenue				270,172,574	
	Total Estimated FY 2015-16 Rebate Revenue					265,402,227

² The revenue figures above are based on the most current and accurate information, which differ from the figures reflected in 2015-16 Governor's Budget fund condition statement.

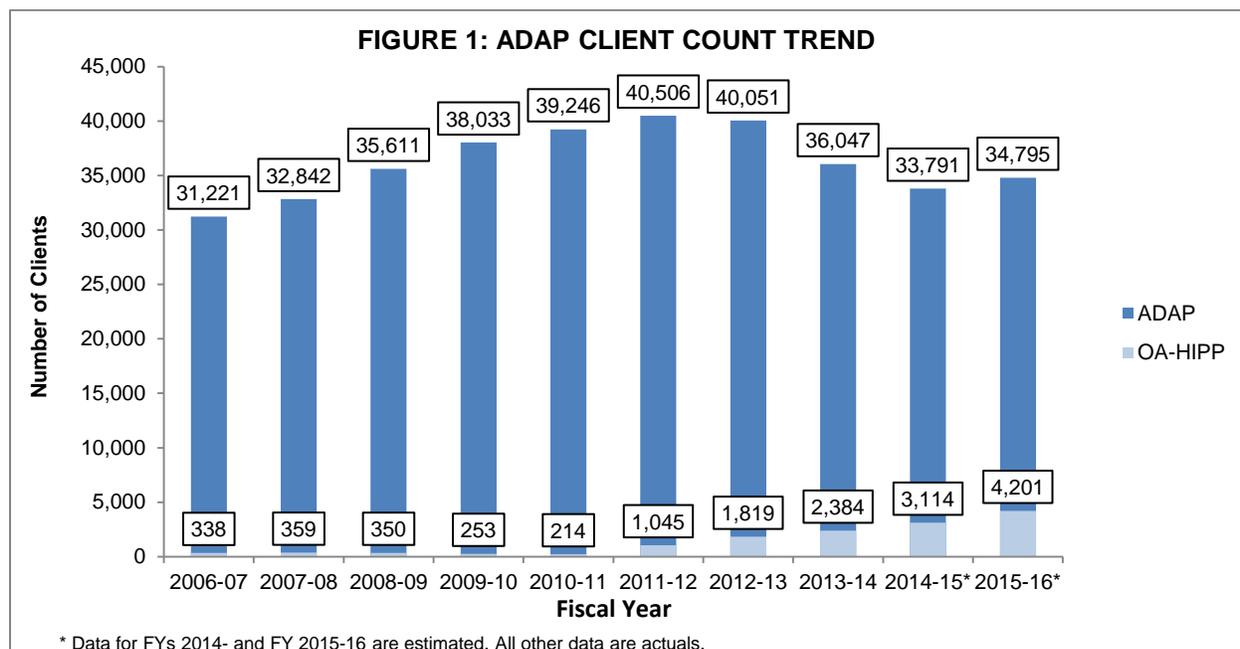
VI. HISTORICAL PROGRAM DATA AND TRENDS*

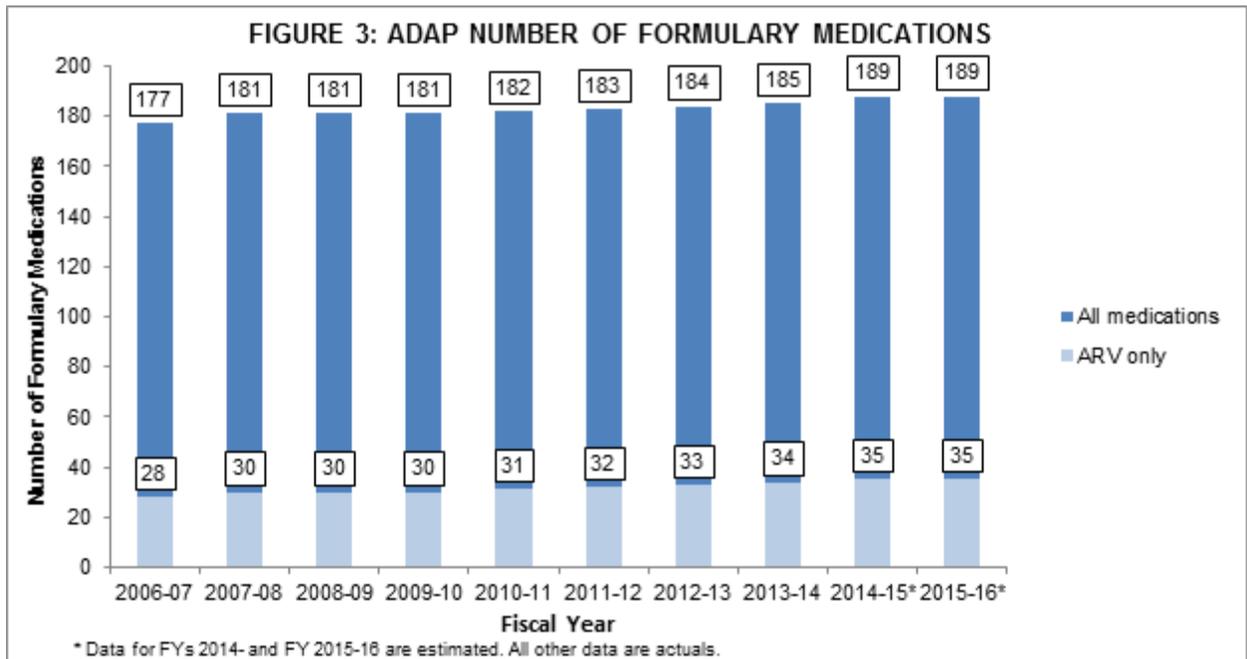
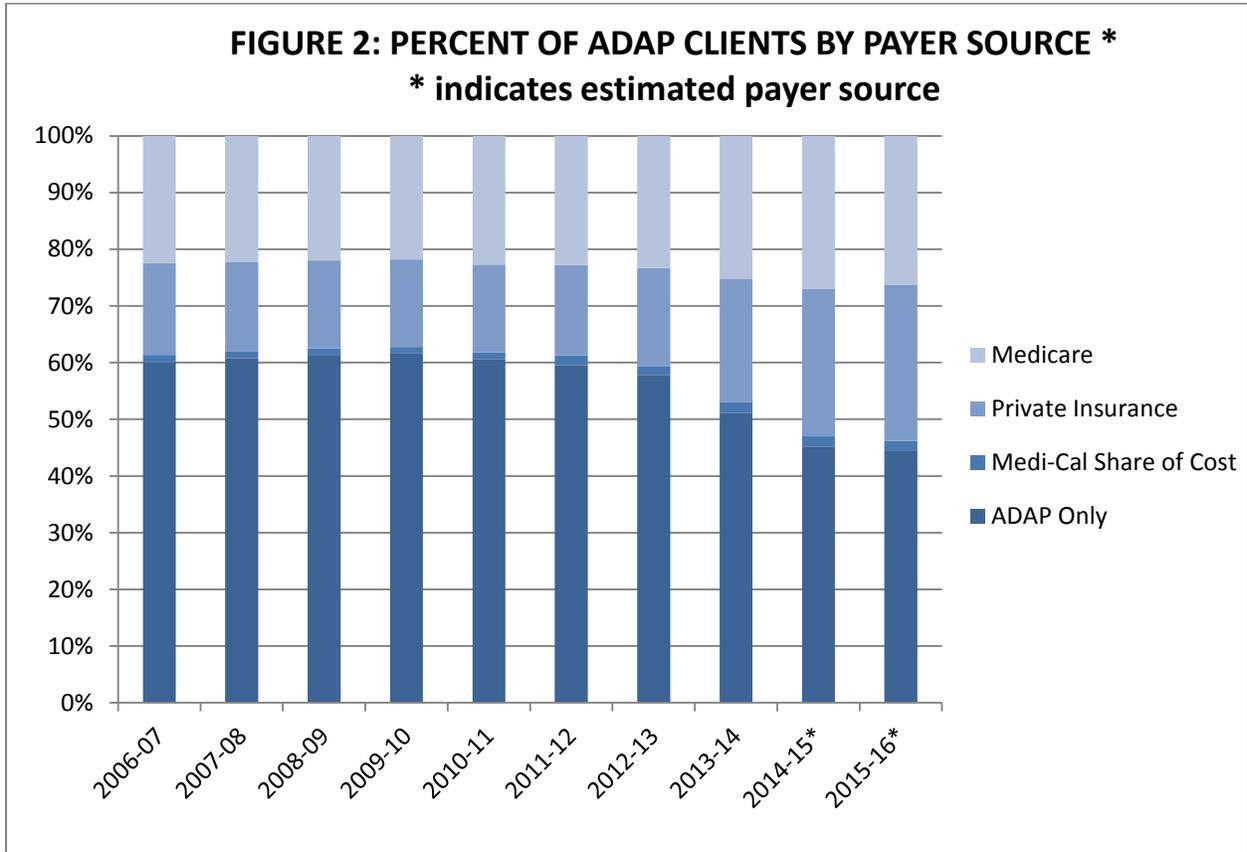
For all figures and tables in this section, the data prior to FY 2014-15 is the observed historical data. Estimates for FYs 2014-15 and 2015-16 are based on the overall projections and include all assumptions contained in this Estimate. Effective March 2013, all OA-HIPP clients are required to be co-enrolled 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 clients who are co-enrolled in OA-HIPP is also shown as a subset of the total ADAP caseload.

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

Figure 3 is the number of medications on the ADAP formulary by fiscal year; the number of antiretroviral medications is also shown as a subset of the total number of medications.





Simeprevir and sofosbuvir (hepatitis C virus medications) were added to the ADAP formulary on July 18, 2014. Co-formulated dolutegravir/lamivudine/abacavir and cobicistat (antiretroviral medications) were added to the ADAP formulary on September 22, 2014 and on December 19, 2014, respectively.

VII. 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 10,528, a decrease of 17.2 percent compared to FY 2013-14. During FY 2015-16, OA estimates the monthly caseload will be 10,682, an increase of 1.5 percent compared to FY 2014-15. These changes are based on the following:
- a. Historic trends and existing/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 two months of FY 2014-15 decreased by 15.8 percent compared to FY 2013-14. These past trends were primarily driven by the Low Income Health Program, the Pre-existing Condition Insurance Plan, Medi-Cal Expansion, and transition of clients to Covered California. Since the impact of the Low Income Health Program and the Pre-existing Condition Insurance Plan was largely historical, OA projects that the caseload will no longer continue to decline, but will stabilize during FY 2014-15 due to ongoing enrollment in Covered California and resolution of the current backlog of Medi-Cal Expansion applications. During FY 2015-16, the ADAP-only caseload will likely start increasing primarily due to newly enrolled clients who are not eligible for Medi-Cal Expansion or Covered California.
 - i. Hepatitis C virus treatment: Not applicable (N/A) – this assumption should not impact the ADAP-only caseload.
 - ii. Covered California: Based on the number of clients that have moved from ADAP-only to a Covered California private insurance plan during FY 2013-14 and on previous client enrollment patterns from the Low Income Health Program and the Pre-existing Condition Insurance Plan, OA estimates that 551 clients will move from ADAP-only to Covered California during FY 2014-15. These clients will move to Covered California coverage starting January 2015. During FY 2015-16, OA estimates that an additional 361 clients will move to Covered California from the ADAP-only program; this estimate does not include the effect of the new assumption regarding medical out-of-pocket costs.
 - b. New assumption:
 - i. 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 733 clients will move from ADAP-only to Covered California due to coverage of medical out-of-pocket costs. A total of 1,094 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. 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 \$2,559, an increase

of 9.4 percent compared to FY 2013-14. During FY 2015-16, OA estimates the average monthly per-client expenditures will be \$2,687, an increase of 5.0 percent compared to FY 2014-15. These changes are based on the following:

- a. Historic trends and existing/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 two months of FY 2014-15 increased by 8.0 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. Hepatitis C virus drug coverage: OA estimates that 38 ADAP-only clients will access hepatitis C virus treatment during FY 2014-15 and 72 ADAP-only clients will access treatment during FY 2015-16. Based on these client estimates, and the average cost of a treatment course, the average monthly per-client expenditures for ADAP-only clients will increase \$219 during FY 2014-15 and \$160 during FY 2015-16 due to hepatitis C virus treatment. Treatment for hepatitis C virus is primarily responsible for the increased expenditures during FY 2014-15.
 - ii. Covered California: N/A.
- b. New assumption:
 - i. Payment of out-of-pocket medical costs for OA-HIPP clients: N/A.

The following figures (Figures 4-6) show the actual ADAP-only caseload and expenditures per-client per-month during July 2012 through August 2014, 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 Affordable Care Act.

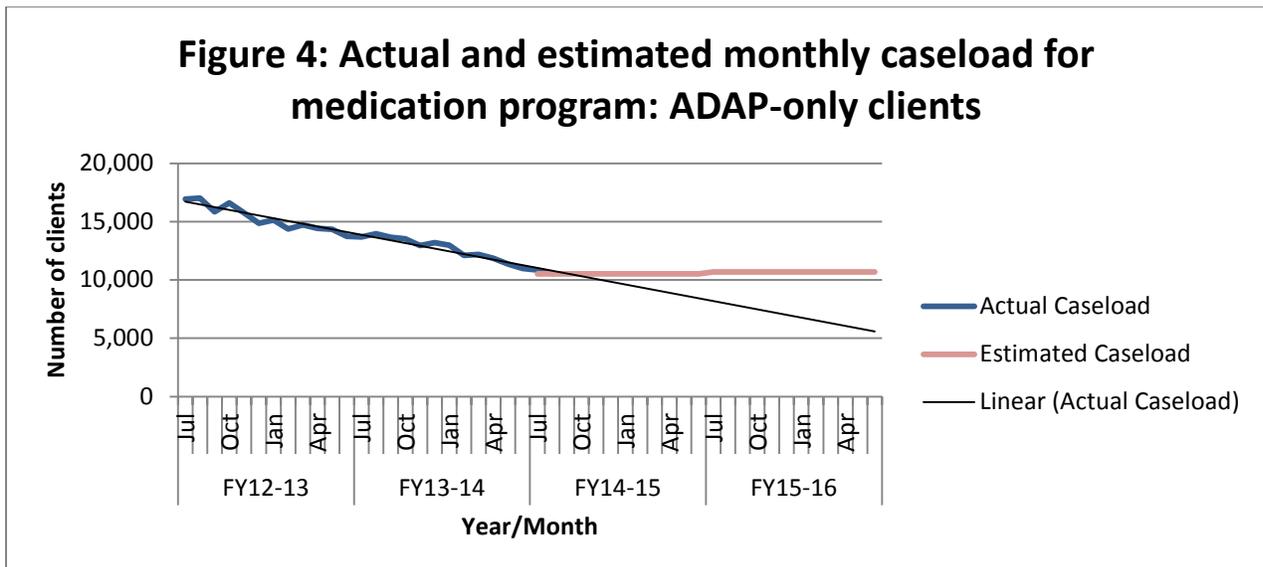
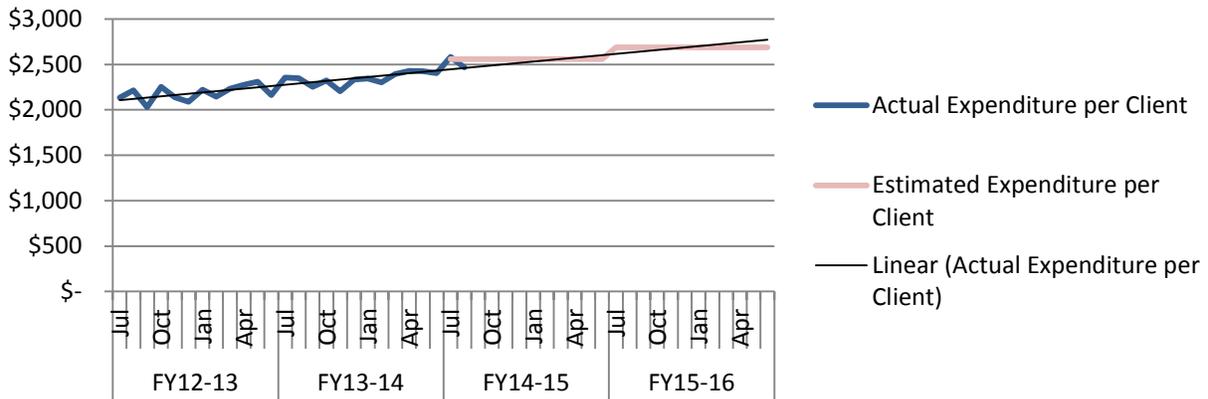


Figure 5: Actual and estimate monthly expenditure per-client for medication program: ADAP-only clients



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

- A. OA estimates that the number of private insurance clients in FY 2014-15 will be 5,423, an increase of 12.4 percent compared to FY 2013-14. During FY 2015-16, OA estimates the number will be 5,919, an increase of 9.2 percent compared to FY 2014-15. These changes are based on the following:
- a. Historic trends and existing/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 and August FY 2014-15, the caseload increased by 8.3 percent compared to FY 2013-14. OA believes that this will continue at this rate of 8.3 percent annually, primarily driven by clients transitioning to private health insurance purchased through Covered California.
 - i. Hepatitis C virus treatment: N/A.
 - ii. Covered California: Based on the number of clients that have enrolled in Covered California during FY 2013-14, OA estimates that 822 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-February 2015). During FY 2015-16, OA estimates that an additional 694 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.
 - b. New assumption:
 - i. 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 588 clients will enroll in Covered California due to coverage of medical out-of-pocket costs. OA estimates that a total of 1,094 clients total will be added to the private insurance caseload due to the general impact of Covered California and coverage of out-of-pocket medical costs.
- B. Private insurance per-client medication expenditures – Overall, OA estimates that the per-client expenditures for private insurance clients will increase to \$345/month for FY 2014-15, an increase of 9.8 percent compared to FY 2013-14. In FY 2015-16, OA estimates that the per-client expenditures for private insurance clients will be \$367/month, an increase of 6.3 percent compared to FY 2014-15. This change is attributable to the following:
- a. Historic trends and existing/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 two months of FY 2014-15 decreased by 16.3 percent, but this is due to regular seasonal variation and does not reflect a long-term trend. The trend of increasing per-client expenditures is largely driven by increasing medication co-pays and deductibles, particularly for Covered California clients as

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

- i. Hepatitis C virus treatment: OA estimates that 14 private insurance clients will access hepatitis C virus treatment during FY 2014-15 and 29 private insurance clients will access treatment during FY 2015-16. Based on this number, and the average cost of a treatment course, the average monthly per-client expenditure for private insurance clients will increase \$22 during FY 2014-15 and \$17 during FY 2015-16 due to hepatitis C virus treatment. Treatment for hepatitis C virus is primarily responsible for the increased expenditures during FY 2014-15.
 - ii. 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 that the average monthly medication expenditure per-client will increase \$28 during FY 2014-15 and \$9 during FY 2015-16 due to Covered California clients.
- b. New assumption:
- i. 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 \$18/month.

The following figures (Figures 7-9) show the actual private insurance caseload and expenditure per-client per-month during July 2012 through August 2014, 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 Affordable Care Act.

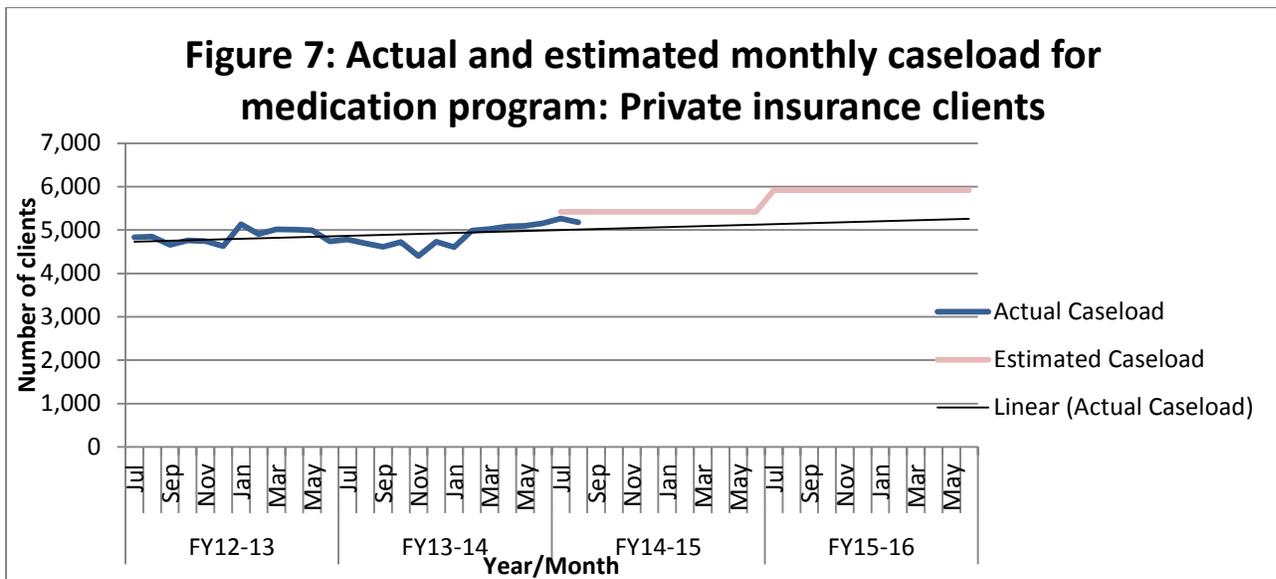


Figure 8: Actual and estimated monthly expenditure per-client for medication program: Private insurance clients

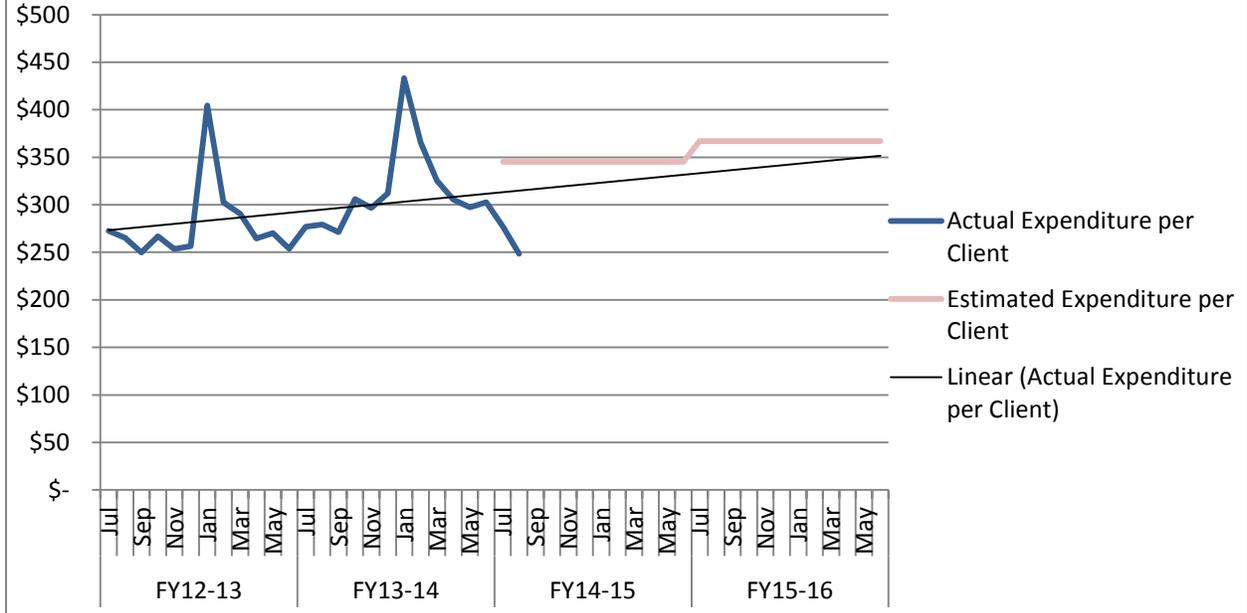
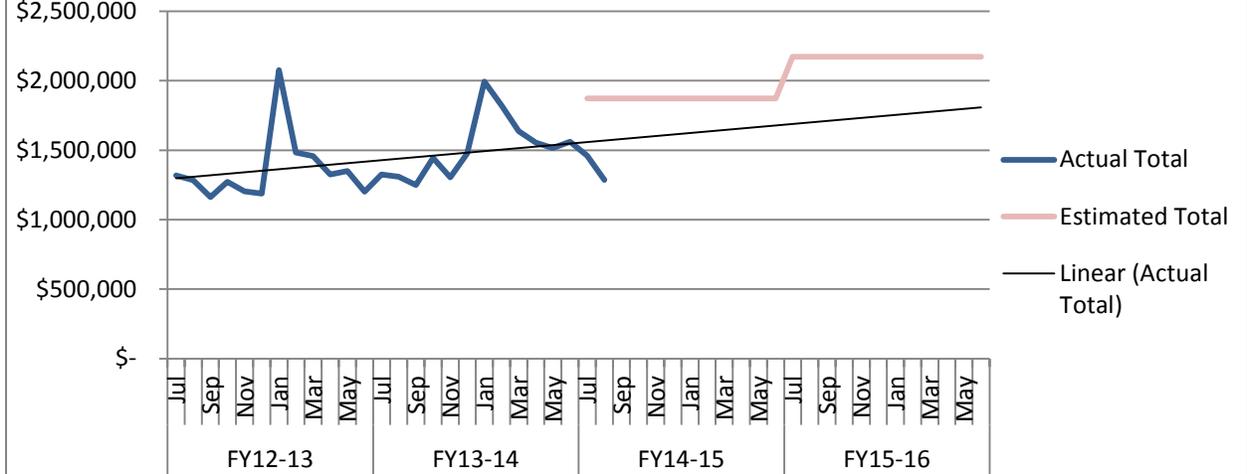


Figure 9: Actual and estimated total monthly expenditures for medication program: Private insurance clients



Appendix C: Assumptions and Rationale for Medication Expenditures – Medi-Cal Share of Cost

- A. Medi-Cal Share of Cost caseload – OA estimates that the number of Medi-Cal Share of Cost clients in FY 2014-15 will be 186, a decrease of 8.1 percent compared to FY 2013-14. During FY 2015-16, OA estimates the number will be 178, an increase of 4.1 percent compared to FY 2014-15. These changes are based on the following:
- a. Historic trends and existing/unchanged assumptions: During FY 2012-13 the Medi-Cal Share of Cost 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 two months of FY 2014-15 decreased by 8.1 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 share of cost are now eligible for full Medi-Cal. This recent historical trend will disappear in early FY 2014-15, as eligible clients with pending Medi-Cal applications are processed and enrolled in that program. In FY 2015-16, OA expects that the caseload will continue to decline although at a slower rate.
 - i. Hepatitis C virus: N/A.
 - ii. Covered California: N/A.
 - b. New assumption:
 - i. Payment of out-of-pocket medical costs for OA-HIPP clients: N/A.
- B. Medi-Cal Share of Cost per-client medication expenditures – OA estimates that the average monthly per-client expenditure for Medi-Cal Share of Cost clients in FY 2014-15 will be \$940, an increase of 5.2 percent compared to FY 2013-14. During FY 2015-16, OA estimates the average monthly per-client expenditure will be \$991, an increase of 1.7 percent compared to FY 2014-15. These changes are based on the following:
- a. Historic trends and existing/unchanged assumptions: During FYs 2012-13 and 2013-14, the Medi-Cal Share of Cost average monthly expenditure per-client increased 1.7 percent and 3.6 percent, respectively. The expenditure per-client during the first two months of FY 2014-15 increased by 1.7 percent compared to the average monthly expenditure per-client during FY 2013-14. This trend is largely driven by Medi-Cal program rules and will similarly impact FYs 2014-15 and 2015-16.
 - i. Covered California: N/A.
 - ii. Hepatitis C virus drug coverage: OA estimates that one Medi-Cal Share of Cost client will access hepatitis C virus treatment during FY 2014-15 and two will access treatment during FY 2015-16. Based on this number, and the average cost of a treatment course, the average monthly per-client expenditure for Medi-Cal Share of Cost clients will increase \$47 during FY 2014-15 and \$84 during FY 2015-16 due to hepatitis C virus treatment. Treatment for hepatitis C virus is primarily responsible for the increased expenditures during FY 2014-15.
 - b. New assumption:
 - i. Payment of out-of-pocket medical costs for OA-HIPP clients: N/A.

The following figures (Figure 10-12) show the actual Medi-Cal Share of Cost caseload and expenditure per-client per-month during July 2012 through August 2014, 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 Affordable Care Act.

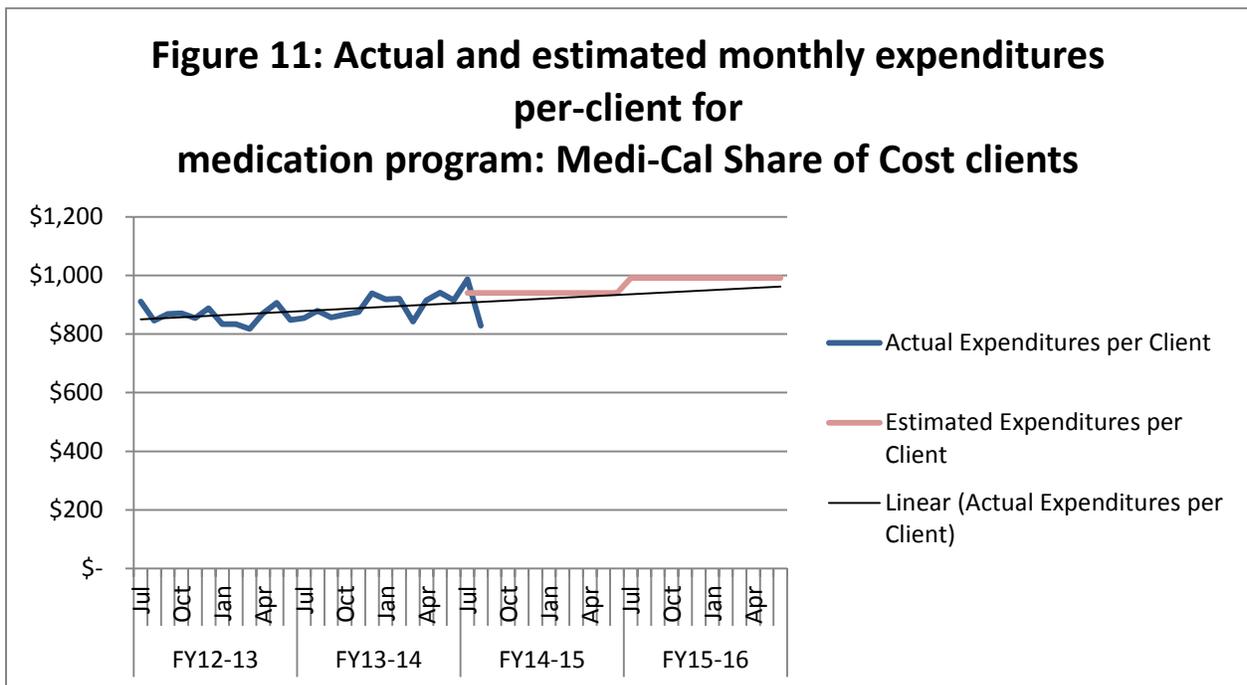
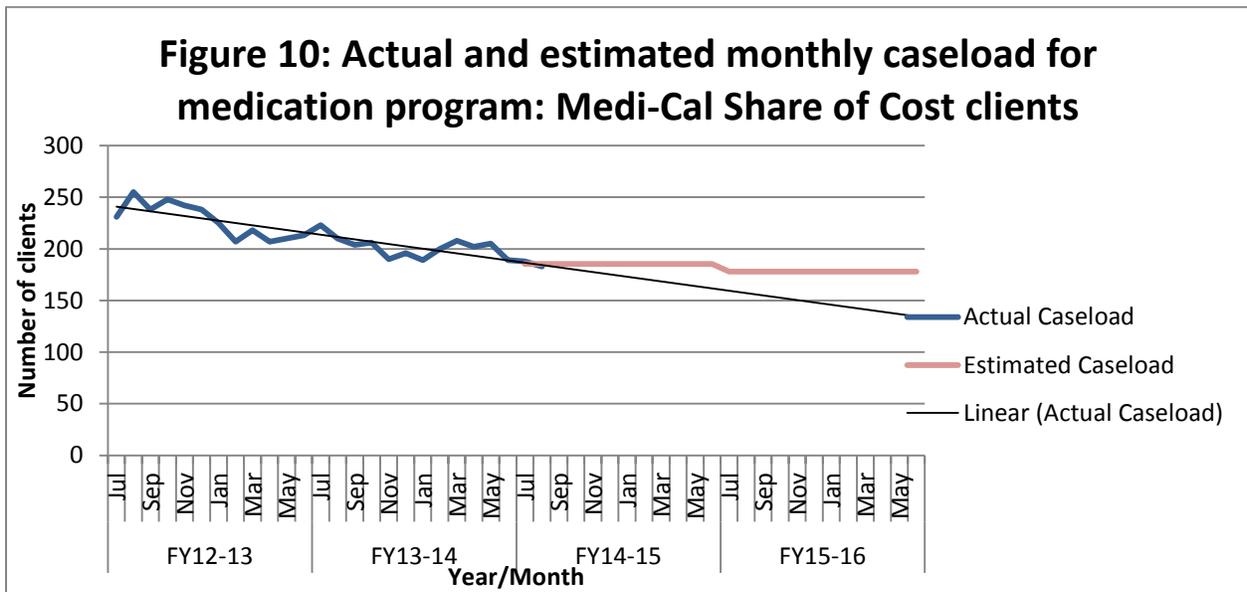
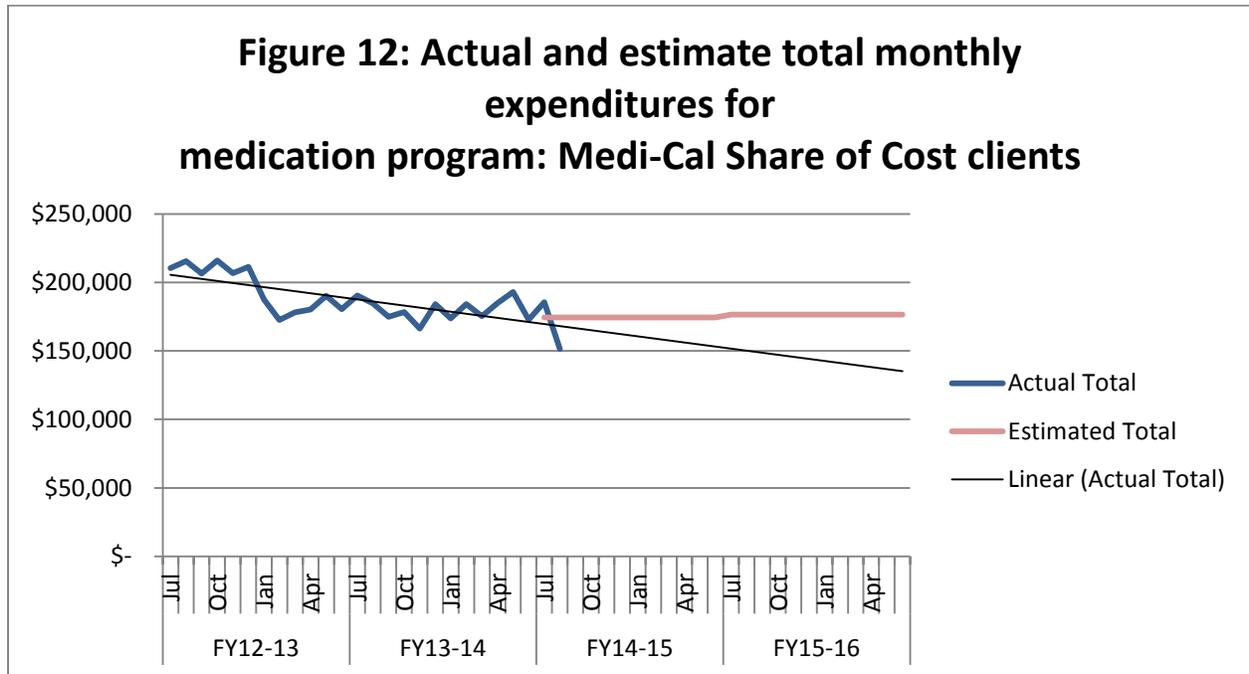


Figure 12: Actual and estimate total monthly expenditures for medication program: Medi-Cal Share of Cost clients



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

- A. Medicare Part D caseload – Overall, OA estimates that caseload for clients in the Medicare Part D program in both FYs 2014-15 and 2015-16 will be 4,780, which is unchanged in comparison to FY 2013-14. This stability is attributable to the following:
- a. Historic trends and existing/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 two months of FY 2014-15 declined, but this is due to normal seasonal variation and does not reflect a long-term trend. Overall, the Medicare Part D caseload has been 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. Hepatitis C virus treatment: N/A.
 - ii. Covered California: N/A
 - b. New assumption:
 - i. Payment of out-of-pocket medical costs for OA-HIPP clients: N/A.
- B. Medicare Part D per-client medication expenditures – OA estimates that the average monthly per-client expenditure for Medicare Part D clients in FY 2014-15 will be \$334, an increase of 11.1 percent compared to FY 2013-14. During FY 2015-16, OA estimates the average monthly per-client expenditure will be \$352, an increase of 5.5 percent compared to FY 2014-15. These changes are based on the following:
- a. Historic trends and existing/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 two months of FY 2014-15 decreased by 41.6 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.
 - i. Hepatitis C virus drug coverage: OA estimates that 16 Medicare Part D clients will access hepatitis C virus treatment during FY 2014-15 and 32 will access treatment during FY 2015-16. Based on this number, the average monthly per-client expenditure for Medicare Part D clients will increase \$19 during FY 2014-15 and \$20 during FY 2015-16 due to hepatitis C virus treatment. Treatment for hepatitis C virus is primarily responsible for the increased expenditures during FY 2014-15.
 - ii. Covered California: N/A.
 - b. New assumption:
 - i. Payment of out-of-pocket medical costs for OA-HIPP clients: N/A.

The following figures (Figure 13-15) show the actual Medicare Part D caseload and expenditure per-client per-month during July 2012 through August 2014, along with OA estimate 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 13: Actual and estimated monthly caseload for medication program: Medicare Part D clients

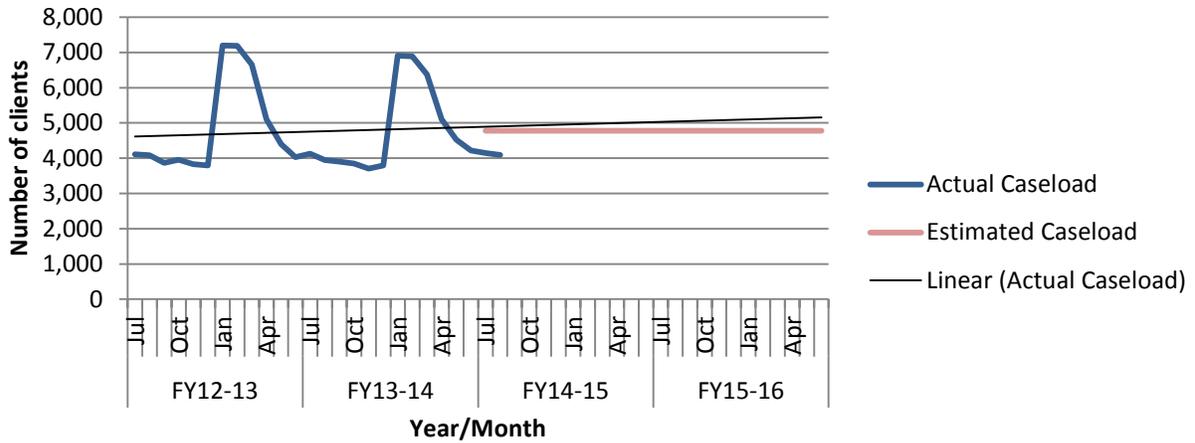
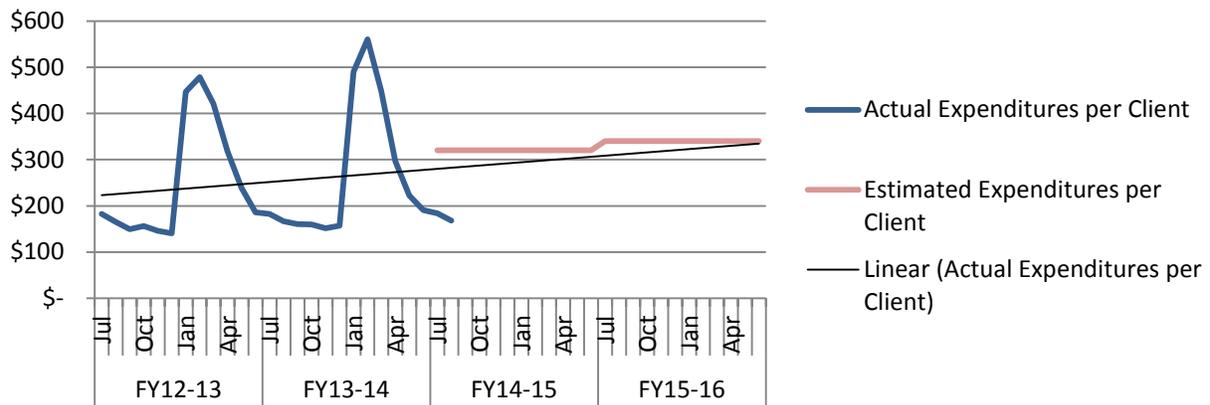
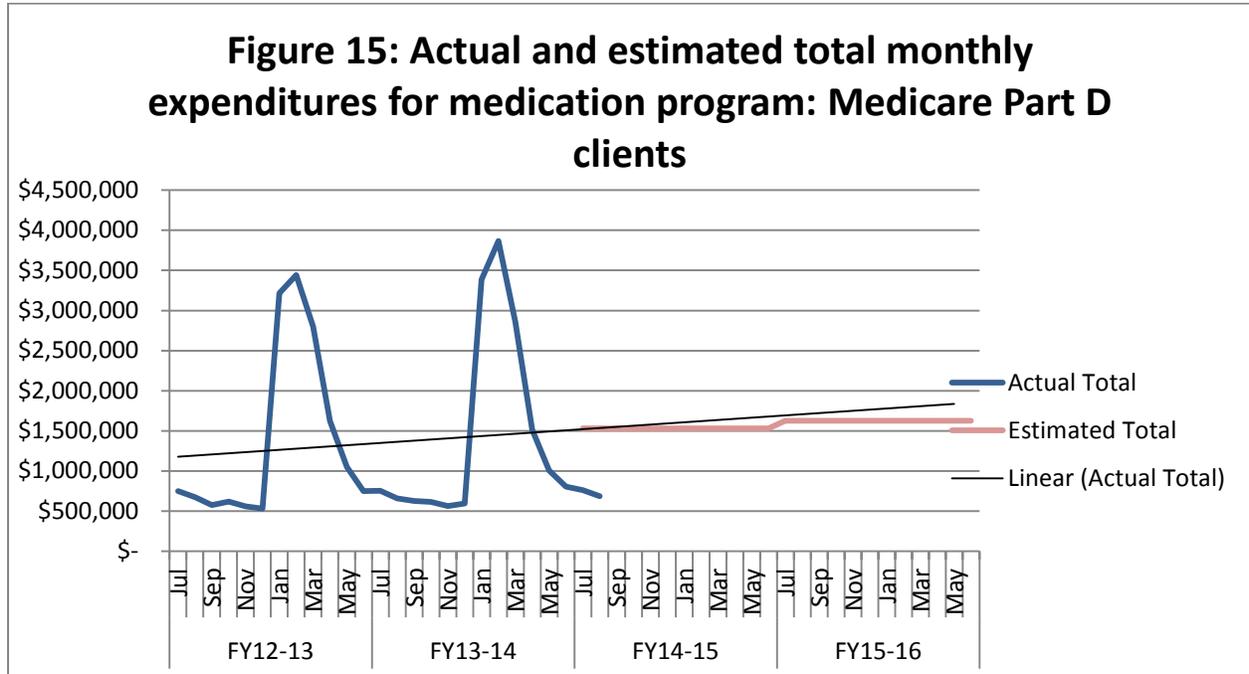


Figure 14: Actual and estimated monthly expenditures per-client for medication program: Medicare Part D clients





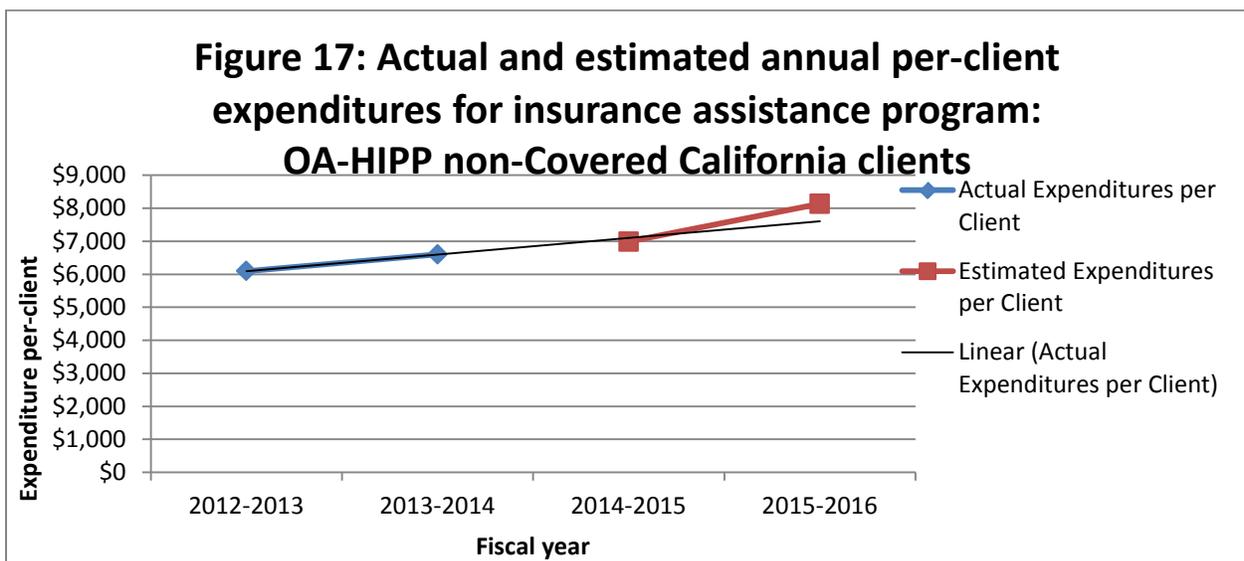
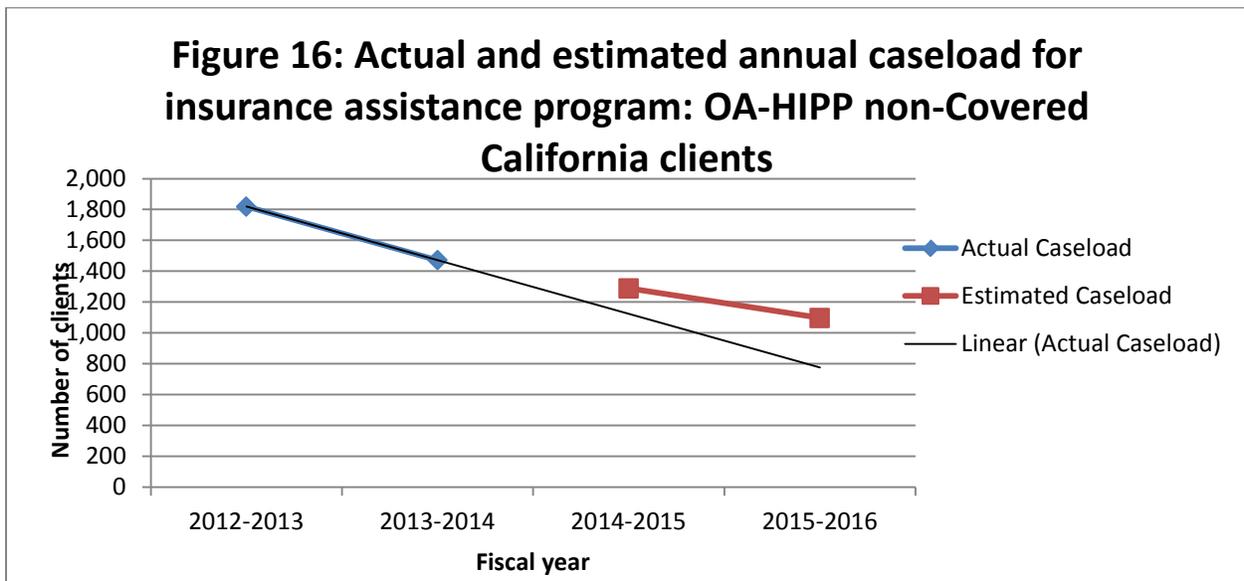
Appendix E: OA-HIPP Non-Covered California Private Insurance Assistance Expenditures

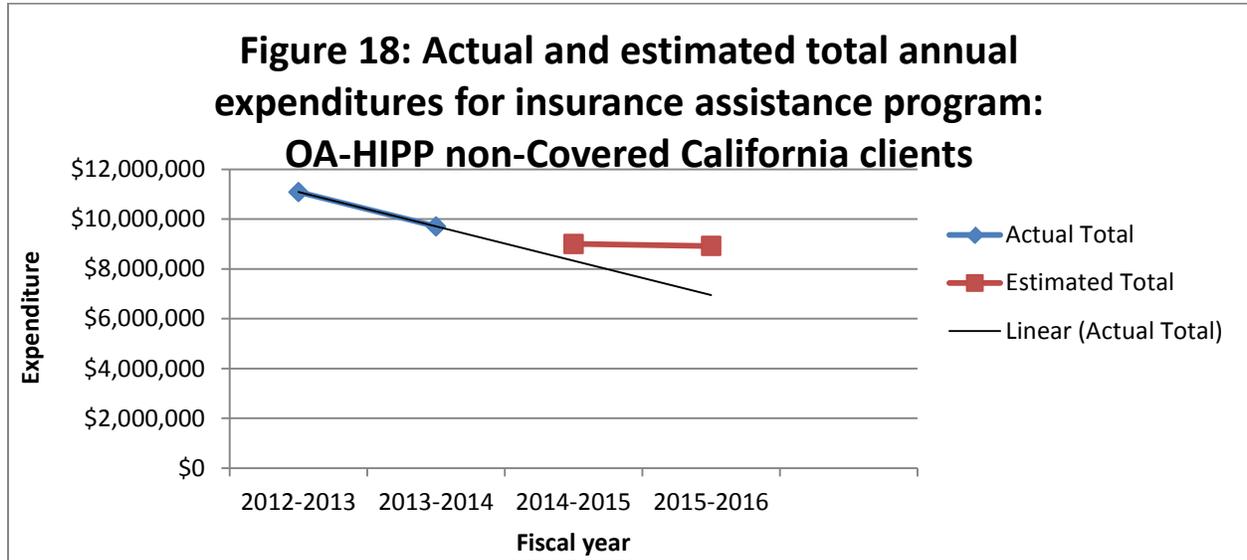
- A. Caseload for OA-HIPP non-Covered California private insurance clients – Overall, OA estimates that annual¹ caseload for clients in the OA-HIPP non-Covered California program in FY 2014-15 will be 1,288, a decrease of 12.4 percent compared to FY 2013-14. During FY 2015-16, OA estimates the number 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 existing/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. These recent changes in OA-HIPP non-Covered California caseload are due to clients enrolling in Covered California, Medi-Cal Expansion, and other Affordable Care Act-related programs, such as the Pre-existing Condition Insurance Plan or the Low Income Health Program. 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. Hepatitis C virus treatment: N/A.
 - ii. Covered California: Covered California will impact the caseload of the OA-HIPP non-Covered California program. OA estimates that 183 clients will transition from non-Covered California to Covered California plans during FY 2014-15, and 85 during FY 2015-16. These estimates do not include the impact of the new assumptions.
 - b. New assumption:
 - i. 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. 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 \$6,988, an increase of 5.9 percent compared to FY 2013-14. During FY 2015-16, OA estimates the expenditure will be \$8,136, an increase of 16.4 percent compared to FY 2014-15. This change is attributable to the following:
- a. Historical data and existing/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 that the Pharmacy Benefits Manager will start electronically paying OA-HIPP premiums in early 2015, which will increase expenditures by \$111/client annually starting in FY 2014-15.
 - i. Hepatitis C virus treatment: N/A.
 - ii. Covered California: N/A.

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

- b. New assumption:
 - i. Payment of out-of-pocket medical costs for OA-HIPP clients: N/A. 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. However, OA projects that these clients will primarily enroll in Covered California plans.

The following figures show the actual OA-HIPP non-Covered California caseload and average expenditure per-client per year during FY 2012-13 and FY 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; caseloads are not projected to follow the linear trend due to the impact of the Affordable Care Act.





Appendix F: OA-HIPP Covered California Insurance Assistance Expenditures

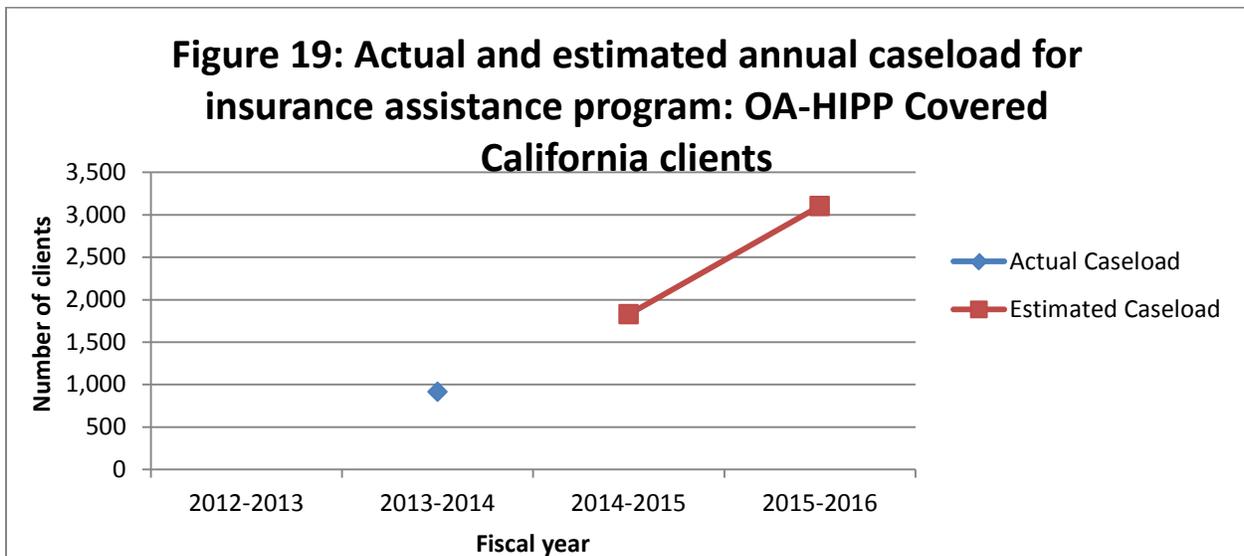
- A. Caseload for OA-HIPP Covered California - Overall, OA estimates that annual² caseload for clients in the OA-HIPP Covered California program in FY 2014-15 will be 1,826, an increase of 100 percent compared to FY 2013-14. During FY 2015-16, OA estimates the number will be 3,104, an increase of 70.0 percent compared to FY 2014-15. This change is attributable to the following:
- a. Historical data and existing/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 that 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. Hepatitis C virus treatment: N/A.
 - ii. Covered California: OA estimates that 913 clients will enroll in the OA-HIPP Covered California program during FY 2014-15, and 567 during FY 2015-16. For FY 2014-15, the second year of Covered California, the projected increase is based on the average increase for the second year of OA-Pre-existing Condition Insurance Plan and OA-HIPP expansion, which was close to 100 percent. For FY 2015-16, the projected increase is based on the third year of OA-HIPP expansion, when the caseload increased approximately 75 percent. 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.
 - b. New assumption:
 - i. Payment of out-of-pocket medical costs for OA-HIPP clients: OA projects that payment of medical out-of-pocket costs will increase program enrollment in the OA-HIPP Covered California program; OA estimates that 711 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 1,278.
- B. Expenditure per-client for OA-HIPP Covered California - Overall, OA estimates that average annual expenditure per-client in OA-HIPP Covered California in FY 2014-15 will be \$2,484, an increase of 20.3 percent compared to FY 2013-14. During FY 2015-16, OA estimates the expenditure will be \$2,907, an increase of 17.1 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 existing/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 6 months; therefore, OA projects that average per-client expenditures will increase due to the program now being in effect for all 12 months of the FY. Additionally,

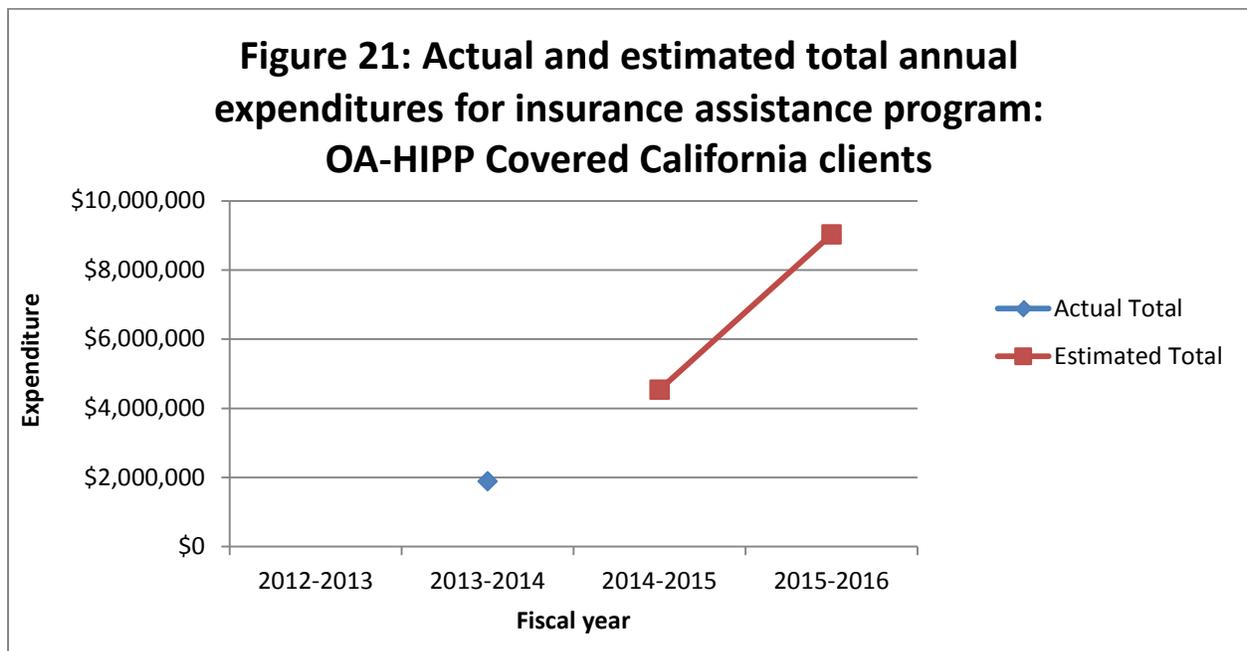
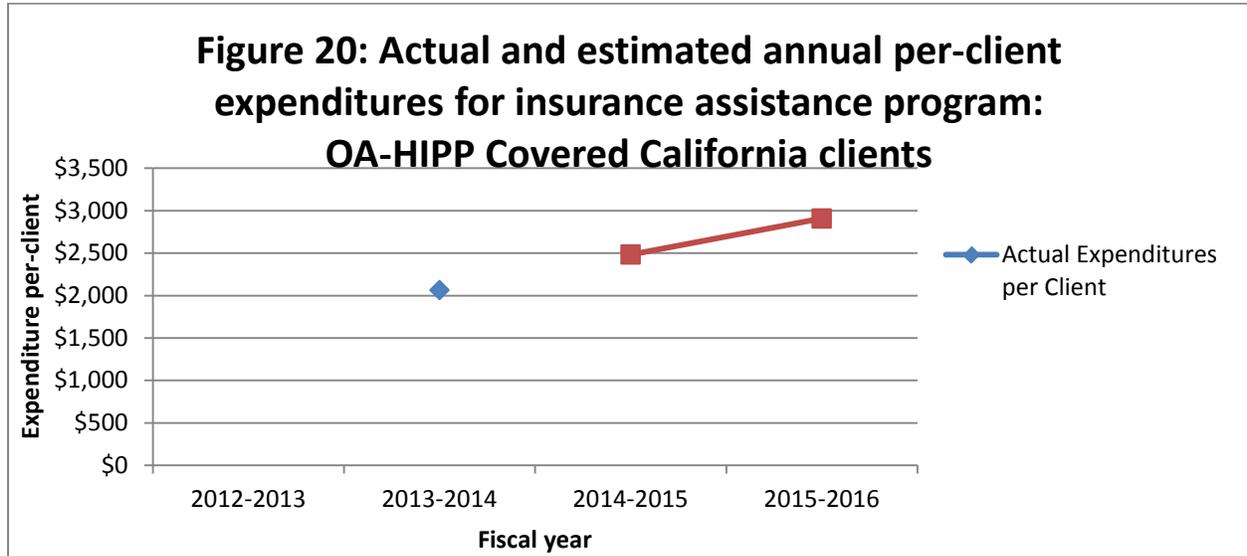
² All OA-HIPP estimates are based on annual data due to data limitations associated with the premium payment system.

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.

- i. Hepatitis C virus treatment: N/A.
 - ii. Covered California: The expenditure per-client during FY 2013-14 only represents expenditures for 6 months; therefore, OA projects that average per-client premium costs will increase due to the 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 Pharmacy Benefits Manager will start electronically paying OA-HIPP premiums in early 2015, which will increase expenditures by \$117/client during both FYs 2014-15 and 2015-16.
- b. New assumption:
- i. 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 that this assumption will increase the annual per-client expenditure for OA-HIPP Covered California clients by \$31 in FY 2015-16.

The following figures show the actual OA-HIPP Covered California caseload and average expenditure per-client per year during FY2013-14, along with our estimated numbers for the current year (FY 2014-15) and budget year (FY 2015-16).





Appendix G: OA Medicare Part D Insurance Assistance Expenditures

- A. Caseload for OA Medicare Part D clients - Overall, OA estimates that annual caseload for clients in the OA 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 3.0 percent compared to FY 2014-15. This change is attributable to the following:
- a. Historical data and existing/unchanged assumptions: During FY 2012-13 the OA 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. Hepatitis C virus treatment: N/A.
 - ii. Covered California: N/A.
 - b. New assumption:
 - i. Payment of out-of-pocket medical costs for OA-HIPP clients: N/A. OA Medicare Part D clients are not included in this assumption.
- B. Expenditure per-client for OA Medicare Part D clients - Overall, OA estimates that average annual premium expenditure per-client in the OA Medicare Part D program in FY 2014-15 will be \$693, an increase of 5.4 percent compared to FY 2013-14. During FY 2015-16, OA estimates the expenditure will be \$713, an increase of 2.9 percent compared to FY 2014-15. This change is attributable to the following:
- a. Historical data and existing/unchanged assumptions: OA did not track expenditures for OA Medicare Part D clients separately from all Insurance Assistance clients prior to FY 2013-14. During FY 2013-14, the average annual expenditure per-client was \$657. Medicare has estimated that Part D premium costs will increase approximately 3.0 percent in 2015. OA projects that this increase will continue in FY 2015-16.
 - i. Hepatitis C virus treatment: N/A.
 - ii. Covered California: N/A.
 - b. New assumption:
 - i. Payment of out-of-pocket medical costs for OA-HIPP clients: N/A.

The following figures show the actual OA Medicare Part D caseload and expenditure per-client per-month 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.

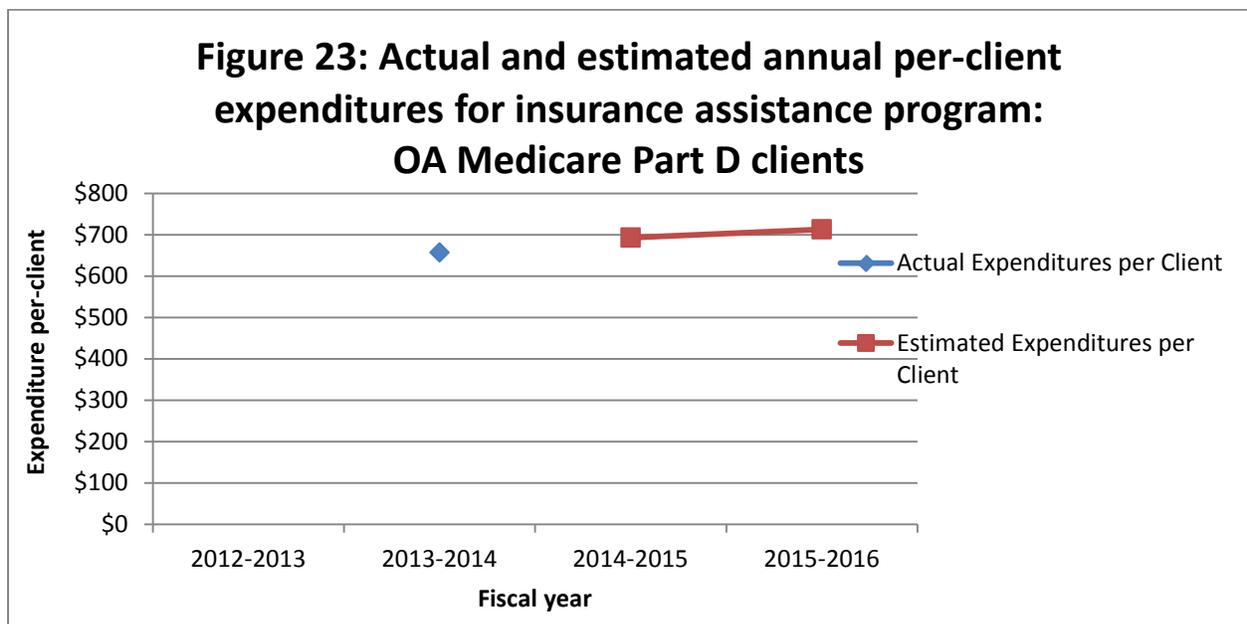
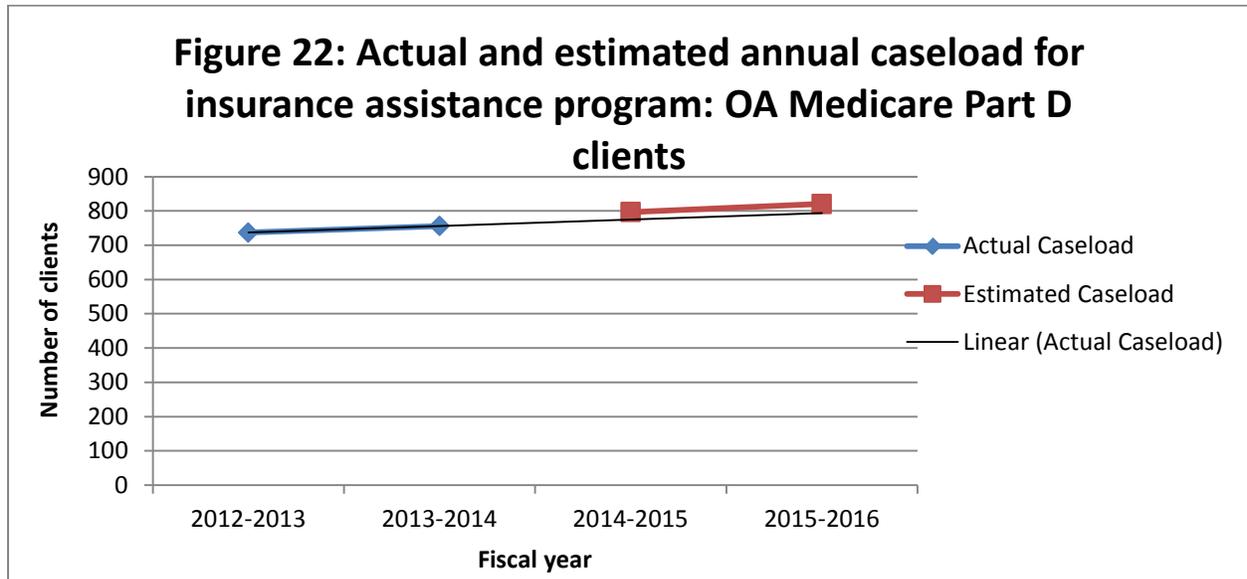


Figure 24: Actual and estimated total annual expenditures for insurance assistance program: OA Medicare Part D clients

