

## HIV/AIDS and the Importance of AIDS Drug Assistance Programs (ADAPs)

### HIV/AIDS before ADAP

In the early 1980s, HIV emerged as the most urgent public health challenge of our time. With no treatment strategies, new infections and deaths increased dramatically: by 1987, 71,514 cases had been reported and 41,330 Americans had died. That same year, the first medication to treat HIV (AZT) was approved. The advent of drugs to treat HIV provided hope for affected communities, but introduced another obstacle: how would patients pay for treatment? AZT alone, for example, could cost \$10,000 per year. Fortunately, legislators recognized the magnitude of the crisis and acted quickly.

### ADAPs and ADAP History

AIDS Drug Assistance Programs (ADAPs) began in 1987, shortly after FDA approval of AZT. Soon thereafter, researchers realized that AZT alone could not successfully treat HIV infection. Fortunately, research progressed rapidly and drug access improved. As more effective treatment became available, ADAPs expanded to pay for other drugs to prevent and treat opportunistic infections (secondary illnesses associated with HIV). With the passage of the Ryan White CARE Act in 1990, Congress allocated funds for state ADAPs (states are required to supplement this funding). In 2003, the Ohio HIV Drug Assistance Program (OHDAP) budget was \$13,116,779, with 20% coming from the state budget.

### Individual and Societal Benefits of ADAPs

ADAPs provide prescription drugs to one-third of all individuals living with HIV/AIDS who are receiving care. Approximately 136,000 individuals and families benefit from ADAPs nationally. The current standard of care, called highly active antiretroviral treatment (HAART), costs \$10,000 to \$20,000 per year. Without ADAPs, few households would be able to access this advanced treatment. ADAPs reinforce the view that all individuals, regardless of circumstances, deserve adequate medical attention. With successful HIV medications available, thousands have returned to healthy, productive lives.

In addition to improving the lives of those living with HIV, there are many societal benefits to ADAPs. While medications can be expensive, overall medical costs for those receiving HAART are reduced. In fact, the earlier HIV is treated, the better the prognosis – and the lower the overall costs. But if HIV goes undetected or is under-treated, immune system damage is often irreversible, even with the best therapies. With early detection and effective treatment through ADAPs, emergency room visits, clinic appointments, and other costs can be avoided.

ADAPs also enhance *prevention* efforts in three ways. **First**, once an HIV-positive individual begins HAART, he or she is more likely to become aware of other programs (such as case management and support groups). This can enhance prevention if an individual is receiving instruction about transmission risks and risk reduction. **Second**, treated HIV infection reduces the risk of transmission, because treatment dramatically reduces the amount of HIV in the body – thus decreasing the possibility of perinatal and sexual transmission. And **third**, once HIV-positive individuals have their medical needs met, care providers can devote more resources to other prevention efforts. ADAP programs, and their subsequent community-based effects, clearly demonstrate that treatment *is* prevention.

Treatment *is* prevention

### Recent ADAP Debate

In recent months, ADAPs have become the subject of new public discussion because of the number of disadvantaged individuals on waiting lists (nearly 1,500 in the United States). Some have died while waiting for medications. In June of 2004, the President announced \$20 million in funding to reduce ADAP waiting lists. This recognition of the crisis is important, but insufficient: the funds only cover about 20% of the funding needed to *eliminate* waiting lists. All 57 states and territories with operating ADAPs have experienced an increased demand for the program (clients up by 10% and drug costs up by 9%) and many have been forced to implement cost-cutting measures such as waiting lists, reduced formularies, or per-person limits – measures, clearly, that have life-or-death impacts. Needed immediately is a \$217 million increase in ADAP funding for FY 2005. Never before has ADAP advocacy been more crucial.

### Ohio HIV Drug Assistance Program (OHDAP)

Compared to other state policies, Ohio's ADAP is exemplary. Ohio provides 74 approved drugs to almost 2,000 HIV-positive clients without any cost-containment measure. In order to be eligible for OHDAP, an Ohio resident must confirm income less than \$3,879.17 per month for one person (amount increases with family size), provide physician's proof of HIV status, and present IRS Income Tax Transcript (1722) for the most recent tax year. **Continued support for this economically sensible program is needed to provide prescription drugs to all HIV-positive individuals in need.**

## OHDAP: The Human Face

The following narrative portrays how OHDAP has greatly influenced the lives of Northeast Ohioans. The man depicted here benefited from OHDAP with the help of a case manager from the AIDS Taskforce of Greater Cleveland.

*Throughout most of his life, “David” was able to maintain a stable, practical lifestyle. In the summer of 2002, David’s life drastically changed when he became unemployed and lost health insurance coverage. He was able to preserve his previous insurance through COBRA (Consolidated Omnibus Budget Reconciliation Act), which temporarily covers benefits in certain unemployment circumstances, but unfortunately, COBRA did not cover his HIV medications. Without medication or suitable employment and health care, he approached the AIDS Taskforce. In early 2004, David met with a senior social worker who assessed his situation.*

*Without the vital assistance of prescriptions for over a year, David’s CD4 count had dropped from 1300 to 700, and his viral load increased substantially.<sup>1</sup> Fortunately, the ATGC social worker recognized that his present condition made him immediately eligible for OHDAP prescription coverage. David and his social worker completed the application together and waited for a response from the Ohio Department of Health. David received medications within three weeks, thankful that Ohio’s ADAP was able to fulfill their urgent request so quickly.*

*Once enrolled, OHDAP sent a three-month supply of medications directly to his residence. After just three months back on medications, his CD4 count climbed once again to over 1100, and his viral load dropped to undetectable levels. Consequently, his improved health allowed him to dedicate more time and energy to locating a job. During the summer of 2004, with employment and health care coverage attained, he was able to gain private medical insurance and discontinue his temporary OHDAP enrollment. He currently receives HIV medications through private insurance with a \$90 monthly co-pay.*

*When asked what his life would be like without OHDAP he replied, “I am sure that my numbers would have continued to deteriorate and the progression of the disease would have continued to a point I don’t want to think about.”*

As this example indicates, HIV-positive individuals can experience periods of critical medical need. Without OHDAP’s intervention, a pervasive episode of dire illness could have easily occurred. By absorbing an immediate cost and meeting an immediate need, ADAPs help avoid the long-term consequences of inadequate medical attention. Hopefully the programs will continue to serve in this capacity, as their impact on individuals, society and prevention are invaluable.

- 136,00 individuals and families benefit from the programs nationally
- Antiretroviral treatment alone can cost between \$10,000 and \$20,000 per year
- The earlier HIV is treated, the better the prognosis, and the lower the subsequent medical costs
  - Almost 1,500 HIV-positive individuals across the nation are on ADAP waiting lists
  - From 2002 to 2003, client enrollment increased by 10% and drugs expenditures by 9%
- An additional \$217 million in ADAP funding in 2005 is needed to remove all waiting lists
  - OHDAP currently serves almost 2,000 clients

**Continued support of this economically sensible program is required to continue providing prescription drugs to all HIV-positive individuals in need.**

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<sup>1</sup>As HIV progresses, CD4 cells (a type of lymphocyte) decrease and viral loads increase. Viral load measures indicate the amount of HIV in one’s bloodstream.