

# **AIDS DRUG ASSISTANCE PROGRAM (ADAP)**

**FY 2016-17 May Revision Estimate**



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

**California**  
**Department of Public Health**

## TABLE OF CONTENTS

<u>SECTION</u>	<u>PAGE</u>
I. PROGRAM OVERVIEW.....	2
II. ESTIMATE OVERVIEW.....	3
III. OVERALL PROJECTIONS.....	4
A. KEY INFLUENCES ON ADAP EXPENDITURES.....	4
B. EXPENDITURES.....	4
C. REVENUE.....	7
IV. ASSUMPTION PROJECTIONS.....	9
V. FUTURE FISCAL ISSUES.....	11
VI. FUND CONDITION STATEMENT.....	13
VII. HISTORICAL PROGRAM DATA AND TRENDS.....	14
VIII. CURRENT HIV/AIDS EPIDEMIOLOGY IN CALIFORNIA.....	17
IX. APPENDICES: ASSUMPTIONS AND RATIONALE FOR MEDICATION AND HEALTH INSURANCE PREMIUM EXPENDITURES.....	18

## 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 (either the full cost of medications or deductibles and co-pays) on the ADAP formulary for the following coverage groups:
  - a. *ADAP-only clients*, for whom ADAP pays 100 percent of the prescription medication cost because these clients do not have another 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 to manufacturers by both programs, 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 for the 2016 May Revision provides revised projection of Current Year [Fiscal Year (FY) 2015-16] and Budget Year (FY 2016-17) local assistance costs for the medication and health insurance programs for ADAP.

Table 1 below shows the estimated ADAP local assistance expenditure need for the Current Year, and compares it to the amount reflected in the *2016-17 Governor's Budget*.

- For FY 2015-16, CDPH estimates that ADAP expenditures will be \$305.7 million, which is a \$11.4 million decrease compared to the *2016-17 Governor's Budget*.
- For FY 2016-17, CDPH estimates that ADAP expenditures will be \$323.9 million, which is a \$6.3 million decrease compared to the *2016-17 Governor's Budget*. 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.

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 *2016-17 Governor's Budget*.

- For FY 2015-16, CDPH estimates ADAP revenue will be \$268.2 million, which is a \$10.2 million decrease compared to the *2016-17 Governor's Budget*.
- For FY 2016-17, CDPH estimates ADAP revenue will be \$260.7 million, which is a \$6.4 million decrease compared to the *2016-17 Governor's Budget*. For both FYs, the decrease in revenue is due mainly to the decrease in the overall medication expenditures. Please see pages 7 and 8 for additional revenue/rebate information.

California Department of Public Health AIDS Drug Assistance Program 2016 May Revision Table 1: Local Assistance (dollars in millions)								
Local Assistance	Current Year FY 2015-16				Budget Year FY 2016-17			
	2016-17 Governor's Budget	2016 May Revision	\$ Change from Governor's Budget to 2016 May Revision	% Change from Governor's Budget to 2016 May Revision	2016-17 Governor's Budget	2016 May Revision	\$ Change from Governor's Budget to 2016 May Revision	% Change from Governor's Budget to 2016 May Revision
<b>Fund:</b>								
<b>Total Funds Requested</b>	\$317.1	\$305.7	-\$11.4	-3.6%	\$330.2	\$323.9	-\$6.3	-1.9%
Federal Funds - Fund 0890	138.1	132.2	-5.9	-4.3%	94.0	126.9	32.9	35.0%
Rebate Funds - Fund 3080	178.1	172.7	-5.5	-3.1%	236.2	197.0	-39.2	-16.6%
Reimbursement Funds (SNCP)	0.9	0.9	0.0	0.0%	0.0	0.0	0.0	0.0%
<b>Caseload</b>	29,798	28,798	-1,000	-3.4%	29,401	29,155	-246	-0.8%

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

Table 2: Rebate Fund Revenues (Fund 3080) 2016 May Revision (dollars in millions)								
Local Assistance	Current Year FY 2015-16				Budget Year FY 2016-17			
	2016-17 Governor's Budget	2016 May Revision	\$ Change from Governor's Budget to 2016 May Revision	% Change from Governor's Budget to 2016 May Revision	2016-17 Governor's Budget	2016 May Revision	\$ Change from Governor's Budget to 2016 May Revision	% Change from Governor's Budget to 2016 May Revision
<b>Total Revenue Requested</b>	\$278.5	\$268.2	-\$10.2	-3.7%	\$267.1	\$260.7	-\$6.4	-2.4%
Rebate Funds - Fund 3080	278.4	268.1	-\$10.2	-3.7%	267.0	260.6	-6.4	-2.4%
Interest Income	0.1	0.1	\$0.0	0.0%	0.1	0.1	0.0	0.0%

### III. Overall Projections

#### A. Key influences on ADAP expenditures

- a. FY 2015-16: Compared to the *2016-17 Governor's Budget*, OA estimates that expenditures during FY 2015-16 will decline by 3.6 percent. This decrease is largely due to Medi-Cal Expansion, which will continue to have an impact on the number of ADAP-only clients receiving ADAP services during FY 2015-16 as clients continue to transition out of ADAP. Although Medi-Cal and Covered California were fully implemented by the end of FY 2014-15, there were still existing ADAP clients who transitioned to Medi-Cal during FY 2015-16. Additionally, the number of new clients enrolling in ADAP continues to decrease although at a slower rate than in prior FYs; this is likely due to the impact of Medi-Cal Expansion.
- b. FY 2016-17: Compared to the *2016-17 Governor's Budget*, OA estimates that expenditures during FY 2016-17 will decline by 1.9 percent. This decrease is also largely due to the ACA-related programs, Medi-Cal Expansion and Covered California. 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 slightly exceeding 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 with an offset due to payment of medical out-of-pocket 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 privately, 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 \$287.1 million, which is a \$9.9 million decrease compared to the *2016-17 Governor's Budget*. 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 \$298.5 million, which is a \$4.5 million decrease compared to the *2016-17 Governor's Budget*. The decrease in FY 2016-17 expenditures is mainly due to the impact of clients transitioning to Medi-Cal in FY 2015-16.

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 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 allow 47 clients to enroll in FY 2015-16, and an additional 47 clients in FY 2016-17. For FY 2015-16, the estimated additional net costs for the medication program will be \$10,000 (\$225,000 in medication expenditures and \$215,000 in rebate revenue). The total estimated net savings for the medication program in FY 2016-17 for the additional 47 new clients will be \$205,000 (\$248,000 in medication expenditures and \$452,000 in rebate revenue).

TABLE 3: ESTIMATED ANNUAL CASELOAD AND MEDICATION EXPENDITURES BY COVERAGE GROUP								
COVERAGE GROUP	FY 2015-16				FY 2016-17			
	CASELOAD		EXPENDITURES		CASELOAD		EXPENDITURES	
	NUMBER	PERCENT	AMOUNT	PERCENT	NUMBER	PERCENT	AMOUNT	PERCENT
ADAP Only	12,565	43.6%	\$255,824,209	89.1%	12,499	42.9%	\$265,923,798	89.1%
Medi-Cal	144	0.5%	\$762,509	0.3%	167	0.6%	\$887,985	0.3%
Private Insurance	7,438	25.8%	\$13,007,306	4.5%	7,837	26.9%	\$13,762,959	4.6%
Medicare Part D	8,651	30.0%	\$17,487,035	6.1%	8,651	29.7%	\$17,902,849	6.0%
<b>TOTALS</b>	<b>28,798</b>	<b>100.0%</b>	<b>\$287,081,058</b>	<b>100.0%</b>	<b>29,155</b>	<b>100.0%</b>	<b>\$298,477,591</b>	<b>100.0%</b>

Estimate 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 \$13.1 million, which is a \$1.5 million decrease compared to the *2016-17 Governor's Budget*. 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 in the spring of 2016; however, OA now anticipates payment of medical out-of-pocket costs will begin on July 1, 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 \$19.9 million, which includes medical out-of-pocket cost expenditures. This is a \$1.7 million decrease compare to the 2016-17 Governor’s Budget. The decrease in health insurance expenditures compared to 2016-17 Governor’s Budget is primarily due to a decrease in new enrollments resulting from the delayed implementation of payment of medical out-of-pocket costs.

Table 4 below shows the estimated number of clients and total expenditures for the health insurance assistance 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 eight clients will enroll in the health insurance assistance programs in FY 2015-16, and an additional eight clients in FY 2016-17, as a result of ADAP’s new income eligibility criteria. The estimated premium expenditures for these new clients will be \$38,000 in FY 2015-16. The total estimated expenditures will be \$96,000 in FY 2016-17 for all 16 new clients, including the eight 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 <sup>3</sup>	997	29.1%	\$6,293,102	48.0%	895	21.3%	\$7,030,594	35.4%
OA-HIPP/CC <sup>3</sup>	1,789	52.3%	\$6,408,333	48.9%	2,684	63.8%	\$12,445,435	62.6%
OA/Medicare Part D	634	18.5%	\$400,197	3.1%	626	14.9%	\$394,776	2.0%
<b>TOTALS</b>	<b>3,421</b>	<b>100.0%</b>	<b>\$13,101,632</b>	<b>100.0%</b>	<b>4,205</b>	<b>100.0%</b>	<b>\$19,870,805</b>	<b>100.0%</b>

<sup>1</sup>Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.  
<sup>2</sup>All premium payment assistance clients are co-enrolled in the ADAP medication program.  
<sup>3</sup>FY 2016-17 expenditures include medical out-of-pocket costs.

**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 enrolling and maintaining clients in ADAP, and successfully transitioning clients between ADAP and another payer source.
- 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 \$1.5 million for FY 2015-16 and \$1.6 million for 2016-17. The new PBM contract does not allow the PBM to bill ADAP for non-approved transactions effective July 1, 2016. However, OA assumes there will be fixed costs and we will provide these estimates in the *2017-18 ADAP November Estimate*.

### 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 decrease by 3.7 percent from \$278.5 million in the *2016-17 Governor's Budget* to \$268.2 million in the revised Current Year forecast.
  - For FY 2016-17, OA estimates ADAP rebate revenues will decrease by 2.4 percent from to \$267.1 million in the *2016-17 Governor's Budget* to \$260.7 million in the revised Budget Year forecast.

These estimates account for decreased expenditures.

- 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 received ADAP's portion of the SNCP funds in the form of a reimbursement from DHCS. In FY 2015-16, ADAP utilized \$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. After the current Medi-Cal 1115 Waiver expired on October 31, 2015, SNCP reimbursement funds are no longer available to ADAP.
- c. Federal Funds – For FY 2015-16, federal fund revenue decreased by \$5.9 million compared to the *2016-17 Governor's Budget*. ADAP utilized one-time federal funds including \$6.4 million in 2015 ADAP Emergency Relief Funds (ERF) and \$18.2 million in unspent 2014 Ryan White carryover funds on ADAP expenditures prior to the March 31, 2016 grant period end date. In addition, ADAP utilized \$10.0 million in 2015 Ryan White Part B Supplemental funds. However, ADAP was unable to spend down all 2015 federal ADAP Earmark funds due to the Health Resources and Services Administration (HRSA) requirement to spend mandatory rebate funds prior to spending federal funds. Therefore, the revised Current Year budget also includes unspent 2015 ADAP Earmark funds of \$5.9 million. OA will submit a carryover request to use these unspent 2015 federal funds for ADAP expenditures in the Budget Year.

For FY 2016-17, ADAP's federal fund expenditure authority increased by \$32.9 million compared to the *2016-17 Governor's Budget*. In December 2015, CDPH applied for the maximum amount of \$11.0 million for the competitive 2016 ADAP ERF supplemental grant. In March 2016, ADAP received the Notice of Award for \$10,991,645. The ADAP ERF awards are intended for states/territories that demonstrate the need for additional resources to prevent, reduce, or eliminate ADAP waiting lists, including through cost-containment measures. ADAP will use these funds for drug expenditures and cost-containment measures including payment of medical out-of-pocket costs. Due to the HRSA requirement to spend mandatory rebate funds prior to spending federal funds, ADAP anticipates utilizing 2016 ADAP ERF (April 1, 2016 to March 31, 2017) in the Budget Year. ADAP's revised FY 2016-17 federal fund expenditure authority also includes ADAP Earmark funds based on the total 2015 ADAP Earmark award instead of a portion of the award.

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 \$65,162,316. 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.

##### **New Assumptions/Premises**

There are no New Assumptions.

##### **Existing Assumptions/Premises**

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

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 private insurance plans, 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 occurred in May 2015 for the month of April 2015. Clients who are found to be enrolled in Medi-Cal without a SOC are disenrolled from ADAP after confirmation of their coverage. As of February 23, 2016, 379 clients identified as enrolled in Medi-Cal with no SOC and who do not have Medicare were dis-enrolled from ADAP with a notation made that they are enrolled in Medi-Cal. When these clients arrive at an ADAP pharmacy to get their medications, the medications are billed to Medi-Cal rather than to ADAP. OA will recoup any prior ADAP expenditures for these clients, to the extent allowable by Medi-Cal, through a back-billing process by the PBM.

This cross match between Ryan White client data and MEDS client data identified ADAP clients who are also Medi-Cal clients with a SOC. As of February 24, 2016, 25 ADAP-only clients have been identified as enrolled in Medi-Cal with a SOC. When these clients arrive at an ADAP pharmacy to get their medications, ADAP pays for medication costs up the SOC amount. OA will recoup any prior ADAP expenditures for these clients, to the extent allowable, through a back-billing process.

- a. FY 2015-16: OA estimates the cross match will achieve savings for 387 clients served by ADAP and enrolled in Medi-Cal during FY 2015-16, including those who were identified in FY 2014-15. This will result in \$5.8 million in expenditure savings and approximately \$630,000 in lost rebate revenue, including the usual six-month rebate delay. The estimated net savings is \$5.1 million.
- b. FY 2016-17: OA estimates the MEDS cross match will identify 96 clients served by ADAP and enrolled in Medi-Cal during FY 2016-17. This will result in \$1.3 million in savings (\$1.5 million in expenditure savings and \$200,000 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 \$7.3 million in FY 2016-17 (\$9.2 million in expenditure savings and \$1.9 million in lost rebate). The total net savings is not additive from each year; ADAP will realize more savings in FY 2016-17 than in FY 2015-16 for the clients identified in FY 2015-16 because these savings are accumulating starting July 2016 to June 2017 rather than their disenrollment month in FY 2015-16 to June 2016.

**Unchanged Assumptions/Premises****1. Payment of Out-of-Pocket Medical Expenses for All OA-HIPP Clients**

The payment of out-of-pocket medical expenses for OA-HIPP clients was an Existing Assumption in the *2016-17 Governor's Budget*. The Insurance Benefits Manager and Medical Benefits Manager contract was awarded on January 5, 2016 to Pool Administrators, Inc. The contract was executed on March 2, 2016. ADAP is working with the contractor on implementation with the goal of providing services starting July 1, 2016.

- a. FY 2015-16: OA estimates that zero additional clients will enroll in OA-HIPP/Covered California due to payment of medical out-of-pocket costs in FY 2015-16, leading to no additional savings during FY 2015-16.
- b. FY 2016-17: OA estimates that 617 additional clients will enroll in OA-HIPP/Covered California due to payment of medical out-of-pocket costs in FY 2016-17, leading to additional savings of approximately \$1.2 million during FY 2016-17.

**2. Hepatitis C Virus (HCV) Drugs**

The expansion of HCV medication to include all HCV co-infected ADAP clients, regardless of liver disease stage, was an Unchanged Assumption in *2016-17 Governor's Budget*. There are no changes to this assumption.

- a. In FY 2015-16, OA estimates 124 clients will be treated for HCV, with \$4.8 million in program expenditures and \$1.2 million in rebate revenue. The estimated net cost is \$3.6 million.
- b. For FY 2016-17, OA estimates 125 clients will be treated for HCV, with \$5.3 million in program expenditures and \$2.5 million in rebate revenue, for a net cost of \$2.8 million.

**Discontinued Major Assumptions**

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 drugs on the ADAP formulary. In addition, the PBM provides enrollment and recertification services including conducting enrollment worker trainings, providing customer service support to ADAP enrollment workers and clients, 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 deductible, co-payment, and/or co-insurance claim for private insurance and Medicare Part D clients. The contract was executed on July 1, 2011 and terminates on June 30, 2016.

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

The PBM contract was awarded on March 11, 2016 to Magellan Rx Management and the EBM contract was awarded on March 4, 2016 to A.J. Boggs & Company. ADAP will work with the PBM contractor during the implementation phase to define the requirements of the agreement by the go-live date including prescription utilization controls for prescription claims processing and adjudication. The go-live date for these contracts is July 1, 2016; therefore, OA will provide estimated costs or savings in the *2017-18 ADAP November Estimate*.

### 2. The HRSA 340B Drug Pricing Program Omnibus Guidance

The Federal Department of Health and Human Services (HHS), 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 full rebates on partial pay claims are a vital part of ADAP's annual budget.

On August 28, 2015, HRSA proposed new 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>). The proposed guidance limits ADAPs' authority to collect full rebates on partial pay claims. The guidance proposes that the 340B discount on partial pay claims only be permitted if ADAP pays the premium on behalf of the client for the health insurance plan tied to the claim. HRSA has proposed a one-year delay in the implementation of the guidance to allow covered entities, such as ADAP, the time to implement changes. Therefore, OA does not anticipate that ADAP's rebate revenue will be impacted in FY 2016-17. On October 27, 2015, CDPH submitted a public comment response to HRSA, stating that if the guidance is finalized as proposed, OA estimates a rebate revenue loss of approximately \$122-145 million annually, starting in FY 2017-18.

The final guidance is expected to be published in September 2016, as listed in the HHS Regulations Agenda webpage: <http://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201510&RIN=0906-AB08>. However, the September 2016 date may be modified because of the high number of responses submitted during the public comment period.

## VI. Fund Condition Statement

<b>Table 5: Fund Condition Statement<sup>1</sup></b> (in thousands)					
<b>Special Fund 3080: AIDS Drug Assistance Program Rebate Fund</b>			<b>FY 2014-15 Actuals</b>	<b>FY 2015-16 Estimate<sup>2</sup></b>	<b>FY 2016-17 Estimate<sup>2</sup></b>
1	BEGINNING BALANCE		14,375	125,142	219,156
2	Prior Year Adjustment		12,888	0	0
3	Adjusted Beginning Balance		27,263	125,142	219,156
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	268,116	260,574
9	Total Revenues, Transfers, and Other Adjustments		309,985	268,236	260,694
10	Total Resources		337,248	393,378	479,850
11	EXPENDITURES AND EXPENDITURE ADJUSTMENTS				
12	Expenditures				
13	8880	FISCal	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	159,554	177,163
17		Insurance Assistance Programs (Premiums)	15,362	13,102	19,871
18					
19	Total Expenditures and Expenditure Adjustments		212,106	174,222	198,682
20	FUND BALANCE		125,142	219,156	281,168
<b>Row 6: Interest Actuals for FY 2014-15, Estimated for FYs 2015-16 and 2016-17</b>			128,957	120,000	120,000
<b>Miscellaneous Revenue</b>					
	Actual Rebate received July - Sept 2015 for Expenditures from Jan - March 2015			80,265,234	
	Estimated Rebates to be received for Actual Expenditures from Apr - June 2015			65,927,942	
	Estimated Rebates to be received for Actual Expenditures from July - Dec 2015			121,922,967	
	Estimated Rebates to be received Jul - Dec 2016 for Estimated Expenditures from Jan - Jun 2016				127,751,071
	Estimated Rebate to be received Jan - Jun 2017 for Estimated Expenditures from July - Dec 2016				132,822,528
	Total Estimated FY 2015-16 Rebate Revenue			268,116,143	
	Total Estimated FY 2016-17 Rebate Revenue				260,573,599

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

<sup>2</sup>Estimate numbers for 2015-16 and 2016-17 are updated for the May Revision Estimate.

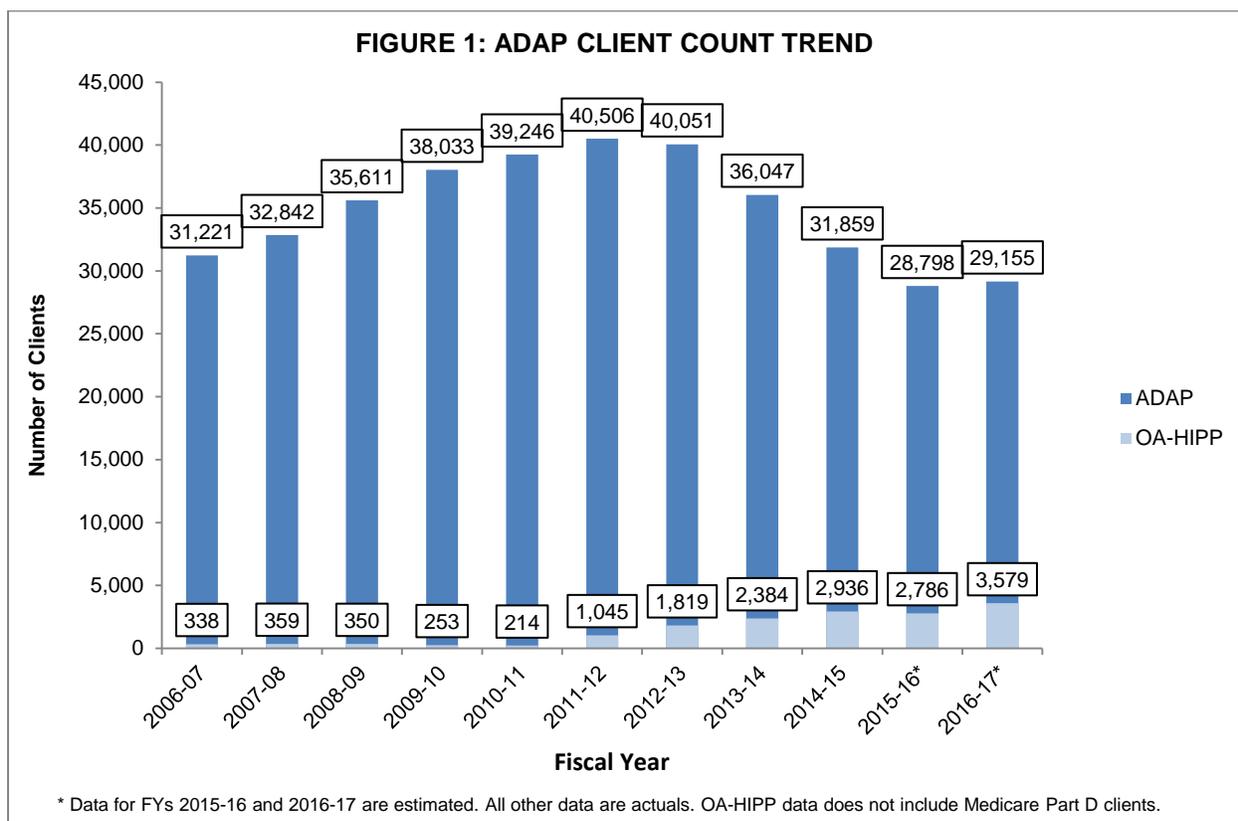
## VII. Historical Program Data and Trends

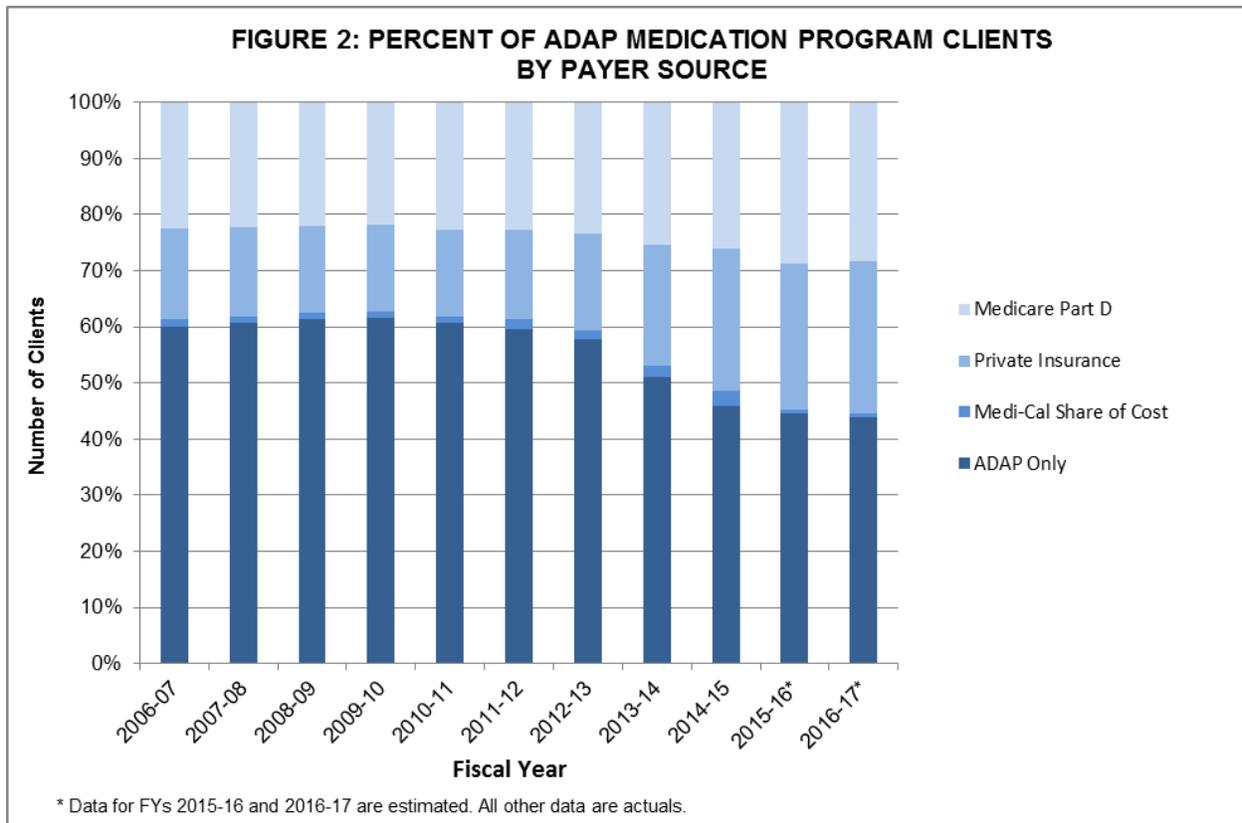
For all figures in this section, the data prior to FY 2015-16 is the observed historical data. Estimates for both FYs 2015-16 and 2016-17 are based on the overall projections and include all assumptions.

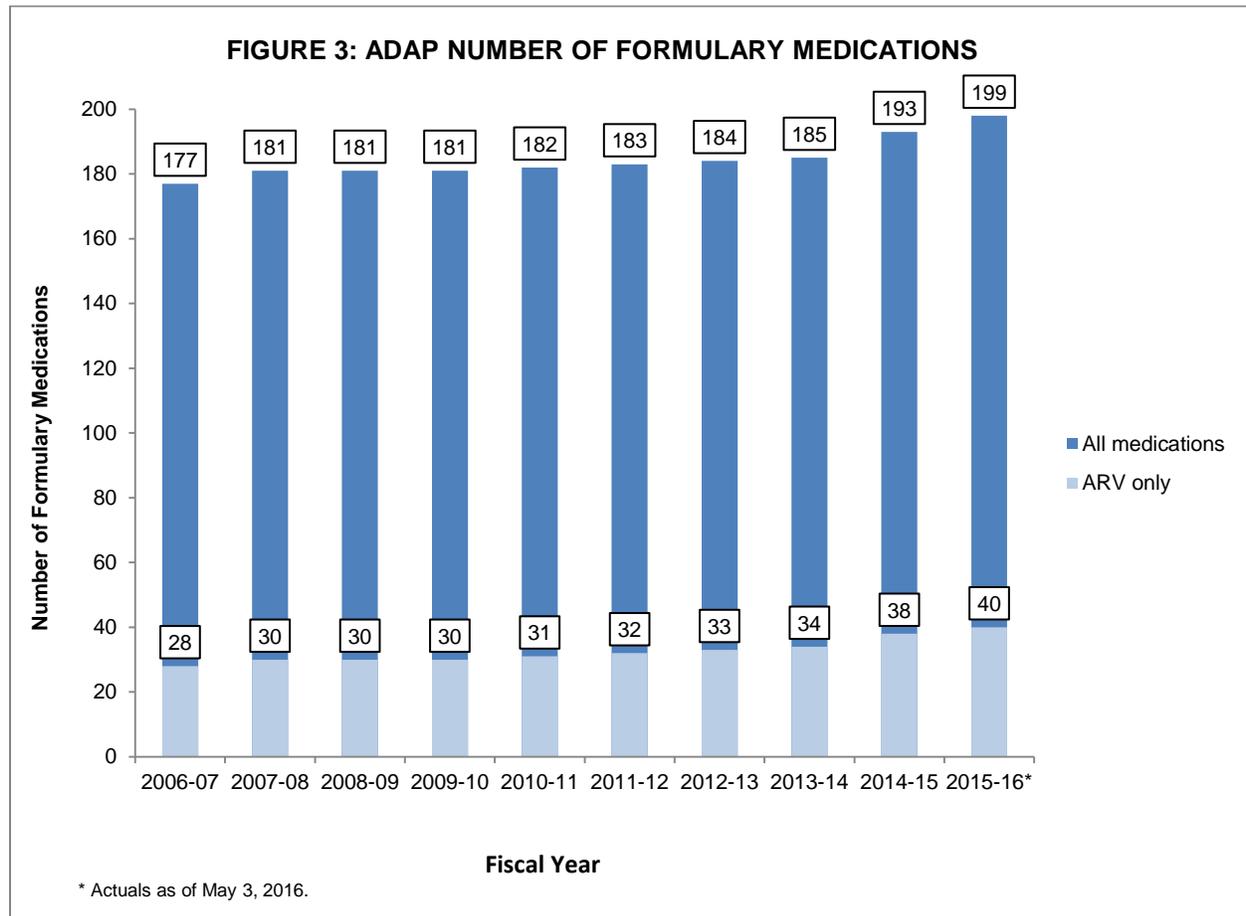
Figure 1 is a summary of total client counts in ADAP by FY; the number of ADAP medication program clients who are co-enrolled in OA-HIPP is also shown. OA-HIPP numbers only include clients with premium assistance for non-Covered California and Covered California plans. Clients with premium assistance 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 antiretroviral (ARV) medications is also shown.







- Ombitasvir/paritaprevir/ritonavir (Technivie™), a HCV medication, was added to the ADAP formulary on March 14, 2016.
- 9-valent human papillomavirus (HPV) vaccine was added to the ADAP formulary on April 22, 2016.
- Emtricitabine/rilpivirine/tenofovir alafenamide (Odefsey) and emtricitabine/tenofovir alafenamide (Descovy), combination ARVs, were added to the ADAP formulary on March 30, 2016 and May 3, 2016, respectively.

## **VIII. Current HIV/AIDS Epidemiology in California**

Approximately 124,694 persons living with HIV in California at the end of 2014 had been diagnosed and reported to OA. However, OA estimates that 9.0 percent of all persons living with HIV in California are unaware of their infection (as of the end of 2013—the latest data available). Therefore, OA estimates that there were approximately 137,000 persons living with HIV in California as of the end of 2014. Since the epidemic began, 101,267 Californians diagnosed with HIV have died, with about 1,483 dying in 2014 alone.

Of persons living with HIV in California, approximately 42.1 percent are White; 18.2 percent are Black/African American; 33.7 percent are Hispanic/Latino; 3.8 percent are Asian; 0.4 percent are American Indian/Alaskan Native; 0.2 percent are Native Hawaiian/Pacific Islander; and 1.7 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 (1,039 per 100,000 population, versus 358 per 100,000 among Whites, and 284 per 100,000 among Hispanics/Latinos).

Most of California's living HIV cases are attributed to male-to-male sexual transmission (66.1 percent); 9.0 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); 6.6 percent to injection drug use; 7.3 percent to men who have sex with men who also inject drugs; 0.6 percent to perinatal exposure; and 10.0 percent to other or unknown sources, including other heterosexual contact.

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 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.

## **IX. Appendices**

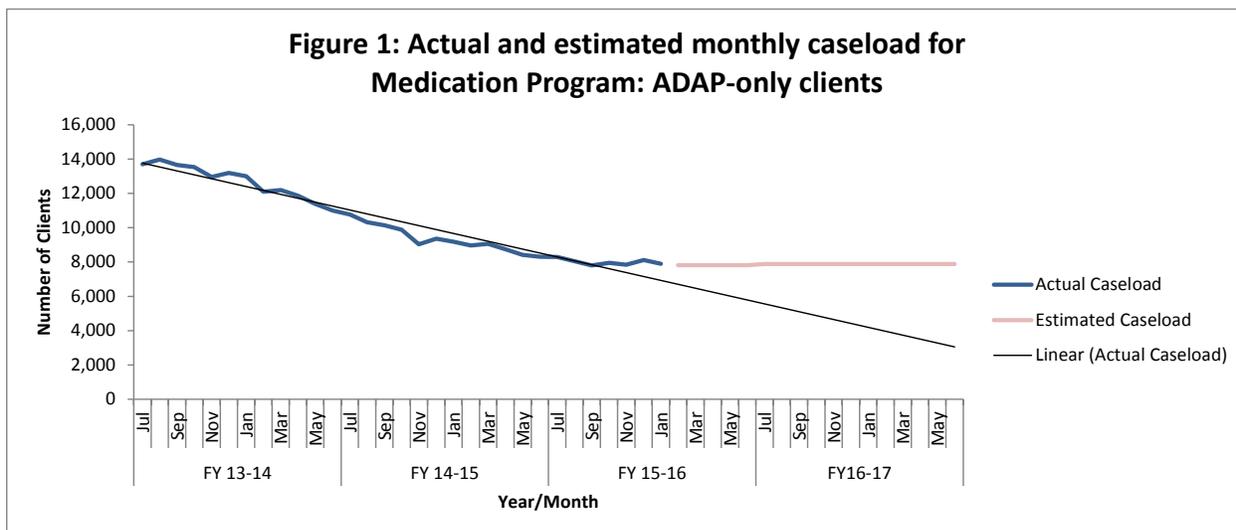
### **Appendix A: Assumptions and Rationale for Medication Expenditures – ADAP-only**

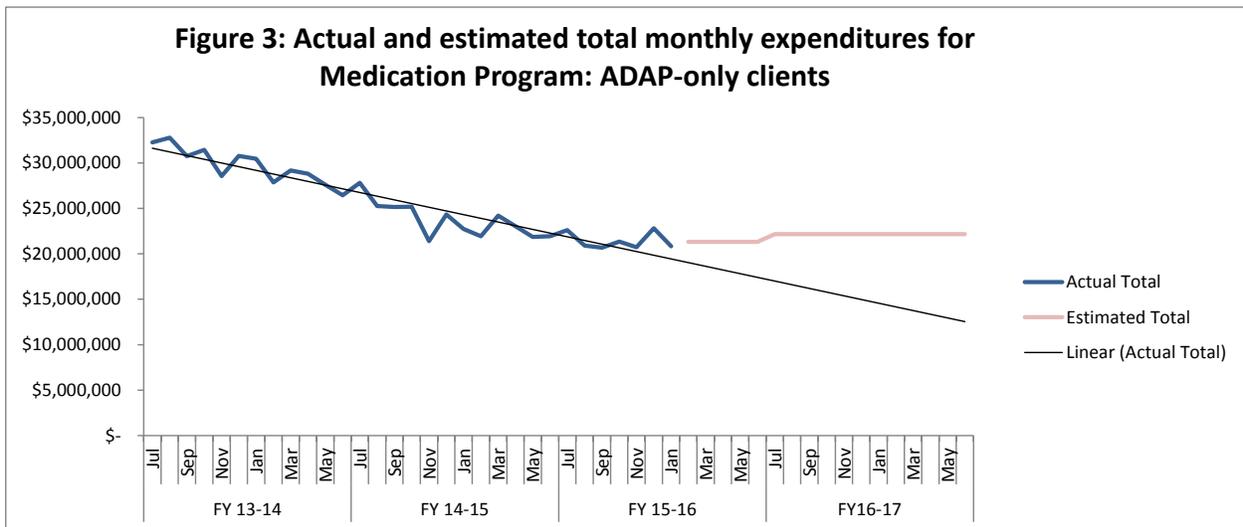
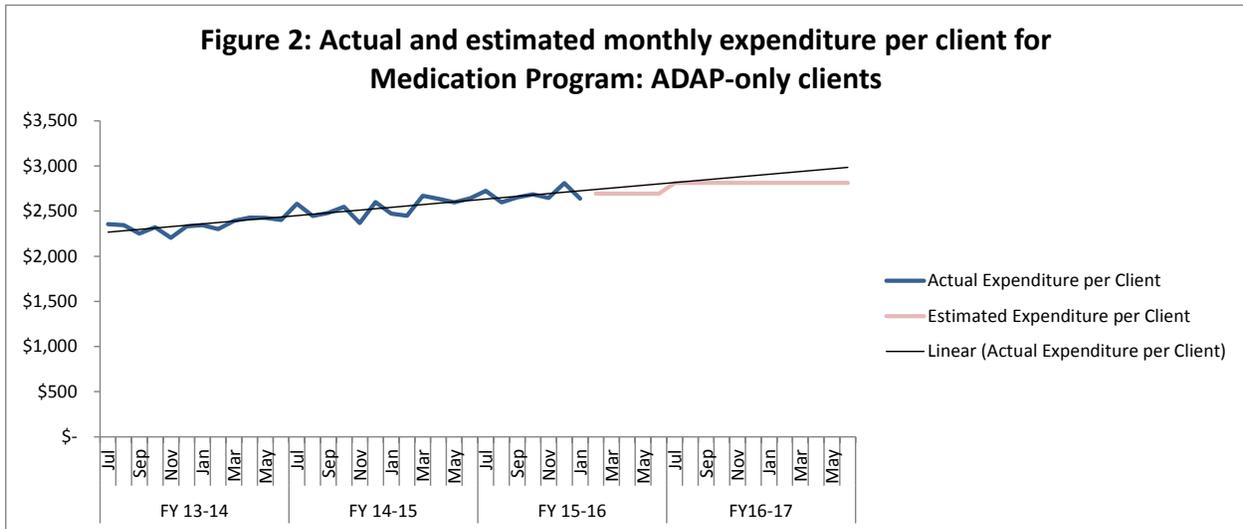
- A. ADAP-only caseload – OA estimates the average monthly caseload for ADAP-only clients in FY 2015-16 will be 7,914, a decrease of 15.4 percent compared to FY 2014-15. During FY 2016-17, OA estimates the monthly caseload will be 7,872, a decrease of 0.5 percent compared to FY 2015-16. These estimates are based on the following:
- a. Historic trends and unchanged assumptions: 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 seven months of FY 2015-16 decreased by 14.5 percent compared to FY 2014-15. These past trends were primarily driven by implementation of the Low-Income Health Program, Medi-Cal Expansion, and the transition of clients to Covered California. OA projects the caseload will continue to decline in FY 2015-16 due to ongoing enrollment in Medi-Cal Expansion and Covered California, although at a slower rate than in the past, and then stabilize in FY 2016-17.
    - 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 zero 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 401 clients will move to Covered California from ADAP only.
    - ii. HCV drugs: Not applicable (N/A) – this assumption will not impact the ADAP-only caseload.
  - b. Existing assumption.
    - i. Cross Match of Ryan White Client Data to MEDS: Based on the initial data matches performed thus far, OA estimates that savings from 387 clients moving from ADAP-only to Medi-Cal will occur during FY 2015-16. During FY 2016-17, OA estimates an additional 96 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 \$2,694, an increase of 6.1 percent compared to FY 2014-15. During FY 2016-17, OA estimates the average monthly per client expenditures will be \$2,815, an increase of 4.5 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 seven months of FY 2015-16 increased by 5.5 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 65 clients in FY 2015-16 and 65 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 \$48 in FY 2015-16 and \$54 in FY 2016-17. However, OA did not estimate the additional expenditures in FY 2016-17 because these expenditures are expected to be stable from year to year and are included in the baseline estimate model.

- b. Existing assumption.
  - 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 January 2016, 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.



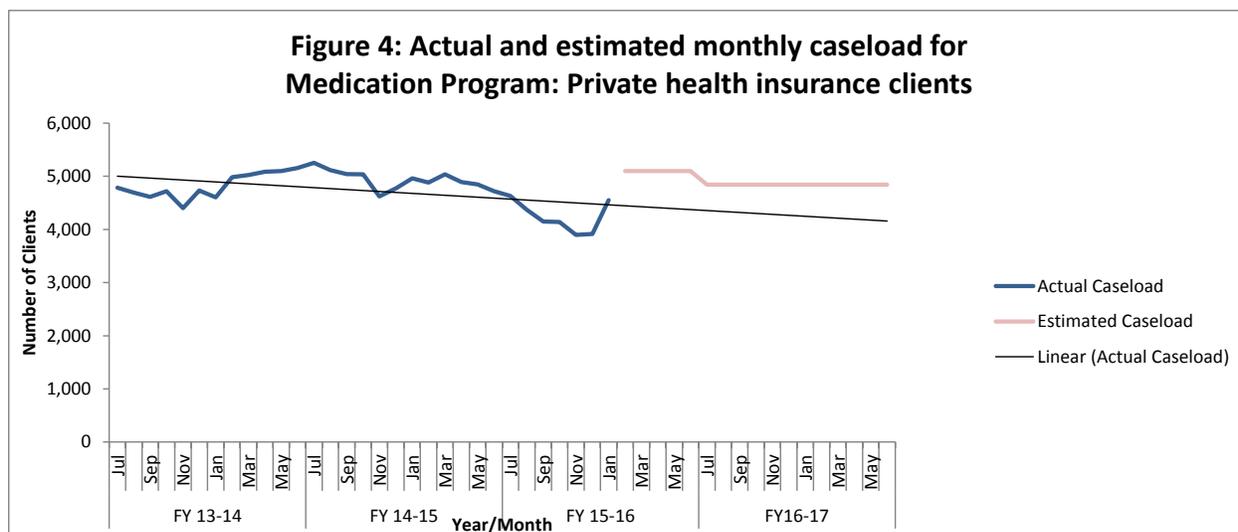


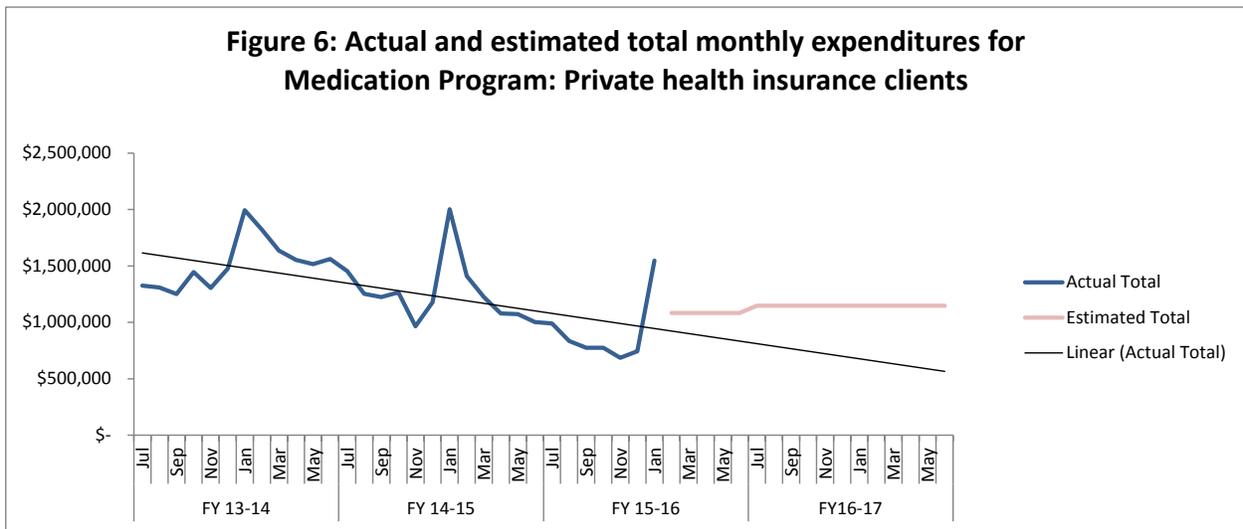
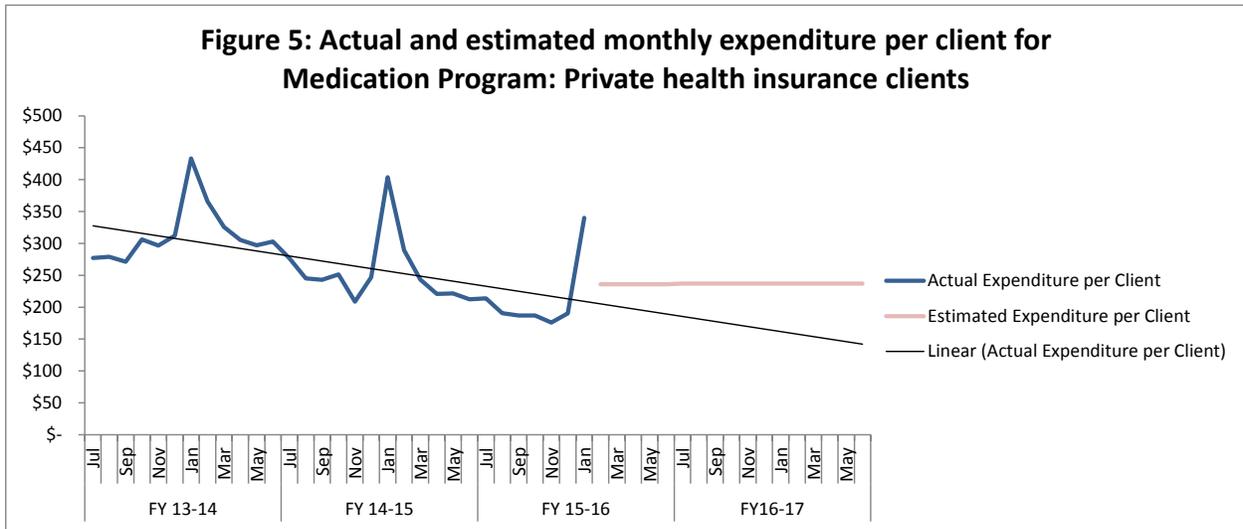
## **Appendix B: Assumptions and Rationale for Medication Expenditures – Private Health Insurance**

- A. Private health insurance medication expenditures caseload: OA estimates the average monthly number of private health insurance clients in FY 2015-16 will be 4,595, a decrease of 6.8 percent compared to FY 2014-15. During FY 2016-17, OA estimates the number will be 4,842, an increase of 5.4 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 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. Even considering normal seasonal variation, it is currently unclear why the number of private insurance clients decreased 14.2 percent in the first seven months of FY 2015-16 compared to FY 2014-15. OA is investigating potential causes for this change; at this point, we have no indication that this will become a new long-term trend.
    - 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 FY 2016-17. OA estimates zero clients will enroll in Covered California in FY 2015-16, and 617 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. Existing assumption.
    - 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 medication expenditures for private health insurance clients will be \$236/month for FY 2015-16, a decrease of 7.8 percent compared to FY 2014-15. In FY 2016-17, OA estimates the per-client medication expenditures for private health insurance clients will be \$237/month, an increase of 0.4 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 12.2 percent compared to the prior year, in part due to Covered California medication deductibles incurred at the beginning of the 2014 calendar 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 equivalents. There is substantial seasonal variation in per-client medication expenditures, reflecting the impact of medication deductibles at the start of the calendar year. The trend in per-client medication expenditures for private health insurance clients is driven by lower medication deductibles and co-pays, particularly for Covered California clients as compared to clients with employer-based health insurance or COBRA plans. Because the number of clients enrolled in Covered California versus non-Covered California plans has stabilized, OA expects the prior impact of these changes to decrease 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 17 private health insurance clients in FY 2015-16 and 18 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 \$0 in FY 2015-16 due to few clients and associated expenditures and \$0 in FY 2016-17 even when HCV drug costs are included in the baseline estimate model.
- b. Existing assumption.
- 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 January 2016, 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.

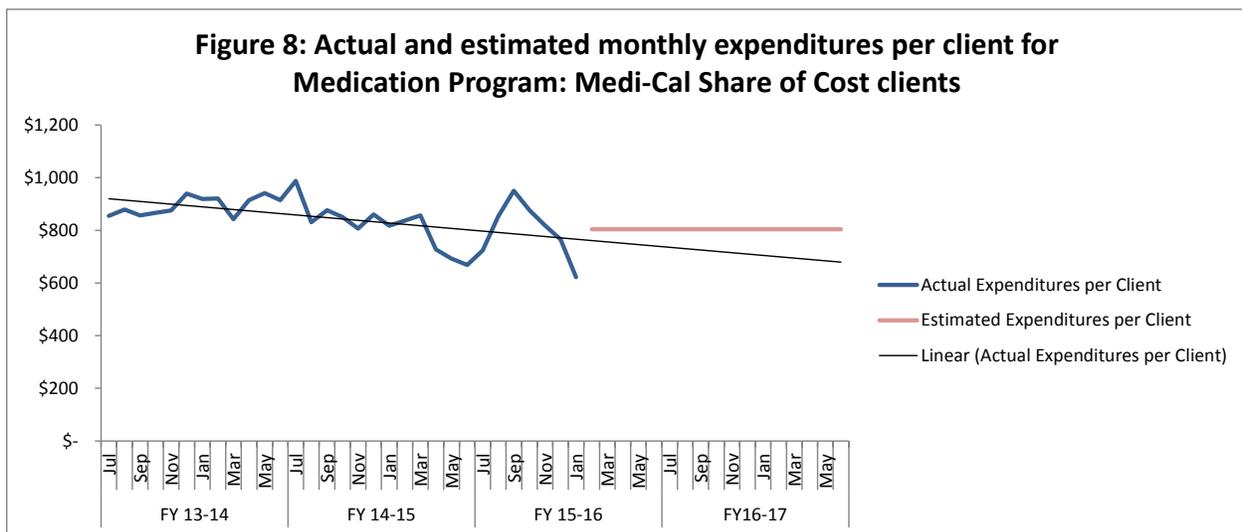
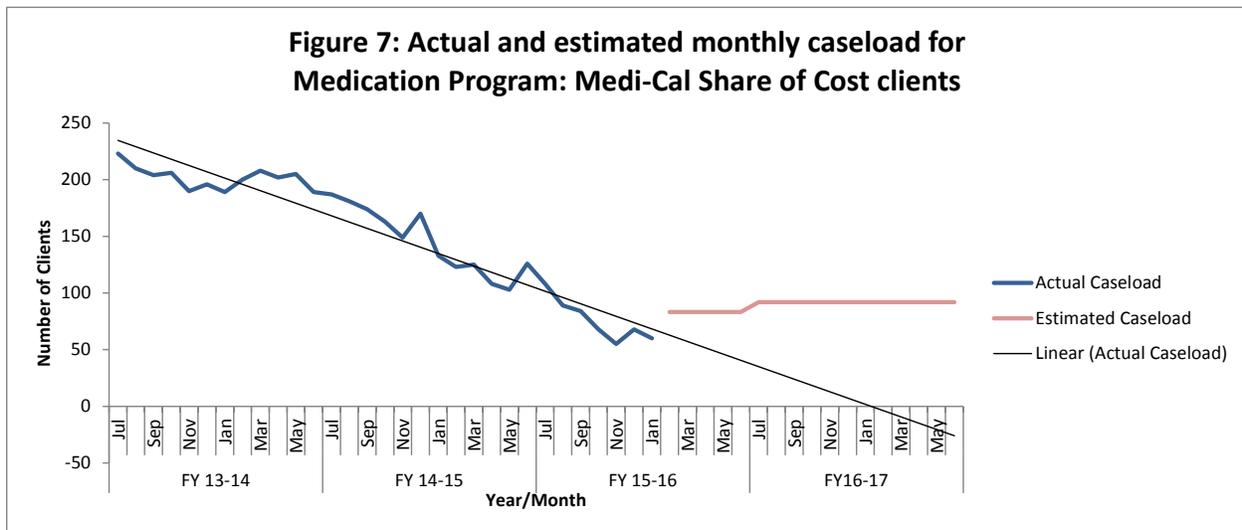


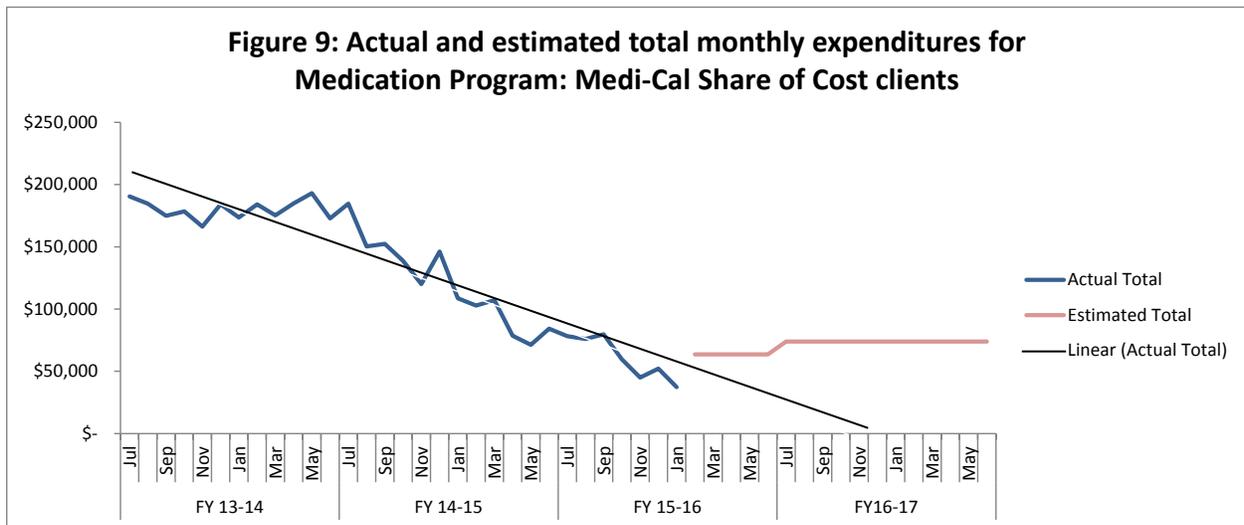


## **Appendix C: Assumptions and Rationale for Medication Expenditures – Medi-Cal SOC**

- A. Medi-Cal SOC caseload – OA estimates the average monthly number of Medi-Cal SOC clients in FY 2015-16 will be 79, a decrease of 45.6 percent compared to FY 2014-15. During FY 2016-17, OA estimates the number will be 92, a 16.5 percent increase 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 seven months of FY 2015-16 decreased by 47.7 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 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 increase due to identifying ADAP-only clients who are Medi-Cal SOC clients.
    - i. Payment of out-of-pocket medical costs for OA-HIPP clients: N/A.
    - ii. HCV drugs: N/A.
  - b. Existing assumption.
    - i. Cross Match of Ryan White Client Data to MEDS: Based on our initial match, OA estimates 27 ADAP-only clients served will transition to Medi-Cal SOC in FY 2015-16 and an additional 36 clients will transition in FY 2016-17.
- 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 \$804, a decrease of 3.1 percent compared to FY 2014-15. During FY 2016-17, OA estimates the average monthly per-client expenditure will also be \$804, no change 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 seven months of FY 2015-16 decreased by 3.1 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 no 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 \$0 in FYs 2015-16 and FY 2016-17 even when HCV drug costs are included in the baseline model.
  - b. Existing assumption.
    - i. Cross Match of Ryan White Client Data to MEDS: Although the cross match will increase the number of Medi-Cal clients with a SOC in ADAP, OA estimates there will be no change to the average monthly per client expenditure at this time.

The following figures (Figure 7-9) show the actual Medi-Cal SOC caseload and expenditures per client per month during July 2013 through January 2016, 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.

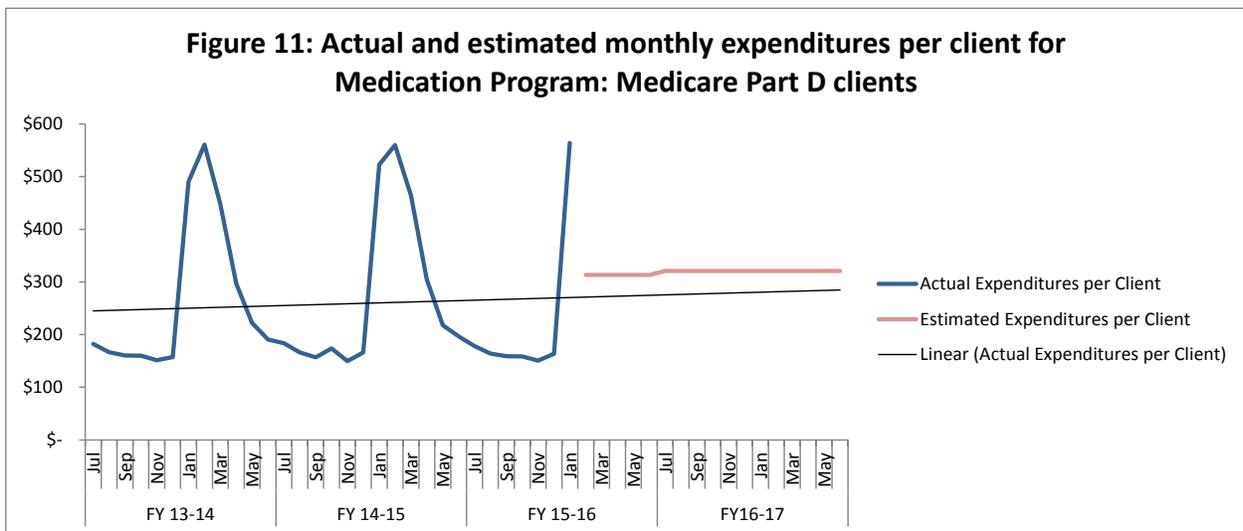
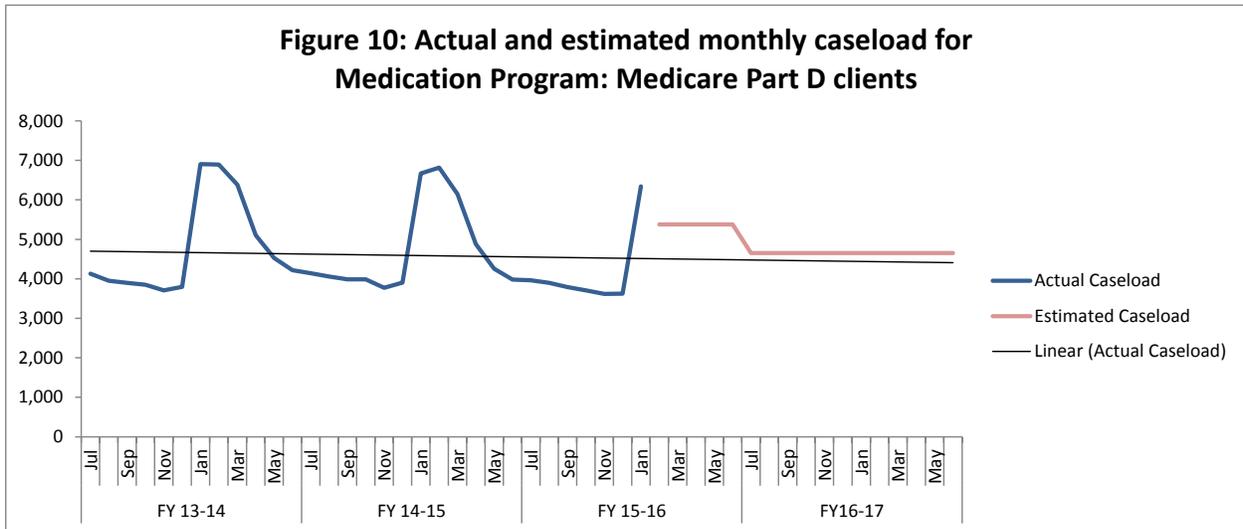


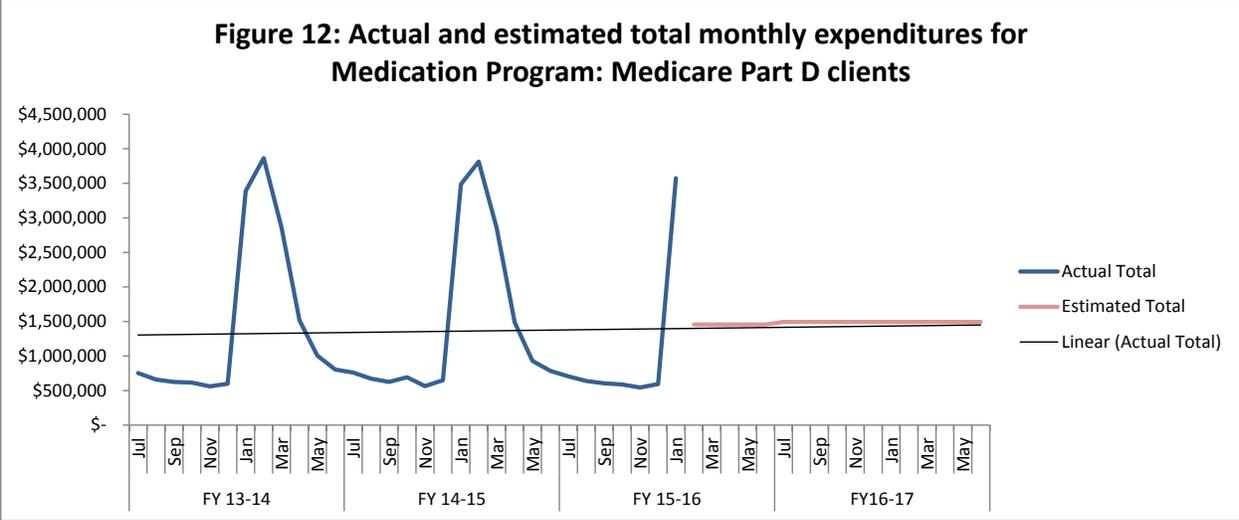


## **Appendix D: Assumptions and Rationale for Medication Expenditures – Medicare Part D**

- A. Medicare Part D caseload – Overall, OA estimates average monthly caseload for clients in Medicare Part D will be 4,652 in FYs 2015-16 and 2016-17, which is a 1.4 percent decrease from FY 2014-15 and no change from FY 2015-16, respectively. This 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 seven months of FY 2015-16 declined 12.4 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. Existing assumption.
    - 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 \$313, an increase of 2.4 percent compared to FY 2014-15. During FY 2016-17, OA estimates the average monthly per-client expenditure will be \$321, another increase of 2.4 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 Medicare Part D average monthly expenditure per client increased 3.7 percent. The expenditure per client during the first seven months of FY 2015-16 decreased by 18.9 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 41 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 \$2 in FY 2015-16 and \$0 in FY 2016-17 when HCV drug costs are included in the baseline estimate model.
  - b. Existing assumption.
    - i. Cross Match of Ryan White Client Data to MEDS: N/A.

The following figures (Figures 10-12) show the actual Medicare Part D caseload and expenditures per client per month during July 2013 through January 2016, 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**

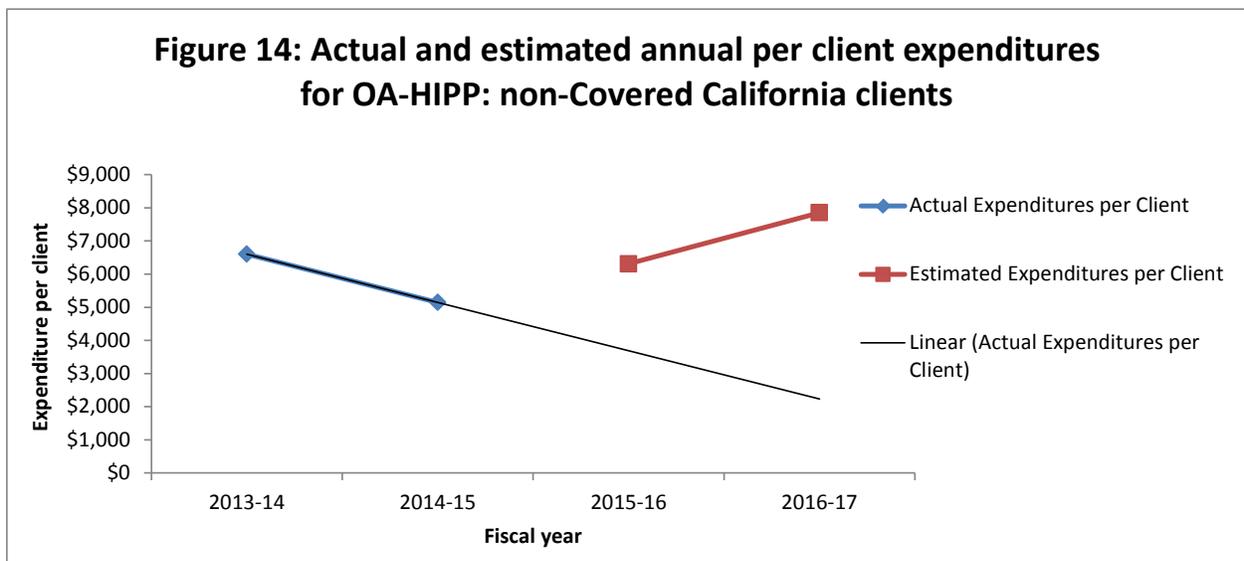
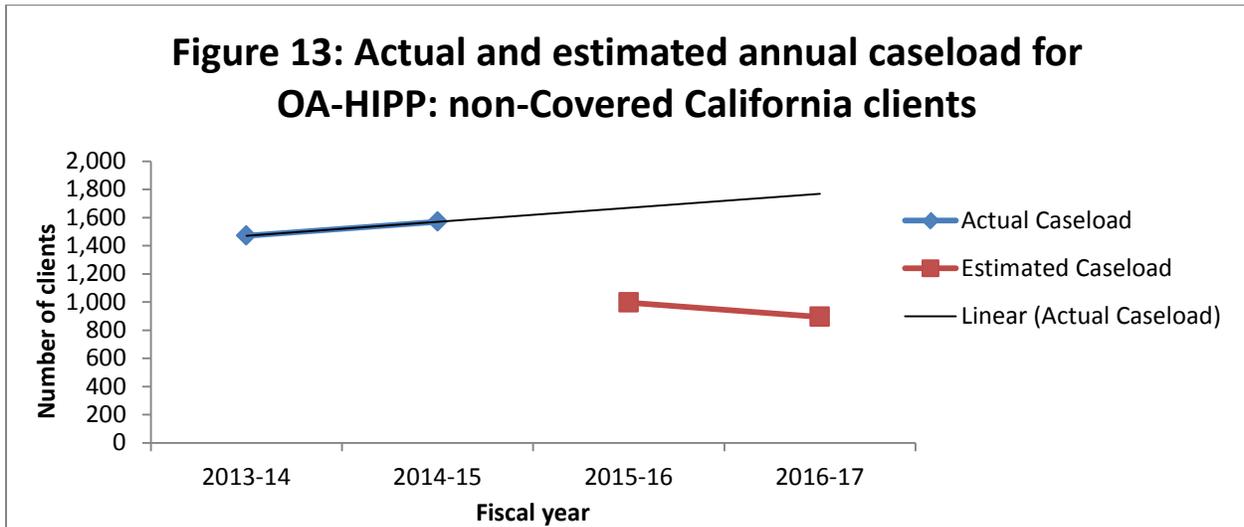
- A. Caseload for non-Covered California private health insurance clients – Overall, OA estimates the annual<sup>1</sup> caseload for clients in the OA-HIPP non-Covered California program in FY 2015-16 will be 997, a decrease of 36.5 percent compared to FY 2014-15. During FY 2016-17, OA estimates the number will be 895, a decrease of 10.2 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.
    - ii. HCV drugs: N/A.
  - b. Existing assumption.  
Cross Match of Ryan White Client Data to MEDS: 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 \$6,312, an increase of 22.7 percent compared to FY 2014-15. During FY 2016-17, OA estimates the expenditures will be \$7,855, an increase of 24.5 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 have increased in Current Year 2015 and 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 \$0 per client in FY 2015-16, and by \$912 per client in FY 2016-17.
    - ii. HCV drugs: N/A.
  - b. Existing assumption.

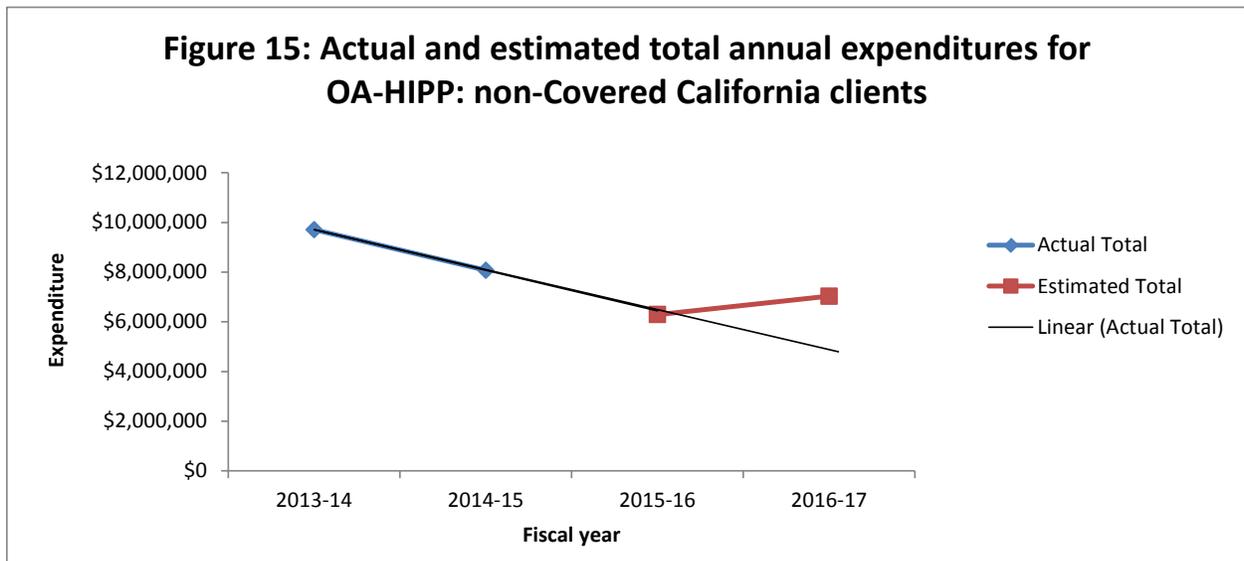
---

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

i. Cross Match of Ryan White Client Data to MEDS: N/A.

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 Current Year (FY 2015-16) and Budget Year (FY 2016-17). The linear trend for the actual data is also shown.





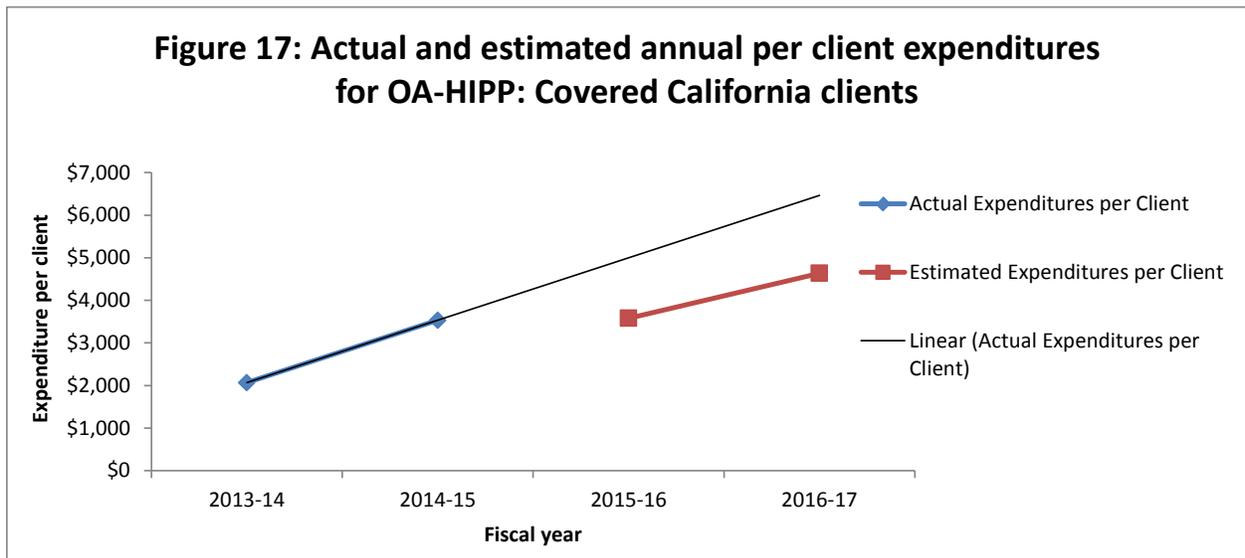
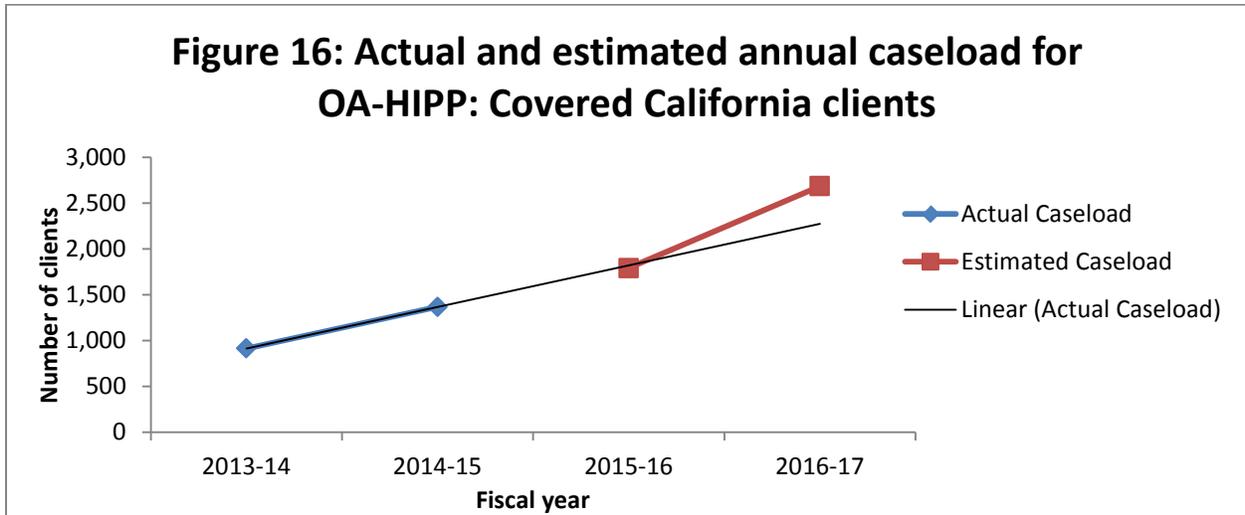
**Appendix F: OA-HIPP Covered California Premium Expenditures**

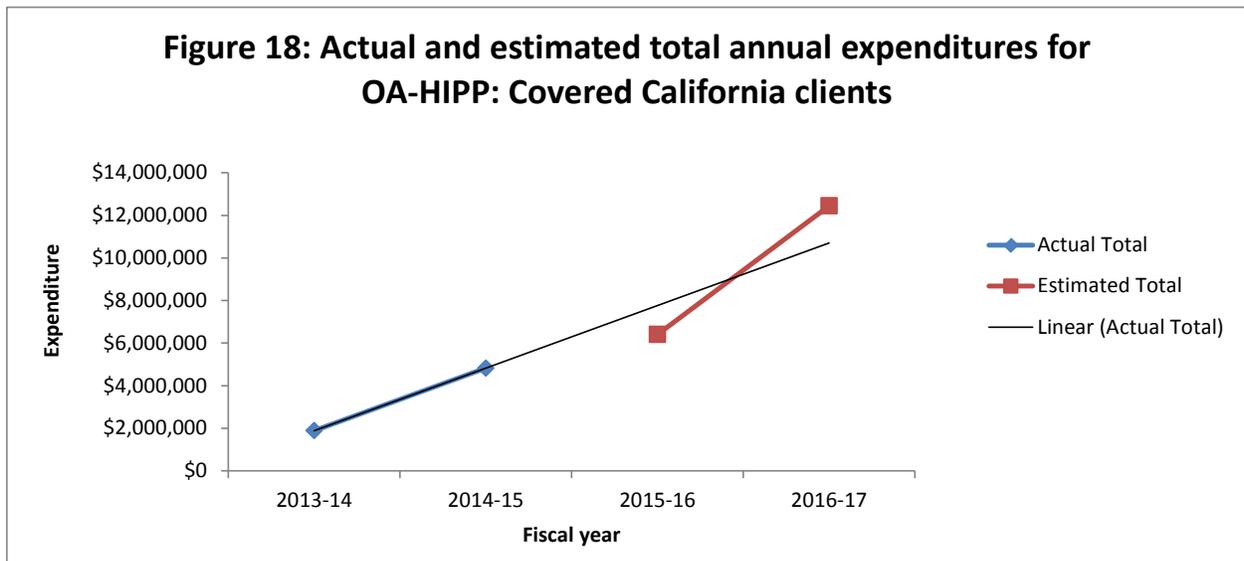
- A. Caseload for OA-HIPP Covered California - Overall, OA estimates annual<sup>2</sup> caseload for clients in the OA-HIPP Covered California in FY 2015-16 will be 1,789, an increase of 31.0 percent compared to FY 2014-15. During FY 2016-17, OA estimates the number will be 2,684, an increase of 50.0 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 increase during FYs 2015-16 and 2016-17 due to increased enrollment in Covered California during open enrollment for Current Year 2016. 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 zero additional clients will enroll in OA-HIPP Covered California in FY 2015-16 due to coverage of out-of-pocket medical costs, and 617 additional clients in FY 2016-17.
    - ii. HCV drugs: N/A.
  - b. Existing assumption.
    - i. Cross Match of Ryan White Client Data to MEDS: 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 \$3,581, an increase of 1.4 percent compared to FY 2014-15. During FY 2016-17, OA estimates the expenditures will be \$4,637, an increase of 29.5 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: 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 that 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 OA-HIPP expenditures. OA anticipates that this assumption, including administrative fees, will increase the annual per-client health insurance expenditure for OA-HIPP Covered California clients by \$0 in FY 2015-16, and by \$912 in FY 2016-17.
    - ii. HCV drugs: N/A.
  - b. Existing assumption.
    - i. Cross Match of Ryan White Client Data to MEDS: N/A.

---

<sup>2</sup> 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 OA-Medicare Part D 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. Payment of out-of-pocket medical costs for OA-HIPP clients: N/A. Medicare Part D clients are not included in this assumption.
    - ii. HCV drugs: N/A.
  - b. New assumptions.
    - i. Cross Match of Ryan White Client Data to MEDS: N/A.
- B. Expenditures per client for OA-Medicare Part D clients - Overall, OA estimates average annual premium expenditures per client in OA-Medicare Part D in FY 2015-16 will be \$631, a zero percent change compared to FY 2014-15. During FY 2016-17, OA estimates the expenditures will continue to 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. 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.

The following figures (Figures 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.

