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AIDS/HIV Program (DHS -- Public Health)

[LFB 2009-11 Budget Summary: Page 373, #2]

CURRENT LAW

The Department of Health Services (DHS) administers several programs that provide assistance to individuals with an AIDS/HIV infection, including: (a) the AIDS drug assistance program (ADAP); (b) the health insurance premium subsidy program; (c) the Mike Johnson life care and early intervention service grants; and (d) prevention activities targeted to individuals who are at risk of HIV infection.

ADAP reimburses pharmacies for certain AIDS/HIV drugs provided to program participants who meet certain financial and AIDS/HIV-related criteria. The program is funded by GPR, federal funds the state receives under the Ryan White AIDS/HIV program, medical assistance (MA) payments, payments made by third parties, and rebates received by the state from drug manufacturers.

The health insurance premium subsidy program subsidizes the premiums for continuation coverage under group and individual insurance policies for individuals who reduced or terminated employment due to an AIDS/HIV infection.

DHS distributes Mike Johnson life care and early intervention services grants to two AIDS service organizations (ASOs) -- the AIDS Resource Center of Wisconsin and the AIDS Network -- to fund case management, support services, and core medical services to individuals with an AIDS/HIV infection. Federal funding is also provided to the two ASOs and 10 community-based organizations to provide individuals with AIDS/HIV with a range of health care and support services. In addition, DHS distributes federal funds and GPR to local agencies for targeted prevention and education activities.

2007 Wisconsin Act 20 created a three-year pilot program that permits the AIDS/HIV program to pay premiums for coverage under the state's health insurance risk-sharing plan

(HIRSP) and copayments for prescription drugs provided under HIRSP, for individuals who: (a) meet eligibility requirements for ADAP; (b) are taking antiretroviral drugs; and (c) do not have health insurance coverage. This allows individuals who do not meet the criteria for the health insurance subsidy program (that is, the individual has not had to terminate or reduce employment due to an AIDS/HIV infection) to enroll in HIRSP. The pilot program began on January 1, 2008, and is scheduled to end on January 1, 2011.

HIRSP policies issued on the basis of a medical condition are subject to a six-month pre-existing condition waiting period, during which any services related to the pre-existing condition are not covered. DHS pays for the full cost of AIDS/HIV medications for pilot program participants during this waiting period. After the pilot program participants have been enrolled in HIRSP for six months, the AIDS/HIV program pays for HIRSP premiums and drug copayments, and HIRSP covers medications after cost-sharing requirements are satisfied.

The AIDS/HIV programs are funded from a variety of sources, including state GPR, federal funds the state receives under the Ryan White AIDS/HIV program, and rebates from manufacturers for ADAP drug purchases. Base GPR support for these programs is shown in Table 1.

TABLE 1

GPR Base Funding for AIDS/HIV Programs

	Amount
Mike Johnson Life Care and Early Intervention Grants	$3,569,900
HIV Prevention and Education	1,034,300
AIDS Drug Assistance Program	464,000
Health Insurance Premium Subsidies	462,200
Total	$5,530,400

GOVERNOR

Increase funding by $1,151,500 GPR in 2010-11 to fully fund projected ADAP and health insurance premium costs in the 2009-11 biennium. This funding increase reflects declining carryover balances of federal funding DHS uses to support these programs and projected increases in costs of the premium subsidy program and drugs purchased for ADAP enrollees.

The bill also includes a 1% across-the-board reduction to most non-federal appropriations. For the AIDS/HIV program, DHS would reduce funding for Mike Johnson life care and early intervention service grants and HIV prevention activities by $55,300 GPR annually. Consequently, the total GPR funding for the AIDS/HIV program would be $5,475,100 in 2009-10 and $6,626,600 in 2010-11.

Finally, the bill includes statutory changes to make the pilot program permanent.

DISCUSSION POINTS

1. The funding recommended by the Governor in AB 75 is based on a reestimate of revenues and expenditures for ADAP and the insurance subsidy program. GPR funding for Mike Johnson life care and early intervention services grants and HIV prevention activities would be reduced by a total of $55,300 annually due to the 1% across-the-board reduction, so that $4,548,900 GPR would be budgeted in each year to support these programs.

2. At the request of this office, DHS has revised its estimates of revenue and program costs for the 2009-11 biennium. These reestimates reflect: (a) more recent information on available revenues and costs than was available at the time the administration prepared its estimate for inclusion in AB 75; and (b) changes that are consistent with the Governor's proposal to make the program permanent.

3. As previously indicated, in 2008-09, ADAP is budgeted $464,000 GPR, and the insurance subsidy program is budgeted $462,200 GPR in 2008-09. In addition, Wisconsin receives federal support for its AIDS/HIV program from grants under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act ("Ryan White grant"). In 2008-09, the state received $5,334,700 in Ryan White grant funding for ADAP. These Ryan White ADAP funds may be used to pay for insurance premiums if purchasing those premiums is shown to be cost-effective, and the Department uses these federal funds to support the insurance premium subsidy program. The Department received notice from the U.S. Department of Health and Human Services, Health Resources and Services Administration, that the 2009-10 Ryan White grant amount for ADAP would be $5,436,400.

4. ADAP and the insurance subsidy program are funded from two other sources: (a) revenue from rebates from drug manufacturers, which the administration anticipates will equal 45% of ADAP medication expenditures in 2009-10 and 2010-11; and (b) reimbursements received for drugs purchased by ADAP that should have been covered by MA or private insurance.

5. Table 2 summarizes the estimated available revenue, by source.

TABLE 2

Available Funding for ADAP and Insurance Premium Subsidy Program
All Sources, 2008-09 through 2010-11

	2008-09	2009-10	2010-11
Federal Ryan White Grant Funds	$5,334,700	$5,436,400	$5,436,400
ADAP GPR Base	464,000	464,000	464,000
Insurance Premium Subsidy Program GPR Base	462,200	462,200	462,200
Drug Manufacturer Rebates	3,988,800	4,960,100	6,100,900
MA or Other Insurance Payments	345,700	389,000	425,700
Total (All Fund Sources)	$10,595,400	$11,711,700	$12,889,200

6. Table 3 shows that enrollment in ADAP and the insurance premium subsidy program has grown steadily over the past several years. Table 3 shows actual program enrollment for fiscal years 2003-04 through 2007-08, and current estimates of program enrollment for 2008-09 through 2010-11 which were developed by applying the average growth rate from 2003-04 to 2007-08.

TABLE 3

ADAP and Insurance Premium Subsidy Program Enrollment,
Actual and Projected 2002-03 through 2010-11

	ADAP		Subsidy Program	
	Enrollment	Percent Change	Enrollment	Percent Change
2002-03	863	--	358	--
2003-04	907	5.1%	405	13.1%
2004-05	965	6.4	427	5.4
2005-06	967	0.2	449	5.2
2006-07	1,033	6.8	491	9.4
2007-08	1,139	10.3	578	17.7
2008-09 (Projected)	1,207	6.0	636	10.0
2009-10 (Projected)	1,280	6.0	699	9.9
2010-11 (Projected)	1,357	6.0	769	10.0

7. ADAP expenditures have averaged annual growth of 23% over the period from 2003-04 to 2007-08. Using year-to-date expenditure information for 2008-09 and applying the average growth rate of over the past five years to the 2009-11 biennium, it is estimated that ADAP

drug expenditures will equal $8,870,500 in 2008-09, $10,910,700 in 2009-10, and $13,420,200 in 2010-11.

8. Insurance subsidy program expenditures have averaged annual growth of 18% over the period from 2003-04 to 2007-08. Using year-to-date expenditure information for 2008-09 and applying the growth rate over the past five years to the 2009-11 biennium, it is estimated that ADAP drug expenditures will equal $3,333,000 in 2008-09, $4,005,500 in 2009-10, and $4,937,600 in 2010-11.

9. The annual expenditures listed above include expenditures for all program enrollees, including participants for whom the state pays HIRSP premiums as part of the pilot program. However, once a participant in the pilot program has fulfilled the HIRSP six-month pre-existing waiting period, HIRSP pays for that individual's medications after any individual cost-sharing requirements. This results in a net savings to the AIDS/HIV program, as the savings to the ADAP program are expected to outweigh the costs of paying for HIRSP premiums and copayments.

10. The estimated savings from the HIRSP pilot program depend upon an assumption that 17 new ADAP participants will enroll in the program every six months. Twenty-one individuals enrolled in the first half of 2008, nine individuals enrolled in the second half of 2008, and five individuals have enrolled so far in 2009. Although HIRSP enrollees benefit from more extensive health coverage than is available through ADAP, the level of HIRSP cost-sharing requirements may deter voluntary enrollment in the pilot program.

11. AB 75 would provide $240,000 in 2010-11 for DHS to implement a pharmacy benefit management (PBM) system to process ADAP pharmacy claims and improve administrative efficiency. The program currently has a paper-based claim processing system; two national chains will not serve ADAP participants due this lack of an electronic system. The bill would provide the funding to contract a vendor to develop the PBM system, with $150,000 for start-up costs, and $90,000 for claims processing costs (based on a $4.50 per claim charge for an estimated 20,000 annual claims). These cost estimates are based on DHS experience with the development of a similar system for HIRSP, when DHS administered that program.

12. Table 4 shows the current projections for expenditures for ADAP medications, insurance subsidies, the PBM system, and program staff. These projections are based on three quarters of expenditure data in 2008-09, actual current participation in the HIRSP pilot program, and an expectation that 17 new pilot participants will join every six months.

TABLE 4

ADAP and Insurance Subsidy Program Expenditures

	2008-09	2009-10	2010-11
Projected ADAP Expenditures	$8,864,000	$9,973,200	$10,915,300
Projected Insurance Premium Subsidy Expenditures	2,964,700	3,857,400	4,817,200
Pharmacy Benefit Management System	0	0	240,000
Program Staff Salary	203,300	208,400	213,600
Total Projected Expenditures	$12,032,000	$14,039,000	$16,186,100

13. Historically, when revenue was insufficient to meet the expenditure needs of the insurance subsidy program and ADAP, DHS has drawn on continuing balances that have carried over from previous years. The balance at the beginning of 2008-09 equaled $5,546,200. Table 5 summarizes the Department's revised estimates of revenues, expenditures, and program balances for fiscal years 2008-09 through 2010-11.

TABLE 5

DHS Revised Estimates of Program Funding and Balances

	2008-09	2009-10	2010-11
Opening Balance	$5,546,200	$4,109,600	$1,782,300
Revenues	$10,595,400	$11,711,700	$12,889,200
Expenditures	$12,032,000	$14,039,000	$16,186,100
Closing Balance	$4,109,600	$1,782,300	-$1,514,600
Funding in AB 75			$1,151,500
Change to AB 75			**$363,100**

14. As Table 5 indicates that, based on the reestimates, the program would have a shortfall of $1,514,600 by the end of 2010-11 if no additional funding were provided to the program. Since AB 75 would provide an additional $1,151,500 GPR for the program in 2010-11, an additional $363,100 GPR would be needed, above the funding in the bill, to fully fund projected program costs (Alternative 2).

15. The Committee may want to consider that the revised cost estimate is based on an assumption that 17 participants would enroll in the HIRSP pilot program every six months. While the enrollment in the first six months of the pilot program exceeded this anticipated level (21), only

nine individuals enrolled in the second half of 2008, and only five individuals have enrolled in the first quarter of 2009. If the pilot program enrollment does not meet the 17 individuals per six month assumption, the savings would be less than anticipated, and the shortfall in the program would be larger than the $1,514,600 currently projected by DHS.

16. Table 6 provides projected program revenues and expenditures under an assumption 10 new individuals would enroll in the pilot program every six months, rather than 17 new participants, as DHS assumes.

TABLE 6

Alternative Estimate of Program Funding and Balances

	2008-09	2009-10	2010-11
Opening Balance	$5,546,200	$4,109,600	$1,746,000
Revenues	$10,595,400	$11,716,100	$12,914,900
Expenditures	$12,032,000	$14,079,700	$16,651,400
Closing Balance	$4,109,600	$1,746,000	-$1,990,500
Funding in AB 75			$1,151,500
Change to AB 75			**$839,000**

Table 6 shows that, under this assumption, an additional $839,000 GPR would be needed, above the funding that the Governor recommended in the bill, to support the AIDS/HIV program in the 2009-11 biennium. This option is presented as Alternative 3.

17. In reviewing these funding options, the Committee may wish to consider the following:

First, the AIDS/HIV programs are not entitlement programs. If revenue from federal or state funds is insufficient to fully fund projected expenditures in the ADAP and health insurance subsidy program, DHS has several options, including reducing funding for services provided by AIDS service organizations, establishing waiting lists for program services, or seeking supplemental funding for the program under s. 13.10 of the statutes. The Department does not currently have a plan for how it would address a situation where revenues are not sufficient to meet expenditure needs.

However, since $9,097,800 GPR of the $12,101,700 GPR budgeted for the AIDS/HIV program (75%) is budgeted for discretionary grants to ASOs and community based organizations, DHS would be able to reallocate funds to fully fund ADAP and the premium subsidy program if it determined that these programs were a priority use of funds.

Second, there is uncertainty regarding future enrollment and program costs. The current estimates of future average increases in costs of ADAP (23% annual growth) and the premium subsidy program (18%), while based on recent experience, may not accurately predict future program costs.

18. The Committee could delete the provision in the bill that makes the HIRSP pilot program a permanent program. However, the AIDS/HIV program would lose estimated savings in the second half of fiscal year 2010-11, since participants would no longer have HIRSP coverage for their medication. Any individual who is unable to pay for HIRSP premiums would leave that program, and would be subject to a new six month pre-existing condition waiting period if he or she wished to reenroll. For this reason, it is estimated that an additional $1,827,700 would be needed to support the AIDS/HIV program, above the amounts provided in the bill, if the Committee chose not to continue the pilot program.

ALTERNATIVES

1. Approve the Governor's recommendations.

2. Modify the Governor's recommendation to reflect the current DHS estimate of program costs, which maintains the Governor's assumption that 17 individuals will join the pilot program every six months. Increase funding in the bill by $363,100 GPR in 2010-11.

ALT 2	**Change to Bill** Funding
GPR	$363,100

3. Modify the Governor's recommendation to reflect the assumption 10 individuals will join the pilot program every six months. Increase funding in the bill by $839,000 GPR in 2010-11.

ALT 3	**Change to Bill** Funding
GPR	$839,000

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