

AIDS DRUG ASSISTANCE PROGRAM (ADAP)

FY 2016-17

November Estimate



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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 medication cost up to the client's Medi-Cal SOC amount;
 - c. *Private health insurance clients*, for whom ADAP pays prescription medication deductibles and co-pays; and
 - d. *Medicare Part D clients*, for whom ADAP pays the Medicare Part D medication deductibles and co-pays.
2. *Health insurance assistance program(s)*, which pay for private health insurance premiums or Medicare Part D premiums for clients co-enrolled in ADAP's medication program. ADAP pays health insurance premiums for eligible clients with one of three different types of health insurance:
 - a. *Non-Covered California private health insurance* [OA's Health Insurance Premium Payment (OA-HIPP)/non-Covered California];
 - b. *Private health 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 health insurance, because people living with HIV/AIDS were unable to purchase affordable health insurance in the private marketplace. However, with the implementation of the Affordable Care Act (ACA), more ADAP clients have been able to access public and private health insurance coverage. ADAP clients are screened for Medi-Cal eligibility, and potentially eligible clients must apply. Clients who enroll in full-scope Medi-Cal are dis-enrolled from ADAP, because these clients have no SOC, no drug co-pays or deductibles, and no premiums. All clients who obtain health coverage through Covered California or other health plans can remain in ADAP's medication program to receive assistance with their drug deductibles and co-pays for medications on the ADAP formulary. Clients with non-employer-based health coverage can co-enroll in ADAP's health insurance assistance programs for assistance with their insurance premiums. Assisting clients with purchasing health insurance is more cost effective than paying the full cost of medications. In addition, assisting clients with purchasing and maintaining health insurance coverage improves the overall health of Californians living with HIV/AIDS because clients have comprehensive health insurance and access to the full spectrum of medical care, rather than only HIV outpatient care and medications through the Ryan White system.

II. Estimate Overview

The ADAP Estimate provides a revised projection of Current Year [Fiscal Year (FY) 2015-16] local assistance costs for the medication and health insurance programs, along with projected local assistance costs for the Budget Year (FY 2016-17).

Table 1 below shows the estimated ADAP local assistance expenditure need for the Current Year, FY 2015-16, and Budget Year, FY 2016-17, and compares them to the amount reflected in the 2015 Budget Act.

- For FY 2015-16, CDPH estimates that ADAP expenditures will be \$317.1 million, which is a \$79.4 million decrease compared to the 2015 Budget Act.
- For FY 2016-17, CDPH estimates that ADAP expenditures will be \$330.2 million, which is a \$66.4 million decrease compared to the 2015 Budget Act. The decrease in expenditures for both FYs is mainly due to ADAP clients continuing to transition from ADAP to Medi-Cal or enrolling directly in Medi-Cal, and ADAP clients continuing to transition to private health insurance.

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 2015 Budget Act.

- For FY 2015-16, CDPH estimates ADAP revenue will be \$278.5 million, which is a \$15.3 million increase compared to the 2015 Budget Act.
- For FY 2016-17, CDPH estimates ADAP revenue will be \$267.1 million, which is a \$3.9 million increase compared to the 2015 Budget Act. For both FYs, the increase in revenue is due mainly to the increase in the overall rebate percentage rate.

California Department of Public Health AIDS Drug Assistance Program 2015 November Estimate Table 1: Local Assistance (dollars in millions)							
Local Assistance	2015 Budget Act	Current Year FY 2015-16			Budget Year FY 2016-17		
		November Estimate	\$ Change from 2015 Budget Act	% Change from 2015 Budget Act	November Estimate	\$ Change from 2015 Budget Act	% Change from 2015 Budget Act
Fund:							
Total Funds Requested	\$396.6	\$317.1	-\$79.4	-20.0%	\$330.2	-\$66.4	-16.7%
Federal Funds - Fund 0890	109.9	138.1	28.2	25.6%	94.0	-16.0	-14.5%
Rebate Funds - Fund 3080	268.4	178.1	-90.3	-33.6%	236.2	-32.2	-12.0%
Reimbursement Funds (SNCP)	18.2	0.9	-17.3	-95.2%	0.0	-18.2	-100.0%
Caseload	33,139	29,798	-3,341	-10.1%	29,401	-3,738	-11.3%

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

Table 2: Rebate Fund Revenues (Fund 3080) November Estimate (dollars in millions)							
Local Assistance	2015 Budget Act	Current Year FY 2015-16			Budget Year FY 2016-17		
		November Estimate	\$ Change from 2015 Budget Act	% Change from 2015 Budget Act	November Estimate	\$ Change from 2015 Budget Act	% Change from 2015 Budget Act
Total Revenue Requested	\$263.2	\$278.5	\$15.3	5.8%	\$267.1	\$3.9	1.5%
Rebate Funds - Fund 3080	263.1	278.4	15.3	5.8%	267.0	3.9	1.5%
Interest Income	0.1	0.1	0.0	0.0%	0.1	0.0	0.0%

III. Overall Projections

A. Key influences on ADAP expenditures

- a. FY 2015-16: Compared to the 2015 Budget Act, OA estimates that expenditures during FY 2015-16 will decline by 20.0 percent. This decrease is largely due to ACA-related efforts. Medi-Cal Expansion and Covered California have had and will continue to have substantial impacts on the number and type of clients receiving ADAP services during FYs 2015-16 and 2016-17 as clients continue to transition out of ADAP or to a different client group within ADAP. Although these programs were fully implemented by the end of FY 2014-15, there remains a number of existing ADAP clients who may be eligible for these ACA-related programs. Therefore, OA expects the number of clients leaving or changing client groups to continue into FYs 2015-16 and 2016-17. Clients who are enrolled in ADAP, but who are in a non-ADAP only client group, have substantially lower program costs than ADAP-only clients, which lead to lower overall expenditures. Additionally, the number of new clients enrolling in ADAP continues to decrease; this is likely due to the impact of Medi-Cal Expansion.
- b. FY 2016-17: Compared to the 2015 Budget Act, OA estimates that expenditures during FY 2016-17 will decline by 16.7 percent. This decrease is also largely due to ACA-related programs. In FY 2016-17, OA expects the number of clients leaving ADAP for Medi-Cal Expansion to stabilize. OA estimates overall client caseloads will be relatively stable, with the number of clients newly enrolling in ADAP to be offset by clients leaving the program. OA also estimates clients will continue to enroll in private health insurance plans through Covered California, leading to lower program costs.

B. Expenditures

ADAP expenditures are broken out into two program areas: medication expenditures and health 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 health insurance clients; and 4) Medicare Part D clients.

Private health insurance and Medicare Part D clients include clients for whom ADAP covers medication deductibles and co-pays. Private health insurance clients can include those who have employer-sponsored health insurance or health insurance purchased either through Covered California or outside of Covered California, and may or may not be co-enrolled in OA-HIPP. The majority of private health insurance and Medicare Part D clients enrolled in ADAP's medication program are not co-enrolled in ADAP's health insurance assistance programs.

- For FY 2015-16, OA estimates medication expenditures will be \$297.0 million, which is a \$72.9 million decrease compared to the 2015 Budget Act. The decrease in expenditures is mainly due to ADAP clients continuing to transition from ADAP to Medi-Cal, or enrolling directly in Medi-Cal.
- For FY 2016-17, OA estimates the medication expenditures will be \$303.0 million, which is a \$66.9 million decrease compared to the

2015 Budget Act. The decrease in expenditures is mainly due to the impact of FY 2015-16, and ADAP clients continuing to transition to private health insurance.

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

The table includes all ADAP clients, including those who are newly eligible for ADAP as a result of ADAP's new income eligibility criteria based on Modified Adjusted Gross Income and household income up to 500 percent of the Federal Poverty Level (FPL). These new eligibility criteria were implemented on June 24, 2015. OA estimates the new income eligibility criteria will cause an additional 306 clients to enroll in FY 2015-16, and another 151 clients in FY 2016-17. For FY 2015-16, the estimated additional net costs for the medication program will be \$0.7 million (\$1.7 million in medication expenditures and \$1.0 million in rebate revenue). The total estimated net savings for the medication program in FY 2016-17 for all 456 new clients, including the 306 new clients from FY 2015-16, will be \$0.9 million (\$2.7 million in medication expenditures and \$3.6 million in rebate revenue).

COVERAGE GROUP	FY 2015-16				FY 2016-17			
	CASELOAD		EXPENDITURES		CASELOAD		EXPENDITURES	
	NUMBER	PERCENT	AMOUNT	PERCENT	NUMBER	PERCENT	AMOUNT	PERCENT
ADAP Only	12,404	41.6%	\$262,968,352	88.5%	11,419	38.8%	\$267,190,805	88.2%
Medi-Cal SOC	191	0.6%	\$1,058,574	0.4%	174	0.6%	\$979,545	0.3%
Private Health Insurance	8,497	28.5%	\$15,104,651	5.1%	9,192	31.3%	\$16,483,626	5.4%
Medicare Part D	8,706	29.2%	\$17,857,520	6.0%	8,615	29.3%	\$18,349,061	6.1%
TOTALS	29,798	100.0%	\$296,989,097	100.0%	29,401	100.0%	\$303,003,037	100.0%

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

b. Health 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 health insurance (OA-HIPP/non-Covered California); 2) private health 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 health 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 2015-16, OA estimates health insurance premium payment expenditures will be \$14.6 million, which is a \$6.0 million decrease compared to the 2015 Budget Act. A reduction in new enrollments in FY 2014-15 led to

a corresponding estimated reduction in FY 2015-16, because FY 2014-15 is the basis for the FY 2015-16 estimate. Additionally, in prior estimates OA had anticipated implementing payment of medical out-of-pocket costs by January 1, 2016; however, OA now anticipates payment of medical out-of-pocket cost will begin in Spring 2016, leading to a decrease in health insurance premium payment expenditures in the Current Year.

- For FY 2016-17, OA estimates health insurance premium payment expenditures will be \$21.6 million, which is a \$1.0 million increase compare to the 2015 Budget Act. The increase in health insurance expenditures compared to 2015 Budget Act is primarily due to an increase in new enrollments resulting from the implementation of payment of medical out-of-pocket costs. However, there will be a corresponding decrease in medication program expenditures due to clients transitioning from ADAP-only to private health insurance purchased through Covered California.

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

The table includes clients who enroll as a result of ADAP's new income eligibility criteria. OA estimates an additional 51 clients will enroll in the health insurance premium payment programs in FY 2015-16, and an additional 25 clients in FY 2016-17 as a result of ADAP's new income eligibility criteria. The estimated premium expenditures and medical out-of-pockets expenses for these new clients will be \$234,000 in FY 2015-16. The total estimated expenditures will be \$430,000 in FY 2016-17 for all 76 new clients, including the 51 new clients from FY 2015-16.

COVERAGE GROUP	FY 2015-16				FY 2016-17			
	CASELOAD		EXPENDITURES		CASELOAD		EXPENDITURES	
	NUMBER	PERCENT	AMOUNT	PERCENT	NUMBER	PERCENT	AMOUNT	PERCENT
OA-HIPP/Non-CC	1,047	28.1%	\$6,051,910	41.5%	895	19.5%	\$6,182,751	28.6%
OA-HIPP/CC	2,049	54.9%	\$8,145,401	55.8%	3,074	66.9%	\$15,041,782	69.6%
OA/Medicare Part D	634	17.0%	\$400,197	2.7%	626	13.6%	\$394,776	1.8%
TOTALS	3,730	100.0%	\$14,597,508	100.0%	4,594	100.0%	\$21,619,309	100.0%

¹Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
²All premium payment assistance clients are co-enrolled in the ADAP medication program.

c. Fixed expenditures

- i. \$4.0 million to support local ADAP enrollment services: In FY 2015-16, each local health jurisdiction (LHJ) allocation is based on the proportion of all ADAP clients the LHJ enrolled during the prior year. LHJs determine how to utilize these funds, although they may only be used for costs associated with ADAP enrollment. 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. In FY 2016-17,

ADAP plans to allocate the funds directly to ADAP enrollment sites based on ADAP and OA-HIPP enrollment numbers at each site. These funds may only be used for costs associated with the administration of 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 does not result in an ADAP covered transaction (e.g., drug not on the ADAP formulary, prescription refilled too soon, etc.). ADAP utilized Safety Net Care Pool (SNCP) funds through October 2015 (the ability to use SNCP funds under the existing Medi-Cal 1115 Waiver expired on October 31, 2015), and will utilize supplemental rebate funds for the remainder of the Current Year and in the Budget Year for these expenditures, as ADAP cannot use Ryan White federal funds or mandatory rebate funds for non-approved transactions. Non-approved transaction fee estimates are \$1.6 million for both FYs 2015-16 and 2016-17.

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 2015-16, OA estimates ADAP rebate revenues will increase by 5.8 percent from \$263.2 million in the 2015 Budget Act to \$278.5 million in the revised Current Year forecast.
 - For FY 2016-17, OA estimates ADAP rebate revenues will increase by 1.5 percent to \$267.1 million when compared to the 2015 Budget Act.These estimates account for decreased expenditures and an increase in ADAP's overall rebate percentage rate.
- 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 SNCP federal funds. CDPH receives ADAP's portion of the SNCP funds in the form of a reimbursement from DHCS. In FY 2015-16, ADAP is requesting \$873,146 of the \$18.2 million SNCP funds available for ADAP, based on the 2015 Budget Act, due to ADAP's requirement to spend mandatory rebate funds prior to spending federal funds. DHCS informed OA that after the current Medi-Cal 1115 Waiver expired on October 31, 2015, SNCP reimbursement funds will no longer be available to ADAP.
- c. Federal Funds – For FY 2015-16, federal fund revenue increased by \$28.2 million compared to the 2015 Budget Act. On September 3, 2015, ADAP received a Notice of Award (NOA) from the Health Resources and Services Administration (HRSA) for the 2015 Ryan White Part B Supplemental award for \$10.0 million. The budget period is from September 2015 to September 2016; OA will use these funds for ADAP expenditures in the Current Year. On October 28, 2015, HRSA issued a NOA for \$18.2 million, approving ADAP's carryover request of unspent 2014 RW Part B funds to the 2015 grant year (April 1, 2015 – March 31, 2016). ADAP will utilize these carryover funds prior to the March 31, 2016 grant period end date. The department is able to absorb the \$18.2 million carryover because the Women,

Infants, and Children (WIC) program is decreasing federal local assistance expenditure authority by approximately \$50 million in its November 2015 Estimate.

For FY 2016-17, ADAP's federal fund expenditure authority decreased by \$16.0 million compared to the 2015 Budget Act. ADAP's FY 2016-17 federal fund revenue includes on-going Ryan White ADAP Earmark funds. If ADAP is awarded additional federal funds via one-time 2016 supplemental funding opportunities, ADAP's federal fund expenditure authority will be updated in the *2016-17 May Revision Estimate*.

Match – HRSA requires grantees to have HIV-related non-HRSA expenditures. California's HRSA match requirement for the 2015 Federal Ryan White Part B Grant year (April 1, 2015 – March 31, 2016) is \$65,519,485. OA will meet the match requirement using CDPH's 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. **Potential Savings Due to Cross Match of Ryan White Client Data to Medi-Cal Eligibility Data System (MEDS) (New Assumption)**

Federal requirements stipulate that Ryan White grant funds are to be used solely as a payer of last resort. 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 or Covered California, CDPH executed an interagency agreement with DHCS in September 2014 that allows for a monthly cross match of Ryan White and MEDS client data. DHCS developed the program that runs the blind electronic match and worked with OA to test and finalize it. The first data match was implemented in May 2015, and matches will continue to be performed on a monthly basis. Clients who are found to be enrolled in Medi-Cal without a SOC are disenrolled from ADAP after confirmation of their coverage. The ADAP PBM contractor will be notified of these clients on a monthly basis. When these clients arrive at an ADAP pharmacy to get their medications, the medications will be billed to Medi-Cal rather than to ADAP. OA will re-coup any prior ADAP expenditures for these clients, to the extent allowable by Medi-Cal, through a pharmacy back-billing process by the PBM.

- a. FY 2015-16: Based on the results of the initial MEDS cross matches, OA estimates the cross match will achieve savings for 295 ADAP clients enrolled in Medi-Cal during FY 2015-16, including those who were identified in FY 2014-15. This will result in \$2.7 million in expenditure savings and approximately \$317,000 in lost rebate revenue, including the usual six-month rebate delay. The estimated net savings is \$2.4 million.
- b. FY 2016-17: OA estimates the MEDS cross match will identify 36 clients enrolled in Medi-Cal during FY 2016-17. This will result in \$627,000 in net savings (\$707,000 in expenditure savings and \$80,000 in lost rebate, including the usual six-month rebate delay). Including the clients identified during the FY 2015-16 MEDS cross match, there will be a total net savings of \$3.1 million in FY 2016-17 (\$4.7 million in expenditure savings and \$1.6 million in lost rebate).

B. **Payment of Out-of-Pocket Medical Expenses for All OA-HIPP Clients (Existing Assumption)**

ADAPs have traditionally provided access to medications through a network of participating pharmacies statewide to eligible clients. However, as the ACA has impacted health care, more ADAP clients have been able to access public and private health insurance coverage. ADAPs are increasingly assisting clients with purchasing health insurance. Purchasing health insurance that includes prescription drug coverage is more cost effective than ADAP's coverage of prescription drugs only, and supports clients having access to comprehensive medical care. However, clients may be reluctant to purchase health insurance if their personal out-of-pocket expenses increase. In June 2014, the Administration and the Legislature approved a proposal to pay for out-of-pocket medical expenses for OA-HIPP clients.

On September 4, 2015, ADAP released one Request for Proposal (RFP) for both Insurance Benefits Manager and Medical Benefits Manager services to pay health insurance premiums and medical out-of-pocket costs, respectively. OA anticipates the contract will be awarded in the Winter 2015 and services will be implemented in the Spring 2016.

- a. FY 2015-16: OA estimates 260 additional clients will enroll in OA-HIPP/Covered California due to payment of medical out-of-pocket costs in FY 2015-16. The medical out-of-pocket projection is based on the Covered California enrollment during FY 2014-15 and the enrollment patterns seen during implementation of other related programs. The total estimated fiscal impact of paying medical out-of-pocket costs during FY 2015-16 is based on the costs and savings associated with these 260 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. OA estimates coverage of medical out-of-pocket costs will lead to additional savings of approximately \$658,000 during FY 2015-16 (\$302,000 in premium costs, \$936,000 in medical out-of-pocket costs with administrative fees, \$318,000 in medication deductibles and co-pays, \$2.2 million savings due to averted medication expenditures and no rebate revenue due to usual six-month rebate delay).
- b. FY 2016-17: OA estimates 747 additional clients will enroll in OA-HIPP/Covered California due to payment of medical out-of-pocket costs in FY 2016-17. These additional clients will lead to a savings of approximately \$1.0 million in FY 2016-17 (\$895,000 in premium costs, \$4.3 million in medical out-of-pocket costs with administrative fees, \$914,000 in medication deductibles and co-pays, \$7.0 million savings in averted drug expenditures, and no rebate revenue due to the usual six-month rebate delay).

OA estimates paying medical out-of-pocket costs during FY 2016-17 for all additional clients from FYs 2015-16 and 2016-17, and clients who are already enrolled or would choose to enroll in OA-HIPP regardless of coverage of medical out-of-pocket costs, will lead to savings of \$5.9 million (\$1.7 million in premium costs, \$4.3 million in medical out-of-pocket costs with administrative fees, \$1.7 million in medication deductibles and co-pays, \$13.2 million savings due to averted medication expenditures, and \$423,000 increase in rebate revenue with the usual six-month rebate delay).

The full impact of the new Covered California clients in FY 2016-17 will not be realized until FY 2017-18 when the additional rebate revenue is received.

C. Hepatitis C Virus (HCV) Drugs (Unchanged Assumption)

The expansion of HCV medication to include all HCV co-infected ADAP clients, regardless of liver disease stage, was approved as a New Assumption in May 2015. There are no changes to this assumption. In FY 2015-16, OA estimates 178 clients will be treated for HCV, with \$7.6 million in program expenditures and \$2.8 million in rebate revenue. The estimated net cost is \$4.8 million. For FY 2016-17, OA estimates 176 clients will be treated for HCV, with \$7.5 million in program expenditures and \$5.7 million in rebate revenue, for a net cost of \$1.9 million.

There are no Discontinued Major Assumptions.

V. Future Fiscal Issues

1. Anticipated Savings in ADAP PBM Fees

ADAP is currently in contract with a PBM, Ramsell Public Health Rx, LLC. The PBM administers a network of approximately 3,800 pharmacies throughout California that provide prescription fulfillment services for medications on the ADAP formulary. In addition, the PBM provides enrollment and re-certification services including conducting Enrollment Worker trainings, providing customer service support, and maintaining a web-based eligibility system utilized by certified ADAP enrollment workers assisting clients enrolling in ADAP services.

As established in the contract, ADAP pays the PBM an administrative transaction fee, a pharmacy dispense fee, and a reimbursement fee for each medication dispensed to an ADAP-only client. In addition, ADAP pays a transaction fee for each medication co-payment and deductible claim for private health insurance and Medicare Part D clients. The contract was executed on July 1, 2011 and terminates on June 30, 2016.

ADAP has developed a RFP for pharmaceutical services in collaboration with the California Department of General Services. This PBM RFP was released on October 20, 2015 and did not include enrollment services; a separate Enrollment Benefits Manager RFP was also released on October 20, 2015, which included enrollment services. The intention of splitting the pharmaceutical and enrollment services is to increase competition among PBMs, thereby lowering the administrative fees and drug reimbursement rates.

2. The HRSA 340B Drug Pricing Program Omnibus Guidance

The federal Department of Health and Human Services, HRSA administers section 340B of the Public Health Services Act, which is referred to as the "340B Drug Pricing Program." Since 1992, HRSA has interpreted the statutory requirements of the 340B Drug Pricing Program (340B Program) through guidance published in the Federal Register. The 340B Program requires drug manufacturers to provide outpatient drugs to eligible covered entities at significantly reduced prices. The 340B Program allows covered entities to stretch finite federal resources to reach more eligible underserved/uninsured patients and provide more comprehensive services.

Eligible covered entities include Ryan White programs such as ADAP. California ADAP receives the 340B discount in the form of drug rebates, including collecting full rebate on claims for which ADAP only pays a portion of the drug cost (e.g., prescription co-pays), as is currently allowed by HRSA. These rebates are a vital part of ADAP's annual budget.

On August 28, 2015, HRSA proposed draft 340B Drug Pricing Program Omnibus Guidance in the Federal Register (<https://www.federalregister.gov/articles/2015/08/28/2015-21246/340b-drug-pricing-program-omnibus-guidance>). All clients who are enrolled in ADAP would still be considered eligible for the 340B Drug Pricing Program; however, the guidance limits ADAPs' authority to collect full rebates on partial pay claims. The guidance proposes that the 340B discount for partial pay claims only be permitted if the ADAP pays the premium for the health insurance plan tied to the claim. HRSA has proposed a delay in implementation for one year after the publication date of the final guidance, to give covered entities time to establish any changes necessary to comply with the new guidance. An open public comment period was established through October 27, 2015. During the comment period, stakeholders were encouraged to review the proposed guidance and provide feedback before the guidance is finalized.

Because the final guidance is expected to be published after January 2016, OA does not anticipate ADAP's rebate revenue will be impacted in FY 2016-17. However, during the public comment period, CDPH sent in a public comment stating that if the guidance is finalized as currently proposed, OA estimates approximately \$122 - \$145 million in rebate revenue will be lost annually starting in FY 2017-18. This estimate may change, given the uncertainty of when the final guidance will be published and implemented. ADAP is maintaining a robust rebate reserve to offset this anticipated upcoming loss in rebate revenue. The fund impacted will be the ADAP Rebate Fund (3080).

3. Potential Increase in Federal Funds: 2016 ADAP Emergency Relief Funds

In December 2015, CDPH applied to HRSA for the maximum amount of \$11 million for the competitive 2016 ADAP Emergency Relief Funds supplemental grant. If awarded, ADAP will use these funds for drug expenditures and cost-containment measures, including payment of medical out-of-pocket costs in the budget year.

4. New HIV Drugs

The following HIV drugs may be approved by the FDA by July 1, 2016:

Gilead Sciences Inc. currently has New Drug Applications (NDA) for antiretroviral (ARV) drugs under review with the FDA that may result in two new ARV drugs/drug combinations becoming available on the market before the end of FY 2015-16:

1. Co-formulated emtricitabine/tenofovir alafenamide (a 200 mg/10 mg tablet and a 200 mg/25 mg tablet) (F/TAF)

On April 7, 2015, a NDA was submitted to the FDA for these two doses of fixed-dose combination F/TAF, both of which are to be used in combination with other ARVs to treat HIV-1-infected patients. On July 1, 2015, Gilead announced the FDA had set a target action date of April 7, 2016.

2. Co-formulated emtricitabine 200mg/tenofovir alafenamide 25mg/rilpivirine 25mg (R/F/TAF)

On July 1, 2015 Gilead, announced a NDA was submitted to the FDA for this once-daily single tablet regimen for the treatment of HIV-1 infection in patients who are treatment-naïve or are virologically suppressed and want to change their treatment regimen. Based on the NDA filing date, a possible approval date may occur as early as January 2016.

If ADAP receives a recommendation from the ADAP Medical Advisory Committee to add any new ARV drug to the ADAP formulary, and OA determines the drug will be cost neutral, ADAP will move forward with adding the drug to the ADAP formulary.

VI. Fund Condition Statement

Table 5: Fund Condition Statement ¹ (in thousands)				
Special Fund 3080: AIDS Drug Assistance Program Rebate Fund		FY 2014-15 Actuals	FY 2015-16 Estimate	FY 2016-17 Estimate
1	BEGINNING BALANCE	14,375	125,142	223,909
2	Prior Year Adjustment	12,888	0	0
3	Adjusted Beginning Balance	27,263	125,142	223,909
4	REVENUES, TRANSFERS AND OTHER ADJUSTMENTS			
5	Revenues			
6	4163000 Income From Surplus Money Investments (Interest)	129	120	120
7	4171400 Escheat - Unclaimed Checks, Warrants, Bonds, and Coupons	21	0	0
8	4172500 Miscellaneous Revenue	309,835	278,353	266,966
9	Total Revenues, Transfers, and Other Adjustments	309,985	278,473	267,086
10	Total Resources	337,248	403,615	490,995
11	EXPENDITURES AND EXPENDITURE ADJUSTMENTS			
12	Expenditures			
13	8880 FI\$Cal	1	2	1
14	4265 Department of Public Health			
15	State Operations	1,203	1,564	1,647
16	ADAP Local Assistance (Medications)	195,540	163,542	214,621
17	Insurance Assistance Programs (Premiums)	15,362	14,598	21,619
18				
19	Total Expenditures and Expenditure Adjustments	212,106	179,706	237,888
20	FUND BALANCE	125,142	223,909	253,107
Row 6: Interest Actuals for FY 2014-15, Estimated for FYs 2015-16 and 2016-17		128,957	120,000	120,000
Miscellaneous Revenue				
Actual Rebate received July - Sept 2015 from Expenditures for Jan - March 2015			80,265,234	
Estimated Rebates to be received Oct - Dec 2015 for Actual Expenditures from Apr - June 2015			65,927,942	
Estimated Rebates to be received Jan - June 2016 for Estimated Expenditures from July - Dec 2015			132,160,148	
Estimated Rebates to be received Jul - Dec 2016 for Estimated Expenditures from Jan - Jun 2016				132,160,148
Estimated Rebate to be received Jan - Jun 2017 for Estimated Expenditures from July - Dec 2016				134,836,351
Total Estimated FY 2015-16 Rebate Revenue			278,353,323	
Total Estimated FY 2016-17 Rebate Revenue				266,966,499

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

VII. HISTORICAL PROGRAM DATA AND TRENDS

For all figures in this section, the data prior to FY 2015-16 is the observed historical data. Estimates for both FYs 2015-16 and 2016-17 are based on the overall projections and include all assumptions.

Figure 1 is a summary of total client counts in ADAP by FY; 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. Clients with premium assistance for Medicare Part D are not included in the OA-HIPP client numbers.

Figure 2 shows the proportion of ADAP medication program clients 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.

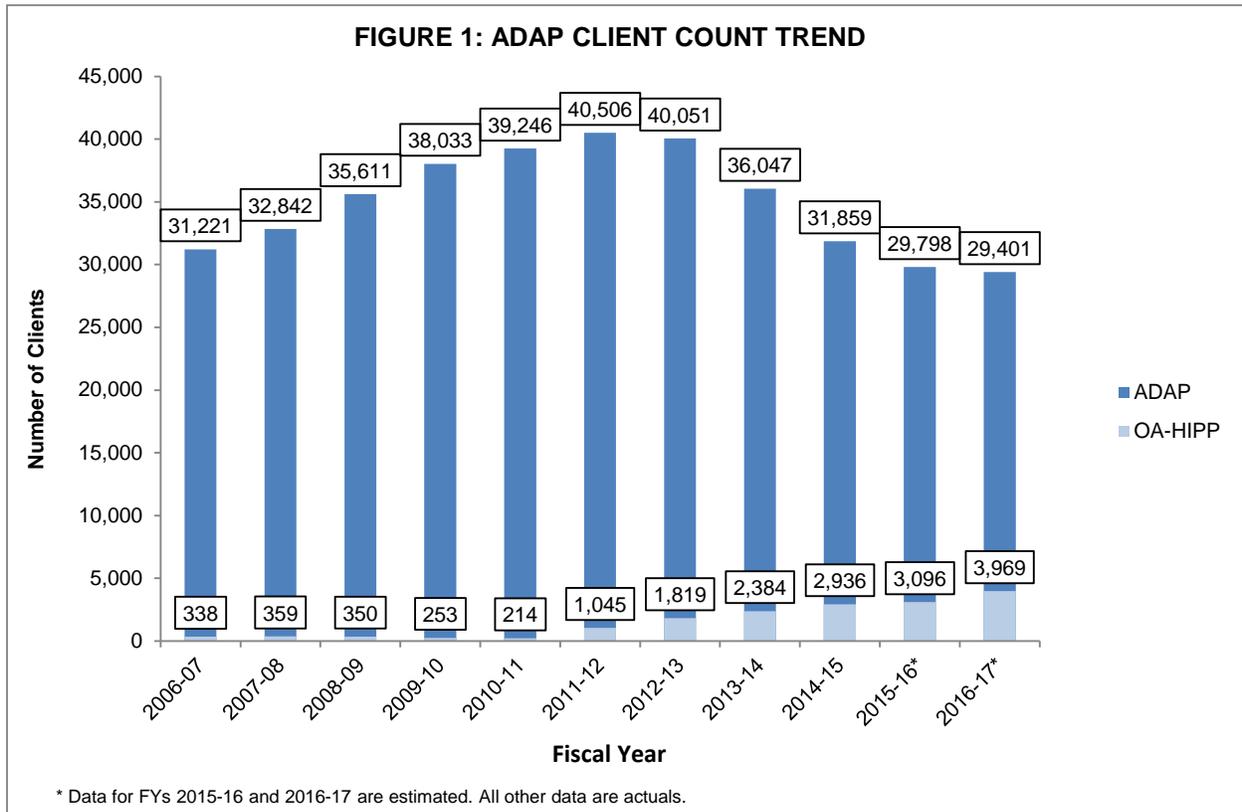
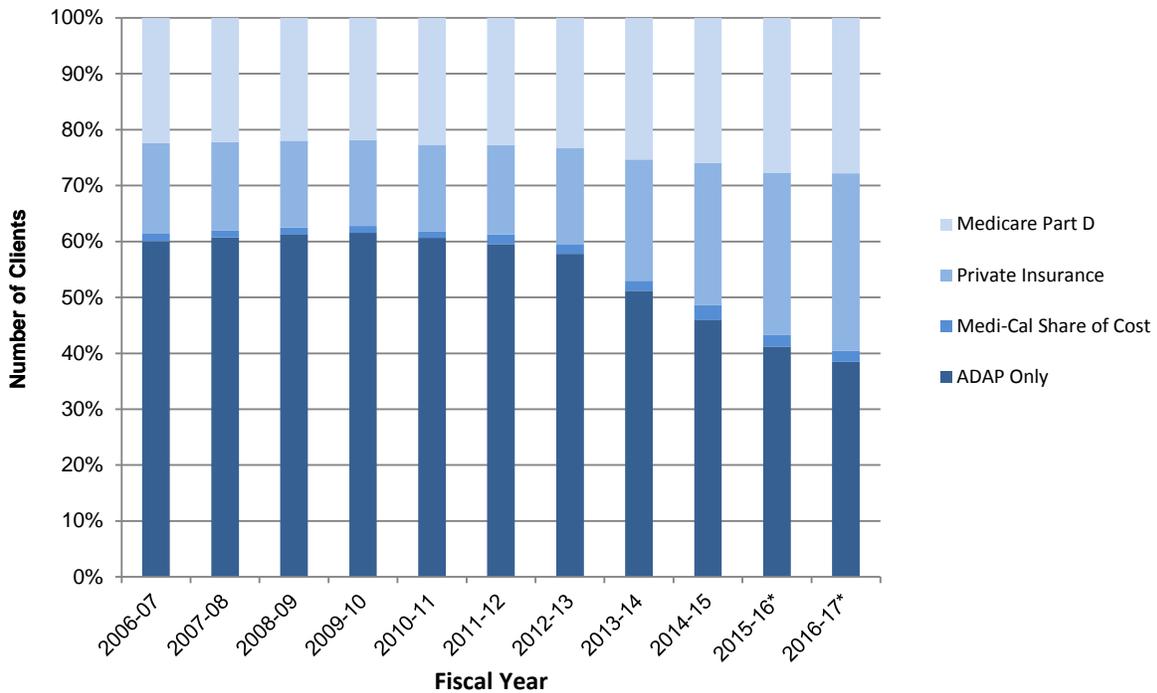
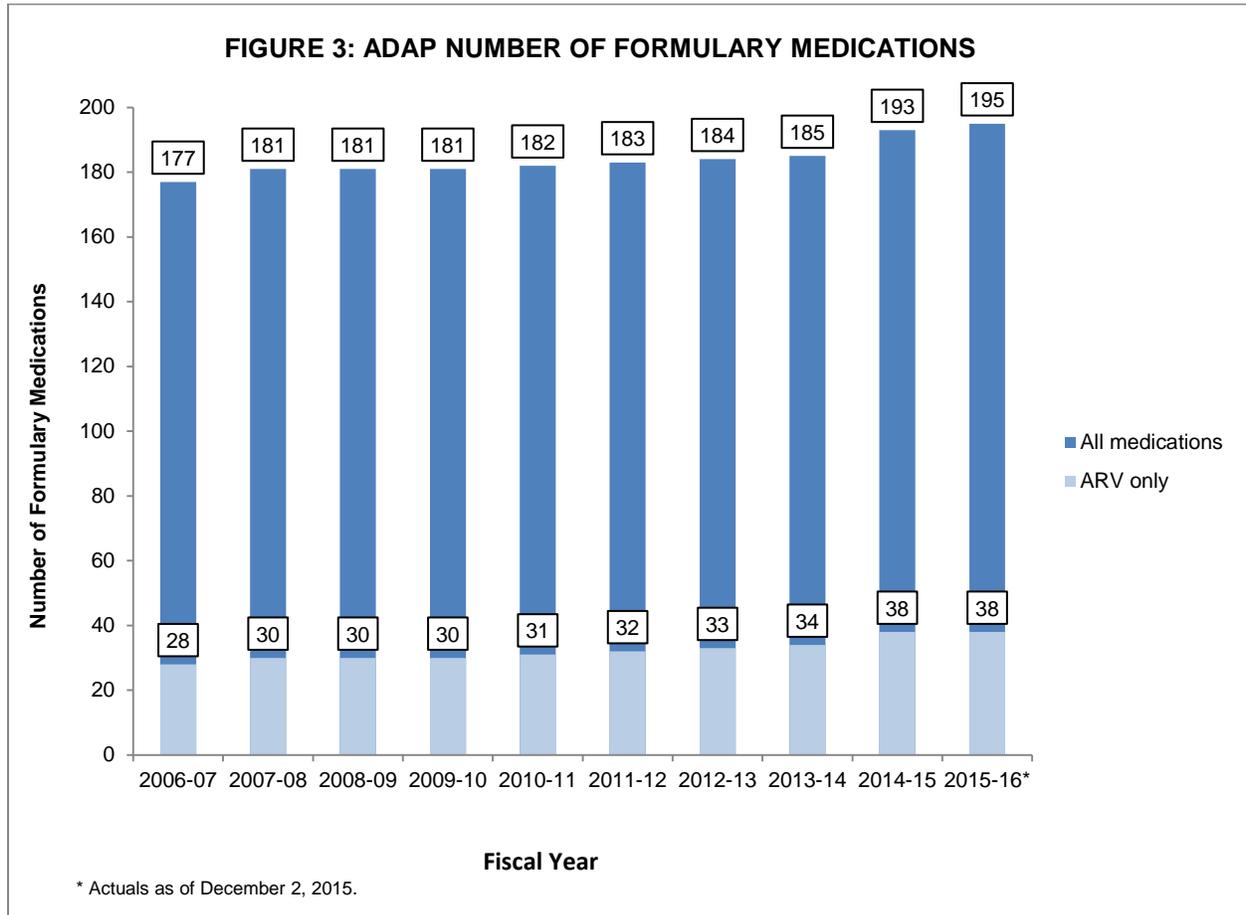


FIGURE 2: PERCENT OF ADAP MEDICATION PROGRAM CLIENTS BY PAYER SOURCE



* Data for FYs 2015-16 and 2016-17 are estimated. All other data are actuals.



- On July 10, 2015, ADAP added two vaccines (pneumococcal conjugate vaccine “PVC 13” and meningococcal vaccine) to the ADAP formulary and removed two ARVs, zalcitabine and amprenavir, which are obsolete and no longer manufactured.
- On October 16, 2015, ADAP added the ARV elvitegravir to the ADAP formulary.
- On December 2, 2015, ADAP added the four-drug combination ARV elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide to the ADAP formulary.

VIII. Current HIV/AIDS Epidemiology in California

Approximately 121,060 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 estimates 11.3 percent of all persons living with HIV in California are unaware of their infection. Therefore, OA estimates that there were approximately 137,000 persons living with HIV in California as of the end of 2013. Since the epidemic began, 91,611 Californians diagnosed with HIV have died, with about 1,368 dying in 2013 alone.

Of persons living with HIV in California, approximately 42.8 percent are White, 18.1 percent are Black/African American, 33.3 percent are Hispanic/Latino, 3.7 percent are Asian, 0.4 percent are American Indian/Alaskan Native, 0.3 percent are Native Hawaiian/Pacific Islander, and 1.6 percent are 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/African Americans is substantially higher (990 per 100,000 population, versus 347 per 100,000 among Whites, and 273 per 100,000 among Hispanics/Latinos).

Most of California's living HIV cases are attributed to male-to-male sexual transmission (66.2 percent); 9.1 percent of living cases are attributable to high-risk heterosexual contact, 6.9 percent to injection drug use, 7.6 percent to men who have sex with men who also inject drugs, 0.6 percent to perinatal exposure, and 9.4 percent 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 until we are able to make more progress in preventing new HIV infections. This increase is attributed to stable incidence rates and longer survival of those infected, primarily due to the effectiveness and availability of treatment.

IX. Appendices

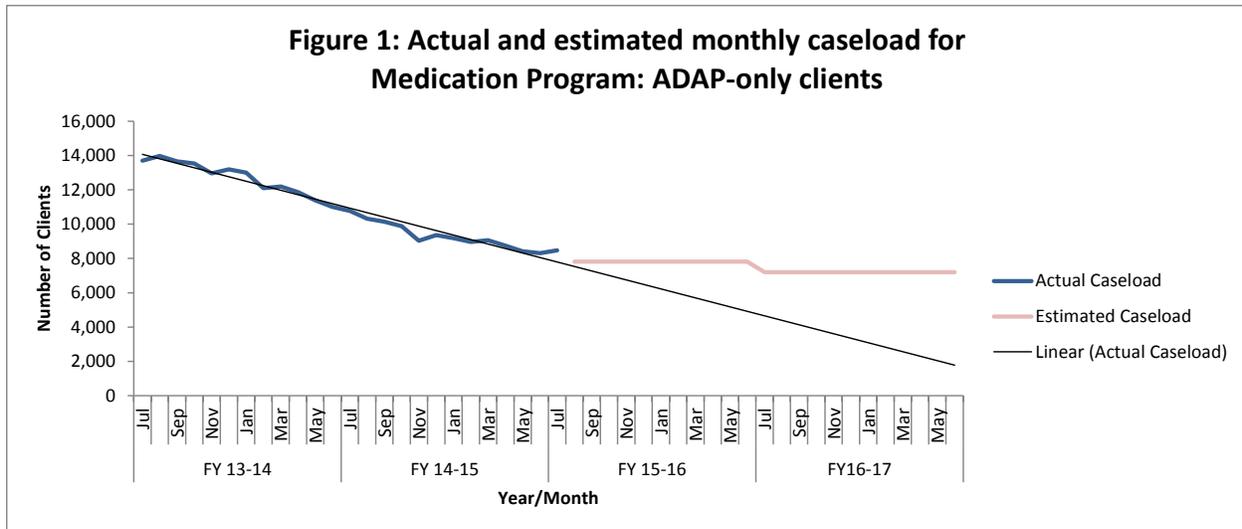
Appendix A: Assumptions and Rationale for Medication Expenditures – ADAP-only

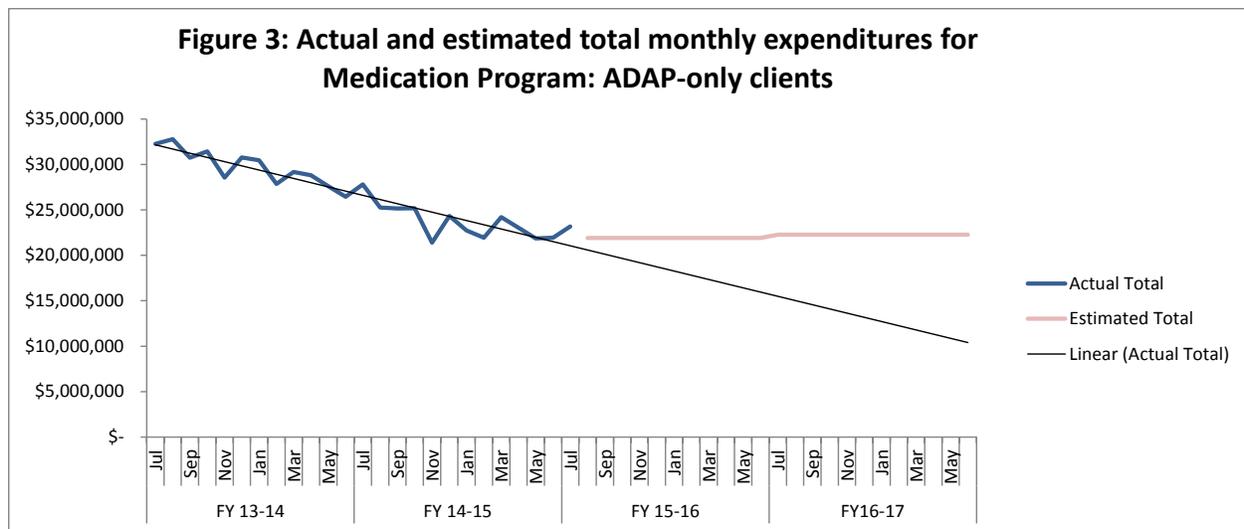
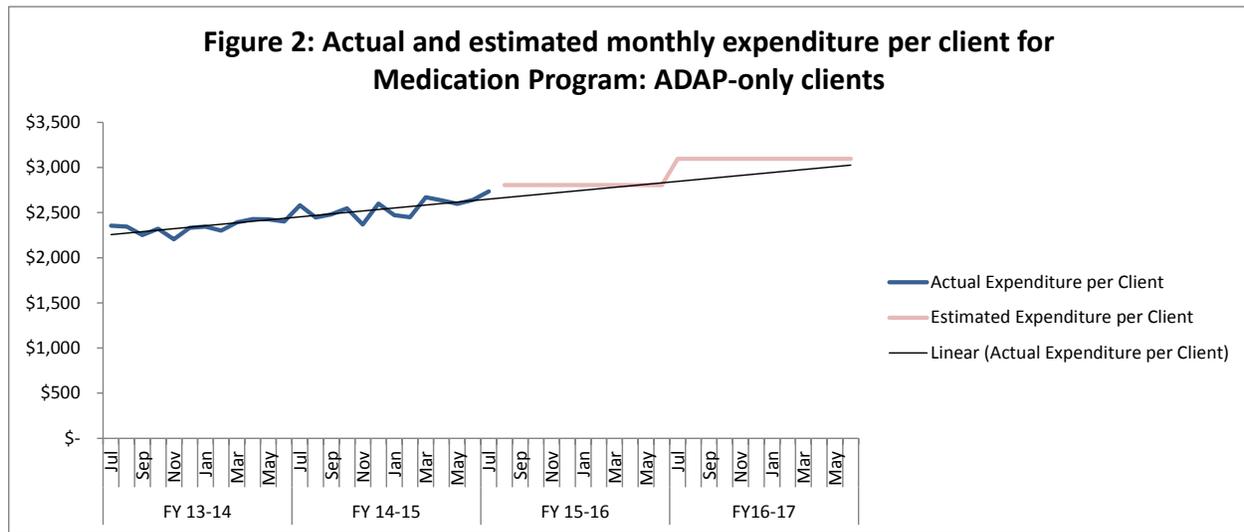
- A. ADAP-only caseload – OA estimates the average monthly caseload for ADAP-only clients in FY 2015-16 will be 7,812, a decrease of 16.4 percent compared to FY 2014-15. During FY 2016-17, OA estimates the monthly caseload will be 7,192, a decrease of 7.9 percent compared to FY 2015-16. These changes are based on the following:
- a. Historic trends: During FYs 2013-14 and 2014-15, the ADAP-only monthly caseload decreased by an average of 21.8 percent per year compared to the prior year. The caseload during the first month of FY 2015-16 decreased by 9.3 percent compared to FY 2014-15. These past trends were primarily driven by the Low-Income Health Program, Medi-Cal Expansion, and the transition of clients to Covered California. OA projects the caseload will continue to decline, although at a slower rate than in the past, due to ongoing enrollment in Medi-Cal Expansion and Covered California.
 - 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 comprehensive health insurance. OA estimates 169 clients will move from ADAP-only to Covered California due to coverage of medical out-of-pocket costs during FY 2015-16. During FY 2016-17, OA estimates an 486 additional clients will move to Covered California from ADAP only.
 - ii. HCV drugs: Not applicable (N/A) – this assumption should not impact the ADAP-only caseload.
 - b. New assumptions.
 - i. Cross Match of Ryan White Client Data to MEDS: Based on the initial data matches performed thus far, OA estimates that savings from 295 clients moving from ADAP-only to Medi-Cal will occur during FY 2015-16. During FY 2016-17, OA estimates an additional 36 clients will move to Medi-Cal from ADAP only.
- B. ADAP-only per client medication expenditures – OA estimates the average monthly per client expenditures for ADAP-only clients in FY 2015-16 will be \$2,805, an increase of 10.5 percent compared to FY 2014-15. During FY 2016-17, OA estimates the average monthly per client expenditures will be \$3,096, an increase of 10.4 percent compared to FY 2015-16. These changes are based on the following:
- a. Historic trends and unchanged assumptions: During FYs 2013-14 and 2014-15, the ADAP-only average monthly expenditures per client increased by an average of 7.9 percent per year compared to the prior year. The expenditures per client during the first month of FY 2015-16 increased by 7.7 percent compared to the average monthly expenditures per client during FY 2014-15. This trend is largely driven by increasing drug expenditures, and OA expects it will similarly impact FYs 2015-16 and 2016-17.
 - i. Payment of out-of-pocket medical costs for OA-HIPP clients: N/A.
 - ii. HCV drugs: For this unchanged assumption, OA estimates a total of 76 clients in FY 2015-16 and 75 clients in FY 2016-17 will receive HCV treatment. The corresponding addition to the average monthly per client

expenditures for ADAP-only clients will be \$70 in FY 2015-16 and \$75 in FY 2016-17.

- b. New assumptions.
 - i. Cross Match of Ryan White Client Data to MEDS: N/A.

The following figures (Figures 1-3) show the actual ADAP-only caseload and expenditures per client per month during July 2013 through July 2015, along with our estimates for the remainder of the Current Year (FY 2015-16) and Budget Year (FY 2016-17). The linear trend for the actual data is also shown.



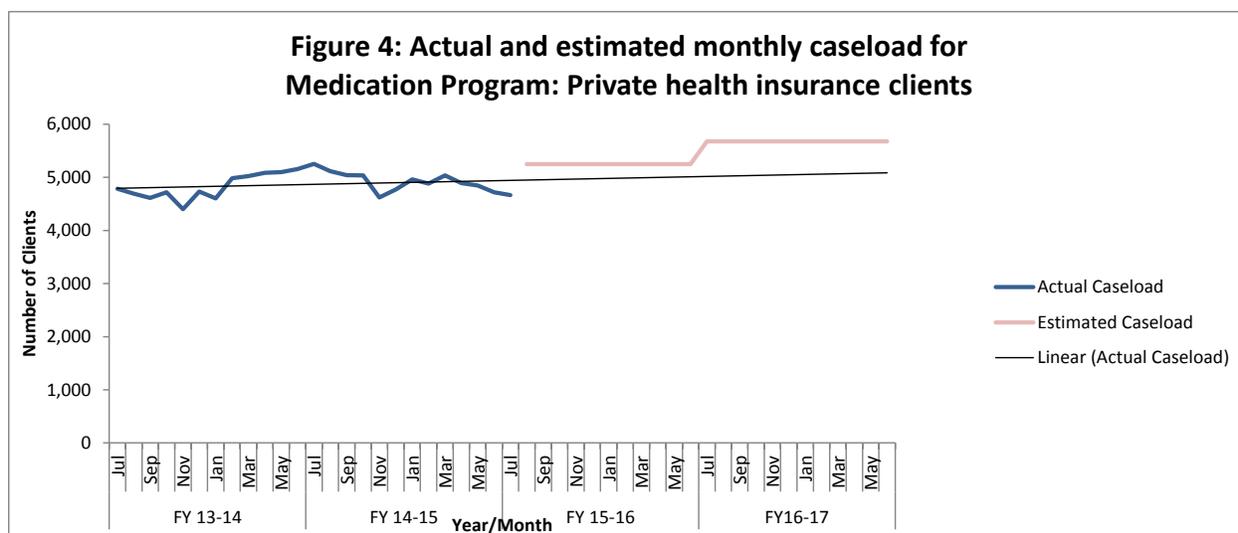


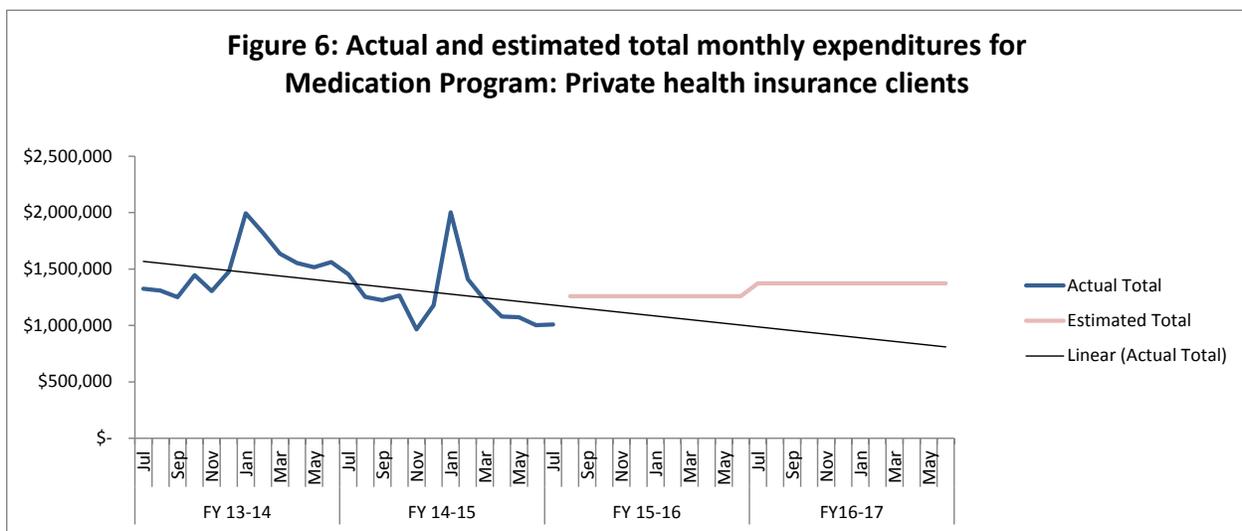
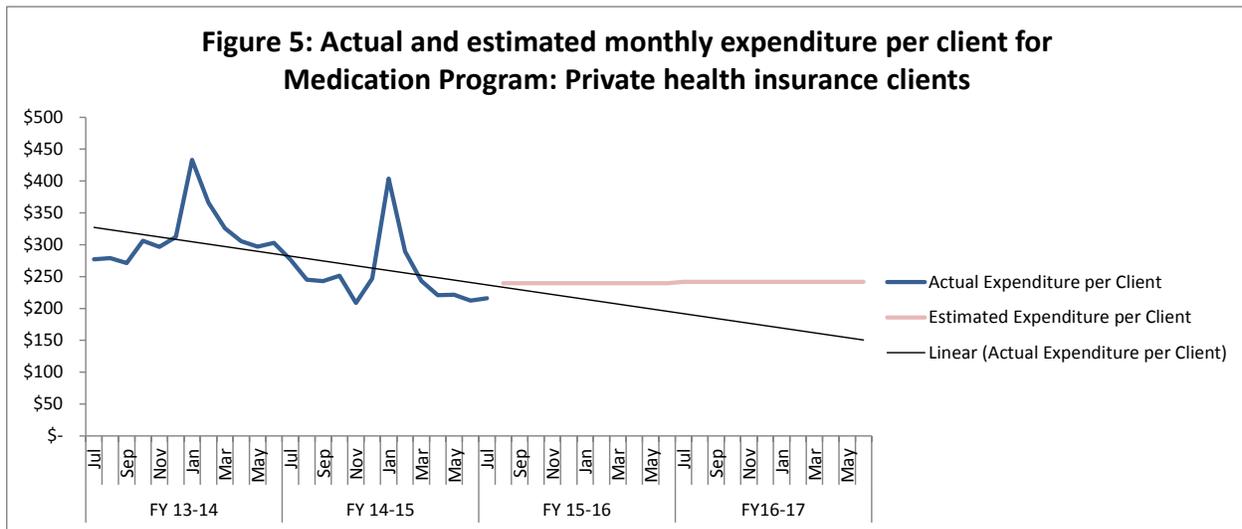
Appendix B: Assumptions and Rationale for Medication Expenditures – Private Health Insurance

- A. Private health insurance medication expenditures caseload: OA estimates the average monthly number of private health insurance clients in FY 2015-16 will be 5,249, an increase of 6.5 percent compared to FY 2014-15. During FY 2016-17, OA estimates the number will be 5,679, an increase of 8.2 percent compared to FY 2015-16. These changes are based on the following:
- a. Historic trends and unchanged assumptions: During FYs 2013-14 and 2014-15, the private health insurance average monthly caseload had some seasonal variation, but was generally stable. During FY 2014-15, the caseload increased 2.2 percent compared to FY 2013-14, primarily driven by clients transitioning to private health insurance purchased through Covered California.
 - 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 health insurance clients, as additional eligible clients will choose to enroll in more comprehensive health insurance coverage programs during FYs 2015-16 and 2016-17. OA estimates 260 clients will enroll in Covered California in FY 2015-16, and 747 will enroll in Covered California in FY 2016-17, due to coverage of medical out-of-pocket costs, and receive ADAP support for medication out-of-pocket costs.
 - ii. HCV drugs: N/A.
 - b. New assumptions.
 - i. Cross Match of Ryan White Client Data to MEDS: N/A.
- B. Private health insurance per client medication expenditures – Overall, OA estimates the per-client expenditures for private health insurance clients will be \$240/month for FY 2015-16, a decrease of 6.3 percent compared to FY 2014-15. In FY 2016-17, OA estimates the per-client expenditures for private health insurance clients will be \$242/month, an increase of 0.9 percent compared to FY 2015-16. This change is attributable to the following:
- a. Historic trends and unchanged assumptions: During FY 2013-14, the private health insurance average monthly medication expenditure per client increased by an average of 12.1 percent compared to the prior year, in part due to Covered California medication deductibles incurred at the beginning of the year. However, in FY 2014-15, the average monthly medication expenditure per client decreased 18.6 percent compared to the prior year, in part due to a full year of Covered California medication deductibles and co-pays, which were lower than their non-Covered California counterparts. There is substantial seasonal variation in per-client expenditures, reflecting the impact of medication deductibles at the start of the calendar year. The trend in per-client expenditures is driven by increasing medication deductibles and co-pays, particularly for Covered California clients as compared to clients with employer-based health insurance or COBRA plans. Thus, OA expects this will have a smaller impact in FY 2015-16 and a minimal impact FY 2016-17.
 - i. Payment of out-of-pocket medical costs for OA-HIPP clients: OA estimates Covered California medical out-of-pocket costs will be relatively comparable to those for OA-HIPP non-Covered California plans. Although more clients will enter Covered California because of the coverage of medical out-of-pocket costs, the impact on per client expenditures for private health insurance clients will be minimal, \$0/month in FY 2015-16 and \$1/month in FY 2016-17.

- ii. HCV drugs: For this unchanged assumption, OA estimates a total of 51 private health insurance clients in FY 2015-16, and 50 private health insurance clients in FY 2016-17, will receive HCV treatment. The corresponding addition to the average monthly per client expenditures for private health insurance clients will be \$8 in FY 2015-16 and \$7 in FY 2016-17.
- b. New assumptions.
 - i. Cross Match of Ryan White Client Data to MEDS: N/A.

The following figures (Figures 4-6) show the actual private health insurance caseload and expenditure per client per month during July 2013 through July 2015, along with our estimated numbers for the remainder of the Current Year (FY 2015-16) and Budget Year (FY 2016-17). The linear trend for the actual data is also shown.

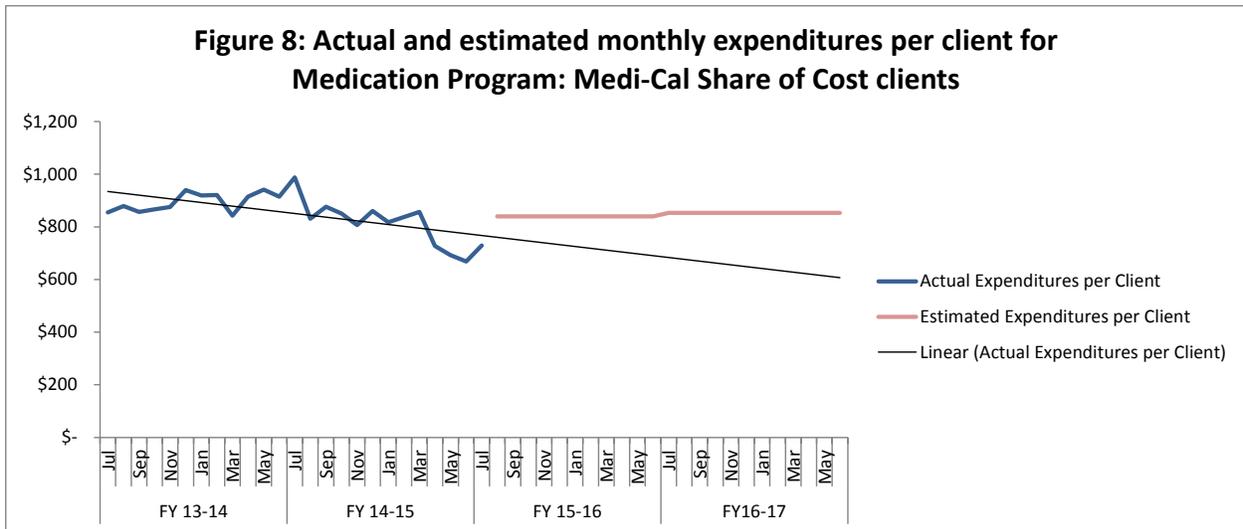
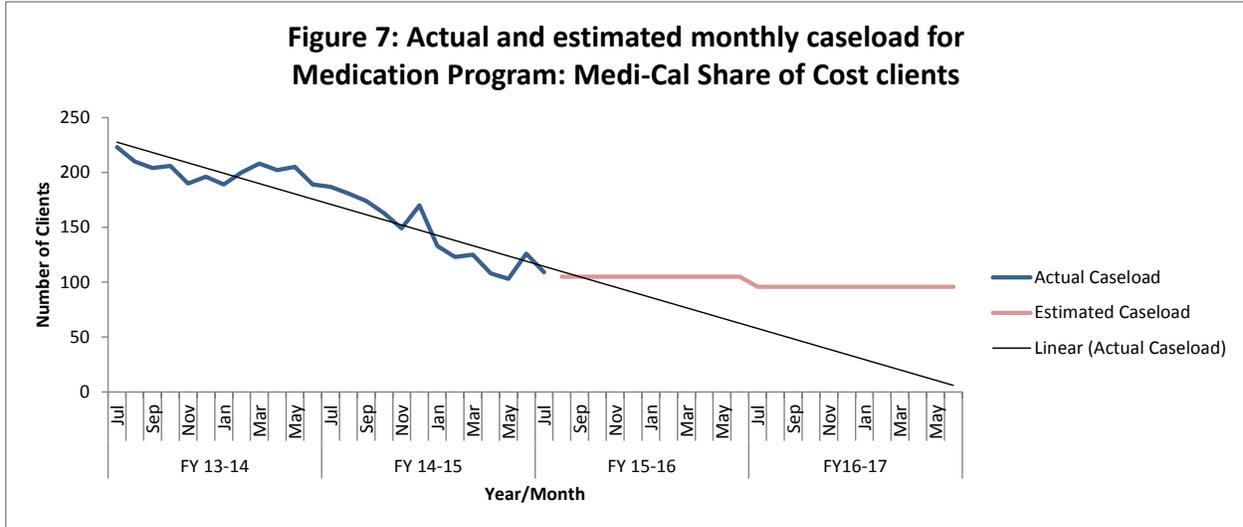


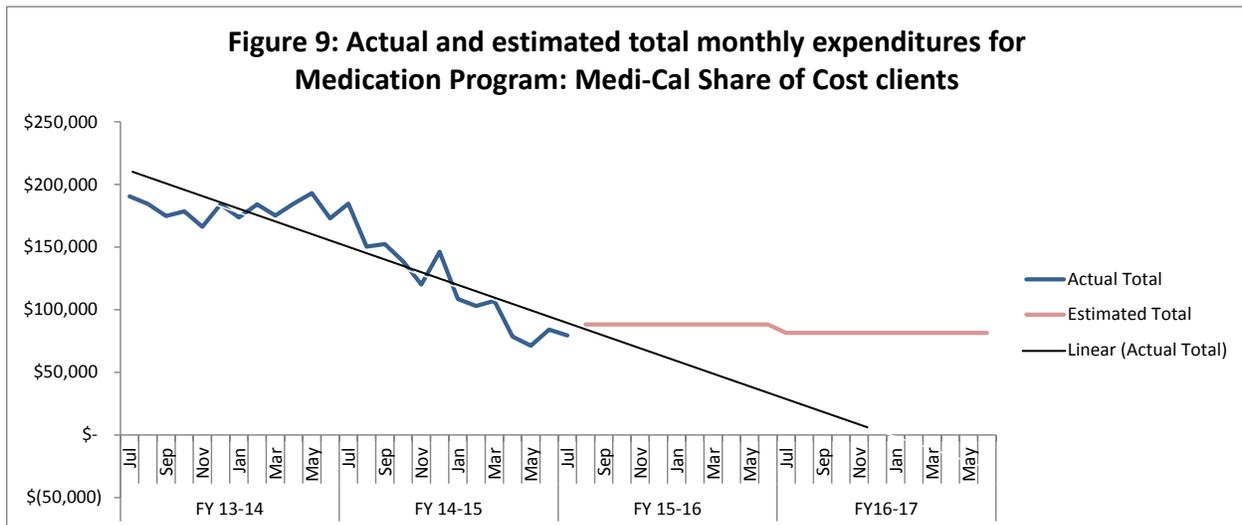


Appendix C: Assumptions and Rationale for Medication Expenditures – Medi-Cal SOC

- A. Medi-Cal SOC caseload – OA estimates the average monthly number of Medi-Cal SOC clients in FY 2015-16 will be 105, a decrease of 27.6 percent compared to FY 2014-15. During FY 2016-17, OA estimates the number will be 96, a decrease of 8.9 percent compared to FY 2015-16. These changes are based on the following:
- a. Historic trends and unchanged assumptions: During FYs 2013-14 and 2014-15, the Medi-Cal SOC average monthly caseload decreased by 19.7 percent per year compared to the prior year. The caseload during the first month of FY 2015-16 decreased by 24.9 percent compared to the average monthly caseload during FY 2014-15. This trend is likely due to Medi-Cal Expansion, as clients with income between 100 percent to 138 percent of FPL who would previously have been given a SOC are now eligible for full-scope Medi-Cal. OA expects this recent trend will continue in FY 2015-16, as eligible clients with pending Medi-Cal applications are processed and enrolled in that program. In FY 2016-17, OA expects the caseload will continue to decline, although at a much slower rate.
 - i. Payment of out-of-pocket medical costs for OA-HIPP clients: N/A.
 - ii. HCV drugs: N/A.
 - b. New assumptions.
 - i. Cross Match of Ryan White Client Data to MEDS: 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 2015-16 will be \$840, an increase of 1.2 percent compared to FY 2014-15. During FY 2016-17, OA estimates the average monthly per-client expenditure will be \$853, an increase of 1.6 percent compared to FY 2015-16. These changes are based on the following:
- a. Historic trends and unchanged assumptions: During FY 2013-14, the Medi-Cal SOC average monthly expenditure per client increased by 3.6 percent. During FY 2014-15, the average monthly expenditure per client decreased by 7.1 percent compared to FY 2013-14. The expenditure per client during the first month of FY 2015-16 decreased by 24.9 percent compared to the average monthly expenditure per client during FY 2014-15. 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. Payment of out-of-pocket medical costs for OA-HIPP clients: N/A.
 - ii. HCV drugs: For both FYs 2015-16 and 2016-17, OA estimates a total of two Medi-Cal SOC clients will receive HCV treatment. The corresponding increase to the average monthly per client expenditures for Medi-Cal SOC clients will be \$73 in FY 2015-16 and \$78 in FY 2016-17.
 - b. New assumptions.
 - i. Cross Match of Ryan White Client Data to MEDS: The first phase of the MEDS data match was to ensure that the medication expenditures for ADAP clients with full-scope Medi-Cal were being appropriately billed to Medi-Cal. The second phase, which is still in progress, is to ensure appropriate billing for ADAP clients with a Medi-Cal SOC. OA cannot yet estimate savings from this second phase, and has assumed the savings to be zero.

The following figures (Figure 7-9) show the actual Medi-Cal SOC caseload and expenditures per client per month during July 2013 through July 2015, along with our estimated numbers for the remainder of the Current Year (FY 2015-16) and Budget Year (FY 2016-17). The linear trend for the actual data is also shown.

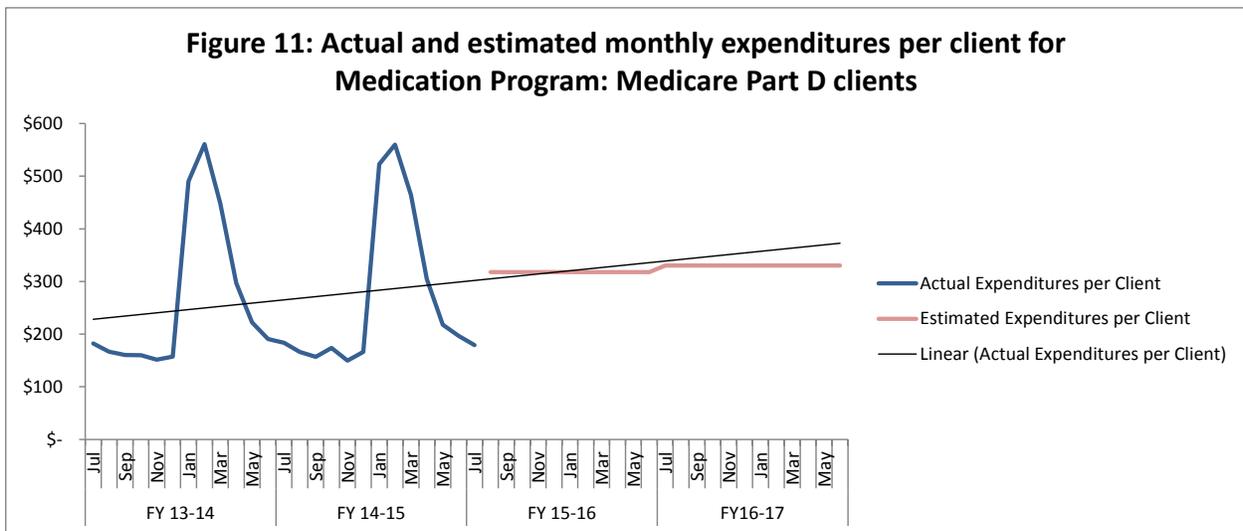
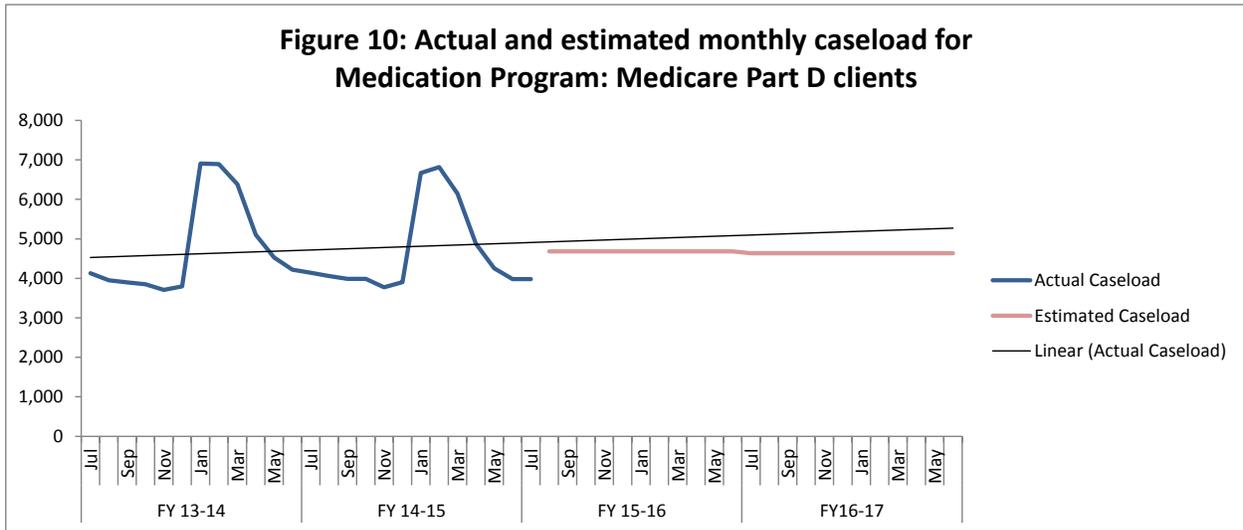


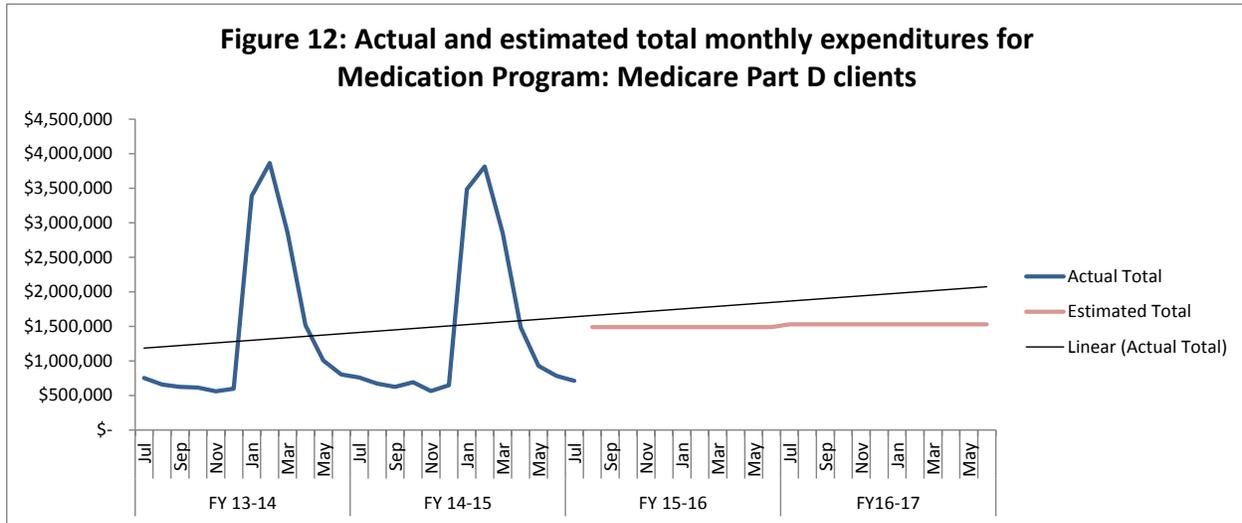


Appendix D: Assumptions and Rationale for Medication Expenditures – Medicare Part D

- A. Medicare Part D caseload – Overall, OA estimates average monthly caseload for clients in the Medicare Part D program will be 4,681 in FY 2015-16 and 4,632 in FY 2016-17, which is a 0.7 percent decrease from FY 2014-15 and 1.0 percent decrease from FY 2015-16, respectively. This relative stability is attributable to the following:
- a. Historic trends and unchanged assumptions: During FYs 2013-14 and 2014-15, the Medicare Part D average monthly caseload decreased 1.4 percent compared to the prior year. The caseload during the first month of FY 2015-16 declined 15.6 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 FYs 2015-16 and 2016-17.
 - i. Payment of out-of-pocket medical costs for OA-HIPP clients: N/A.
 - ii. HCV drugs: N/A.
 - b. New assumptions.
 - i. Cross Match of Ryan White Client Data to MEDS: 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 2015-16 will be \$318, an increase of 3.9 percent compared to FY 2014-15. During FY 2016-17, OA estimates the average monthly per-client expenditure will be \$330, an increase of 3.9 percent compared to FY 2015-16. These changes are based on the following:
- a. Historic trends and unchanged assumptions: During FYs 2013-14 and 2014-15, the Medicare Part D average monthly expenditure per client increased 3.7 percent. The expenditure per client during the first month of FY 2015-16 decreased by 15.6 percent compared to the average monthly expenditure per client during FY 2015-16. This trend is largely driven by normal seasonal variation and does not reflect a long-term trend. OA projects the general increasing trend in per-client expenditures seen in FY 2015-16 will continue. This trend is primarily due to Medicare Part D plan co-pays and program rules.
 - i. Payment of out-of-pocket medical costs for OA-HIPP clients: N/A.
 - ii. HCV drugs: For both FYs 2015-16 and 2016-17, OA estimates 49 Medicare Part D clients will receive HCV treatment each year. The corresponding increase to the average monthly per client expenditures for Medicare Part D clients will be \$7 in both FYs 2015-16 and 2016-17.
 - b. New assumptions.
 - i. Cross Match of Ryan White Client Data to MEDS: N/A.

The following figures (Figure 10-12) show the actual Medicare Part D caseload and expenditures per client per month during July 2013 through July 2015, along with OA estimates for the remainder of the Current Year (FY 2015-16) and Budget Year (FY 2016-17). The linear trend for the actual data is also shown.



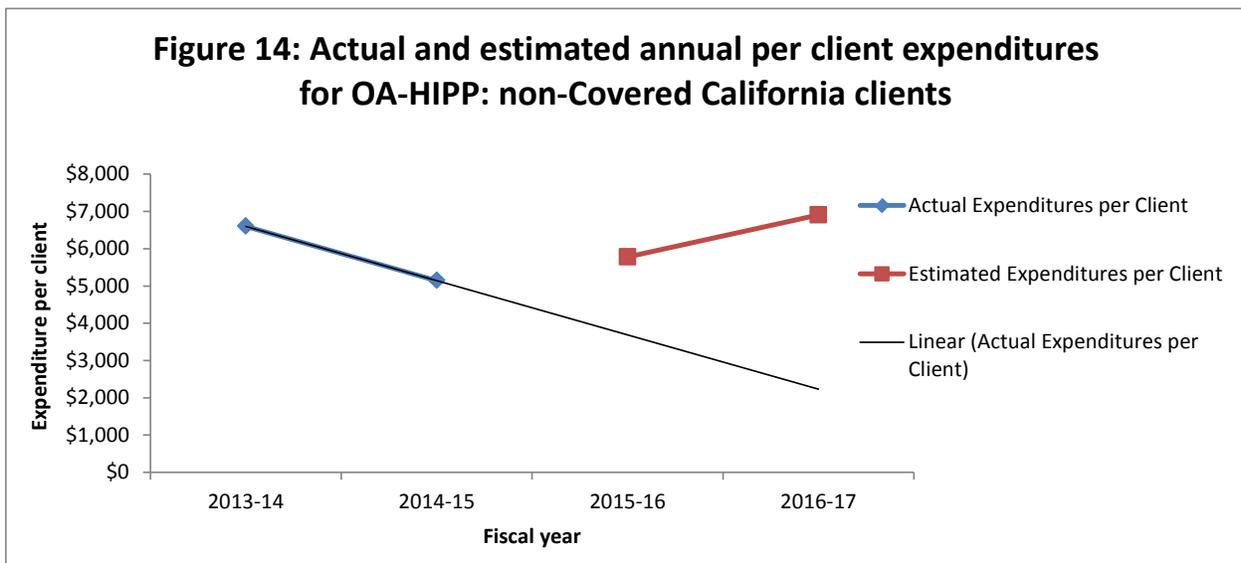
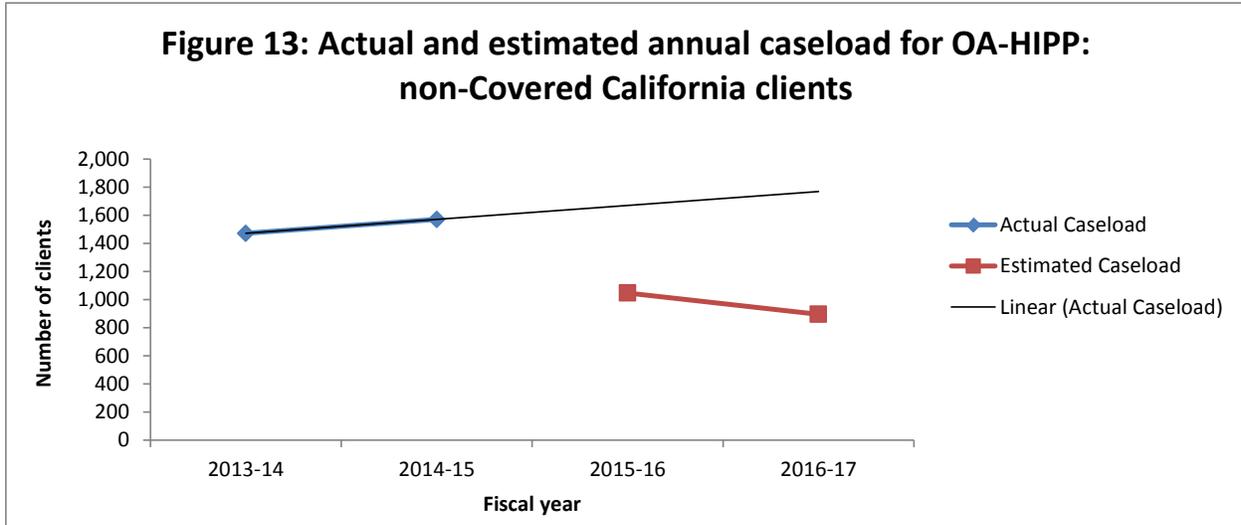


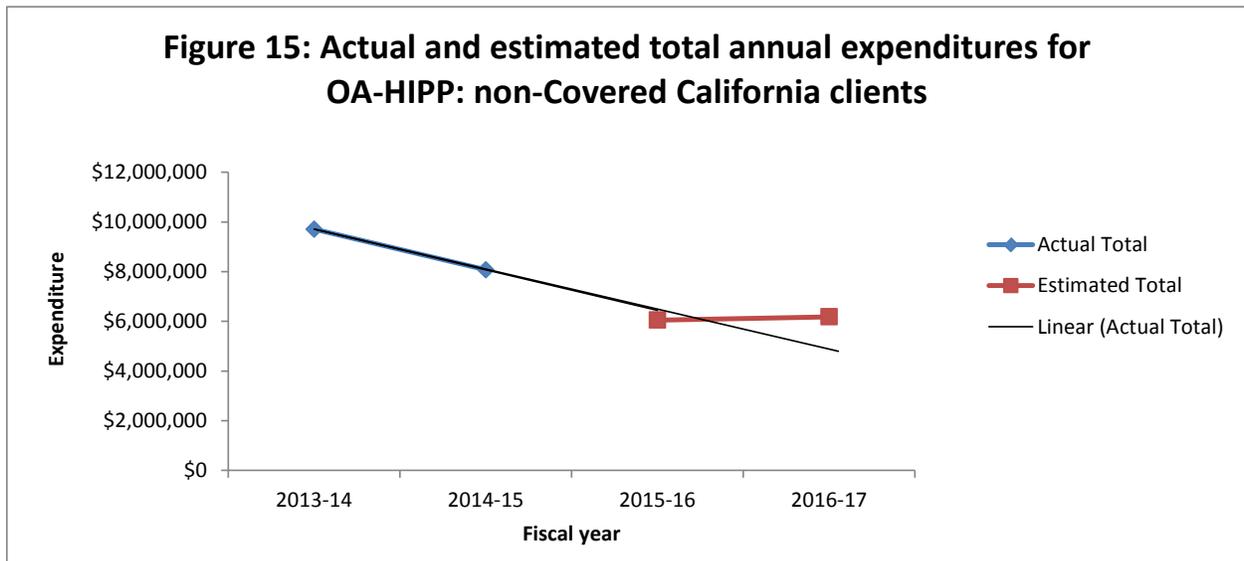
Appendix E: OA-HIPP – Non-Covered California Private Health Insurance Premium Expenditures

- A. Caseload for non-Covered California private health insurance clients – Overall, OA estimates the annual¹ caseload for clients in the OA-HIPP non-Covered California program in FY 2015-16 will be 1,195, a decrease of 33.3 percent compared to FY 2014-15. During FY 2016-17, OA estimates the number will be 895, a decrease of 14.5 percent compared to FY 2015-16. This change is attributable to the following:
- a. Historical data and unchanged assumptions: During FY 2013-14, the annual caseload was 1,471, a decrease of 19.1 percent compared to the prior year. During FY 2014-15, the annual caseload was 1,570, an increase of 6.8 percent compared to the prior year. The recent changes in OA-HIPP non-Covered California caseload are due to OA-HIPP non-Covered California clients transitioning to Medi-Cal Expansion, Covered California, and potentially other sources of coverage such as employer-based coverage. These factors have led to year-to-year instability in the caseload, although there is a general downward trend. OA projects clients will continue to move out of non-Covered California plans to Covered California plans during FYs 2015-16 and 2016-17.
 - 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 these clients will enroll in Covered California plans rather than non-Covered California plans.
 - b. New assumptions.
 - i. HCV drugs: N/A.
- B. Expenditures per client for OA-HIPP non-Covered California - Overall, OA estimates average annual expenditures per client in the OA-HIPP non-Covered California program in FY 2015-16 will be \$5,780, an increase of 12.4 percent compared to FY 2014-15. During FY 2016-17, OA estimates the expenditures will be \$6,908, an increase of 19.5 percent compared to FY 2015-16. Expenditures for FYs 2015-16 and 2016-17 include both premiums and medical out-of-pocket costs. This change is attributable to the following:
- a. Historical data and unchanged assumptions: During FY 2013-14, the average expenditure per client increased by 8.3 percent compared to the prior year. During FY 2014-15, the average expenditure per client decreased by 22.1 percent compared to the prior year. Overall, it is unclear if this trend will continue during FYs 2015-16 and 2016-17 but monthly premiums for non-Covered California plans are expected to increase each year.
 - 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 will also lead to increased health insurance program expenditures. OA estimates coverage of medical out-of-pocket costs, including administrative fees, will increase per client health insurance expenditures by \$302 per client in FY 2015-16, and by \$1,074 per client in FY 2016-17.
 - b. New assumptions.
 - i. HCV drugs: N/A.

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

The following figures (Figure 13-15) show the actual OA-HIPP non-Covered California caseload and average expenditure per client per year during FYs 2013-14 and 2015-16, along with our estimated numbers for the remainder of the Current Year (FY 2015-16) and Budget Year (FY 2016-17). The linear trend for the actual data is also shown.



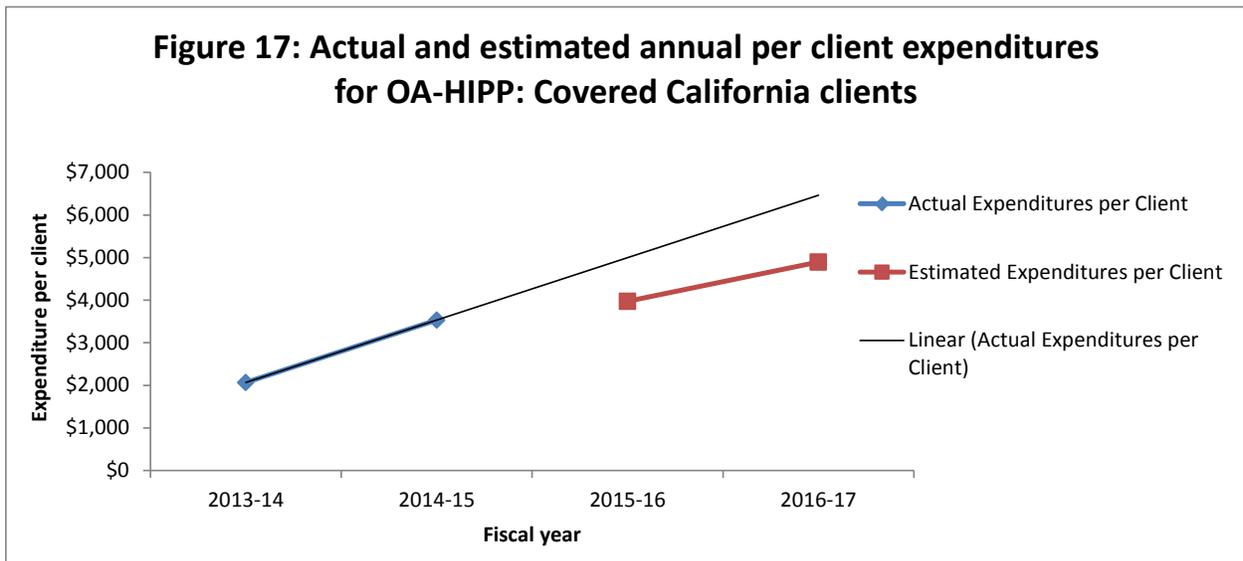
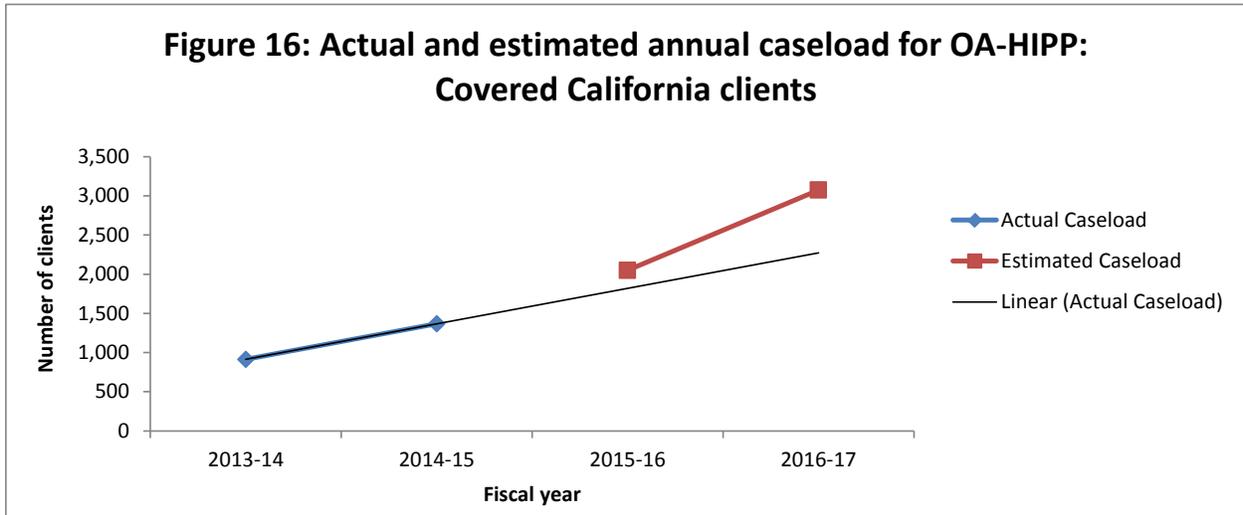


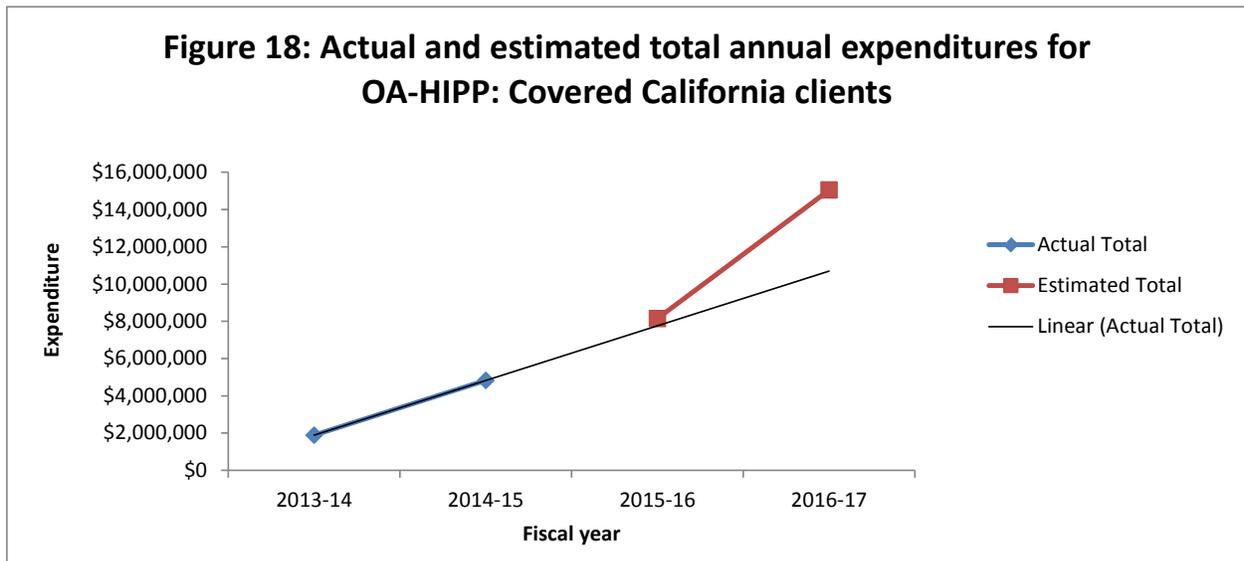
Appendix F: OA-HIPP Covered California Premium Expenditures

- A. Caseload for OA-HIPP Covered California - Overall, OA estimates annual² caseload for clients in the OA-HIPP Covered California program in FY 2015-16 will be 2,049, an increase of 50.0 percent compared to FY 2014-15. During FY 2016-17, OA estimates the number will be 3,074, another increase of 50.0 percent compared to FY 2015-16. 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 Covered California existed. During FY 2014-15, the annual caseload for OA-HIPP Covered California was 1,366, an increase of 50.0 percent compared to the prior year. OA expects the number of OA-HIPP Covered California clients will continue to increase during FYs 2015-16 and 2016-17 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. 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 260 additional clients will enroll in OA-HIPP Covered California in FY 2015-16 due to coverage of out-of-pocket medical costs, and 747 additional clients in FY 2016-17.
 - b. New assumptions.
 - i. HCV drugs: N/A.
- B. Expenditures per client for OA-HIPP Covered California - Overall, OA estimates average annual expenditures per client in OA-HIPP Covered California in FY 2015-16 will be \$3,975, an increase of 12.5 percent compared to FY 2014-15. During FY 2016-17, OA estimates the expenditures will be \$4,894, an increase of 23.1 percent compared to FY 2015-16. Expenditures for FYs 2015-16 and 2016-17 include both premiums and medical out-of-pocket costs. This change is attributable to the following:
- a. Historical data and unchanged assumptions: Covered California started in January 2014. 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 a maximum of six months. During FY 2014-15, the average premium expenditure per client for OA-HIPP Covered California clients was \$3,532. Covered California has estimated premium costs will increase 4.0 percent during FY 2015-16; OA has used that percentage to estimate increases in general program expenditures in FYs 2015-16 and 2016-17.
 - 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 will also lead to increased health insurance program expenditures. OA estimates this assumption, including administrative fees, will increase the annual per client health insurance expenditure for OA-HIPP Covered California clients by \$303 in FY 2015-16, and by \$1,074 in FY 2016-17.
 - b. New assumptions.
 - i. HCV drugs: N/A.

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

The following figures (Figure 16-18) show the actual OA-HIPP Covered California caseload and average expenditures per client per year during FYs 2013-14 and 2014-15, along with our estimated numbers for the Current Year (FY 2015-16) and Budget Year (FY 2016-17).





Appendix G: OA-Medicare Part D - Premium Expenditures

- A. Caseload for OA-Medicare Part D clients - Overall, OA estimates annual caseload in the OA-Medicare Part D program in FY 2015-16 will be 634 clients, a decrease of 1.4 percent compared to FY 2014-15. During FY 2016-17, OA estimates the number will be 626, another decrease of 1.4 percent compared to FY 2015-16. This change is attributable to the following:
- a. Historical data and unchanged assumptions: During FY 2013-14, the average annual caseload increased by 2.6 percent compared to the prior year. During FY 2014-15, the average annual caseload decreased by 1.4 percent compared to FY 2013-14.
 - 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-Medicare Part D clients - Overall, OA estimates average annual premium expenditures per client in the OA-Medicare Part D program in FY 2015-16 will be \$631, a zero percent change compared to FY 2014-15. During FY 2016-17, OA also estimates the expenditures will be \$631, another zero percent change compared to FY 2015-16. This lack of 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. During FY 2014-15, the average annual expenditure per client was \$631. Medicare has estimated that premium costs will not increase in 2016. OA projects this stability will continue in both FYs 2015-16 and 2016-17.
 - 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-Medicare Part D caseload and expenditures per client per year during FYs 2013-14 and 2014-15, along with our estimated numbers for the Current Year (FY 2015-16) and Budget Year (FY 2016-17). The linear trend for the actual data is also shown.

