2017 AIDS Drug Assistance Program Report

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Contents

EXECUTIVE SUMMARY

The Virginia Department of Health (VDH) had 6,359 clients enrolled in the Virginia (VA) Acquired Immunodeficiency Syndrome (AIDS) Drug Assistance Program (ADAP) as of March 31, 2017. Approximately 76% of VA ADAP clients are currently receiving medications through insurance support mechanisms (i.e., Affordable Care Act (ACA), Medicare Part D, and Insurance Continuation), and 24% are directly receiving medications distributed through local health departments (LHDs) or other clinic sites. Providing medication through purchasing insurance plays a key role in ADAP sustainability and has allowed ADAP to avoid implementing a waiting list since the elimination of its prior waiting list in 2012.

Background

VA ADAP provides access to life-saving medications for the treatment of Human Immunodeficiency Virus (HIV) and related illnesses for low-income clients through the direct provision of medications or by paying insurance premiums and/or co-payments on the client's behalf. The program is supported with federal Ryan White Treatment Extension Act Part B grant funding, which is distributed to jurisdictions utilizing a formula based on the number of HIV and AIDS cases in each state or territory. VA ADAP also receives an annual appropriation of $200,000 from state general funds. Other funding sources include Medicaid reimbursements for clients who receive retroactive eligibility and rebates on eligible medications from pharmaceutical manufacturers.

Accomplishments

- As of March 31, 2017, VA ADAP successfully supported enrollment of 3,695 clients through ACA plans, with 570 persons newly enrolled into ACA plans in 2017. Cost savings to ADAP from insurance enrollment enabled VDH to support more core medical and support services for people living with HIV in the state.

- The continuing collaboration between VDH and statewide ADAP stakeholders contributed to enrollment success. VDH provided regular updates on enrollment progress through multiple communication strategies and worked proactively with partners to identify and solve challenges to maximize insurance enrollment.

Challenges

- VDH experienced difficulties with receiving and processing information on enrollment into ACA plans.
- Several variables will affect future program need, including potential changes to ACA and the stability of rebates from the pharmaceutical industry. For 2018, three major challenges will be the shortened ACA open enrollment period, which at 45 days is half the time of open enrollment periods since the start of the ACA, the loss of at least two insurers from the health insurance Marketplace, and the exclusion of ADAP clients' HIV medical providers from some carrier networks.

Recommendations

- Current projections indicate that program resources will enable VA ADAP to serve all eligible clients if ACA and other insurance plan options and enrollment remain stable. If ACA were repealed, however, VA ADAP would face significant cost increases. This could result in a large shortfall for the program and a waiting list for ADAP services. Monitoring of all variables and reassessment, therefore, will be necessary to determine if resources are adequate to serve all eligible clients in both the current and upcoming grant year.
- In order to maintain adequate insurance enrollment to ensure sustainability, VA ADAP needs to increase its insurance analysis capabilities and enrollment capacity. VDH is implementing multiple new strategies to meet these needs.

List of Acronyms

ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immunodeficiency Syndrome
BOI	Bureau of Insurance
CDC	Centers for Disease Control and Prevention
CD4	Cluster of Differentiation 4
CMS	Centers for Medicare and Medicaid Services
CSR	Cost Sharing Reduction
CY	Calendar Year
DIS	Disease Intervention Specialist
DDP	Division of Disease Prevention
DMAS	Department of Medical Assistance Services
E2VA	E2 Virginia
FTE	Full-time Equivalent
FPL	Federal Poverty Level
FY	Fiscal Year
GY	Grant Year
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
ICAP	Insurance Continuation Assistance Program
LHD	Local Health Department
MOOP	Maximum Out-of-Pocket
MPAP	Medicare Part D Assistance Program
PBM	Pharmacy Benefits Manager
PCIP	Pre-Existing Condition Insurance Plan
SPAP	State Pharmaceutical Assistance Program
STD	Sexually Transmitted Diseases
TES	Total Early Syphilis
UVA	University of Virginia
VA	Virginia
VDH	Virginia Department of Health

Background

VA ADAP helps to ensure that people living with HIV who are uninsured and underinsured have access to life-saving medications for the treatment of HIV and related illnesses. During grant year 2010,[1] VA ADAP experienced historically high pharmaceutical expenditures and unprecedented program utilization compared to the previous two years due to rising unemployment rates and corresponding loss of insurance, expanded HIV testing efforts, and new HIV treatment guidelines recommending initiation of HIV treatment as early as possible. Subsequently, in November 2010, aggressive cost containment measures were instituted in an effort to balance client demands with available resources. These included the implementation of a waiting list for VA ADAP services, the transition of some clinically stable patients to other sources of medication access, a reduction to the VA ADAP formulary, and enrollment restrictions. Through the implementation of a medical triaging process and increased program and pharmaceutical efficiencies, VDH began enrolling new and wait-listed clients in November 2011 and fully eliminated the waiting list in August 2012. Since this time, VDH has stabilized and expanded access to VA ADAP through direct purchase of medications and assistance with insurance premiums and medication co-payments. Figure 1 shows VA ADAP clients served[2] and enrolled from April 2009 to March 2017, with an overlay of the waiting list period.

VA ADAP client enrollment continues to increase, with a net enrollment of 22 clients per month between April 2016 and March 2017. The net enrollment each month accounts for clients dis-enrolling due to inactivity, death, moving out of state, or becoming ineligible for other reasons. As of March 31, 2017, there were 6,359 clients enrolled in VA ADAP, with 76% receiving medications through insurance support and 24% directly receiving medications through LHDs or

[1] Ryan White Part B grant years run from April 1 to March 31 and are named for the year in which they begin.
[2] Any eligible Ryan White Part B ADAP client who has a premium paid or medication/copay charged to ADAP.

other clinic sites.

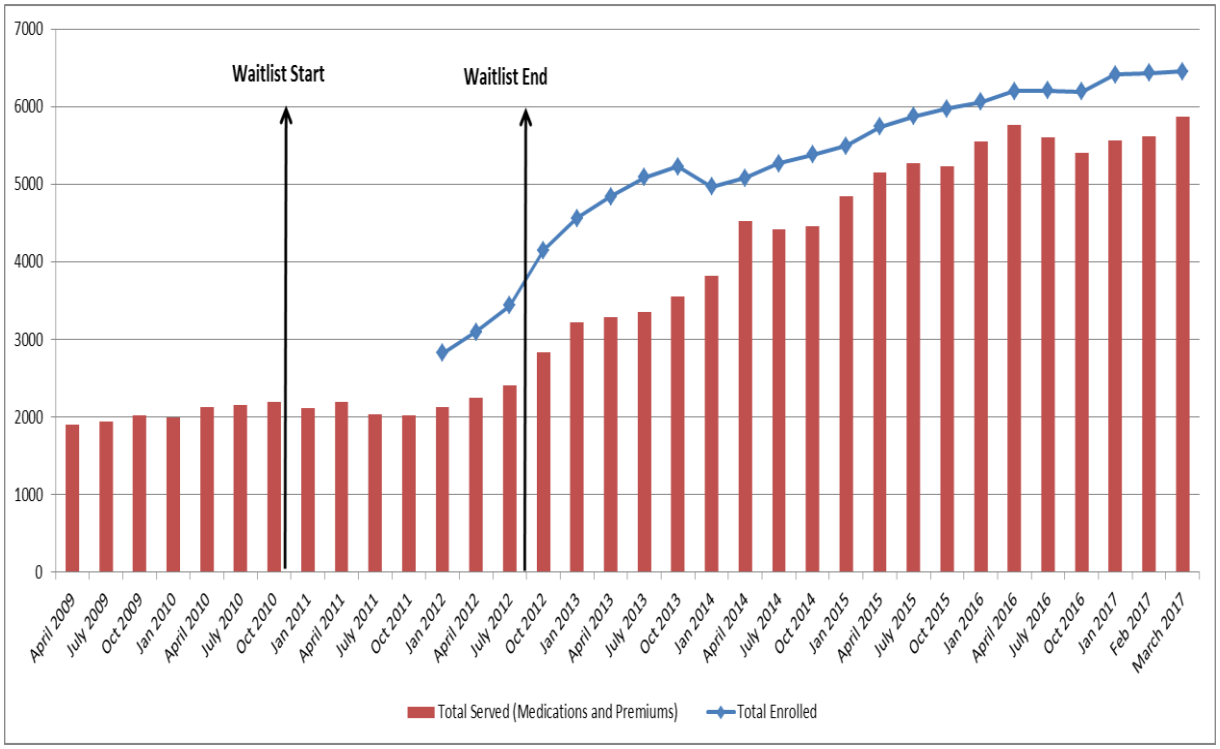

Figure 1. VA ADAP Clients Enrolled and Served: 2009 to 2017[3]

Directly purchased medications and insurance cost support are provided in the following ways:

- ACA and Other Insurance: The ACA provides an unprecedented opportunity to increase access to health insurance for eligible residents of the United States. VA ADAP pays premiums and medication cost shares (co-payments, coinsurance, and deductibles) for plans that meet federal and state ADAP criteria. Payments for medication cost shares count toward an individual's annual total maximum out-of-pocket expenditures (MOOP). For calendar year 2017, the MOOP is capped annually at $7,150 (or less depending on income) for ACA plans. Additionally, VA ADAP supports medication cost shares for eligible clients who have other forms of private insurance meeting federal and state ADAP criteria under

[3] Total served (medications and premiums) uses estimates prior to January 2014 for those receiving premium payments, as these data were not tracked historically. Source: VA ADAP Database.

the Insurance Continuation Assistance Program (ICAP). VA ADAP can support about 1.7 clients annually through ACA insurance for the cost[4] of serving one person through direct purchase of medications.

- Medicare Part D Assistance Program (MPAP): The MPAP pays insurance premiums and medication cost shares for VA ADAP eligible clients enrolled in Medicare Part D. VA ADAP began paying these costs in 2007 and is supported by state-appropriated State Pharmaceutical Assistance Program (SPAP) funds. As client needs for this program increased, SPAP and ADAP funding were utilized. VA ADAP can support over two clients annually on MPAP for the cost[4] of serving one person through direct purchase of medications.
- Direct Purchase ADAP: Medications on the ADAP formulary are purchased at discounted rates by the Central Pharmacy and are sent to LHDs and other sites for client distribution. Clients who are not eligible for or unable to enroll in other insurance or Medicare Part D receive medications through Direct Purchase ADAP.

The ADAP medication formulary includes antiretroviral medications indicated for the treatment of HIV, selected vaccines, antilipidemics, antiglycemics, mental health treatment, medications to treat hepatitis C virus (HCV) infection, medications to treat or prevent opportunistic infections, and smoking cessation medications. Antiemetics, gastroesophageal reflux disease agents, osteoporosis prevention agents, and other medications were added to the formulary in the past year. These medications are beneficial to VA ADAP because the pricing is significantly lower due to 340B pricing, which makes it more cost effective than the previous purchase mechanism using non-ADAP funds. VA ADAP covers all cost shares for medications on selected insurance plans'

[4] These costs are prior to rebates being applied. Inclusion of rebates results in a significantly lower net cost.

formularies. Eligible clients must have household incomes at or below 500% of the federal poverty level (FPL). Financial eligibility for VA ADAP was increased from 400% to 500% FPL effective July 1, 2017, to align VA with eligibility requirements of Maryland and the District of Columbia. Despite this change, the majority of enrolled clients (89%) have incomes below 250% FPL. As of March 31, 2017, 52% of the VA ADAP population had incomes at or below 100% FPL. Eligibility is assessed every six months to ensure VA ADAP serves only those who meet program criteria. Historically, Direct Purchase ADAP served the majority of clients. The majority (76%) of VA ADAP clients, however, now receive insurance support. Cost savings from insurance enrollment enabled VA ADAP to support more core medical and support services for people living with HIV in the state.

ACA Enrollment and Implementation

During the 2017 open enrollment period, November 1, 2016, through January 31, 2017, VDH facilitated the enrollment of 3,695 VA ADAP clients in ACA Marketplace plans. VA ADAP supported plans in all metal levels in 2017, including Gold, Platinum, Silver, and Bronze. Clients enrolling in ACA plans could select among approved eligible plans available in their jurisdiction of residence. Clients at certain income levels were instructed to enroll in a Silver level plan, which is the most cost-effective plan due to tax credits and subsidies. Similar to 2016, no single carrier covered the entire state; and one carrier reduced its coverage area significantly from the previous year.

Implementation Strategies

Prioritized Enrollment

Due to the limited time period to enroll clients into insurance plans, VA ADAP prioritized client groups for enrollment. Eligible clients who had not yet enrolled in an ACA plan were prioritized based on income and subsidy levels to ensure access to insurance. Clients with incomes between

100-250% FPL are most cost effective to insure due to tax credits and subsidies that reduce premium and medication cost share amounts. These clients, therefore, were contacted first. Clients with incomes of 251%-400% FPL were prioritized next as they receive tax credits that lower their monthly premiums. Clients with incomes below 100% FPL were contacted next for enrollment. Although clients with incomes less than 100% of the FPL receive no tax credit or subsidization for ACA plans, purchasing insurance remains more cost effective than directly purchasing medications for this group, who would be covered through Medicaid expansion if Virginia joins the 32 states who have implemented this option. Clients needing to enroll with a different carrier due to the discontinuation of their 2016 plan were the next priority. Finally, clients eligible for insurance plan re-enrollment were contacted to obtain updated 2017 information to ensure continuous coverage.

Outreach Efforts

In 2017, VA ADAP continued utilization of successful client engagement efforts from the 2016 open enrollment period. Strategies included direct mailings to VA ADAP clients that were tailored for those either re-enrolling and newly enrolling to ACA plans. The mailings provided information about VA ADAP-supported plans, directions for re-enrollment, and a referral list of selected Certified Application Counselor enrollment sites. VA ADAP-supported plans and criteria for obtaining ADAP assistance with plan costs were posted to the VA ADAP website and were communicated widely to clients and other stakeholders.

VA ADAP also worked with Ryan White service providers throughout the state to implement innovative strategies to help enroll clients into ACA plans. Service providers utilized Certified Application Counselors and other enrollment assistors, including social workers and medical case managers. Service providers referred eligible clients to community sites and developed an enrollment tracking system to coordinate efforts with VA ADAP. VA ADAP again encouraged

enrollment assistors to assess a client's potential need for services other than medications when choosing an insurance plan.

Stakeholder Communication

VA ADAP continued communication strategies implemented in previous years with stakeholders by distributing an email prior to the start of open enrollment to Ryan White providers, LHDs, clients, insurance assistors, and community advocates to make them aware of updates, challenges, and information needed to make a premium payment. All communications were posted to the VA ADAP website. VA ADAP held monthly statewide calls for Certified Application Counselors to provide updates on progress toward enrollment goals, information about ADAP-approved insurance plans and premium payment requirements, and an opportunity to address any concerns or problems. VA ADAP held debriefings at the conclusion of open enrollment with its staff, clients, Certified Application Counselors, and Ryan White service providers to assess the overall ACA open enrollment process and to strategize how to improve the process for the next open enrollment period. In summer of 2017, VA ADAP conducted a survey of medical providers, case managers, and clients to obtain feedback and to identify future needs regarding VA ADAP and open enrollment for the individual Marketplace. Several concerns and challenges from the survey findings are discussed below.

Challenges and Resolutions

Obtaining Updated Plan Information from Insurance Carriers

Navigating the re-enrollment process and obtaining updated information on available insurance plans from insurance companies again presented challenges in 2017. VDH continued its collaboration with the VA Bureau of Insurance (BOI) to obtain timely access to carriers' insurance plan information. This allowed ADAP to prepare client communication and instructions regarding VA ADAP insurance cost support as early as possible. Some insurance

carriers, however, instituted substantial changes in geographic coverage from the previous year. For example, a plan carrier that offered statewide coverage in 2016 was available only in the Eastern health region, parts of Northern VA, and parts of the Southwest health region for 2017. All enrollees were required to contact the Marketplace to confirm income and any other changes that may have occurred since their last insurance enrollment, as changes to family size, marital status, income, or residence can impact tax credit eligibility. VA ADAP worked closely with clients and enrollment assistors to ensure this action occurred.

Incomplete medication formularies offered by insurers continued to be challenging. While no insurers eliminated HIV medications from their formularies, they also did not add new medications. Medical providers continue to express concern regarding the amount of time required to complete the prior authorization and medication exception process through insurers. To help navigate this process and reduce these delays, VA ADAP referred providers to the guidance it created for each insurance carrier's unique medication exception and prior authorization procedures and posted it on the VA ADAP website.

Receiving Individual Insurance Plan Data from Clients

To make premium payments on behalf of insured clients, VDH must receive several critical pieces of information about each individual's insurance plan, including premium payment amount, group identification number, and other required data. Currently, clients or providers must submit plan information to VA ADAP via mail or fax, which creates a heavy volume of paper documents that must be processed and submitted for payment during the limited time frame of open enrollment. Providers and clients expressed concerns about the difficulty of communicating this information to VA ADAP in a timely manner. Inefficient handling of this large volume of documents, the receipt of incomplete information, or technology break downs may cause delays in processing an insurance payment. The insurer may dis-enroll a client from a

plan if premiums are not paid on time or an incorrect amount is paid. This can cause some clients to lose insurance coverage until the next open enrollment period and, therefore, switch to the more costly option of Direct Purchase ADAP to avoid interruptions in medication access. In response to these challenges, VDH worked closely with one insurance carrier and obtained updated 2017 premium information for approximately 1,000 clients in order to make correct payments and avoid dis-enrollments. Direct communication with insurance companies will continue to be pursued during the 2018 open enrollment period to efficiently receive individual plan information and premium amounts. VDH is also working on an electronic ACA information submission process via a checklist module in E2 Virginia (e2VA), the HIV services database, for the 2018 open enrollment period.

Program Infrastructure and Staff Capacity

Due to the limited time frame and high volume of work during open enrollment, VDH experienced challenges in maintaining timely responsiveness to client and provider needs. Specifically, due to the high call volume on the Medication Eligibility Hotline, stakeholders expressed concerns about being able to speak to a VA ADAP staff member when needed. To improve timely communication for stakeholders, an additional dedicated cell phone was established for ADAP calls. An additional fax line was made available for clients and others to send insurance plan information to VDH.

Current Utilization

ADAP utilization has continued to increase steadily from 2014 to 2017 as illustrated in Figure 1. ADAP pays insurance-related medication cost shares until the MOOP is met. As the year progresses, deductible and co-payment MOOP limits are often met for ACA plans. Clients continue to access medications, but ADAP is not able to track those prescriptions because the program does not have any cost share after the MOOP is met. VA ADAP initiated an incentive

payment to pharmacies to improve data capture on these no-cost co-payments, but there has not been high utilization of this incentive. Figure 2 illustrates monthly utilization by program from January 2014 through March 2017.

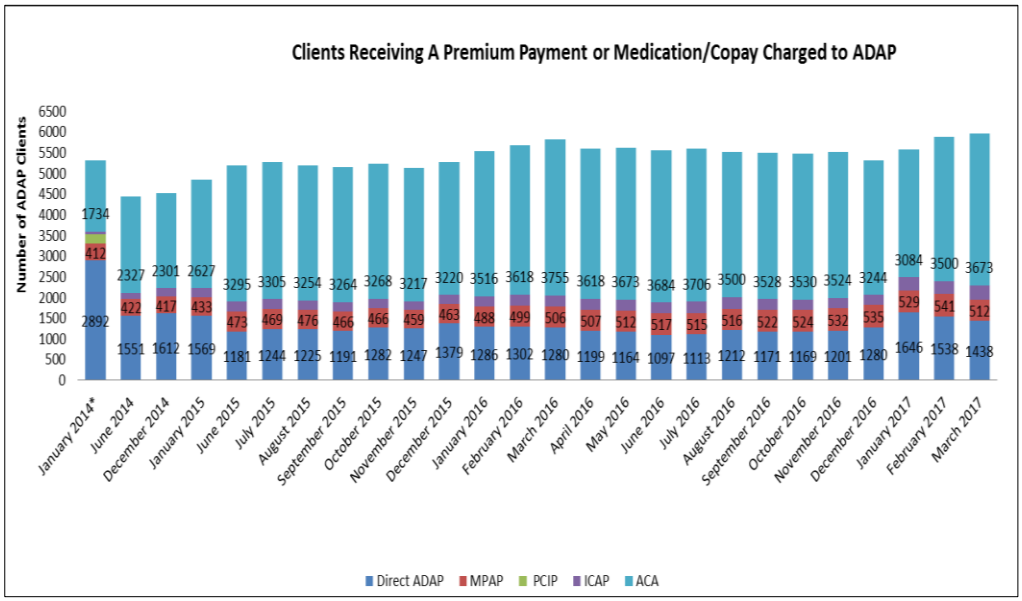

Figure 2. ADAP Utilization by Program: January 2014 to March 2017

Note: The chart depicts clients receiving a premium payment or medication/copay charged to ADAP, with the asterisk (*) indicating the start of full ACA plan coverage. The Pre-Existing Condition Insurance Plan (PCIP) was a temporary feature of ACA, used as a stop-gap method of coverage until the first open enrollment period, with the asterisk (*) indicating the start of full ACA plan coverage.

Monitoring ADAP enrollment and utilization is critical to ensuring that resources can meet growing program needs. Currently, the ADAP Leadership Team (a multidisciplinary group consisting of program, data, fiscal, pharmacy, and administrative staff) reviews ADAP enrollment and utilization numbers by program component on a weekly basis. Demand for ADAP services continues to grow with 7,147 unduplicated clients receiving services in grant year 2016 compared to 6,132 unduplicated clients in grant year 2015. This growth is driven by several key factors, including coverage of medication co-payments for those with private insurance to assure medication adherence, heightened efforts that have expanded HIV testing, improved outreach efforts linking clients into care or re-engaging clients in care, and Department of Health and Human Services HIV treatment guidelines that support the initiation of treatment

with medications early in the course of disease. The goal of early treatment initiation is to suppress HIV, lowering the amount of virus in the body. Viral suppression improves health outcomes for people living with HIV and reduces transmission to uninfected individuals. Increasing medication access for people living with HIV in order to maximize viral suppression is an important factor in effectively ending HIV transmission. A recent study has shown that sustained viral suppression is highly effective at preventing HIV transmission. The study found that antiretroviral therapy reduces sexual transmission of HIV by more than 96% in HIV-serodiscordant couples.[5]

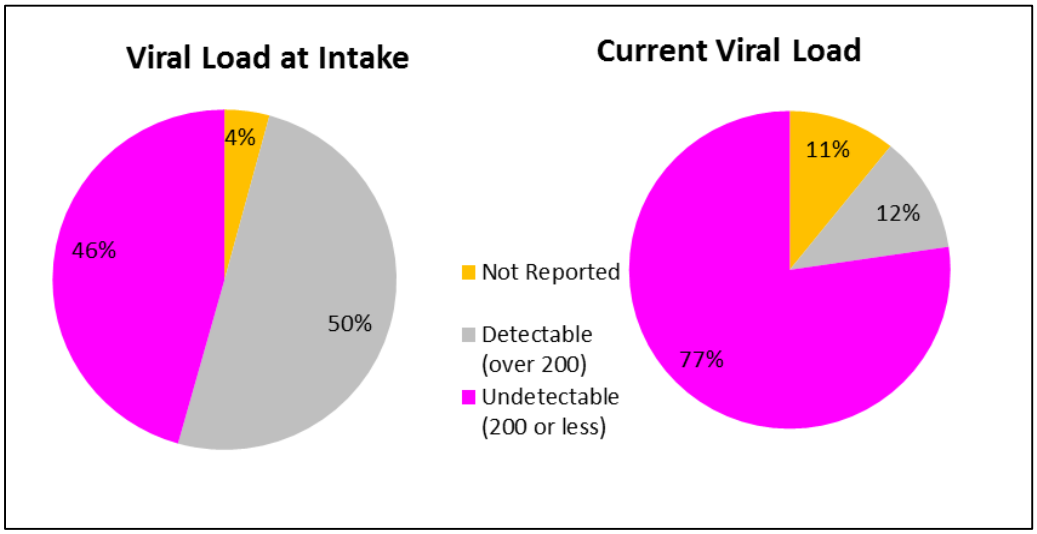

Figure 3. Clinical Outcomes: Viral Load for ADAP Clients, March 2017

Figure 3 above presents viral loads both at ADAP intake and currently for clients enrolled for at least 12 months as of March 2017 (n=5,053). This figure illustrates improvements for clients with an increase from 46% to 77% of those having an undetectable (less than 200 copies/ml) viral load. Figure 4 below illustrates the cluster of differentiation 4 (CD4) count distribution at intake and currently for ADAP clients enrolled for at least 12 months as of March 2017 (n=5,053). Improvements are seen over time, with an increase from 35% to 58% of those with a CD4 count of

[5] Cohen, M S, McCauley, M, & Gamble, T R (2012) HIV treatment as prevention and HPTN 052 Current Opinion in HIV and AIDS, 7(2), 99–105 https://www.ncbi.nlm.nih.gov/pubmed/22227585.

≥ 500. CD4 count is an important health measure for people living with HIV as it provides information on an individual's immune system, with higher CD4 counts indicating better health.

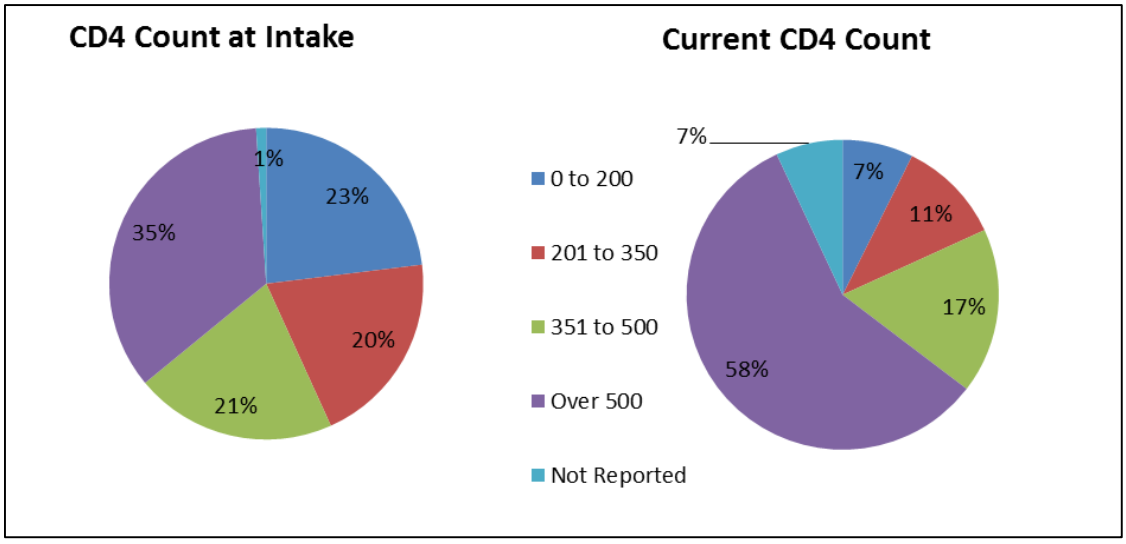

Figure 4. Clinical Outcomes: CD4 Count for ADAP Clients, March 2017

ADAP endeavors to ensure services are provided only to eligible persons with medication need. Eligibility criteria for VA ADAP include being an HIV-positive resident of VA, income at or below 500% FPL, and ineligible for Medicaid. Ryan White legislation requires clients to provide updated eligibility information every 6 months. Between April 2016 and March 2017, 1,433 persons were disenrolled from ADAP or denied upon initial application. Primary reasons for disenrollment included: automatic disenrollment for not filling Direct ADAP or insurance prescription within the last six months (65%); having another payer source for medications, including Medicaid (16%); and moving out of state (5%).

Fiscal Status

Based on projections, anticipated ADAP costs for April 1, 2017 to March 31, 2018, (Ryan White Part B, grant year 2017) will be approximately $49.2 million. The following resources are being utilized to meet this need.

Grant Year 2017 Resources	**Amount**
Medication inventory	$11.9 million
Federal Ryan White Part B and	$14.2 million
Federal ADAP Emergency Relief Funds	$9 million
State funds	$2.1 million
Program revenue	$12 million
TOTAL	**$49.2 million**

VA ADAP started grant year 2017 with a medication inventory of $11.9 million, thereby reducing grant year 2017 remaining need to $37.4 million. Federal funds, including Ryan White Part B awarded through the Health Resources and Services Administration (HRSA) formula-based funding and one-time ADAP Emergency Relief Funding, make up 62% of the current budget to meet the remaining need. In grant year 2017, state funds make up 6%, including the $200,000 annual SPAP appropriation. Program revenue generated from pharmaceutical rebates and Medicaid retroactive billing make up the remaining 32%.

Federal Ryan White Part B funds and pharmaceutical rebates are VA ADAP's largest funding sources. The annual formula-based award amounts fluctuate due to changes in congressional appropriations and the number and distribution of living HIV cases nationally. As illustrated in Figures 5 and 6 below, 49% of ADAP medication expenditures and 53% of insurance expenditures in grant year 2016 were supported by federal funds. Federal funding included $9 million in ADAP Emergency Relief Funding. ADAP Emergency Relief Funding, Ryan White Part B Supplemental funds, and ADAP Supplemental (when eligible) are unpredictable. ADAP Emergency Relief Funding and Part B Supplemental funds are awarded competitively, and the amount available for award changes each year. ADAP Supplemental eligibility is determined

annually by HRSA-set criteria. Previous ADAP Emergency Relief Funding awards have ranged from $3 million to $11 million in grant year 2016. During grant year 2016, ADAP Emergency Relief Funding was used to directly purchase medications and insurance for eligible ADAP clients.

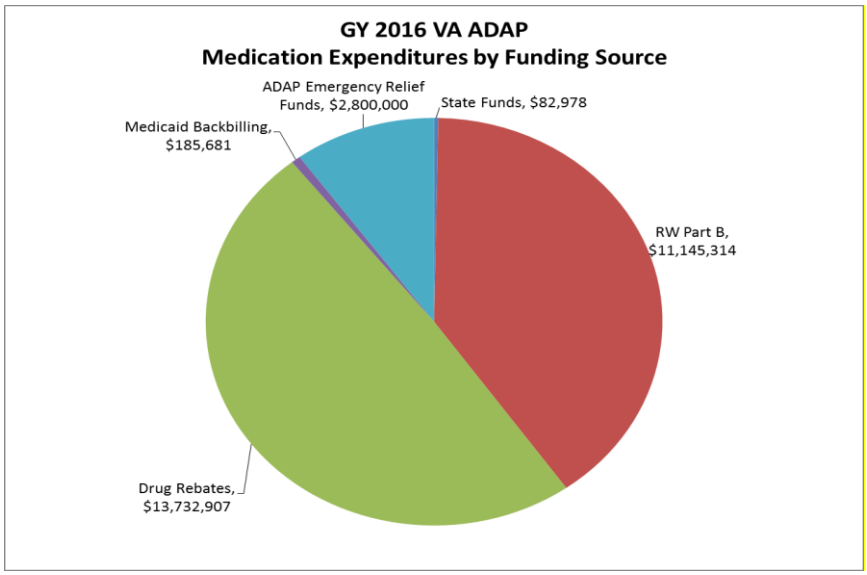

Figure 5. Grant year 2016 VA ADAP Medication Expenditures by Funding Source

During grant year 2016, $82,978 in state funds was expended for medications and $226,770 was expended on insurance costs. The grant and state fiscal years overlap but do not coincide. The timing of receipt of revenue and end of grant year requirements impacts when state funds are spent.

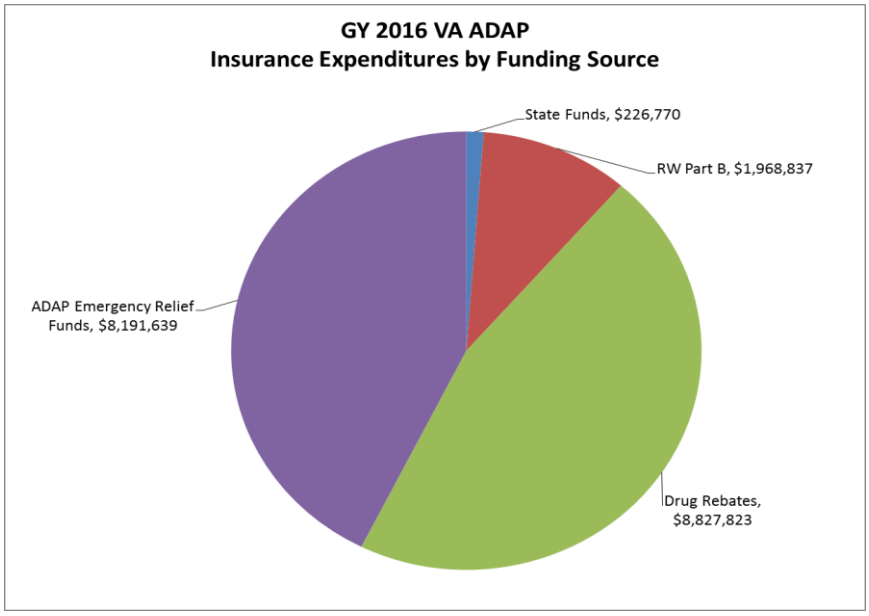

Figure 6. Grant year 2016 VA ADAP Insurance Expenditures by Funding Source

Projections of Program Utilization and Costs

Forecasting for VA ADAP is done on a regular basis, as data on utilization and enrollment for each program component (ACA, ICAP, MPAP, and directly purchased medications) is tracked monthly. The number of clients served (those actively receiving ADAP medications, a premium payment, or a medication cost share payment through insurance support) is the best predictor for ADAP costs. For grant year 2016, of the 7,147 unduplicated clients who received ADAP services, 1,612 people received only direct medication services; 3,857 people received only insurance services; and 1,678 received both direct medication and insurance services (some clients access medications to avoid treatment disruption until insurance support is established). For grant year 2017, 7,751 clients are projected to receive services and 8,056 clients in grant year 2018. The annual number of clients served is estimated utilizing a formula based on a regression analysis of 19 years of historical data using monthly rather than annual averages. This methodology of averaging by month is necessary to account for variances due to program structure and dis-enrollments. Projections that do not account for monthly variations would result in an under-projection of program costs and over-projection of clients served.

Projections for Medicare Part D and ACA insurance support account for the calendar year cost structure of the insurance plans (ADAP pays higher costs at the beginning of the calendar year and reduced or no costs as the year progresses and deductibles, coinsurance, and MOOP expenditures are satisfied); client changes in program eligibility occurring throughout the year; and variations in MOOP expenditures based on client income and tax credit eligibility. For example, Medicare Part D has larger client cost outlays in the early part of the calendar year (paid by VA ADAP). When clients reach $4,950 in costs for calendar year 2017, the cost outlay reduces to 5% of the medication costs. Most ADAP clients whose HIV medications are costly reach this limit by March, and Medicare pays 95% of costs for the remainder of the year, resulting in reduced costs to ADAP.

ACA costs for calendar year 2017 were released in late 2016 and the MOOP expenditures (paid by VA ADAP) for those not receiving any tax subsidies had a ceiling of $7,150 per person annually. Projections were completed for grant year 2017 and grant year 2018 using the data available for the ACA plans from 2017, as 2018 and 2019 cost structures are not yet available. For those currently receiving subsidy tax credits whose household incomes are between 100% and 250% of the FPL, this MOOP expenditure is reduced to a percentage of the client's income and can be as low as $750 annually. Those with incomes between 100% and 400% FPL are also eligible for premium subsidies. Those with incomes below 100% FPL and over 400% are not eligible for any subsidies, and ADAP pays full premiums and MOOP for those clients. Coverage through insurance is still more cost effective in these cases than purchasing medications due to capped costs and the ability to generate rebates from pharmaceutical companies on medication copayments.

Projections for client cost and utilization in 2017 through 2019 have been developed utilizing the current FPL distribution of the ADAP population and current enrollment numbers for ACA in

2017. The FPL distribution by program for clients enrolled in ADAP in March 2017 is illustrated in Figure 7 below. The majority of clients for both Direct Purchase ADAP (64%) and ACA (54.6%) are at or below 100% FPL.

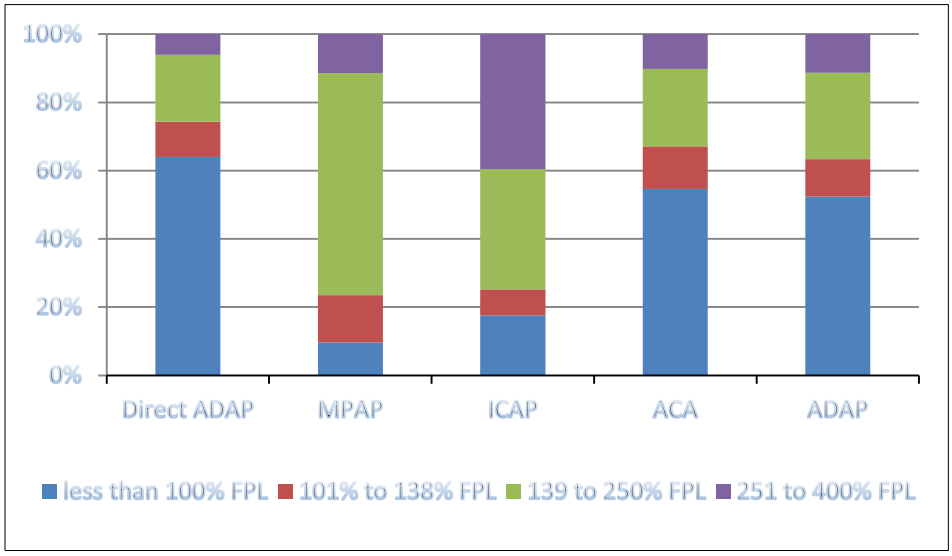

Figure 7. FPL Distribution by Program for Clients Enrolled in ADAP in March 2017

Using the average 2017 ACA costs from the plans supported by VA ADAP, average annual costs for the population below 100% FPL would be $11,500 per client per year ($7,150 out of pocket + $4,350 premiums). This annual cost is reduced by pharmaceutical rebates received on cost shares paid for medications. The assumptions for receiving rebate revenue are explained below.

Rebates

Rebates are paid by the pharmaceutical companies to state ADAPs through voluntary agreements where full rebates are currently received on partial payments for medications purchased through insurance cost shares with ADAP funding. Rebate terms are negotiated between the ADAP Crisis Task Force, a representative group of state ADAPs led by the National Alliance of State and Territorial AIDS Directors. Rebates made up 36% of national ADAP funding in grant year 2016 and constituted 49% of VA ADAP expenditures in the same period. Rebates can be used

strategically to either purchase medications or offset other HIV program costs so that federal dollars can be maximized for medication purchase.

Calculating revenue projections from the rebates is challenging. The amount of rebates received varies over time. Medication prices, upon which rebates are based, are proprietary information that is not released by the pharmaceutical companies. There is also a significant lag time in receiving rebates after the initial cost outlay by ADAP. The rebate can be received from the pharmaceutical company anywhere from 3 to 18 months after the initial copayment. These factors make it difficult to project rebate revenue and to determine whether the revenue will be available within a specific grant or fiscal year.

Cost Projections

Cost projections were done for grant year 2017 (which runs April 1 through March 31) and grant year 2018 for three different scenarios. Costs associated with ACA plans for the next two calendar years are still unknown and will impact projections and subsequent budget needs. Increased costs due to medication co-payments prior to meeting out-of-pocket limits are generally seen in the first quarter of the calendar year, which is the final quarter of the currently budgeted grant year 2017.

The three scenarios were calculated to show the impact of different potential changes in payer source for ADAP clients. These scenarios include: Scenario 1) continuation of ACA in its current form with a 25% reduction in ACA enrollment and 20% premium increases in 2018 and 2019; Scenario 2) a larger reduction in ACA enrollment in 2018 and 2019 of 39% and loss of cost-sharing reductions (CSRs) for those in the 101% to 250% FPL group and 20% premium increases in 2018 and 2019; and Scenario 3) the discontinuation of ACA and other insurance, except for Medicare Part D in 2018, with the majority of ADAP clients on direct purchase medications. Scenario 1 includes the following assumptions: There will be a 25% reduction in

the number of ADAP clients enrolled into ACA plans in calendar year 2018 and calendar year 2019 resulting from the shorter enrollment period and the loss of carriers in the ACA Marketplace. Enrollment in ACA plans is reduced to 75% of current enrollment in both years. Scenario 2 additionally assumes a smaller percentage of persons enrolling into ACA resulting from the shortened enrollment period and loss of carriers. Scenario 2 also assumes that all CSRs currently in place will be eliminated in 2018. Currently, 28.2% of all ADAP ACA enrollees have some form of CSR, which reduces the annual MOOP. In calendar year 2017, the average CSR for an ADAP client was $4,188 annually. Scenario 3 assumes that all persons enrolled in ACA and ICAP will be enrolled to Direct ADAP in January 2018 with Medicare Part D remaining the only insurance option for a limited number of ADAP clients.

One important consideration in examining costs for VA ADAP is that rebate revenue is not realized in the month in which it is generated but can take a variable period of time to be received and is dependent on billing schedules and reimbursement practices of pharmaceutical companies. In 2017, one large pharmaceutical company changed the required billing schedule and format for rebates. This change will result in VA ADAP receiving 15 months of rebates in grant year 2017. Figure 8 shows the differences over grant year 2017 and grant year 2018 by month of rebates earned and rebates realized (actual revenue received) for each scenario. Solid lines reflect rebates earned in a month while dotted lines represent rebates realized.

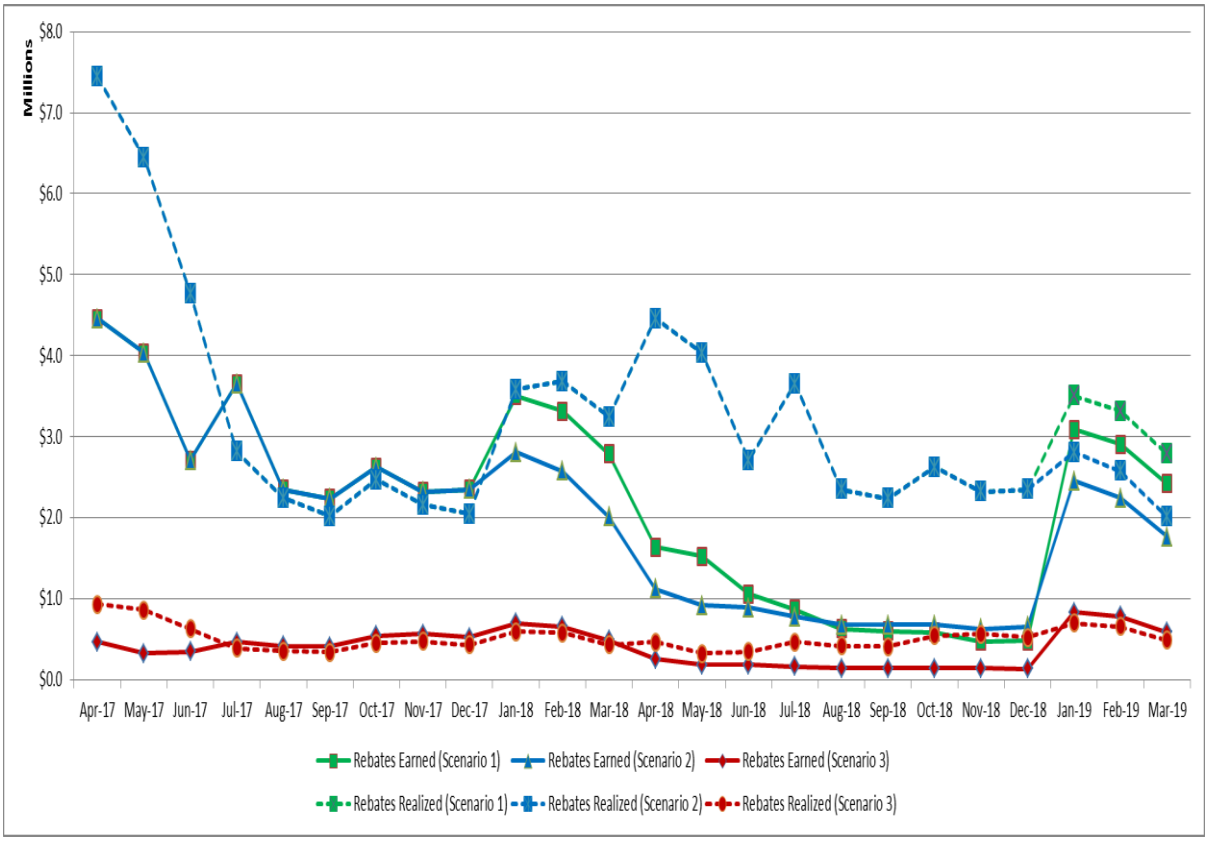

Figure 8: Rebates Earned and Realized, April 2017 to March 2019: Three Scenarios

Rebate revenue is higher in Scenarios 1 and 2 where a significant number of ADAP clients remain enrolled in ACA, with a larger reduction in rebates earned in Scenario 2 in 2018 and 2019 than in Scenario 1. The difference between Scenario 1 and Scenario 2 in rebates realized is not significant until calendar year 2019 because of the assumed 12-month lag in receiving rebates from the date of co-payment. This difference will become even more significant in grant year 2019 as fewer people are insured under Scenario 2. Rebates earned and realized in Scenario 3 are significantly lower than the other scenarios because only persons enrolled in Medicare Part D will generate rebate revenue.

The grant year costs for each scenario are shown in Figures 9a, 9b, and 9c using both rebates earned and rebates realized. As ACA enrollment decreases from Scenario 1 to Scenario 2, the amount of rebate revenue decreases as well, resulting in increased costs to ADAP in grant year 2018, with an increase of $2.6M from Scenario 1 to Scenario 2 using the rebates earned figures.

Scenario 3 is the costliest with overall program costs after rebates earned of $64.3M in grant year 2018. Costs before rebates, shown in Figure 9c, demonstrate the same pattern with the same costs for Scenarios 1 and 2 at $56.1 million in grant year 2018 and Scenario 3 at $68 million.

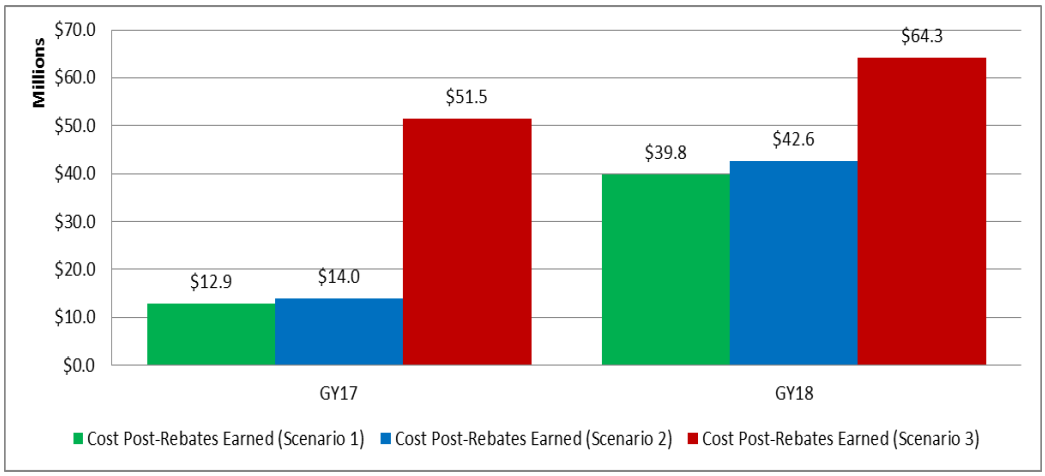

Figure 9a. VA ADAP Projected Costs (Rebates Earned) Grant Year 2017 and Grant Year 2018

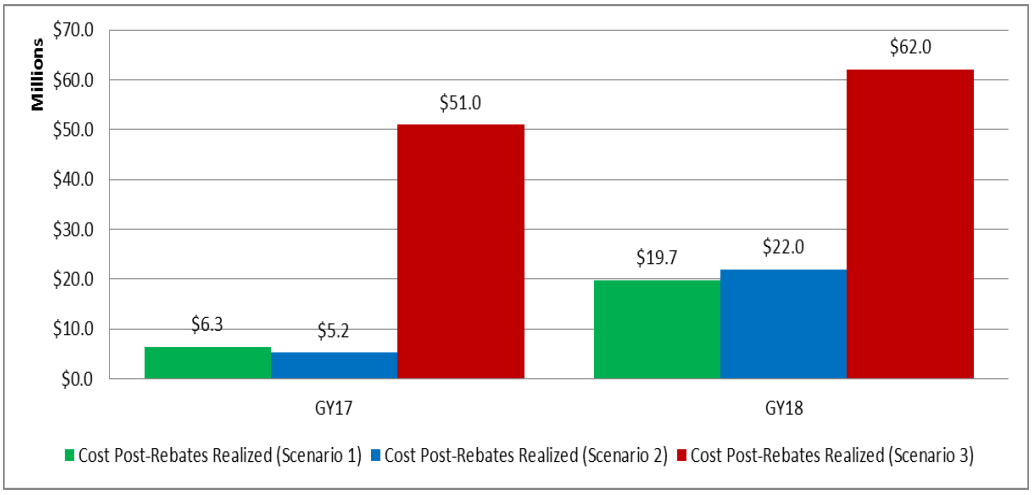

Figure 9b. VA ADAP Projected Costs (Rebates Realized) Grant Year 2017 and Grant Year 2018

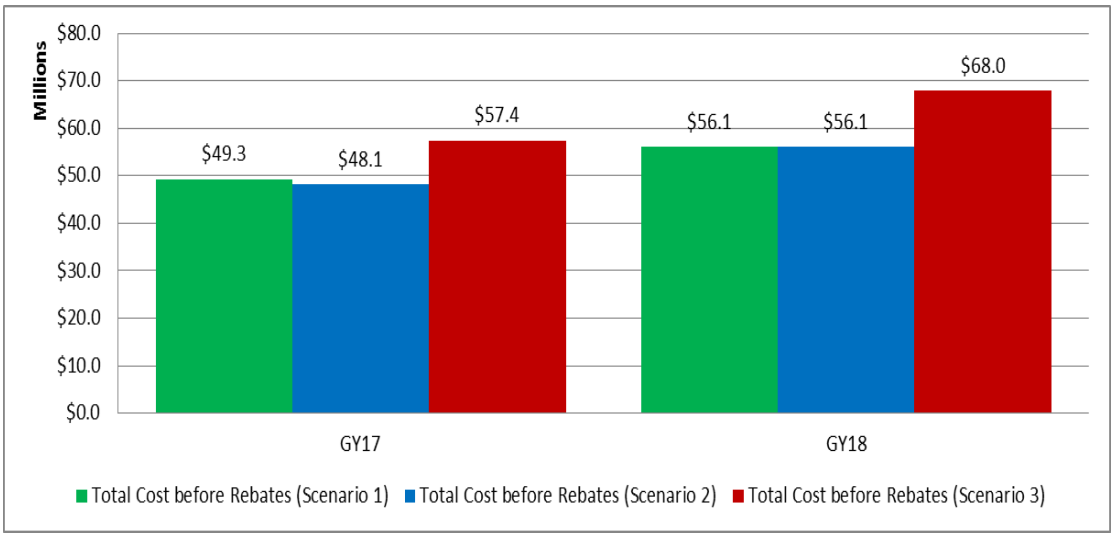

Figure 9c. VA ADAP Projected Costs (Before Rebates) Grant Year 2017 and Grant Year 2018

Sustainment

The projections described above play a critical role in determining whether VA ADAP will have sufficient resources to meet projected need. As described in this report, a number of factors will impact the ability to continue to meet the growing demand for VA ADAP services. ADAP infrastructure and policy strive to support a program that is cost effective, carefully monitored, and beneficial to public health. Key drivers in determining how resources will meet the growing need include program utilization trends, future costs related to insurance plans offered under the ACA, and future changes to federal and state legislation.

Maximizing Client Enrollment into Insurance Plans

VA ADAP is assessing the cost effectiveness and feasibility of enrolling clients into off-Marketplace plans. These plans, like those found through the Marketplace, provide essential health benefits, expand access to medical care, and do not have pre-existing condition exclusions. While off-Marketplace plans would not have the benefit of ACA tax credits or subsidies, they are still a cost-effective mechanism for medication access because of MOOP limits. In addition to these efforts, VDH is working to formally contract with enrollment

assistors across the state to directly assist ADAP clients during 2018's shortened open enrollment period. Finally, VDH is collaborating with other organizations to enroll clients into ACA and Medicare Part D insurance plans, including two large university hospitals that will be conducting enrollment fairs, as well as Certified Application Counselor and Patient Navigation sites that serve as important referral bases.

Maintaining Stakeholder Engagement

Collaboration and communication between VDH and statewide stakeholders have proven to be critical to sustaining program success. VA ADAP regularly provides communication and enrollment resources prior to and during open enrollment to ADAP clients, medical providers, case managers, and other interested parties. Additionally, the ADAP Advisory Committee created in 1996 and composed of HIV/AIDS medical providers, a pharmacist, clients, and LHD representation continues to provide critical guidance to VA ADAP. Committee members represent the five health regions of the state, as well as Ryan White grantees funded through Parts A, B, C, D, and F. The committee has traditionally advised VA ADAP on formulary changes, as well as programmatic, clinical, and educational issues as needed. The committee evaluates the impact of changes to statewide HIV services on medication access and uses its findings to formulate recommendations. Additionally, the committee reviews data on ADAP utilization and assesses implications of trends and program changes, including the impact on other statewide HIV services. Most recently, the ADAP Advisory Committee recommended that naloxone, an opioid reversal agent, be added to the ADAP formulary. The committee also approved increasing the FPL eligibility for ADAP to 500%.

ADAP Data System Improvements

VA ADAP made a number of improvements to its data systems in grant years 2016 and 2017 to account for the changing nature of the program, including collecting information to facilitate

insurance enrollment and tracking utilization of ACA and private insurance assistance. These changes include tracking client enrollment progress and collecting insurance premiums and medication cost share data needed to ensure timely payment by VA ADAP. Payments are reconciled with data received from the third-party vendor, who makes premium payments for clients enrolled in any of ADAP-approved insurance plans, including Medicare Part D. Payment dates are tracked to ensure no disruption in coverage due to missed payments.

The ADAP database continues to track all application and recertification data for clients. Reports on eligibility, enrollment, recertification, and service utilization are available for staff to run in real-time. LHDs receive weekly data updates that include eligibility, enrollment status, and date of the last prescription filled. Access to these reports was extended to include additional medication access sites and Ryan White contract and medical provider sites. These reports will be transitioned to the web-based e2VA system in 2017.

Cooperation regarding data sharing within DDP units at VDH has helped to improve data quality. Data from HIV Surveillance and Ryan White services have been utilized to supplement missing laboratory data in ADAP, including CD4 counts and viral loads. Claims data from the VA Department of Medical Assistance Services (DMAS), which oversees Medicaid, is now obtained on a quarterly basis, and a match is run with ADAP data. Eligibility data from DMAS is obtained every two weeks and is matched with ADAP to determine which clients may no longer be eligible for ADAP in addition to those that may be eligible for VA ADAP to retroactively bill Medicaid, thereby recouping ADAP expenditures if clients become retroactively eligible for Medicaid. As of March 31, 2017, VA ADAP has recouped $185,681 from Medicaid retroactive billing and projects an additional $130,000 will be recouped in grant year 2017.

VDH received a Special Projects of National Significance Health Information Technology grant

from HRSA, which provided funding to improve reporting systems for ADAP, Ryan White services, and HIV prevention in the state. The new system, e2VA, was launched in February 2016 and includes information on eligibility for ADAP and Ryan White services, as well as medical data such as viral loads, CD4 counts, and antiretroviral medication prescribing information. VA ADAP is exploring options for a paperless system that will create a more convenient process for clients and service providers, as well as a more streamlined process for eligibility staff. Effective streamlining will create time efficiencies for eligibility determinations with reduced paper handling; will decrease the likelihood that clients will lose insurance coverage and, therefore, need Direct ADAP services; and will enable the ADAP staff to provide improved customer service to clients and service providers.

VDH continues to utilize the in-house developed Care Markers Database, which houses data from a number of systems related to HIV diagnosis and care, including ADAP, HIV surveillance, and Ryan White care data. The Care Markers Database allows VDH to more effectively monitor and improve client (including ADAP clients) health outcomes along the HIV care continuum. Out of care lists have been sent to community providers and medical staff to identify clients who may need re-engagement services. Coordinated efforts among medical sites, Patient Navigation programs, and other VDH programs will result in reaching clients and assisting them in re-engagement and remaining in care. Linking increased numbers of clients to care will likely increase the amount of resources needed to provide medications and purchase insurance. At the same time, sustained retention of clients in care can result in more cost-efficient care, healthier clients with fewer serious acute illness episodes requiring hospitalizations or emergency room visits, and fewer new cases due to decreased transmission as a result of sustained HIV viral suppression.

Integrated Planning for HIV Prevention and Care

HIV Prevention and Care are funded by separate government agencies (the Centers for Disease Control and Prevention (CDC) and HRSA, respectively) and traditionally have operated under different planning cycles with unique reporting requirements. The context of HIV Prevention and Care, however, has changed in the United States with the implementation of the ACA; updates to the National HIV/AIDS Strategy; and advances in biomedical, behavioral, and structural strategies that can improve outcomes along an integrated HIV Prevention and Care Continuum to prevent and control HIV. VDH now has a 5-year Integrated HIV Prevention and Care Plan, calendar years 2017 through 2021, that serves as a roadmap to reduce new HIV infections; increase access to care and improve health outcomes for people living with HIV; reduce HIV-related health disparities and health inequities; and achieve a more coordinated response to the HIV epidemic. Provision of antiretrovirals and the other medical services paid for through ADAP and insurance plans increase retention in care and viral suppression in VA, a key goal of the plan.

Future Budget Needs

Several factors to be determined in the next few months will influence budgetary needs in upcoming years. These include insurance premium increases, continuation of the current version of the ACA, insurance coverage of all necessary HIV medications, continuation of pharmaceutical industry rebates to ADAP, and the availability of future ADAP Emergency Relief Funding. VA ADAP has identified adequate and reliably anticipated resources to meet the projected $56 million program cost depicted in Scenarios 1 and 2 for grant year 2018. ADAP Emergency Relief Funding and pharmaceutical company rebates may vary substantially in availability and amount in future years. The ability for ADAP to meet projected needs will depend primarily on the availability of rebates and ADAP Emergency Relief Funding. ADAP

Emergency Relief Funding has varied significantly over a seven-year period. Funds are competitively awarded and are not guaranteed year to year. In addition, the future of pharmaceutical industry rebates is unknown until upcoming completion of national negotiations. The National Alliance of State and Territorial AIDS Directors' ADAP Crisis Taskforce leads negotiations and has indicated that there may be reductions to future rebate criteria. Terms are now in effect through December 2017 for most medications.

If a worst case scenario of unavailable ADAP Emergency Relief Funding and elimination of the ACA (and resulting rebates) were to occur, then VA ADAP would face an unmet need exceeding $10 million in grant year 2018 (based on Scenario 3).

Future Considerations

Treating ADAP Clients Co-infected with Hepatitis C

The CDC estimates that approximately 25% of people living with HIV in the United States are co-infected with HCV, which places them at increased risk for serious, life-threatening complications. The CDC also estimates that nearly 75% of people living with HIV who inject drugs also have HCV.[6] New medications are available to cure HCV with fewer side effects than former interferon-based regimens. These newer medications are costly, and some pharmaceutical companies are declining to negotiate lower costs with ADAP. Clients receiving medications through Direct Purchase ADAP can access these treatments through the VA ADAP formulary. Clients with health insurance, however, may have difficulty accessing these medications if their insurance plan does not include them on its formulary, if the plan requires numerous preauthorization processes, or if the medication exception or preauthorization requests are denied. VA ADAP implemented the VA ADAP HCV Treatment Assistance Program in

[6] Centers for Disease Control and Prevention (2017) HIV and viral hepatitis [Fact sheet] Retrieved from https://wwwcdcgov/hiv/pdf/library/factsheets/hiv-viral-hepatitispdf.

April 2015 to provide immediate access to HCV medications for insured clients. VA ADAP has been able to add costly HCV medications to the Direct Purchase ADAP formulary and implement the HCV Treatment Assistance Program because of the tremendous cost savings from enrolling eligible clients in cost-effective health insurance and from the aforementioned pharmaceutical company rebates. As of March 31, 2017, 71 clients have accessed the treatment assistance program due to insurance denial or a request from the insurer for the client to have an invasive liver biopsy. An additional 14 ADAP clients not in the treatment assistance program accessed HCV treatment through their insurance. Overall, uptake to the treatment assistance program has continued to be slower than anticipated. To address slow uptake and medical provider feedback regarding barriers to this program, VA ADAP revised eligibility criteria and processes. People infected with HCV face many of the same barriers to accessing treatment as people living with HIV, including comorbid conditions, a lack of awareness regarding infection, stigma, poverty, inadequate housing, instability in their personal or work life, and difficulty navigating health or insurance systems.[7,8,9,10] Providers also have important criteria to consider regarding treatment and philosophy about how patients are determined to be ready for treatment.[11] VDH is improving access to HCV treatment by collaborating with the University of Virginia's (UVA) Office of Telemedicine, Lenowisco Health District's Ryan White Part B

[7] Evon, D M, Simpson, K M, Esserman, D, Verma, A, Smith, S, & Fried, M W (2010) Barriers to accessing care in patients with chronic hepatitis C: the impact of depression Alimentary Pharmacology & Therapeutics, 32(9), 1163–1173 http://doiorg/101111/j1365-2036201004460x.

[8] McGowan, C E and Fried, M W (2012), Barriers to hepatitis C treatment Liver International, 32: 151–156 http://onlinelibrary.wiley.com/doi/10.1111/j.1478-3231.2011.02706.x/full.

[9] Oramasionwu, C U, Moore, H N, & Toliver, J C (2014) Barriers to Hepatitis C Antiviral Therapy in HIV/HCV Co-Infected Patients in the United States: A Review AIDS Patient Care and STDs, 28(5), 228–239 http://doiorg/101089/apc20140033.

[10] Broeckaert, L, & Challacombe, L (2015) Does multidisciplinary care improve health outcomes among people living with HIV and/or HCV? A review of the evidence Retrieved from http://wwwcatieca/en/printpdf/pif/fall-2015/does-multidisciplinary-care-improve-health-outcomes-among-people-living-hiv-andor-hcv-.

[11] Osilla, K C, Wagner, G, Garnett, J, Ghosh-Dastidar, B, Witt, M, Bhatti, L, & Goetz, M B (2011) Patient and Provider Characteristics Associated with the Decision of HIV Co-infected Patients to Start Hepatitis C Treatment AIDS Patient Care and STDs, 25(9), 533–538 http://doiorg/101089/apc20110048.

Program, and the UVA Infectious Disease Clinic. This partnership resulted in the establishment of a telemedicine clinic in Wise, VA. The telemedicine clinic provides HIV specialty care, HCV specialty care for clients co-infected with HIV, and mental health services. Providers from UVA travel quarterly to Lenowisco to see patients in person in addition to telehealth visits. VDH is using Ryan White Part B funds to address the aforementioned barriers to care through funding short-term and transitional housing to provide stable housing to people living with HIV, community-based mental health services, inpatient and outpatient substance use treatment, and Patient Navigation interventions to assist clients in using the health delivery system and health insurance coverage. The goal of these services is to increase longer-term viral suppression and maximize health outcomes.

Sexually Transmitted Disease Increases in VA

CDC indicates that people infected with syphilis and/or gonorrhea often may have HIV or are more likely to acquire HIV.[12] The increasing incidence of sexually transmitted diseases (STD) observed in VA during 2015 continued into 2016. VA's 2016 rate of total early syphilis (TES) diagnoses, which includes primary, secondary, and early latent syphilis, increased by 11.5% compared to 2015 following a 55.9% increase in diagnoses rates from 2014-2015. There was also a 22.8% increase in the rate of gonorrhea cases diagnosed from 2015 to 2016 (from 103.7 to 127.4 cases per 100,000 populations). VDH expects VA's trends to be consistent with national trends, although national 2016 data are not yet available. In response to these increases, VDH has established eight additional disease intervention specialists (DIS) positions, which are placed in high-morbidity areas to assist with HIV and STD case investigations and partner services. Funding for these positions currently includes Ryan White Part B Supplemental funds and will

[12] Centers for Disease Control and Prevention (2015) STDs and HIV [Fact sheet] Retrieved from https://wwwcdcgov/std/hiv/stdfact-std-hiv-detailedhtm.

include the aforementioned pharmaceutical rebate dollars when these Supplemental funds are no longer available. Additionally, VDH has hired four regional DIS coordinators throughout the state to support local DIS. VDH is also asking LHDs to continue to report syphilis cases as soon as possible to ensure that syphilis and gonorrhea are treated appropriately and to work with local prenatal and maternal health providers to ensure they are screening pregnant women for syphilis at appropriate intervals. Since having an STD puts a person at higher risk for acquiring HIV, there is the potential for collaboration with VA ADAP. DIS also routinely refer persons newly diagnosed with HIV to VA ADAP for access to medications and early initiation of treatment.

Maintaining Client Eligibility

Enrollment in VA ADAP has continued to grow over time. This growth has made it more difficult to maintain accurate and timely eligibility information on ADAP clients utilizing a largely paper-based system. During grant year 2017, VDH is implementing several critical changes to the processes for maintaining client eligibility for ADAP services, including synchronizing client eligibility expiration dates to ADAP application approval dates. The new process includes standardized outreach to clients at defined intervals prior to their eligibility expiration date. Additionally, VDH is instituting new procedural changes, including a new method for triaging paper documents and an electronic log for all recertification files. To address the challenges associated with a paper-based system, VDH is exploring electronic systems to manage ADAP eligibility and insurance enrollment processes. Systems under consideration include utilizing ADAP funds to contribute toward an agency-wide electronic internal/external facing system. Finally, VA ADAP relies heavily on contractual staff to conduct daily operations. This workforce experiences high rates of staff turnover due to lack of benefits and other employment incentives associated with full-time classified positions. Although VDH has mobilized other DDP staff to assist in ADAP operations during times of maximum demand,

additional positions are needed to stabilize ADAP operations without adversely impacting other critical functions, such as prevention and surveillance when staff are reassigned. DDP, therefore, has requested 2 new FTEs as part of VDH's internal 2018 budget amendment development process. VA ADAP seeks to add FTE positions to stabilize this critical work force and ensure adequate staff capacity at all times.

Rebates Received from Pharmaceutical Companies

While rebates have become a critical revenue source supporting ADAP sustainability, their future continues to remain uncertain. Revised federal 340B requirements that will address the future of rebates were withdrawn with no updated release date. The revised requirements had been anticipated for the past two years. A large pharmaceutical company, however, has negotiated reduced rebate amounts based on specific criteria related to the client's insurance coverage. This agreement will be implemented during 2017 and 2018. The key changes are the inclusion of a premium payment to the rebate criteria and the loss of rebates for persons enrolled in Medicare Part D. VA ADAP pays for premiums for all ACA clients, but it does not pay premiums for privately insured clients and some Medicare Part D clients. If VA ADAP does not pay a premium, the associated co-payment would not be eligible for rebates. Currently, full rebates are received on partial payments (co-payments) for medications purchased through insurance with VA ADAP funding. Additional changes in rebate terms or decreases in health insurance coverage for VA ADAP could reduce rebate revenue substantially and change the program's ability to meet ongoing VA ADAP need. VA ADAP has two staff members on the national ADAP Crisis Taskforce, which engages in pricing and rebate negotiations. Participating in this group provides VA ADAP with the most accurate and up-to-date information about important changes to rebates. VA ADAP also maintains an ongoing dialogue with the largest pharmaceutical company to actively engage and educate them on issues important to ADAP.

Instability in the Health Insurance Market

Specific details on insurer participation, geographic coverage, benefit design, and premium amounts in the health insurance Marketplace are difficult to predict for future calendar years. This is a point of concern because VA ADAP clients face significant health challenges, frequently utilize costly medications, and were difficult to insure prior to the implementation of the ACA. Insurance carriers can potentially increase health insurance premiums or make other changes to decrease their costs, such as reduce plan formularies, limit the provider network, change geographic coverage areas, or withdraw from the Marketplace altogether.

Based on public comments by insurance carriers and the current proposed rate filings submitted to the VA BOI that are available for public view, VA will lose at least two insurance carriers from the individual ACA Marketplace in 2018. In addition, two carriers have made sequential changes to their 2018 geographic coverage areas compared to their 2017 offerings. At one point during this process, over 60 counties had no ACA Marketplace plan option, however a large carrier reversed its course and re-entered Virginia's Marketplace to provide coverage in those areas. Based on the net result of these changes, VDH estimates that 1,896 VA ADAP clients would need to enroll in a plan with a new carrier in 2018 during a shortened 45-day enrollment period for ACA plans. The number of ADAP clients that must enroll with a new carrier in 2018 is nearly twice the number that needed to switch in 2017. Additionally, information on premium increases for one carrier have significantly changed, with 80% increases expected in 2018 for persons who do not receive subsidies. Projections indicate that this increase would result in an additional annual cost of approximately $2,424,240 over the amount in the scenarios in this report. Provider networks are more limited with two carriers excluding major HIV medical providers who currently serve a high number of ADAP clients. The high number of counties

with only one carrier exacerbates this problem since ADAP clients must either enroll in insurance that does not include their HIV medical provider or forego health insurance coverage. The federal government has made significant changes to the health insurance market that will also have an impact on ADAP. In 2017, the federal government significantly reduced funding for federal advertising and outreach regarding the Marketplace. The Centers for Medicare and Medicaid Services (CMS) issued its final Market Stabilization rule in April 2017, which reduces the open enrollment time frame for the health insurance Marketplace from 90 to 45 days starting November 1, 2017.[13] Approximately 58% of VA ADAP clients obtain coverage through the Marketplace. Additionally, as indicated above, over 1,800 VA ADAP clients will need to pick a new Marketplace plan in 2018 because of carrier withdrawal and geographic coverage changes. The shortened open enrollment, coupled with the need to change carriers, will make it more difficult for VA ADAP ACA clients to maintain coverage.

Previous reports to the General Assembly have demonstrated that Medicaid expansion would significantly reduce the number of clients requiring ADAP coverage. As additional information about further changes to Virginia's Marketplace has become available, it is important to note that 63.2% of the current ADAP population (n=4,015) would be eligible for expanded Medicaid. The majority of these clients are currently enrolled in ACA (n=2,244) and Direct ADAP (n=1,488). Expanding Medicaid would prevent a shortfall in ADAP resources in future grant years.

The Future of the Affordable Care Act

Prior to full ACA implementation in 2014, people living with HIV in VA had few viable options for health insurance. At that time, Ryan White funding was directly supporting the costs of

[13] United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (2017) Patient Protection and Affordable Care Act Market Stabilization Final Rule Retrieved from https://s3amazonawscom/public-inspectionfederalregistergov/2017-07712pdf.

medical care, medications, and support services. The ACA, however, has provided eligible VA ADAP clients with unparalleled access to health insurance. The future of the ACA and the structure of the health insurance Marketplace are currently unknown. While recent efforts to repeal the ACA did not pass, discussion of these issues at the national level continues. Possible changes that may cause a negative impact to VA ADAP clients include the implementation of a continuous coverage provision that would impose a waiting period on Marketplace enrollees if they had a time-specific gap in coverage in the previous 12 months. Additional proposed provisions of concern include the elimination of cost-sharing reductions for co-payments or a waiver process where states could choose to either alter the essential health benefits offered by insurance plans or increase limits on out-of-pocket spending. Eliminating cost-sharing reductions would have a significant impact on ADAP. While the majority of ADAP clients are not eligible for cost-sharing reductions because the reductions are not available to people below 100% FPL, any changes to Marketplace regulations affect overall carrier participation and cost. Health policy experts agree that eliminating cost-sharing reductions would cause insurers to leave the Marketplace or to limit plan offerings.[14] This could either raise premium amounts or limit the availability of plans for all enrollees, including ADAP clients. Altering essential health benefits may decrease the cost of health insurance but would also reduce access to medications and services.[15] These types of changes will weaken the ability of VA ADAP to provide cost-effective health insurance and increase the burden on VDH to fund medical care, medications, and support services for people living with HIV who can no longer access insurance. Any

[14] Levitt, L, Cox, C, and Claxton, G The Effects of Ending the Affordable Care Act's Cost-Sharing Reduction Payments Retrieved from: http://www.kff.org/health-reform/issue-brief/the-effects-of-ending-the-affordable-care-acts-cost-sharing-reduction-payments/.

[15] Claxton, G, Pollitz, K, Semanskee, A, and Levitt, L Would States Eliminate Key Benefits if AHCA Waivers are Enacted? Retrieved from: http://www.kff.org/health-reform/issue-brief/would-states-eliminate-key-benefits-if-ahca-waivers-are-enacted/.

change to the ACA or structure of the Marketplace needs to be fully analyzed so VA ADAP can continue to serve the needs of uninsured or underinsured people living with HIV in the Commonwealth.

Conclusion

VA ADAP continues to have a steady growth rate and successfully manages medication access for over 6,300 low-income people living with HIV in the Commonwealth. The program supports optimum health by providing therapeutics to treat HIV disease or prevent the serious deterioration of health in eligible individuals in the Commonwealth. VA ADAP will continue to identify and meet client needs while ensuring programmatic sustainability. In preparation for an uncertain national health care future, it is imperative that VA ADAP address challenges and begin to strategize alternative plans of actions based on projected future scenarios that could alter the program significantly. Responses include refining internal processes to respond to client and medical provider needs in the face of a changing health insurance Marketplace and requesting to add FTEs to stabilize the ADAP workforce. Ultimately, the sustainability of ADAP services will be determined by the availability of resources, enrollment growth, the future of the ACA, and health insurance Marketplace specifics, such as open enrollment time frames and other regulatory changes, carrier participation, insurance premium costs, medication formulary completeness, and the geographic availability of insurance plans.