

AIDS DRUG ASSISTANCE PROGRAM

2026-27

November Estimate



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Table of Contents

I. Program Overview..... 1

II. Stakeholder Engagement..... 3

III. Estimate Methodology 5

 A. Expenditure Forecasts..... 5

 B. Revenue Forecasts..... 5

IV. Estimate Overview 6

V. Summary of Expenditures and Revenue 7

 A. Expenditure Types 7

 B. Revenue and Federal Grants..... 8

VI. Assumptions..... 10

VII. Expenditure Details..... 30

VIII. Historical Program Data and Trends 36

IX. Current HIV Epidemiology in California 41

I. Program Overview

The California Department of Public Health (CDPH), Center for Infectious Diseases, Office of AIDS (OA), Acquired Immunodeficiency Syndrome (AIDS) Drug Assistance Program (ADAP) Branch administers ADAP and the Pre-Exposure Prophylaxis (PrEP) Assistance Program (PrEP-AP). ADAP provides access to life-saving medications, health insurance premium payment assistance, and assistance with medical out-of-pocket costs for eligible California residents living with Human Immunodeficiency Virus (HIV). PrEP-AP provides assistance with medication and medical out-of-pocket costs related to HIV PrEP for clients at risk for acquiring HIV and post-exposure prophylaxis (PEP) for clients who may have been exposed to HIV. Services are provided to five groups of clients:

1. **Medication-only clients** are people with HIV (PWH) who do not have private insurance and are not enrolled in Medi-Cal or Medicare. ADAP covers the full cost of prescription medications on the ADAP formulary for these individuals. This group only receives services associated with medication costs.
2. **Medi-Cal Share of Cost (SOC) clients** are PWH enrolled in Medi-Cal who have a SOC for Medi-Cal services. ADAP covers the SOC for medications for these clients. This group only receives services associated with medication costs.
3. **Private insurance clients** are PWH who have some form of health insurance, including insurance purchased through Covered California, privately-purchased health insurance, or employer-based health insurance. This group is divided into three client sub-groups: Covered California clients, non-Covered California clients, and employer-based insurance clients. These groups receive medication benefits and may also receive assistance with health insurance premiums and medical out-of-pocket costs.
4. **Medicare clients** are PWH who are enrolled in a Medicare plan. This group is divided into three client sub-groups: Part B, Part C, and Part D. These groups receive medication benefits and may also receive assistance with health insurance premiums and medical out-of-pocket costs.
5. **PrEP-AP clients** are HIV-negative individuals who are at risk of HIV infection and who have chosen to take PrEP as a way to prevent infection. For insured clients, PrEP-AP pays for PrEP and PEP related medical out-of-pocket costs and covers the gap between what the client's insurance plan and the manufacturer's copayment assistance program pays towards medication costs. For uninsured clients, PrEP-AP only provides assistance with PrEP and PEP-related medical costs and medication costs for clients who are ineligible for a medication assistance program through a drug manufacture or other assistance programs.

As a covered entity in the Health Resources & Services Administration (HRSA) 340B Drug Pricing Program, ADAP collects rebates for most prescriptions purchased for ADAP clients. ADAP does not collect rebates for prescriptions purchased for Medi-Cal SOC or PrEP-AP clients. To prevent duplicate rebate discounts on the same claim, which is prohibited, ADAP does not invoice manufacturers for rebates on Medi-Cal SOC claims. As the primary payer, Medi-Cal has the right to claim mandatory rebate on prescriptions for Medi-Cal SOC clients. ADAP also does not collect rebate on medication purchases for PrEP-AP clients because PrEP-AP is separate and distinct from ADAP and is not a 340B covered entity.

Historically, most ADAP clients were medication-only clients without health insurance because PWH were unable to purchase affordable health insurance in the private marketplace. 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 to safeguard ADAP as the payer of last resort. Clients who enroll in full-scope Medi-Cal are disenrolled from ADAP because these clients have no SOC, no drug copays 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 copays for medications on the ADAP formulary.

Eligible clients with health insurance can also coenroll in ADAP's health insurance assistance programs for assistance with their insurance premiums and medical out-of-pocket costs, which can only be paid if ADAP pays the client's premium. Helping ADAP clients purchase and maintain comprehensive health insurance is more cost effective than paying the full cost of medications and improves health outcomes by providing access to the full spectrum of medical care beyond the HIV outpatient care and medications available through the HRSA Ryan White HIV/AIDS Program (RWHAP).

II. Stakeholder Engagement

OA conducts effective strategic stakeholder engagement across multiple efforts and programs. Through ongoing stakeholder engagement outlined below, CDPH will develop enhancements to ADAP and related programs in consultation with stakeholders and the Legislature, while ensuring that proposed activities are an eligible use of the ADAP Rebate Fund. Program enhancements will be proposed on an ongoing basis through the annual ADAP Estimate process.

Monthly Office of AIDS & Sexually Transmitted Diseases (STD)/Hepatitis Stakeholder Engagement Calls: Monthly stakeholder webinars are designed to engage OA stakeholders in providing program updates, share best practices among attendees, and provide specific presentation topics addressing HIV-related emerging issues. Required attendees include all funded Local Health Jurisdictions (LHJ), Community Based Organizations (CBO), the Ending the Epidemic (ETE) Coalition, and California Planning Group (CPG) members. Many CBOs are contracted as ADAP and/or PrEP-AP Enrollment Sites and provide enrollment services directly to clients. Stakeholders are invited to contribute agenda items and to discuss issues.

CPG (HIV, STD, Hepatitis C and Harm Reduction): OA's HIV Care Branch, HIV Prevention Branch, and the STD Control Branch (STDCB) collaborate in conducting all strategic community engagement activities of the statewide planning body consisting of HIV, STD, Hepatitis C and Harm Reduction. CPG, OA, and STDCB meet publicly in-person or virtually twice a year to conduct CPG business, discuss prevailing issues in the community, and to build capacity amongst the community members. Select ADAP staff serve as staff liaisons to the CPG and CPG feedback is solicited to inform ADAP policy and initiatives.

ADAP/PrEP-AP Stakeholder Engagement: The ADAP Branch Monthly Enrollment Worker Calls are conference calls designed to engage ADAP and PrEP-AP stakeholders in providing program updates, share best practices among attendees, and provide specific presentation topics relevant to ADAP and PrEP-AP programs. Required attendees include all ADAP and PrEP-AP Enrollment Workers. Enrollment Workers conduct enrollment services for ADAP and/or PrEP-AP at contracted enrollment sites, which include community-based non-profit organizations, clinics, medical providers, and case management service providers. The Monthly Enrollment Worker Calls include an open forum for Enrollment Workers to ask questions, voice concerns, and provide programmatic feedback, and suggestions.

ADAP facilitates two additional stakeholder bodies that inform ADAP and PrEP-AP programs and initiatives. The ADAP/PrEP-AP Enrollment Worker Advisory Committee (AEWAC) is comprised of ADAP and PrEP-AP Enrollment Workers from high volume enrollment sites who consult on matters of ADAP and PrEP-AP policy and accessibility of the programs for clients. The Medical Advisory Committee (MAC) advises on medications added to the ADAP Formulary and consists of health care professionals, and individuals with expertise and/or experience, that benefit the program and the population ADAP serves, including HIV-specialized physicians, pharmacists, psychiatrists, treatment advocacy representatives, and community representatives.

Following strategic stakeholder engagement across multiple efforts and programs, OA will propose expansions to ADAP and PrEP-AP that advance access to services through the ADAP Estimate via assumptions that are eligible uses of the ADAP Rebate Fund.

III. Estimate Methodology

The ADAP Estimate uses a Cost Per Client methodology to estimate expenditure and revenue associated with medication and insurance assistance services as they relate to changes in the volume of activity. This methodology looks at two input variables, the number of clients served and cost per service/expenditures per client, to calculate the estimated number of expenditures for service provided. Forecasts are modeled conservatively, with the objective of reducing the risk of underestimating budget needs.

A. Expenditure Forecasts

Program data describing client counts and costs per client are summarized by month and insurance coverage group and combined with external cost drivers which account for trends in current and historical program growth, changes in pharmacy utilization, administrative policies, and seasonal effects.

Separate estimates are created for each insurance coverage group and total projected costs are based on the following drivers:

- Expected number of clients served per month
- Expected cost per client per month

Total costs are estimated by multiplying the expected cost per client by the expected number of clients per month.

B. Revenue Forecasts

Revenue is estimated based on the results of the expenditure forecasts, historical rebate payment amounts, average time between medication dispense, and receipt of rebate payments.

Revenue is estimated by quarter to reflect manufacturer agreements and may be adjusted to reflect expected implementation of any newly negotiated voluntary rebate terms.

IV. Estimate Overview

The 2026-27 ADAP November Estimate provides revised projections of 2025-26 and 2026-27 Local Assistance costs for medication; health insurance premiums; medical out-of-pocket costs; administrative costs associated with pharmacy, insurance and medical benefits management services; and enrollment site payments. Total estimated budget authority needs for 2025-26 and 2026-27, below, include all assumptions.

Table 1 displays the estimated ADAP Local Assistance budget authority need for 2025-26 (column C) and 2026-27 (column G) and compares that need to the amount reflected in the 2025 Budget Act (columns B and F)¹.

- 2025-26: OA estimates the ADAP budget authority need will be \$444 million (\$340.6 million ADAP Rebate Fund (Fund 3080) and \$103.4 million Federal Trust Fund (Fund 0890)), which is \$42.7 million lower than reported in the 2025 Budget Act (Table 1). The 8.8 percent decrease is driven primarily by lower medication and insurance premium expenditures than previously estimated due to decreased caseload, and refinements to Health Trailer Bill components following the implementation of Assembly Bill (AB) 144 which makes funding available for state operations (reducing local assistance) (Table 8)².
- 2026-27: OA estimates the ADAP budget authority need will be \$443.7 million (\$340.3 million ADAP Rebate Fund (Fund 3080) and \$103.4 million Federal Trust Fund (Fund 0890)), which is \$43 million lower than reported in the 2025 Budget Act (Table 1). The 8.8 percent decrease is driven primarily by the expiration of one-time investments (Table 11)³.

Table 2 displays the estimated ADAP revenue for 2025-26 (column C) and 2026-27 (column G) and compares them to the amount reflected in the 2025 Budget Act (columns B and F).

- 2025-26: OA estimates ADAP revenue will be \$277.2 million (Table 2), \$35.5 million lower than reported in the 2025 Budget Act. The 11.4 percent

¹ Table 1 includes a \$75 million increase to the ADAP Rebate Fund expenditure authority associated with the Health Trailer Bill that was not included in the 2025-26 ADAP May Revision Estimate.

² Table 8 includes a \$75 million increase to the ADAP Rebate Fund expenditure authority associated with the Health Trailer Bill that was not included in the 2025-26 ADAP May Revision Estimate.

³ Table 11 includes a \$75 million increase to the ADAP Rebate Fund expenditure authority associated with the Health Trailer Bill that was not included in the 2025-26 ADAP May Revision Estimate.

decrease is driven primarily by lower medication expenditures due to decreased caseload that make up the projected revenue in FY 2025-26.

- 2026-27: OA estimates ADAP revenue will be \$326 million (Table 2), \$13.3 million higher than FY 2025-26 reported in the 2025 Budget Act. The 4.3 percent increase is driven primarily by increased rebates due to higher medication expenditures.

California Department of Public Health AIDS Drug Assistance Program and PrEP Assistance Program 2026-27 November Estimate Table 1: Local Assistance Budget Authority (In Thousands)								
Local Assistance	2025-26 Budget Act	Current Year 2025-26			2025-26 Budget Act	Budget Year 2026-27		
		November Estimate	\$ Change from Budget Act	% Change from Budget Act		November Estimate	\$ Change from Budget Act	% Change from Budget Act
(A)	(B)	(C)	(D) = (C)-(B)	(E) = (D)/(B)	(F)	(G)	(H) = (G)-(F)	(I) = (H)/(F)
Total Funds Requested	\$486,693	\$443,969	-\$42,725	-8.8%	\$486,693	\$443,657	-\$43,037	-8.8%
Federal Trust Fund - Fund 0890	\$110,263	\$103,389	-\$6,874	-6.2%	\$110,263	\$103,389	-\$6,874	-6.2%
ADAP Rebate Fund - Fund 3080	\$376,430	\$340,580	-\$35,850	-9.5%	\$376,430	\$340,268	-\$36,162	-9.6%
Caseload	36,744	28,318	-8,426	-22.9%	36,744	29,285	-7,459	-20.3%

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
ADAP Rebate Fund - Fund 3080 authority includes an ongoing \$2 million from the 2018 Budget Act.

2026-27 November Estimate Table 2: ADAP Rebate Fund (Fund 3080) Revenues (In Thousands)								
Revenue	2025-26 Budget Act	Current Year 2025-26			2025-26 Budget Act	Budget Year 2026-27		
		November Estimate	\$ Change from Budget Act	% Change from Budget Act		November Estimate	\$ Change from Budget Act	% Change from Budget Act
(A)	(B)	(C)	(D) = (C)-(B)	(E) = (D)/(B)	(F)	(G)	(H) = (G)-(F)	(I) = (H)/(F)
Total Revenue Requested	\$312,724	\$277,215	-\$35,510	-11.4%	\$312,724	\$326,020	\$13,296	4.3%
ADAP Rebate Fund - Fund 3080	\$294,636	\$263,795	-\$30,841	-10.5%	\$294,636	\$312,600	\$17,964	6.1%
Interest Income	\$18,088	\$13,420	-\$4,668	-25.8%	\$18,088	\$13,420	-\$4,668	-25.8%

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

V. Summary of Expenditures and Revenue

A. Expenditure Types

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

- a) Health care expenditures include prescription medication costs for drugs on the ADAP formulary (including deductibles, copays, and co-insurance), health insurance premiums, and medical out-of-pocket costs (e.g., deductibles and copays for physician visits, laboratory tests, etc.). Estimated variable expenditures by client group are shown in Table 3. A detailed display of caseload and expenditures by client group and service type is in Section VII, Tables 6 – 11.

b) Administrative expenditures include costs associated with pharmacy, insurance and medical benefits management services; and payments to local enrollment sites for services needed to enroll and maintain clients in the programs. Administrative expenditure estimates are adjusted annually through the ADAP Estimate, based on caseload and service type projections. Estimated variable expenditures for administrative services are also shown in Table 3.

TABLE 3: ESTIMATED VARIABLE EXPENDITURES BY CLIENT GROUP		
CLIENT GROUP	EXPENDITURES	
	FY 2025-26	FY 2026-27
Medication-only	\$205,461,242	\$232,250,082
Medi-Cal SOC	\$1,852,721	\$2,432,939
Private Insurance	\$119,272,630	\$134,829,338
Medicare	\$16,557,967	\$21,072,630
PrEP-AP	\$22,894,726	\$28,503,676
SUBTOTAL	\$366,039,286	\$419,088,666
Admin: ADAP	\$5,173,857	\$5,691,243
Admin: PrEP-AP	\$5,418,898	\$5,487,001
Admin: Enrollment Sites	\$7,734,000	\$8,232,500
Health Management Systems (HMS)	-\$14,000,000	-\$14,000,000
Health Trailer Bill	\$71,602,636	\$17,157,364
TOTAL	\$441,968,676	\$441,656,774
Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.		

B. Revenue and Federal Grants

a) ADAP Special Funds – ADAP receives both mandatory and voluntary supplemental rebates from drug manufacturers for ADAP medication expenditures. An approximate six-month delay in receipt of rebate revenue, from the time the medication expenditure occurs, exists because of the time required for billing the drug manufacturers. 2025-26 revenue projections are based on estimated rebates from actual and estimated medication expenditures from January through December 2025. 2026-27 revenue projections are based on estimated rebates from estimated medication expenditures from January through December 2026.

b) Federal Funds – ADAP receives federal funds from HRSA through the Ryan White Part B Program.

- 2025-26: Total federal fund budget authority is projected to be \$103.4 million (Table 1), \$6.9 million (6.2%) lower than reported in the 2025 Budget Act. Federal fund budget authority includes the following federal grant assumptions:
 - 2025 Ryan White Part B: \$95.1 million

- 2025 Ryan White Part B Supplemental: \$3.6 million
- 2025 ADAP Emergency Relief Funds (ADAP Shortfall Relief): \$4.7 million
- 2024 Ryan White Part B Carryover: \$0

- 2026-27: Total federal fund budget authority is projected to be \$103.4 million (Table 1), \$6.9 million (6.2%) lower than reported in the 2025 Budget Act. Federal fund budget authority includes the following estimated federal grant funding:
 - 2026 Ryan White Part B: \$95.1 million
 - 2026 Ryan White Part B Supplemental: \$3.6 million
 - 2026 ADAP Emergency Relief Funds (ADAP Shortfall Relief): \$4.7 million

- c) Federal Match – HRSA requires grantees to have HIV-related non-HRSA expenditures. OA meets the match requirement using ADAP Rebate Fund (Fund 3080) expenditures. California's HRSA match requirement for the 2025 Ryan White Part B grant budget period (April 1, 2025, through March 31, 2026) is \$69.7 million.

VI. Assumptions

Future Fiscal Issue

Enhanced Premium Tax Credit Expiring

Background: Changes made to premium tax credits in the American Rescue Plan of 2021, and extended by the Inflation Reduction Act of 2022, have assisted individuals in purchasing health insurance through ACA marketplaces such as Covered California. The enhanced premium tax credits led to a surge in ACA marketplace insurance sign-ups and helped achieve historically low rates of uninsured individuals. However, the enhanced premium tax credits will end after 2025 unless extended by Congress, preventing adverse effects on marketplace enrollment as insurers and regulators require time to adjust premium rates. If Congress does not extend the enhanced premium tax credits, most marketplace enrollees across all states will experience a considerable increase in premium expenses.

Description of Change: As of early fall 2025, it remains unknown if Congress will extend the enhanced premium tax credits starting in January 2026. If Congress does not extend the enhanced premium tax credits, ADAP can expect to pay higher premiums for clients concurrently enrolled in the OA Health Insurance Premium Payment Program (OA-HIPP) and a Covered California health plan, effective January 2026. In addition, the fund source has been corrected from the 2025-26 May Revision to reflect a fiscal impact to ADAP Rebate Fund (Fund 3080) only.

Discretionary: No

Reason for Change/Adjustment:

- Federal requirement
- Enhanced premium tax credits set to expire after 2025
- ADAP can expect to pay higher premiums for clients co-enrolled in OA-HIPP and Covered California

Fiscal Impact and Fund Source: The fiscal impact is currently unknown. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Transition from Medi-Cal to ADAP or PrEP-AP, as a result of Medi-Cal's Premiums for Undocumented Clients

Background: In recent years, the Medi-Cal program has undergone significant expansions, primarily driven by the ACA and state-led initiatives. These expansions have extended full scope Medi-Cal eligibility to undocumented

children, young adults, and older adults over age 50. This reduced the ADAP and PrEP-AP caseload and program costs by transitioning eligible clients to Medi-Cal, ensuring ADAP and PrEP-AP remain the payers of last resort. As a result, undocumented individuals who applied for ADAP or PrEP-AP and qualified for full scope Medi-Cal were referred to Medi-Cal during enrollment screening.

Description of Change: The recent Medi-Cal expansions are set to be reversed due to AB 116 (Chapter 21, Statutes of 2025, Section 75). AB 116 adds subdivision (j) to WIC Section 14007.8, which introduces significant changes to Medi-Cal premiums for individuals with undocumented immigration status no sooner than July 1, 2026. Per DHCS, starting July 1, 2027, undocumented individuals aged 19 to 59 must pay a \$30 per-month premium to keep full scope Medi-Cal. Those who are required to pay this premium will also be eligible for ADAP or PrEP-AP as they are not fully covered by Medi-Cal. OA anticipates that eligible clients may instead prefer to transition to the respective programs, ADAP or PrEP-AP, as a result of Medi-Cal charging for premiums.

Discretionary: No

Reason for Change/Adjustment:

- Statutory requirement

Fiscal Impact and Fund Source: The fiscal impact is currently unknown. The funds impacted are the ADAP Rebate Fund (Fund 3080) and the Federal Trust Fund (Fund 0890).

New Assumptions

AB 116, Section 118: Support Current or Eligible Services and Programs

Background: On April 2, 2025, the ETE Coalition, comprised of community-based advocates, raised concerns of decisions at the federal level to terminate funding to CDPH, and requested use of the ADAP Rebate Fund (Fund 3080) to: support efforts related to HIV, including HIV prevention; continue funding the STD Disease Intervention Specialist (DIS); and support efforts related to minimizing HIV-Hepatitis C Virus (HCV) coinfection.

On June 30, 2025, AB 116 (Chapter 21, Statutes of 2025, Section 118) authorized CDPH to spend up to \$75 million from the ADAP Rebate Fund (Fund 3080) to support current or eligible services and programs, consistent with Sections 120955, 120956, 120960, 120972, 120972.1, and 120972.2 of the Health and Safety Code (HSC), beginning July 1, 2025:

- up to \$65 million to supplement or fund Centers for Disease Control and Prevention (CDC) PS-24-0047: High-Impact HIV Prevention and Surveillance Programs for Health Departments activities which have been reduced or eliminated.
- \$9 million to fund state and local DIS for the last six months of FY 2025-26 to develop, train, and sustain the DIS workforce and address jurisdictional prevention and response needs for sexually transmitted infections (STIs), HIV, HCV, and mpox. The funding is intended to scale prevention, increase capacity to conduct disease investigation, ensure appropriate treatment, link people to care and ongoing case management, monitor disease trends and rapidly respond to changes in disease trends and outbreaks of STIs, HIV, HCV, and mpox or other emerging sexually transmissible diseases.
- \$1 million to purchase rapid HCV testing equipment for distribution to local health departments and community-based organizations.

Description of Change: On September 17, 2025, AB 144 (Chapter 105, Statutes of 2025) modified AB 116, making up to \$18 million of the above-described \$65 million available for state operations (allowing \$47 million for local assistance); and \$1.6 million of the above-described \$9 million available for state operations (allowing \$7.4 million for local assistance).

Discretionary: No

Reason for Change/Adjustment:

- Statutory requirement

Fiscal Impact and Fund Source: For 2025-26, the fiscal impact is \$55.4 million (\$75 million total allocation minus \$19.6 million allocated in State Operations). There is no fiscal impact for 2026-27. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Condom Availability Program (CAP)

Background: Senate Bill (SB) 159 (Chapter 40, Statutes of 2024, Section 83), subdivision (a), paragraph (8) authorized an allocation of \$5 million in FY 2024-25, available until June 30, 2027, to distribute funding to a community-based organization to make internal and external condoms available, pursuant to Section 35292.7 of the Education Code, if SB 954 (Menjivar, 2024) became effective, aimed at preventing the transmission of HIV and sexually transmitted infections as part of the Early Action Package approved in the Budget Act of 2024. SB 954 (Menjivar, 2024) was vetoed by the Governor on September 25, 2024.

Description of Change: On June 30, 2025, AB 116 (Chapter 21, Statutes of 2025, Section 116) amended Chapter 40, Statutes of 2024, Section 83 by deleting the requirement of SB 954 (Menjivar, Vetoed, 2024) to be effective in order to allocate the funding, and by extending the availability of the funding one year, to June 30, 2028. Funding allocation remains authorized as of FY 2025-26.

Discretionary: No

Reason for Adjustment/ Change:

- Legislative requirement

Fiscal Impact and Fund Source(s): For 2025-26, the fiscal impact is \$2 million. For 2026-27, the fiscal impact is \$3 million. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Medi-Cal Asset Test Reinstated

Background: Due to the passage of AB 133 (Chapter 143, Statutes of 2021), the Medi-Cal asset test for Non-Modified Adjusted Gross Income (Non-MAGI) Medi-Cal programs was eliminated in a two-phase approach. On July 1, 2022, as part of phase one, DHCS increased the asset limit for Non-MAGI Medi-Cal programs to \$130,000 per individual and \$65,000 for each additional household member. On January 1, 2024, as part of phase two, the asset test was eliminated entirely. This primarily affects seniors and people with disabilities, allowing more applicants to qualify for Medi-Cal benefits and enabling current beneficiaries to retain more non-exempt assets.

Description of Change: On June 30, 2025, AB 116 (Chapter 21, Statutes of 2025, Section 59) added Section 14005.62 to the WIC to reinstate an asset test for Non-MAGI Medi-Cal programs. This section introduces a disregard of \$130,000 in nonexempt property for single-member households and \$65,000 for each additional member, up to 10 members. The reinstatement shall become operative on January 1, 2026. OA anticipates that individuals who become ineligible for Medi-Cal due to the reinstatement of the asset test will transition to the respective programs, ADAP or PrEP-AP.

Discretionary: No

Reason for Adjustment/ Change:

- Statutory requirement

Fiscal Impact and Fund Source(s): For 2025-26, the estimated fiscal impact to ADAP is \$647,000 (no rebate in 2025-26 due to the six-month delay in receipt of rebate following the January 2026 implementation) for 42 ADAP clients. For 2026-

27, the estimated net fiscal impact to ADAP is \$2.7 million (\$4.3 million expenditures minus \$1.6 million rebate) for 115 ADAP clients. The funds impacted are the ADAP Rebate Fund (Fund 3080) and the Federal Trust Fund (Fund 0890).

For 2025-26, the estimated fiscal impact to PrEP-AP is \$28,000 for six PrEP-AP clients. For 2026-27, the estimated fiscal impact to PrEP-AP is \$187,000 for 18 PrEP-AP clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Medi-Cal Enrollment Ceased for New Individuals with Undocumented Immigration Status, ages 19 and older

Background: In recent years, the Medi-Cal program has undergone significant expansions, primarily driven by the ACA and state-led initiatives. These expansions have extended full scope Medi-Cal eligibility to undocumented children, young adults, and older adults over age 50. This reduced ADAP and PrEP-AP caseload and program costs by transitioning eligible clients to Medi-Cal, ensuring ADAP and PrEP-AP remain the payers of last resort. As a result, undocumented individuals who applied for ADAP or PrEP-AP and qualified for full scope Medi-Cal were referred to Medi-Cal during enrollment screening.

Description of Change: The recent Medi-Cal expansions are set to be reversed due to AB 116 (Chapter 21, Statutes of 2025, Section 75), which amends WIC Section 14007.8, subdivisions (b) and (c). AB 116 introduces significant changes to Medi-Cal enrollment for individuals with undocumented immigration status no sooner than January 1, 2026. Starting January 1, 2026, Medi-Cal enrollment for undocumented individuals aged 19 and older will cease and no new undocumented individuals in this age group will be able to enroll in Medi-Cal after this date. OA anticipates that individuals who are ineligible for Medi-Cal due to their immigration status will transition to the respective programs, ADAP or PrEP-AP.

Discretionary: No

Reason for Adjustment/ Change:

- Statutory requirement

Fiscal Impact and Fund Source(s): For 2025-26, the estimated fiscal impact to ADAP is \$1.7 million (no rebate in 2025-26 due to the six-month delay in receipt of rebate following the January 2026 implementation) for 112 ADAP clients. For 2026-27, the estimated net fiscal impact to ADAP is \$7.4 million (\$11.6 million expenditures minus \$4.2 million rebate) for 308 ADAP clients. The funds impacted are the ADAP Rebate Fund (Fund 3080) and the Federal Trust Fund (Fund 0890).

For 2025-26, the estimated fiscal impact to PrEP-AP is \$76,000 for 17 PrEP-AP clients. For 2026-27, the estimated fiscal impact to PrEP-AP is \$503,000 for 49 PrEP-AP clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Deferred Action for Childhood Arrivals (DACA) Recipients No Longer Eligible for Covered California

Background: Prior to November 1, 2024, DACA recipients were generally excluded from purchasing health insurance through the ACA Marketplace and accessing related subsidies. However, a rule change that became effective on November 1, 2024, classified DACA recipients as "lawfully present" for the purposes of health coverage, allowing them to purchase plans through the ACA Marketplace such as Covered California and, if eligible, receive premium tax credits and cost-sharing reductions to make coverage more affordable.

Description of Change: As of June 2025, people with DACA status are no longer eligible to get health insurance through Covered California due to new federal rules. Those covered through Covered California were able to receive medical services under their plan through August 2025. OA anticipates that individuals who are ineligible for Covered California due to their immigration status will transition to becoming ADAP only clients or will remain as a Private Insured ADAP client, but will have insurance through an off-exchange plan rather than an on-exchange plan.

Discretionary: No

Reason for Adjustment/ Change:

- Federal requirement

Fiscal Impact and Fund Source(s): For 2025-26, the estimated net fiscal impact is \$51,000 (\$70,000 expenditures minus \$19,000 rebate) for 10 clients. For 2026-27, the estimated net fiscal impact is \$5,000 (\$238,000 expenditures minus \$233,000 rebate) for 14 clients. The funds impacted are the ADAP Rebate Fund (Fund 3080) and the Federal Trust Fund (Fund 0890).

Decrease in Federal Funds: 2025 Ryan White Part B Supplemental

Background: The HRSA Ryan White Part B Supplemental grant develops and/or enhances access to a comprehensive continuum of high-quality care and treatment services for low-income individuals living with HIV. The amount of each award is based on submitted data demonstrating the severity of the HIV epidemic in the applicant's state/territory, comorbidities, cost of care, and service needs of emerging populations.

The following table displays historical application amounts for which OA applied, total funds awarded per grant budget period, and total ADAP Local Assistance received per grant budget period.

Table 4: Ryan White Part B Supplemental Funds			
Grant Budget Period	Application Amount	Total Funds Awarded	Total Local Assistance
2021 (09/30/2021 – 09/29/2022)	\$9,000,000	\$1,941,558	\$1,916,558
2022 (09/30/2022 – 09/29/2023)	\$9,000,000	\$2,250,912	\$2,250,912
2023 (09/30/2023 – 09/29/2024)	\$9,000,000	\$5,337,315	\$5,337,315
2024 (09/30/2024 – 09/29/2025)	\$9,000,000	\$9,000,000	\$9,000,000
2025 (09/30/2025 – 09/29/2026)	\$9,000,000	\$3,616,421	\$3,616,421

Description of Change: On March 13, 2025, OA applied for the competitive 2025 Ryan White Part B Supplemental grant. OA requested the maximum amount of \$9 million, all of which is designated for ADAP Local Assistance. On September 16, 2025, OA received the Notice of Award for the 2025 Ryan White Part B Supplemental grant in the amount of \$3.6 million, all of which is ADAP Local Assistance.

Discretionary: Yes

Reason for Change/Adjustment:

- Competitive funding opportunity
- Prior funding does not guarantee funding will be provided in the future

Fiscal Impact and Fund Source: Decrease of \$5.4 million in Local Assistance for 2025-26 and 2026-27. The fund impacted is the Federal Trust Fund (Fund 0890). Decreases in federal funding result in the fiscal impact being absorbed by the ADAP Rebate Fund (Fund 3080).

Non-receipt of Federal Funds: 2024 Ryan White Part B Grant Carryover

Background: The HRSA Ryan White Part B grant is a non-competitive grant and the largest of the three federal grants for which ADAP receives funding. Grant funding is appropriated in five, 12-month grant budget periods that run from April 1 to March 31. Within the five-year funding cycle, funding from year to year is provided if the program remains eligible and submits all reporting requirements in a timely manner. Funding from the Ryan White Part B grant that is not fully expended by the end of the budget period can be carried over to the next budget period with approval from HRSA.

Description of Change: At the end of August 2025, OA closed out the 2024 Ryan White Part B grant with HRSA. Upon closure of the grant, the amount of unobligated funding from the 2024 grant budget period (April 1, 2024, through March 31, 2025) was determined, for which the ADAP Branch applied. The request for HRSA approval was due at the end of August 2025. On August 28, 2025, OA was informed that HRSA disapproved the application for carryover funding of unobligated funds.

Discretionary: Yes

Reason for Change/Adjustment:

- Fully leverage federal funding

Fiscal Impact and Fund Source: There is no award for 2025-26. The fund impacted is the Federal Trust Fund (Fund 0890). Non-receipt of federal funding results in the fiscal impact being absorbed by the ADAP Rebate Fund (Fund 3080).

Existing Assumptions

ADAP Open Formulary

Background: ADAP's mission is to provide HIV-related prescription drugs to low-income PWH who have limited or no prescription drug coverage. ADAP directly pays for the cost of medications that are covered on the [California ADAP formulary](https://cdph.primetherapeutics.com/cms/cdph/static-assets/documents/formulary-and-documents/CDPH_Formulary.pdf) (https://cdph.primetherapeutics.com/cms/cdph/static-assets/documents/formulary-and-documents/CDPH_Formulary.pdf) for people who only have ADAP coverage and pays for the copay for these medications for people who have primary comprehensive insurance (e.g., Covered California or Medicare). In the 1990s, the focus of ADAP was to pay for expensive HIV antiretroviral (ARV) medications to keep people alive. As HIV treatments have improved, PWH are living longer and healthier lives.

Medical needs have also shifted from a need to treat opportunistic infections that occur without HIV treatment to a need to treat medical conditions (e.g., high cholesterol) that are common in people as they age. Now 55.7 percent of PWH in California are 50 years of age or older and 15.6 percent are 65 years of age or older. As PWH have aged, their number of comorbid medical conditions has increased exponentially with a resultant need for additional medications to treat these additional medical conditions (e.g., diabetes, hypertension, hypothyroidism).

ADAP currently has a closed formulary meaning that medications are added one at a time after a review of the cost implications, approval from the CDPH Director, and approval in an annual estimate if the cost is significant. This model leads to a

restrictive, basic level of coverage and the current ADAP formulary has 348 medications (including 47 HIV ARV medications). By contrast, an open formulary covers all FDA-approved medications except for medications that have been specifically excluded from the formulary (usually due to high cost or safety issues).

Medi-Cal is an example of an open formulary as all FDA-approved drugs are added to the formulary and Medi-Cal decides which drugs to exclude from coverage. To quantify the difference in these formularies, the ADAP formulary is less than 20 pages long and the Medi-Cal formulary is more than 250 pages long. Many PWH move between Medi-Cal and ADAP depending on year-to-year changes in their income and life circumstances and these drastic differences in medication coverage leads to interruptions and undertreatment of common but serious medical conditions.

Thirteen states, including Illinois, Maryland, New Jersey, Washington, and Oregon, have already expanded their ADAP to an open formulary to help PWH in their states live longer and healthier lives. OA engaged in conversations with these states and determined that a shift to an open formulary is feasible for California's ADAP for three reasons:

1. These states report that, even with their expansion to an open formulary, HIV ARV medications still account for most of the cost to the program. The amount of rebate generated from ARV medications has covered the cost of other medications in their open formularies.
2. People with high medication needs are also highly motivated to navigate to comprehensive insurance in which case ADAP only pays for copays on their medications. People with multiple comorbidities also require specialist medical appointments, diagnostic studies, and procedures that can only be paid for with comprehensive insurance.
3. These open ADAP formularies exclude the most expensive medications such as tumor necrosis factor (TNF)-alpha blockers, monoclonal antibodies, and recombinant human growth hormone. With the most expensive (non-HIV) medications excluded, these formularies can add access to a very wide range of medications within their allocated budgets.

In addition to the drugs listed in (3.), examples of highest cost medications that would be excluded are: botulinum toxin; compounded medications for infusion; gonadotropin; hyaluronic acid derivatives; synthetic growth hormone; antirheumatic antimetabolites; cosmetic medications; durable medical equipment; erectile dysfunction medications; female sexual dysfunction medications; fertility drugs; herbal medications; injectable muscle relaxants; nutrition supplements; vaccines/immunizing biologicals; weight loss medications; schedule II, III, IV and V controlled substances.

California has always been a leader in access to healthcare and HIV treatment. Opening the [ADAP formulary to mirror the DHCS Medi-Cal formulary](https://medicalrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal_Rx_Contract_Drugs_List_FINAL.pdf) (https://medicalrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal_Rx_Contract_Drugs_List_FINAL.pdf) will be another step toward healthier lives and improved health equity for PWH in California.

As communicated in the 2025-26 November Estimate, SB 159 (Chapter 40, Statutes of 2024, Section 83) authorized CDPH to implement certain program enhancements, consistent with HSC Sections 120955, 120956, 120960, 120972, 120972.1, and 120972.2, to the extent that these activities are an allowable use of the ADAP Rebate Fund (Fund 3080). This included modifications to the ADAP formulary (from a closed to an open formulary) that were to begin January 1, 2025, or as soon as technically feasible thereafter. To provide sufficient time for discovery, coordination with ADAP's contractors, and seamless program implementation, ADAP identified FY 2025-26 as technically feasible. Following the FY 2025-26 implementation, the fiscal impact of changing to an open formulary will be ongoing and closely monitored as it is anticipated to result in an increase in expenditures.

Observations of decreasing ADAP client counts subsequently decreased the number of clients that would have access to more drugs from an open formulary. As such, the 2025-26 May Revision client count and cost per client data was refined and reflected a decrease in expenditures compared to the 2025-26 November Estimate.

Description of Change: There is a slight delay in implementation due to processing timeframes for contracting with the pharmacy benefits manager. Implementation is anticipated early January 2026. The 2026-27 November Estimate cost and client count data have been refined to reflect a decrease from the 2025-26 May Revision.

Discretionary: No

Reason for Adjustment/ Change:

- Legislative requirement
- Ensure access for PWH to medications needed to treat common medical conditions that develop with aging (e.g., diabetes, hypertension, hypothyroidism)
- Align California's ADAP benefits with the level of medication coverage in other states
- Reduce treatment interruptions and undertreatment of common but serious medical conditions for PWH during transitions between Medi-Cal and ADAP

- Provide comprehensive approaches to chronic health to improve patient adherence and overall health outcomes

Fiscal Impact and Fund Source(s): For 2025-26, the estimated net fiscal impact is \$6.5 million (receipt of rebate is delayed in conjunction with the delay in contract implementation) for 6,380 clients. For 2026-27, the estimated net fiscal impact is \$10.2 million (\$13 million expenditures minus \$2.8 million rebate) for 12,481 clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Early Action Package: Annual Allocation for Three Years beginning July 1, 2024

Background: SB 159 (Chapter 40, Statutes of 2024, Section 83) authorized CDPH to spend up to \$23 million from the ADAP Rebate Fund (Fund 3080) to implement various program enhancements, consistent with HSC Sections 120955, 120956, 120960, 120972, 120972.1, and 120972.2, to the extent that these activities are an allowable use of the ADAP Rebate Fund (Fund 3080), as part of the Early Action Package approved in the Budget Act of 2024.

Per SB 159, a portion of the \$23 million would fund Section 83. (a)(5), Harm Reduction Supply Clearinghouse, to fund HIV prevention supplies to California syringe access programs for three years beginning July 1, 2024.

Description of Change: In FY 2024-25, \$1.6 million of the \$10 million allocation was expended, leaving \$8.4 million unspent. The unspent funds will be split into two allocations of \$4.2 million and carried over to be spent in conjunction with the \$10 million allocated for FY 2025-26 and the \$10 million allocated for FY 2026-27.

Discretionary: No

Reason for Adjustment/ Change:

- Legislative requirement

Fiscal Impact and Fund Source(s): For 2025-26, the fiscal impact is \$14.2 million. For 2026-27, the fiscal impact is \$14.2 million. The fund impacted is the ADAP Rebate Fund (Fund 3080).

ADAP Pilot Program for Jails

Background: Prior to 2008, 36 local county jails participated in ADAP to provide medication assistance to qualifying detainees. The program was terminated in 2008 due to the elimination of funding from the State's General Fund. Subsequently, in 2018, HRSA released Policy Clarification Notice (PCN) 18-02, which permitted the use of HRSA funds for individuals who are detained in a county jail and are not yet convicted of a crime or are not covered by federal or

state health benefits. After the PCN release, Orange County asked CDPH to provide ADAP services at their county jail.

Providing ADAP services to jail detainees expands outreach to a vulnerable population while supporting continuity of care for those navigating the judicial system. Incarcerated clients who meet ADAP eligibility requirements can enroll in ADAP with the help of a certified enrollment worker from the county jail, which must be approved as an enrollment site. New and existing clients can access medication(s) at the jail pharmacy, thus maximizing potential adherence to medicinal regimens. Additionally, the jail pharmacy can provide a prescription refill to clients scheduled for release, so that the client has a supply of medication available until they can access ADAP services through a community enrollment site.

In response to Orange County's request, OA initiated a pilot program in FY 2021-22 with the Orange County jail. OA, in consultation with the Department of Finance, is expanding the pilot program to other interested county jails after careful consideration of the impact to the ADAP Rebate Fund (Fund 3080), both in the short and long term.

OA met with the other interested county jails in the summer of 2022 to understand how they address the transitional needs of PWH who have been incarcerated. OA determined whether each respective jail would be a suitable ADAP jail enrollment site. Prior to becoming an enrollment site, interested county jails will need to submit a new Enrollment Site Application, begin the contracting process with OA, be added to the Pharmacy Benefits Manager Pharmacy Network, and complete the new enrollment worker training. Clients will not be enrolled until a contract is in place and the enrollment worker training is completed.

The 2022-23 May Revision approved seven counties which expressed interest: Orange, Los Angeles, Marin, Riverside, San Francisco, San Luis Obispo, and Siskiyou. With a contract in place with Orange County, OA continued to conduct outreach to the remaining six counties.

The 2023-24 November Estimate approved addition of three interested counties in conjunction with the seven aforementioned counties: San Bernardino, San Joaquin, and Tuolumne. Additional funding was requested in FY 2022-23 for the seven counties, and for both the original seven counties and additional three (ten counties total) in FY 2023-24 following updated information from the counties.

With Orange County's contract in place since FY 2021-22, outreach efforts continued for five remaining counties (Los Angeles, Riverside, San Francisco, San Joaquin, and Tuolumne); four counties withdrew interest (Marin,

San Bernardino, San Luis Obispo, and Siskiyou). As contracts for the remaining counties were not anticipated to be executed until July 2023, the FY 2022-23 fiscal impact decreased from the 2023-24 November Estimate, reflecting only Orange County expenditures in the 2023-24 May Revision. The FY 2023-24 fiscal impact reflected six counties total which, due to updated county interest and client count data, decreased in the 2023-24 May Revision compared to the 2023-24 November Estimate.

On July 1, 2023, the ADAP enrollment site contract for San Joaquin County was executed. Los Angeles, Riverside, and San Francisco counties submitted enrollment site applications and proceeded with the contract process. Tuolumne County, the last of the previously approved interested counties, anticipated submitting a completed ADAP enrollment site application after conclusion of internal discussions and prior to the fall of 2023.

Following the end of the Public Health Emergency, ADAP resumed pre-COVID-19 outreach efforts to the remaining 48 counties for renewed interests in the pilot program and a FY 2024-25 implementation. A total of 25 counties responded to ADAP's outreach. Four of the 25 counties confirmed interest in becoming an ADAP enrollment site, the fiscal impact of which was included in FY 2024-25: Contra Costa, Sacramento, San Mateo, and Tulare. The remaining 21 counties confirmed they were not interested or unable to participate at that time.

As communicated in the 2024-25 May Revision, outreach efforts continued with Contra Costa, Sacramento, San Mateo, Tulare, and Tuolumne counties; these five counties remained interested but had not submitted ADAP enrollment site applications. No new counties were on record as having expressed interest in becoming ADAP enrollment sites. The 2024-25 May Revision reflected a decrease in projected clients following receipt of a few months of actual client data, subsequently decreasing projected expenditures compared to the 2024-25 November Estimate.

The 2025-26 November Estimate communicated that five counties withdrew interest or were unable to participate in the pilot program for FY 2024-25: Contra Costa, San Mateo, Sacramento, Tulare, and Tuolumne. Four counties had approved enrollment site locations and OA continued outreach to encourage enrollment and provide training: Los Angeles, Riverside, San Francisco, and San Joaquin. Orange County remained the only active enrollment site with clients enrolled. Compared to the 2024-25 May Revision, the 2025-26 November Estimate projected a decrease in projected expenditures.

Orange County continues to enroll clients into ADAP. San Joaquin County began enrolling clients into ADAP in July 2024. San Francisco and Riverside counties, while having approved enrollment sites, had not designated staff to complete

training to begin enrolling clients. Enrollment could begin once training is completed. Los Angeles County's enrollment site contract required updated signatures, causing a slight delay in client enrollment. The 2025-26 May Revision client count and cost per client data was refined and reflected a decrease in FY 2024-25 expenditures, and an increase in FY 2025-26 expenditures, compared to the 2025-26 November Estimate.

Description of Change: There is no change to Orange or San Joaquin counties. The Los Angeles County contract was executed and they began enrolling clients in July 2025. San Francisco and Riverside counties remain as approved enrollment sites without designated staff to begin enrolling clients. Sacramento and Trinity counties expressed interest in joining the pilot program as part of the 2026-27 November Estimate. A contract needs to be executed before they can start enrolling, therefore a fiscal impact to ADAP Rebate Fund (Fund 3080) is not anticipated until FY 2026-27.

Discretionary: Yes

Reason for Adjustment/Change:

- HRSA PCN 18-02, which permits the use of funds for individuals who are currently detained in a county jail
- Treatment and suppression of HIV/AIDS and HIV/AIDS-related opportunistic infections among high-risk individuals
- Effective outreach to underserved populations
- Continuity of care

Fiscal Impact and Fund Source(s): For 2025-26, the estimated net fiscal impact of the five approved pilot counties (Orange, Los Angeles, Riverside, San Francisco, and San Joaquin) with staggered implementations is \$5.1 million (\$7.9 million expenditures minus \$2.8 million rebate) for 663 eligible clients. For 2026-27, the estimated net fiscal impact of the five approved pilot counties plus the two new counties (Sacramento and Trinity) is \$6.6 million (\$14.1 million expenditures minus \$7.5 million rebate) for 1,023 eligible clients. The funds impacted are the ADAP Rebate Fund (Fund 3080) and Federal Trust Fund (Fund 0890).

Full Scope Medi-Cal Coverage for Justice Involved Individuals

Background: On January 26, 2023, California became the first state in the nation to be approved to offer a targeted set of Medicaid (Medi-Cal in California) services to youth and adults in state prisons, county jails, and youth correctional facilities for up to 90 days prior to release. Currently, Medi-Cal services are generally available only after release from incarceration. Through a federal Medicaid 1115 demonstration waiver, DHCS will establish a coordinated community reentry process that will assist people leaving incarceration to

connect to the physical and behavioral health services they need upon release. As codified by AB 133 (Chapter 143, Statutes of 2021), the California Advancing and Innovating Medi-Cal (CalAIM) Initiative's pre-release eligibility and enrollment went live on January 1, 2023, and will help ensure that, if determined eligible, all incarcerated adults and youths within County Correctional Facilities and County Youth Correctional Facilities have access to needed Medi-Cal services upon their re-entry into the community.

Historically, Californians in prisons, jails, and juvenile detention facilities have difficulty accessing health care services after they have been released and are transitioning back into their communities, including PWH. As outlined in Penal Code Section 4011.11, the board of supervisors, in consultation with the county sheriff and chief probation officer, respectively, shall designate an entity or entities to assist both county jail inmates and juvenile inmates with the application process for health insurance affordability programs consistent with federal requirements. AB 133 allows jails to help connect an individual to a community-based Medi-Cal provider 90 days prior to their release to ensure they can continue care and treatment once returning to the community. Each county is expected to implement at different points in time as they work with Medi-Cal to create an implementation plan for Medi-Cal services within their respective county jails. Starting no sooner than April 2024, individuals would be able to receive up to 90 days of Medi-Cal coverage prior to being released from a public institution, including medication coverage.

Through ADAP's Pilot Program for Jails, ADAP provides medication assistance to qualifying detainees at local county jails. ADAP does not provide services for individuals incarcerated in youth correctional facilities or adults in state prisons. Individuals enrolled in ADAP's Pilot Program for Jails who are due to be released from jail may be enrolled into Medi-Cal pre-release services 90 days prior to release, if eligible. At the time, ADAP's pilot program was only implemented in Orange and San Joaquin counties.

Individuals who are granted pre-release services will be disenrolled from ADAP by their Enrollment Worker to safeguard ADAP as the payer of last resort. ADAP will back-bill Medi-Cal for dual enrolled clients via the established Medi-Cal Eligibility Data System (MEDS) match process. OA anticipates a gradual uptake of ADAP clients found on the MEDS match which will result in cost savings for ADAP as Medi-Cal will be back-billed for these services.

On December 8, 2023, OA was informed that DHCS pre-release services commencing April 1, 2024, were postponed until October 1, 2024. Then, each correctional facility would have a two-year period to implement the 90-day pre-release services, between October 1, 2024, and September 20, 2026. Due to the postponed implementation, the 2024-25 May Revision reflected a decrease in

projected clients, subsequently decreasing projected savings compared to the 2024-25 November Estimate.

The 2025-26 November Estimate client count and cost per client data was refined and reflected a decrease compared to the 2024-25 May Revision.

OA was informed that several counties across California started implementing DHCS pre-release services; however, this assumption focuses on the select counties set to participate in the ADAP Pilot Program for Jails (Los Angeles Orange, Riverside, San Francisco, and San Joaquin). Of those counties, San Joaquin implemented pre-release services in January 2025, and Orange was scheduled to implement pre-release services in April 2025. The 2025-26 May Revision client count and cost per client data was refined and reflected a decrease in expenditures compared to the 2025-26 November Estimate.

Description of Change: OA received clarification that Orange County did not implement pre-release services in April 2025, as anticipated in the 2025-26 May Revision. Subsequently, Orange County does not yet have a go-live date to implement pre-release services. San Francisco County went live in April 2025. The 2026-27 November Estimate client count and cost per client data was refined to reflect fewer clients enrolled than initially projected in the 2025-26 May Revision following receipt of the first months of actuals. Los Angeles and Riverside counties are anticipated to go live in October 2026. In addition, Sacramento and Trinity counties have expressed interest in participating in the ADAP Pilot Program for Jails. Their implementation of pre-release services will be monitored.

Discretionary: No

Reason for Adjustment/Change:

- Federal Medicaid 1115 demonstration waiver
- Legislative requirement

Fiscal Impact and Fund Source(s): For 2025-26, the estimated savings is \$1.3 million (no rebate following receipt of the first months of actuals) for 105 clients. For 2026-27, the estimated net savings is \$5.8 million (\$9.3 million savings minus \$3.5 million decrease in rebate) for 672 clients. The funds impacted are the ADAP Rebate Fund (Fund 3080) and Federal Trust Fund (Fund 0890).

PrEP Medication: Lenacapavir

Background: Lenacapavir (Sunlenca) is an HIV capsid inhibitor that was developed as a long-acting injectable ARV treatment. Lenacapavir is administered via subcutaneous injection every six months, providing PWH with a

very long-acting treatment option that was safe and well tolerated in clinical trials.

On December 22, 2022, lenacapavir (Sunlenca) was approved by the FDA for HIV treatment. On April 25, 2023, it was added to the ADAP formulary. Lenacapavir was then evaluated in five phase three (III) HIV prevention trials as a possible PrEP medication. Results from those trials could be available in late 2024/early 2025.

OA will add lenacapavir to the PrEP-AP formulary for use in select situations where patients cannot access lenacapavir through an insurance plan or the manufacturer's assistance program. Utilization of lenacapavir is anticipated to be at a volume that is not cost neutral and is projected to have a moderate fiscal impact, commencing in FY 2025-26. The fiscal impact accounts for the cost of the medication and administration.

Description of Change: On June 18, 2025, Lenacapavir, brand name Yeztugo®, received FDA approval for PrEP use. The 2026-27 November Estimate reflects minor adjustments to the cost and client counts from the 2025-26 May Revision to account for administrative functions that occur prior to incurring costs for Lenacapavir following confirmation of the FDA approval date.

Discretionary: Yes

Reason for Adjustment/ Change:

- Drug under development specifically indicated for the prevention of HIV infection
- Per HSC Section 120972, eligible PrEP-AP persons have access to drugs listed on the ADAP drug formulary
- Reduce structural and administrative barriers often resulting in long wait times, denial of coverage, and ultimately failure to initiate treatment
- Alleviate barriers and improve client access to new injectable PrEP treatments available

Fiscal Impact and Fund Source(s): For 2025-26, the estimated fiscal impact is \$2.9 million for 183 clients. For 2026-27, the estimated fiscal impact is \$5.7 million for 292 clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Increase in Federal Funds: 2025 Ryan White Part B Grant

Background: The HRSA Ryan White Part B grant is a non-competitive grant and the largest of the three federal grants from which ADAP receives funding. Grant funding is appropriated in five, 12-month grant budget periods that run from April 1 to March 31. Within the five-year funding cycle, funding from year to year

is provided if the program remains eligible and submits all reporting requirements in a timely manner.

Description of Change: On November 18, 2024, OA applied for the 2025 Ryan White Part B grant, the fourth year of the latest five-year funding cycle. The total funding requested in the grant application was \$139.9 million, of which \$94.7 million is designated ADAP Local Assistance.

On March 28, 2025, OA received a partial Notice of Award in the amount of \$62.6 million, of which \$41.8 million is ADAP Local Assistance. On June 11, 2025, OA received a second partial Notice of Award in the amount of \$37.2 million, of which \$25.4 million is ADAP Local Assistance. On August 12, 2025, OA received the third and final Notice of Award in the amount of \$41.2 million, of which \$27.9 million is ADAP Local Assistance. In total, of the \$140.1 million awarded through the 2025 Ryan White Part B grant, \$95.1 million is ADAP Local Assistance.

Discretionary: Yes

Reason for Change/Adjustment:

- Fully leverage federal funding

Fiscal Impact and Fund Source: Increase of \$442,000 in Local Assistance for 2025-26 and 2026-27. The fund impacted is the Federal Trust Fund (Fund 0890). Increases in federal funding alleviate impact to the ADAP Rebate Fund (Fund 3080).

Decrease in Federal Funds: 2025 ADAP Emergency Relief Funds Grant (ADAP Shortfall Relief Grant)

Background: The HRSA ADAP Emergency Relief Funds grant (ADAP Shortfall Relief grant) is intended for states/territories that demonstrate the need for additional resources to prevent, reduce and/or eliminate ADAP waiting lists through implementation of cost-containment measures. OA cost-containment measures include maintaining data match agreements to safeguard ADAP as the payer of last resort.

The following table displays the historical grant application amounts for which OA has applied, and the total funds awarded per grant budget period:

Table 5: ADAP Emergency Relief Funds (Shortfall Relief) Grant		
Grant Budget Period	Application Amount	Total Funds Awarded
2021 (04/01/2021 – 03/31/2022)	\$7,000,000	\$5,307,130
2022 (04/01/2022 – 03/31/2023)	\$7,000,000	\$5,850,650
2023 (04/01/2023 – 03/31/2024)	\$7,000,000	\$6,433,858
2024 (04/01/2024 – 03/31/2025)	\$7,000,000	\$6,584,874
2025 (04/01/2025 – 03/31/2026)	\$7,000,000	\$4,652,262

Description of Change: On October 30, 2024, OA applied for the competitive 2025 ADAP Emergency Relief Funds grant. The total funding requested in the grant application was the maximum amount of \$7 million, all of which is designated ADAP Local Assistance.

On March 28, 2025, OA received a partial Notice of Award in the amount of \$1.7 million, all of which is ADAP Local Assistance. On July 18, 2025, OA received a second Notice of Award in the amount of \$3 million, all of which is ADAP Local Assistance. In total, the ADAP Local Assistance awarded through the 2025 ADAP Emergency Relief Funds grant is \$4.7 million.

Discretionary: Yes

Reason for Change/Adjustment:

- Competitive funding opportunity
- Prior funding does not guarantee future funding

Fiscal Impact and Fund Source: Decrease of \$1.9 million in Local Assistance for 2025-26 and 2026-27. The fund impacted is the Federal Trust Fund (Fund 0890). Decreases in federal funding result in the fiscal impact being absorbed by the ADAP Rebate Fund (Fund 3080).

Unchanged Assumptions

Payments for Medicare Part B Premiums

Payment of Medicare Part B Medical Out-of-Pocket Costs

EB-HIPP Program Expansion to ADAP Clients who are not the Primary Insured

PrEP and PEP Initiation and Retention Initiative (PPRI)

PrEP-AP Lab Fee Reimbursement Rate Increase

Discontinued Assumptions

Amended HSC Section 120960: Increase ADAP and PrEP-AP Income Limits from 500 Percent to 600 Percent of Federal Poverty Level (FPL)

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since it was previously approved in the 2025-26 May Revision and included in the base estimate. Both the ADAP and PrEP-AP FPL were increased to 600 percent on January 1, 2025.

Increasing Premium Threshold for Insurance Assistance Programs

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since it was previously approved in the 2025-26 May Revision and included in the base estimate. The premium threshold was increased to \$2,996 on January 1, 2025.

Medicare Part D: Out-of-Pocket Prescription Cap

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since it was previously approved in the 2025-26 May Revision and included in the base estimate. Designed to make prescription drugs more affordable, improve health outcomes, and reduce costs for enrollees, Medicare began placing an annual cap on out-of-pocket costs under the Medicare Part D program on January 1, 2025.

Paying above Medicare Part D Benchmark Premiums

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since it was previously approved in the 2025-26 May Revision and included in the base estimate. OA started the process of paying above Medicare Part D Benchmark premiums on January 1, 2025.

MPPP Expansion to Dental and Vision

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since it was previously approved in the 2025-26 May Revision and included in the base estimate. MPPP began offering dental and vision premium assistance to MPPP clients on July 1, 2024.

Gilead's Plans to Discontinue Patient Assistance Program for Truvada

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since it was previously approved in the 2025-26 May Revision and

included in the base estimate. Gilead ended enrollment into the Gilead Patient Assistance Program for Truvada on December 31, 2024. OA added generic Truvada to the PrEP-AP formulary on January 1, 2025.

Increase in Federal Funds: 2024 Ryan White Part B Grant

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since 2024-25 has ended and funding has been expended.

Increase in Federal Funds: 2024 Ryan White Part B Supplemental

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since 2024-25 has ended and funding has been expended.

Increase in Federal Funds: 2024 ADAP Emergency Relief Funds Grant (ADAP Shortfall Relief Grant)

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since 2024-25 has ended and funding has been expended.

Increase in Federal Funds: 2023 Ryan White Part B Grant Carryover

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since 2024-25 has ended and funding has been expended.

VII. Expenditure Details

Tables 6 through 11, starting on the next page, break down caseload and expenditures by client group and service type.

TABLE 6: November Estimate Caseload and Variable Expenditures; Current Year 2025-26

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-only	7,514	26.5%	\$205,461,242	\$0	\$0	\$205,461,242
Medi-Cal SOC	113	0.4%	\$1,852,721	\$0	\$0	\$1,852,721
Private Insurance*	9,364	33.1%	\$31,773,336	\$84,163,946	\$3,335,349	\$119,272,630
Medicare*	6,528	23.1%	\$8,537,439	\$7,663,505	\$357,024	\$16,557,967
PrEP-AP	4,799	16.9%	\$19,674,106	\$0	\$3,220,620	\$22,894,726
SUBTOTAL	28,318	100%	\$267,298,843	\$91,827,450	\$6,912,992	\$366,039,286
Admin: ADAP	-	-	\$2,010,083	\$2,076,309	\$1,087,464	\$5,173,857
Admin: PrEP-AP	-	-	\$0	\$0	\$5,418,898	\$5,418,898
Admin: Enrollment Sites	-	-	\$0	\$0	\$0	\$7,734,000
HMS	-	-	-\$14,000,000	\$0	\$0	-\$14,000,000
Health Trailer Bill**	-	-	\$0	\$0	\$0	\$71,602,636
TOTAL	28,318	100%	\$255,308,927	\$93,903,760	\$13,419,354	\$441,968,676

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
 * Subgroup of 12,812 clients receiving assistance for premium payments and medical-out-of-pocket costs.
 ** Items in the 2024-25 and 2025-26 Health Trailer Bills. 2024-25: Harm Reduction, previously under Early Action Package. 2025-26: CAP and AB-116, Section 118: Support Current or Eligible Services and Programs.

TABLE 7: 2025 Budget Act Caseload and Variable Expenditures

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-only	7,763	21.1%	\$218,969,711	\$0	\$0	\$218,969,711
Medi-Cal SOC	138	0.4%	\$1,637,978	\$0	\$0	\$1,637,978
Private Insurance*	10,451	28.4%	\$40,643,946	\$90,063,774	\$3,268,878	\$133,976,598
Medicare*	6,646	18.1%	\$8,732,419	\$7,907,658	\$695,623	\$17,335,700
PrEP-AP	11,746	32.0%	\$19,828,296	\$0	\$3,711,673	\$23,539,968
SUBTOTAL	36,744	100%	\$289,812,350	\$97,971,432	\$7,676,174	\$395,459,955
Admin: ADAP	-	-	\$2,195,786	\$1,969,227	\$1,103,001	\$5,268,014
Admin: PrEP-AP	-	-	\$0	\$0	\$5,430,998	\$5,430,998
Admin: Enrollment Sites	-	-	\$0	\$0	\$0	\$8,270,500
HMS	-	-	-\$14,736,186	\$0	\$0	-\$14,736,186
Health Trailer Bill**	-	-	\$0	\$0	\$0	\$85,000,000
TOTAL	36,744	100%	\$277,271,950	\$99,940,658	\$14,210,172	\$484,693,280

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
 *Subgroup of 11,625 clients receiving assistance for premium payments and medical-out-of-pocket costs.
 **Items in the 2024-25 and 2025-26 Health Trailer Bills. 2024-25: Harm Reduction, previously under Early Action Package. 2025-26: AB-116, Section 118: Support Current or Eligible Services and Programs. Expenditures for increasing the FPL to 600 percent, ADAP Open Formulary, and increasing the premium threshold are accounted for in their respective client groups and service type expenditures.

TABLE 8: Difference Between November Estimate and 2025 Budget Act; Current Year 2025-26

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-only	-250	-3.2%	-\$13,508,469	\$0	\$0	-\$13,508,469
Medi-Cal SOC	-25	-18.2%	\$214,743	\$0	\$0	\$214,743
Private Insurance*	-1,087	-10.4%	-\$8,870,611	-\$5,899,828	\$66,471	-\$14,703,968
Medicare*	-118	-1.8%	-\$194,981	-\$244,153	-\$338,600	-\$777,733
PrEP-AP	-6,947	-59.1%	-\$154,189	\$0	-\$491,053	-\$645,243
SUBTOTAL	-8,426	-22.9%	-\$22,513,506	-\$6,143,981	-\$763,182	-\$29,420,669
Admin: ADAP	-	-	-\$185,703	\$107,083	-\$15,536	-\$94,157
Admin: PrEP-AP	-	-	\$0	\$0	-\$12,100	-\$12,100
Admin: Enrollment Sites	-	-	\$0	\$0	\$0	-\$536,500
HMS	-	-	\$736,186	\$0	\$0	\$736,186
Health Trailer Bill**	-	-	\$0	\$0	\$0	-\$13,397,364
TOTAL	-8,426	-22.9%	-\$21,963,023	-\$6,036,898	-\$790,818	-\$42,724,604

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
 * Subgroup increased by 1,187 clients receiving assistance for premium payments and medical-out-of-pocket costs.
 **Previously titled Early Action Package.

TABLE 9: November Estimate Caseload and Variable Expenditures; Budget Year 2026-27

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-only	7,904	27.0%	\$232,250,082	\$0	\$0	\$232,250,082
Medi-Cal SOC	137	0.5%	\$2,432,939	\$0	\$0	\$2,432,939
Private Insurance*	9,476	32.4%	\$36,090,816	\$94,572,576	\$4,165,946	\$134,829,338
Medicare*	6,528	22.3%	\$8,537,439	\$11,879,192	\$656,000	\$21,072,630
PrEP-AP	5,241	17.9%	\$24,107,288	\$0	\$4,396,388	\$28,503,676
SUBTOTAL	29,285	100%	\$303,418,564	\$106,451,768	\$9,218,334	\$419,088,666
Admin: ADAP	-	-	\$2,211,092	\$2,283,940	\$1,196,211	\$5,691,243
Admin: PrEP-AP	-	-	\$0	\$0	\$5,487,001	\$5,487,001
Admin: Enrollment Sites	-	-	\$0	\$0	\$0	\$8,232,500
HMS	-	-	-\$14,000,000	\$0	\$0	-\$14,000,000
Health Trailer Bill**	-	-	\$0	\$0	\$0	\$17,157,364
TOTAL	29,285	100%	\$291,629,655	\$108,735,708	\$15,901,546	\$441,656,774

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
 * Subgroup of 13,445 clients receiving assistance for premium payments and medical-out-of-pocket costs.
 ** Items in the 2024-25 and 2025-26 Health Trailer Bills. 2024-25: Harm Reduction, previously under Early Action Package. 2025-26: CAP and AB-116, Section 118: Support Current or Eligible Services and Programs.

TABLE 10: 2025 Budget Act Caseload and Variable Expenditures

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-only	7,763	21.1%	\$218,969,711	\$0	\$0	\$218,969,711
Medi-Cal SOC	138	0.4%	\$1,637,978	\$0	\$0	\$1,637,978
Private Insurance*	10,451	28.4%	\$40,643,946	\$90,063,774	\$3,268,878	\$133,976,598
Medicare*	6,646	18.1%	\$8,732,419	\$7,907,658	\$695,623	\$17,335,700
PrEP-AP	11,746	32.0%	\$19,828,296	\$0	\$3,711,673	\$23,539,968
SUBTOTAL	36,744	100%	\$289,812,350	\$97,971,432	\$7,676,174	\$395,459,955
Admin: ADAP	-	-	\$2,195,786	\$1,969,227	\$1,103,001	\$5,268,014
Admin: PrEP-AP	-	-	\$0	\$0	\$5,430,998	\$5,430,998
Admin: Enrollment Sites	-	-	\$0	\$0	\$0	\$8,270,500
HMS	-	-	-\$14,736,186	\$0	\$0	-\$14,736,186
Health Trailer Bill**	-	-	\$0	\$0	\$0	\$85,000,000
TOTAL	36,744	100%	\$277,271,950	\$99,940,658	\$14,210,172	\$484,693,280

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
 * Subgroup of 11,625 clients receiving assistance for premium payments and medical-out-of-pocket costs.
 ** Items in the 2024-25 and 2025-26 Health Trailer Bills. 2024-25: Harm Reduction, previously under Early Action Package. 2025-26: AB-116, Section 118: Support Current or Eligible Services and Programs. Expenditures for increasing the FPL to 600 percent, ADAP Open Formulary, and increasing the premium threshold are accounted for in their respective client groups and service type expenditures.

TABLE 11: Difference Between November Estimate and 2025 Budget Act; Budget Year 2026-27

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-only	141	1.8%	\$13,280,371	\$0	\$0	\$13,280,371
Medi-Cal SOC	-1	-0.8%	\$794,961	\$0	\$0	\$794,961
Private Insurance*	-975	-9.3%	-\$4,553,131	\$4,508,803	\$897,068	\$852,740
Medicare*	-118	-1.8%	-\$194,981	\$3,971,534	-\$39,623	\$3,736,930
PrEP-AP	-6,506	-55.4%	\$4,278,993	\$0	\$684,715	\$4,963,708
SUBTOTAL	-7,458	-20.3%	\$13,606,214	\$8,480,336	\$1,542,160	\$23,628,711
Admin: ADAP	-	-	\$15,305	\$314,714	\$93,210	\$423,229
Admin: PrEP-AP	-	-	\$0	\$0	\$56,004	\$56,004
Admin: Enrollment Sites	-	-	\$0	\$0	\$0	-\$38,000
HMS	-	-	\$736,186	\$0	\$0	\$736,186
Health Trailer Bill**	-	-	\$0	\$0	\$0	-\$67,842,636
TOTAL	-7,458	-20.3%	\$14,357,705	\$8,795,050	\$1,691,374	-\$43,036,507

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
 * Subgroup increased by 1,820 clients receiving assistance for premium payments and medical-out-of-pocket costs.
 ** Previously titled Early Action Package.

a) Medication-only Clients

1. Medication:

- 2025-26: Costs are projected to be \$205.5 million (Table 6), \$13.5 million lower than reported in the 2025 Budget Act (Table 8). The decrease is driven primarily by a lower cost per client per month offset with a higher monthly caseload than previously estimated.
- 2026-27: Costs are projected to be \$232.3 million (Table 9), \$13.3 million higher than FY 2025-26 reported in the 2025 Budget Act (Table 11). The increase is driven primarily by higher monthly caseload offset with a lower cost per client per month.

2. Health Insurance Premiums: There are no costs for medication-only clients.

3. Medical Out-Of-Pocket Costs: There are no costs for medication-only clients.

b) Medi-Cal SOC Clients

1. Medication:

- 2025-26: Costs are projected to be \$1.9 million (Table 6), \$215,000 higher than reported in the 2025 Budget Act (Table 8). The increase is driven primarily by higher cost per client per month than previously estimated.
- 2026-27: Costs are projected to be \$2.4 million (Table 9), \$795,000 higher than FY 2025-26 reported in the 2025 Budget Act (Table 11). The increase is driven by the same factor above.

2. Health Insurance Premiums: There are no costs for Medi-Cal SOC clients.

3. Medical Out-Of-Pocket Costs: There are no costs for Medi-Cal SOC clients.

c) Private Insurance Clients

1. Medication:

- 2025-26: Costs are projected to be \$31.8 million (Table 6), \$8.9 million lower than reported in the 2025 Budget Act (Table 8). The decrease is driven primarily by lower monthly caseload and lower cost per client per month than previously estimated.
- 2026-27: Costs are projected to be \$36.1 million (Table 9), \$4.6 million lower than FY 2025-26 reported in the 2025 Budget Act (Table 11). The decrease is driven primarily by the same factors above.

2. Health Insurance Premiums:

- 2025-26: Costs are projected to be \$84.2 million (Table 6), \$5.9 million lower than reported in the 2025 Budget Act (Table 8). The decrease

is driven primarily by higher monthly caseload offset with a lower cost per client per month than previously estimated.

- 2026-27: Costs are projected to be \$94.6 million (Table 9), \$4.5 million higher than FY 2025-26 reported in the 2025 Budget Act (Table 11). The increase is driven primarily by the same factors above.
3. Medical Out-Of-Pocket Costs:
- 2025-26: Costs are projected to be \$3.3 million (Table 6), \$66,000 higher than reported in the 2025 Budget Act (Table 8). The increase is driven primarily by higher cost per client per month offset with a lower monthly caseload than previously estimated.
 - 2026-27: Costs are projected to be \$4.2 million (Table 9), \$897,000 higher than FY 2025-26 reported in the 2025 Budget Act (Table 11). The increase is driven primarily by the same factors above.

d) Medicare Clients

1. Medication:
- 2025-26: Costs are projected to be \$8.5 million (Table 6), \$195,000 lower than reported in the 2025 Budget Act (Table 8). The decrease is driven primarily by lower monthly caseload offset with a higher cost per client per month than previously estimated.
 - 2026-27: Costs are projected to be \$8.5 million (Table 9), \$195,000 lower than FY 2025-26 reported in the 2025 Budget Act (Table 11). The decrease is driven primarily by the same factors above.
2. Health Insurance Premiums:
- 2025-26: Costs are projected to be \$7.7 million (Table 6), \$244,000 lower than reported in the 2025 Budget Act (Table 8). The decrease is driven primarily by lower monthly caseload offset with a higher cost per client per month than previously estimated.
 - 2026-27: Costs are projected to be \$11.9 million (Table 9), \$4.0 million higher than FY 2025-26 reported in the 2025 Budget Act (Table 11). The increase is primarily driven by higher monthly caseload and higher cost per client per month.
3. Medical Out-Of-Pocket Costs:
- 2025-26: Costs are projected to be \$357,000 (Table 6), \$339,000 lower than reported in the 2025 Budget Act (Table 8). The decrease is driven primarily by a lower cost per client per month than previously estimated.
 - 2026-27: Costs are projected to be \$656,000 (Table 9), \$40,000 lower than FY 2025-26 reported in the 2025 Budget Act (Table 11). The decrease is driven primarily by lower cost per client per month offset with higher monthly caseload.

e) PrEP-AP Clients

1. Medication:

- 2025-26: Costs are projected to be \$19.7 million (Table 6), \$154,000 lower than reported in the 2025 Budget Act (Table 8). The decrease is driven primarily by lower monthly caseload offset with a higher cost per client per month than previously estimated.
- 2026-27: Costs are projected to be \$24.1 million (Table 9), \$4.3 million higher than FY 2025-26 reported in the 2025 Budget Act (Table 11). The increase is driven primarily by the same factors above.

2. Health Insurance Premiums: There are no costs for PrEP-AP clients.

3. Medical Out-Of-Pocket Costs:

- 2025-26: Costs are projected to be \$3.2 million (Table 6), \$491,000 lower than reported in the 2025 Budget Act (Table 8). The decrease is driven primarily by lower cost per client per month than previously estimated.
- 2026-27: Costs are projected to be \$4.4 million (Table 9), \$685,000 higher than reported in the 2025 Budget Act (Table 11). The increase is driven by lower monthly caseload offset with a higher cost per client per month than previously estimated.

VIII. Historical Program Data and Trends

Figures 1 – 3 describe clients served. Enrolled clients who do not incur program costs are excluded.

Figure 1 summarizes ADAP clients served by fiscal year and those also receiving insurance assistance.

In FY 2024-25, a total of 24,842 individuals received ADAP services (with 12,812 of those being insurance assistance clients). For FY 2025-26, OA projects the total ADAP caseload to decrease to 23,518 individuals (with insurance assistance clients remaining consistent at 12,812). For FY 2026-27, OA projects the total ADAP caseload to increase to 24,045 individuals (with insurance assistance clients increasing to 13,445).

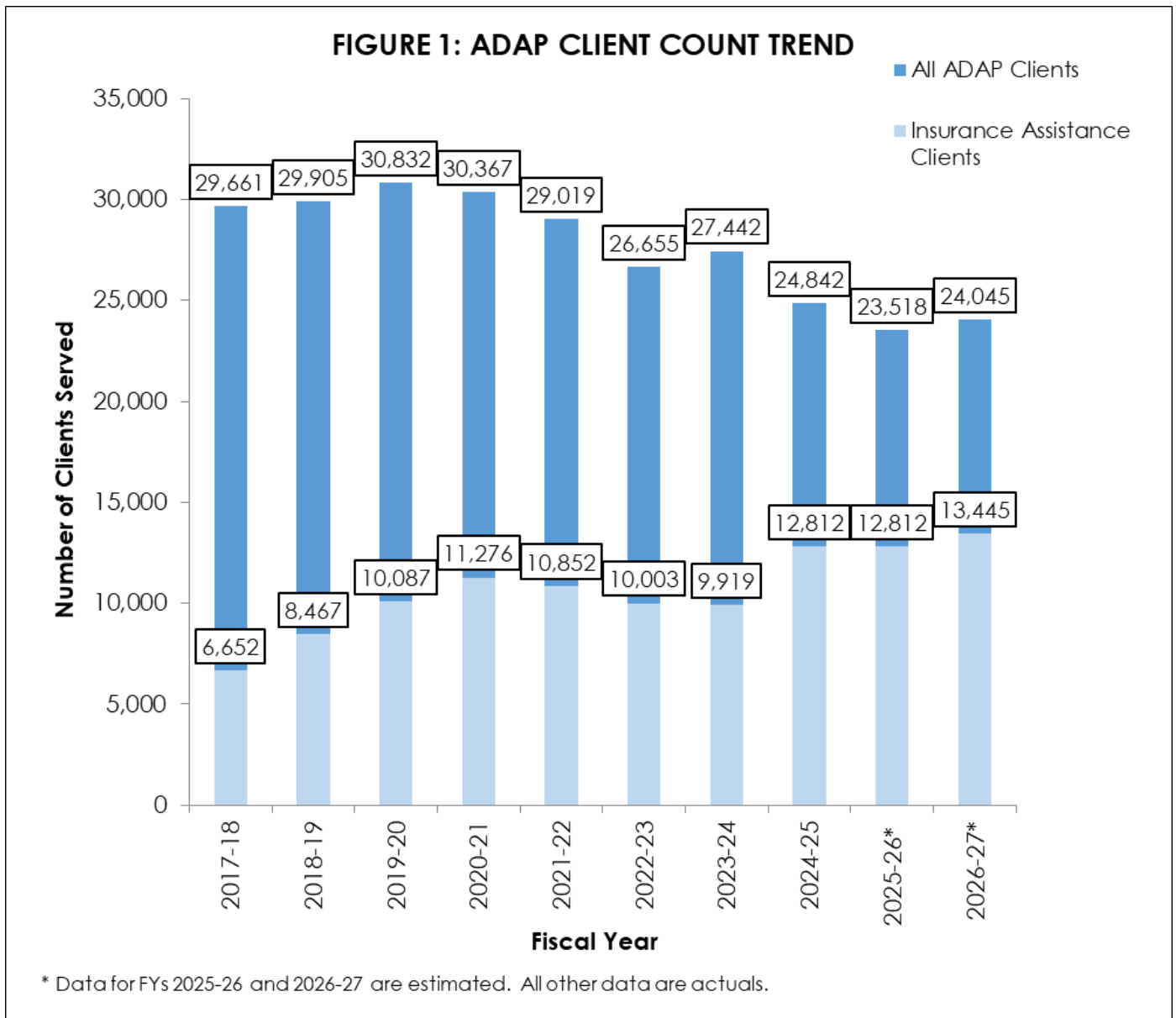
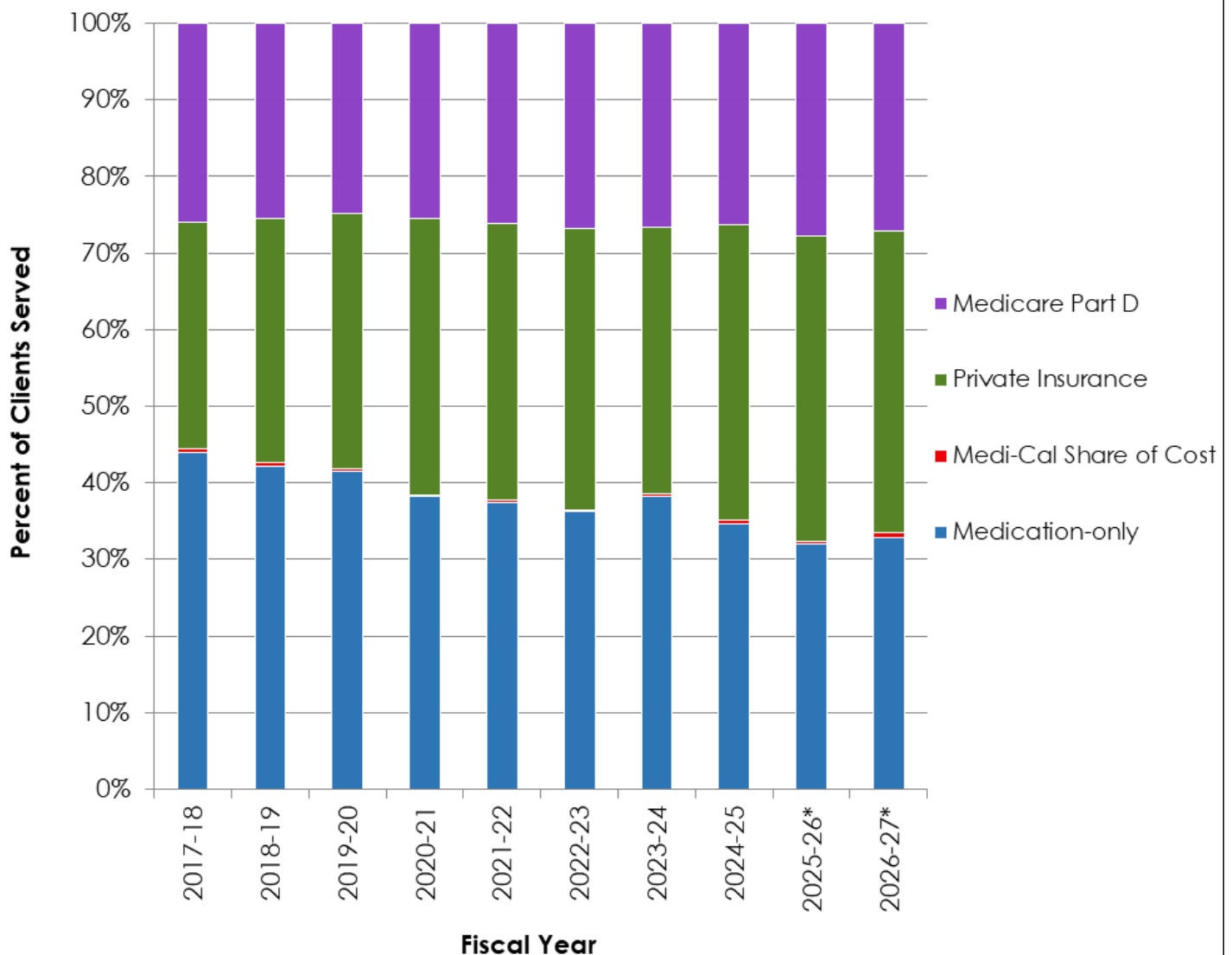


Figure 2 summarizes the proportion of ADAP medication program clients enrolled in the various payer groups by fiscal year.

For FY 2025-26, of the projected 23,518 ADAP medication program clients, the payer source percentages are estimated to be 31.9 percent Medication-only, 39.8 percent Private Insurance, 27.8 percent Medicare Part D, and 0.5 percent Medi-Cal SOC. For FY 2026-27, of the projected 24,045 ADAP medication program clients, the payer source percentages are estimated to be 32.9 percent Medication-only, 39.4 percent Private Insurance, 27.1 percent Medicare Part D, and 0.6 percent Medi-Cal SOC.

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



* Data for FYs 2025-26 and 2026-27 are estimated. All other data are actuals.

Figure 3 summarizes PrEP-AP clients served by fiscal year.

In FY 2024-25, a total of 4,799 individuals received PrEP-AP services. For FY 2025-26, OA projects the total PrEP-AP caseload to remain consistent at 4,799. For FY 2026-27, OA projects the total PrEP-AP caseload to increase to 5,241.

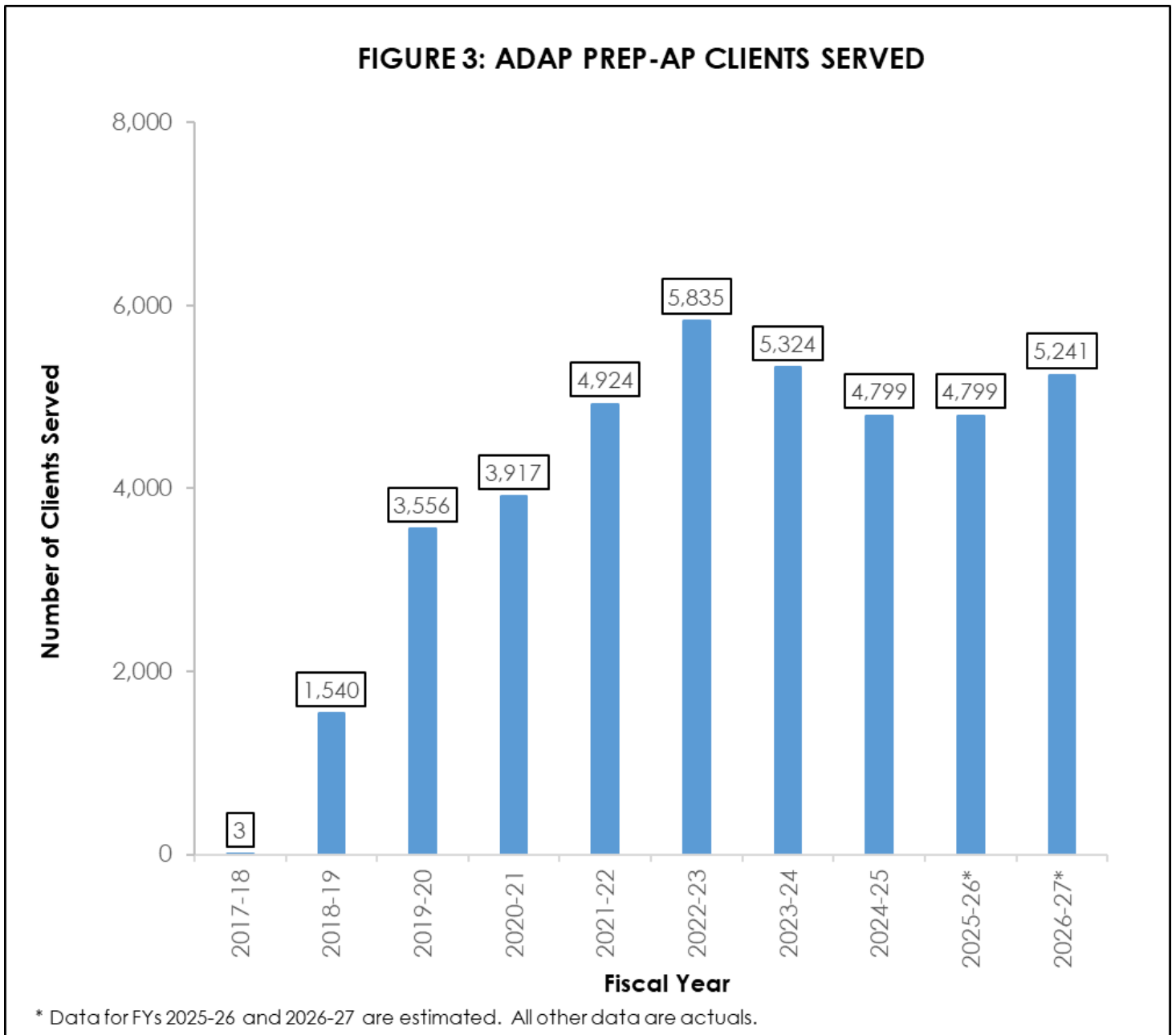
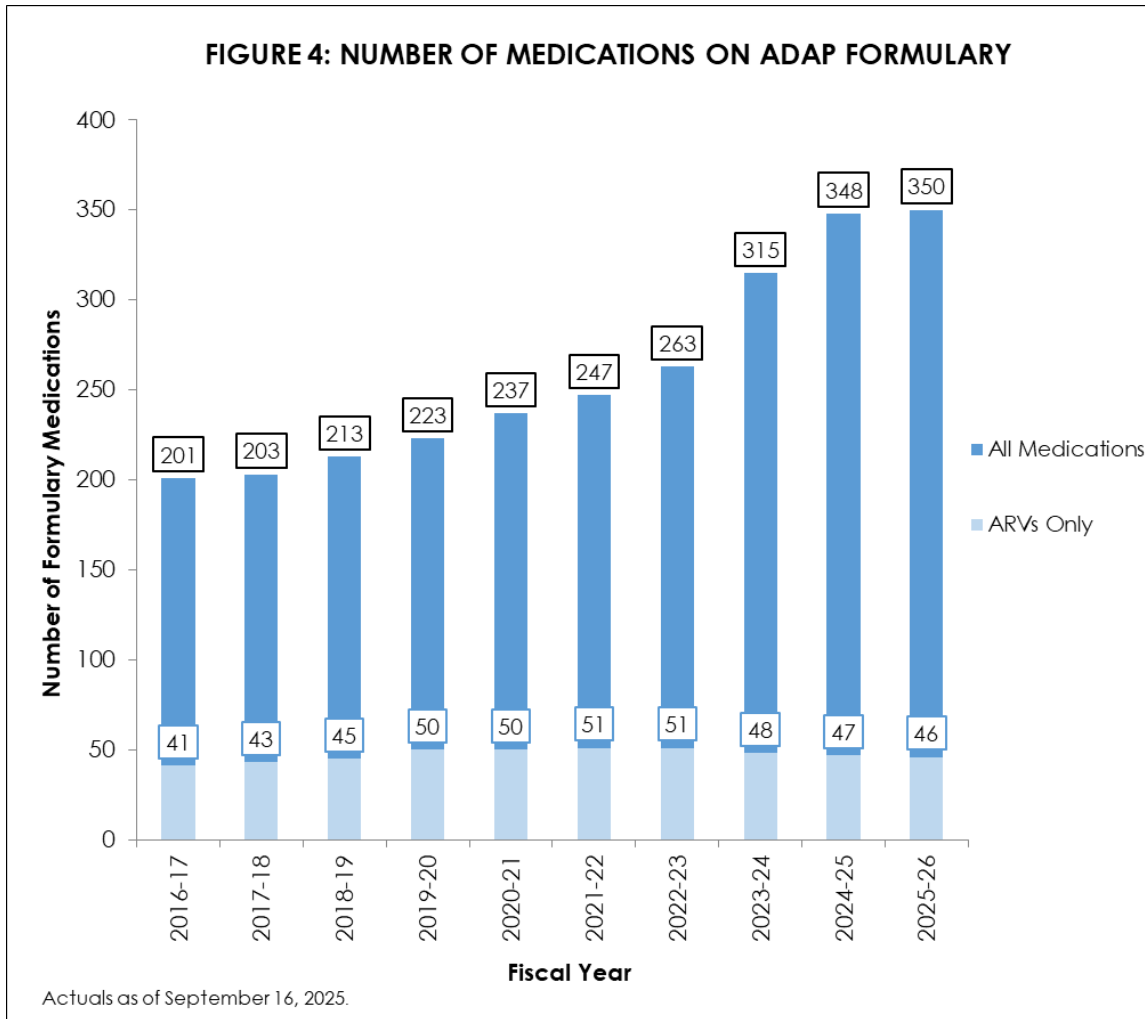


Figure 4 summarizes the number of medications on the ADAP formulary by fiscal year; the number of ARV medications is also shown.

In FY 2024-25, a total of 348 medications were on the ADAP formulary (with 47 of those being ARVs). As of September 16, 2025, there are 350 medications on the ADAP formulary (with 46 of those being ARVs).



Additions to the ADAP Formulary

The following medications were added to the ADAP formulary on:

January 15, 2025

- semaglutide (Ozempic®), non-ARV glucagon-like peptide-1 receptor agonist (GLP-1 RA) antidiabetic

April 4, 2025

- buprenorphine extended release (Brixadi®), non-ARV mixed opiate agonist-antagonist for opioid use disorder

May 1, 2025

- ribavirin (Rebetol®), non-ARV guanosine analog antiviral for Hepatitis C and Respiratory Syncytial Virus (RSV) infection

July 29, 2025

- continuous glucose monitoring systems (Dexcom, FreeStyle, Guardian™), non-ARV diabetic supply

Deletions from the ADAP Formulary

The following medications were deleted from the ADAP formulary:

January 15, 2025

- oxycodone/aspirin (Percodan®), non-ARV opioid analgesic/salicylate analgesic

March 10, 2025

- didanosine (Videx, Videx EC), ARV, nucleoside reverse transcriptase inhibitor
- efavirenz 50 mg capsule (Sustiva®), ARV, non-nucleoside reverse transcriptase inhibitor
- efavirenz 200 mg capsule (Sustiva®), ARV, non-nucleoside reverse transcriptase inhibitor
- fosamprenavir 50 mg/mL oral suspension (Lexiva®), ARV, protease inhibitor

IX. Current HIV Epidemiology in California

Approximately 143,000 people in California living at the end of 2023 had been diagnosed with HIV and reported to OA. Since the epidemic began in 1981, approximately 112,000 Californians diagnosed with HIV have died, with over 2,200 dying in 2023 alone.

Of the approximately 143,000 people living with diagnosed HIV (PLWDH) in California, approximately 2.1 percent are Latine; 32.9 percent are White; 15.9 percent are Black/African American; 4.5 percent are Asian; 4.2 percent are multi-racial; 0.2 percent are American Indian/Alaskan Native; and 0.2 percent are Native Hawaiian/Pacific Islander. While Latine and Whites make up the largest percentage of PLWDH in California, the rate of HIV among Blacks/African Americans is substantially higher (977.0 per 100,000 population, versus 309.3 per 100,000 among Whites and 375.7 per 100,000 among Latine).

Most of California's living HIV cases are attributed to male-to-male sexual transmission (65.8 percent); 8.1 percent of living cases are attributable to high-risk heterosexual contact (defined as contact with a sex partner or partners of the opposite gender who are either known to be HIV infected or known to be someone who injects drugs, has hemophilia, or is a man who has sex with other men); 5.8 percent to men who have sex with men who also inject drugs; 5.2 percent to injection drug use; 2.1 percent to transgender sexual contact; 0.5 percent to perinatal exposure; and 12.6 percent to other or unknown sources including other heterosexual contact.

From 2019 to 2023, there was an average of approximately 4,700 new HIV cases reported in California each year. Please note COVID-19 may have impacted rates of testing as well as reporting completeness in 2020. The number of PWH in the state is expected to grow by approximately one percent each year for the foreseeable future until more progress is made in preventing new HIV infections. This increase is attributed to stable incidence rates and longer survival of those infected primarily due to the effectiveness and availability of treatment.