

## The Impact of Varied ADAP Programs on Individuals with HIV/AIDS

With variations in the structure of ADAPs from state to state, there are significant effects on the health outcomes of individuals with HIV/AIDS and their access to appropriate HIV/AIDS care. Since 1987, ADAP programs have been covering the financial costs of HIV treatments and medications for uninsured individuals who are ineligible for Medicaid and have no form of private insurance. Since 1996, however, ADAP programs across the country have been struggling in their ability to cover the costs of their clients. This is attributed to increased prevalence of HIV/AIDS in the United States and a greater number of uninsured individuals.<sup>1</sup>

Early screening methods and advanced treatments have increased the life expectancy rates for HIV/AIDS significantly. These treatments, however, are very expensive and create huge financial implications for the patient as well as the ADAP program. With a disproportionate impact of HIV/AIDS on minority populations, it is difficult for these individuals to afford treatments due to issues related to cost, health coverage and access to care.<sup>2</sup>

Significant shifts in the type of HIV care being utilized by patients (inpatient to outpatient) has resulted in a tremendous increase in the amount of funds being consumed by the ADAP program to meet the needs of its clients.<sup>3</sup> In many cases, there is definite inequality in resource distribution since many ADAP programs are implementing cost containment measures (waiting lists, cost-sharing, eligibility restrictions and reduced formularies) because they are unable to provide services to all individuals in need of HIV/AIDS treatment.<sup>4</sup>

Research has shown that ADAP programs that offer the recommended standard of care will have a positive impact on the life expectancy of an individual with HIV/AIDS and possibly represent a cost-effective use of HIV care resources.<sup>3</sup> Combination therapy has been defined as the recommended standard of care when initiating treatment for individuals diagnosed with HIV/AIDS.<sup>5</sup> In 2004, only 45.6 percent of individuals between 18-64 years of age reported ever receiving an HIV test<sup>6</sup>, which demonstrates that early screening and preventive measures are still inadequate. Since a significant portion is left unscreened, it could result in individuals not receiving the recommended standard of care to manage the disease. In short, it is obvious that the differences in administrative operations of ADAP programs are contributing to a growing number of inequities in ADAP coverage and interfering with proper access to care and the health outcomes of patients with HIV/AIDS.

### Sources:

<sup>1</sup>Johri M. Paltiel AD, Goldie SJ, and Freedberg KA. (2002). State AIDS Drug Assistance Programs. *Medical Care*, 40(5):429-441.

<sup>2</sup>CDC, Presentation by Dr. Harold Jaffe. HIV/AIDS in America Today. 2003 National HIV Prevention Conference, June 2003

<sup>3</sup>Walensky RP, Paltiel AD, Freedberg KA. (2002). AIDS Drug Assistance Programs: Highlighting Inequities in Human Immunodeficiency Virus-Infection Health care in the United States.

<sup>4</sup>Kaiser Family Foundation. (March 2006) HIV/AIDS Policy Fact Sheet: AIDS Drug Assistance Programs (ADAPs).

<sup>5</sup>DHHS and Henry J. Kaiser Family Foundation Panel on Clinical Practices for the Treatment of HIV Infection, *Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents*, May 5, 1999, p. 2.

<sup>6</sup>Behavioral Risk Factor Surveillance System, HIV Testing-United States, 2001, *Morbidity and Mortality Weekly Report* Vol. 52 (23), Centers for Disease Control and Prevention, Department of Health and Human Services, June 2003. Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5223a2.htm>



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