



Safety Net Intersection: AIDS Drug Assistance Programs and the Medicare Prescription Drug Benefit

The Medicare prescription drug benefit, also referred to as Medicare Part D, was initiated through the *Medicare Prescription Drug, Improvement, and Modernization Act (MMA)*, enacted in December 2004. The benefit, which took effect January 1, 2006, provides prescription drug coverage to Medicare beneficiaries through a model that mirrors private health insurance. State and federal programs that previously supplied medications to those now eligible for Medicare Part D have been impacted by this new benefit. For people living with HIV/AIDS, the most significant programs that are impacted are Medicaid and state AIDS Drug Assistance Programs (ADAPs). This report provides background on the interaction between ADAPs and Medicare Part D as well as outlines the approaches ADAPs took in wrapping around the benefit based on a survey completed in 2007.

Background on Medicare Part D and ADAP

Medicare and HIV/AIDS

Medicare is the second largest federal payer for HIV/AIDS health coverage.¹ The majority of the 85,000 – 100,000 people living with HIV/AIDS that Medicare serves are eligible through Social Security Disability Insurance (SSDI). Individuals who have a disability that prevents them from working and have sufficient work credits are eligible for SSDI payments; however, there is a 24 month waiting period to receive Medicare benefits. These beneficiaries also tend to be in more advanced stages of illness – 65 percent have CD4 counts below 200 (the threshold for an AIDS diagnosis). Approximately 82 percent of Medicare beneficiaries with HIV/AIDS are under the age of 50.

Medicare Part D

In order to receive Medicare Part D coverage, Medicare beneficiaries must sign up for a prescription drug plan (PDP) that is either a stand-alone PDP or one offered through a Medicare Advantage plan. Each year, costs to the beneficiary are adjusted based on the increase in average total drug expenses of Medicare beneficiaries. In addition to a monthly premium, which in 2007 averaged approximately \$22², all plans must be equal to, or actuarially equivalent to, the following standard benefit:

¹ Kaiser Family Foundation. *Trends in U.S. Government Funding for HIV/AIDS: Fiscal Years 1981 to 2004*. March 2004.

² Centers for Medicare and Medicaid Services. *Medicare Part D Plan Premiums for 2008 Show Continued Impact of Strong Competition*. Retrieved August 29, 2007 from <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=2401>

Table 1: Medicare Part D Benefit Design

	2006	2007	2008
Deductible: <i>Beneficiary is responsible for the deductible payment</i>	\$250	\$265	\$275
Initial Coverage Limit: <i>Beneficiary pays 25 percent of total drug costs after the deductible up to this point</i>	\$2,250	\$2,400	\$2,510
Out-of-pocket threshold: <i>Beneficiary is responsible for 100 percent of drug costs after reaching the initial coverage limit until they reach the out-of-pocket threshold – this is known as the “doughnut hole”</i>	\$3,600	\$3,850	\$4,050
Total Drug Spending Threshold (Catastrophic Limit): <i>After reaching the catastrophic limit in total drugs costs, the beneficiary pays 5 percent coinsurance or a co-pay of \$2 for generic drugs and \$5 for brand name drugs</i>	\$5,100	\$5,451	\$5,726

Source: Centers for Medicare and Medicaid Services

http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/07_PartDBenefitParameters.asp#TopOfPage

Under Medicare Part D, the true out of pocket (TrOOP) costs of beneficiaries are tallied to determine when a beneficiary reaches the catastrophic coverage limit. As indicated in Table 1, beneficiaries’ cost sharing amounts are greatly reduced once they have reached the threshold limit of \$4,050 (2008). Payments for drugs, co-payments and co-insurance made by the beneficiary, friends, family members, State Pharmacy Assistance Programs (SPAPs), charities, and the Medicare low-income subsidy count towards TrOOP costs.³ Payments for premiums, drugs not on plan formularies, and payments by other types of insurance including group health programs, government-funded health programs (such as ADAPs) and several other third party payers are not counted as TrOOP costs.

A low-income subsidy (LIS) is available to assist beneficiaries who qualify based on income or who are dually eligible for both Medicaid and Medicare. The vast majority (two-thirds) of beneficiaries living with HIV/AIDS are dually eligible for Medicaid and Medicare.⁴ Table 2 summarizes the groups who qualify for the low-income subsidy and their corresponding required costs.

³ Centers for Medicare and Medicaid Services. Understanding True Out-of-Pocket (TrOOP) Costs. May 2006. Retrieved August 2006 from <http://www.cms.hhs.gov/partnerships/downloads/troop.pdf>.

⁴ Bozette, S., et al. “The Care of HIV Infected adults in the United States.” *NEJM*, Vol 339, No 26. December 1998.

Table 2: Medicare Part D Low Income Subsidy

Medicare Prescription Drug Benefit Subsidies for Low-Income Beneficiaries 2008			
Low-Income Subsidy Level	Monthly Premium	Annual Deductible	Co-payments
Full-benefit dual eligibles <100 percent of poverty	\$0	\$0	\$1.05/\$3.10 /brand-name; no co-pays after total drug spending reaches \$5,451.25
Full-benefit dual eligibles	\$0	\$0	\$2.25/\$5.60 /brand-name; no co-pays after total drug spending reaches \$5,451.25
Institutionalized full-benefit dual eligibles	\$0	\$0	No co-pays
Individuals with income <135 percent of poverty and resources <\$7,500/individual; \$12,000/couple	\$0	\$0	\$2.25/\$5.60 /brand-name; no co-pays after total drug spending reaches \$5,451.25
Individuals with income 135 percent -150 percent of poverty	Sliding scale based on income	\$50	15 percent of total costs up to \$5,451.25; \$2.25/\$5.60 /brand-name thereafter
Note: Resources include \$1,500/individual and \$3,000/couple for funeral and burial expenses. Source: Kaiser Family Foundation summary of Medicare prescription drug benefit low-income subsidies in 2008.			

ADAPs

ADAPs provide FDA approved HIV-related prescription drugs to underinsured and uninsured individuals living with HIV/AIDS. Part B (formerly Title II) of the Ryan White Program gives states broad authority to set program eligibility criteria and to decide which HIV-related treatments to include on ADAP formularies.⁵ With over 142,000 enrollees and more than 96,000 clients served in June 2006, ADAPs serve approximately 25 percent of all people with HIV/AIDS in care. Almost 60 percent of ADAP clients are racial/ethnic minorities and seventy-five percent of clients have incomes at or below 200 percent of the Federal Poverty Level (FPL). In FY2007, the national ADAP budget was \$1.4 billion, nearly all of which supported direct client services.⁶

Intersection of Medicare Part D and ADAP

The Health Resources and Services Administration (HRSA), the agency that oversees the Ryan White Program, requires ADAPs to ensure that all Medicare Part D eligible clients are enrolled in a PDP. Under Medicare Part D, individuals who have incomes above 150 percent of the FPL and do not qualify for the LIS are required to make

⁵ The 2006 reauthorization of the Ryan White Program implemented a minimum formulary requirement for ADAPs. Effective July 1, 2007, ADAPs are required to cover at least one medication from each of the approved antiretroviral drug classes, as indicated in the Department of Health and Human Services “Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents.”

⁶ Kaiser Family Foundation and National Alliance of State and Territorial AIDS Directors. National ADAP Monitoring Project Annual Report (April 2008).

significant payments to receive their drugs. Therefore, most ADAPs have chosen to provide wrap-around coverage for people with HIV/AIDS enrolled in Medicare Part D by:

- Picking up costs for the beneficiary when they reach the “doughnut hole” (see Table 1);
- Paying for co-pays;
- Paying for monthly premiums; and,
- Paying for deductibles.

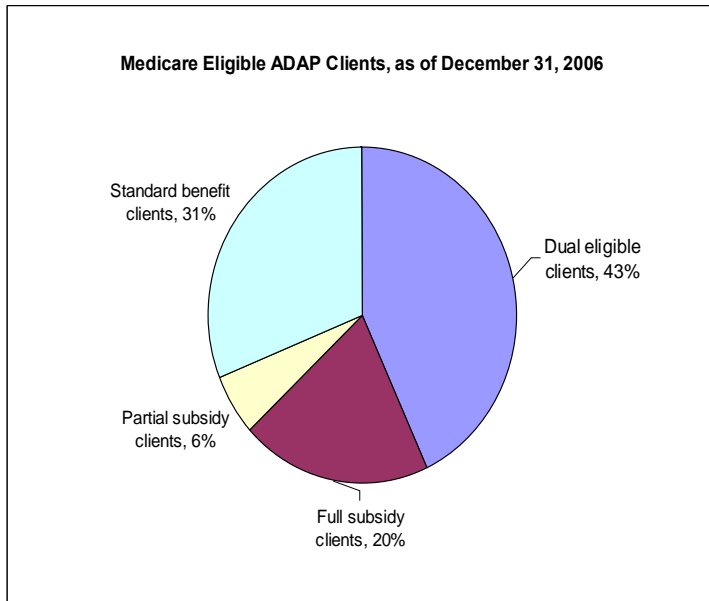
To facilitate these payments, ADAPs are permitted to coordinate with PDPs. Coordinating with plans, however, is difficult for ADAPs as some states have up to 40 different plans available. Most third-party payments made on behalf of beneficiaries (including ADAP payments) *do not* count towards TrOOP. Therefore, for beneficiaries for whom ADAP is picking up all costs, getting out of the “doughnut hole” to reach the catastrophic limit is generally not possible. Coordination with plans involves working with both clients, PDPs and pharmacies to ensure that clients are receiving all the appropriate HIV/AIDS-related medication and being assessed correct co-pays, expenditures are being flagged as not counting towards TrOOP, and wrap-around expenditures are being calculated correctly.

Throughout 2006 and 2007, ADAPs implemented policies and procedures in an attempt to provide comprehensive prescription drug coverage to clients who were also eligible for Part D and to conserve ever-limited ADAP dollars. ADAPs experienced many complicating factors during this process ranging from confusion regarding CMS and HRSA guidance, client trepidation amongst news reports of Part D problems, PDP resistance to working with ADAPs and others. The information in this report is based upon surveys distributed to state health departments as part of NASTAD’s Medicare Education and Monitoring Project. Survey responses were received during the months of April and May 2007 from 38 states—a 72 percent response rate. All data described in this report refer to the data collected by ADAPs as of December 31, 2006, the end of the first year of the benefit.

Identification of Medicare-eligible ADAP Clients

From the 38 surveys received with Medicare Part D eligible client numbers, 17 percent of ADAP clients were eligible for Part D on December 31, 2006. As mentioned above, a low-income subsidy is available to assist beneficiaries who qualify based on income or to those who are dually eligible for both Medicaid and Medicare. The subsidy substantially reduces or eliminates cost sharing obligations. All full benefit dually eligible clients as well as individuals under 150 percent of FPL are eligible to receive either a full or partial low-income subsidy. Of the states participating in the survey, 69 percent of ADAP clients qualified for Medicare Part D also qualified for the low-income subsidy as of December 31, 2006. Chart One summarizes the different benefit levels for ADAP clients eligible for Part D.

Chart One



As of December 31, 2006:

- 7,843 Medicare eligible ADAP clients were dually eligible for both Medicare and Medicaid
- 3,703 Medicare eligible ADAP clients qualified for the full LIS
- 1,110 Medicare eligible ADAP clients qualified for the partial LIS.
- 5,690 Medicare eligible ADAP clients received the standard benefit

Application for Low Income Subsidy

Since beneficiaries eligible for the LIS are responsible for substantially less cost-sharing, many ADAPs have instituted policies requiring all Medicare-eligible clients to apply for LIS. At the time of the survey, approximately 84 percent of programs had policies regarding Medicare eligible ADAP clients applying for the low-income subsidy. Eighteen states reported that all ADAP clients must apply and 15 states reported that only low-income clients must apply.⁷ Thirteen states reported that they require a clients' acceptance or denial letter for LIS for the client's ADAP file.

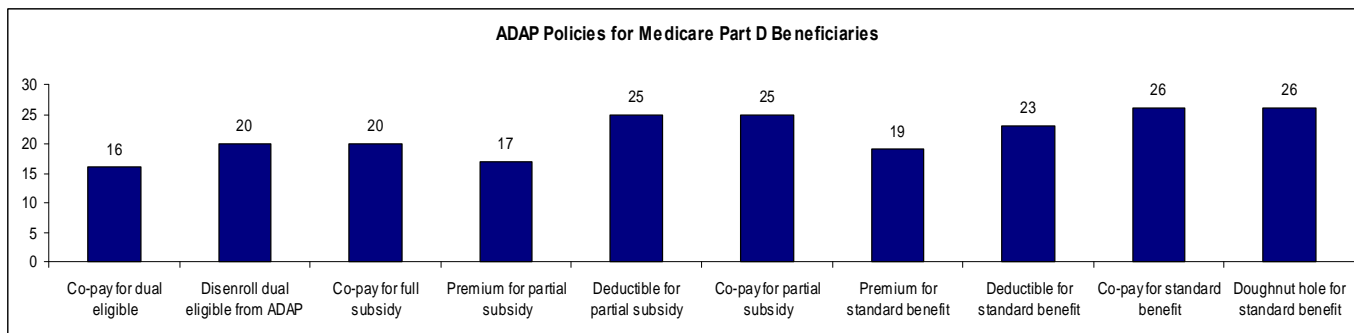
Wrap-around Policies

The majority of ADAPs (30 ADAPs) are providing some sort of wrap-around services to certain populations of Part D beneficiaries. State ADAPs had to evaluate a variety of factors when deciding which wrap-around services they could provide. Factors that were considered included: the fiscal condition of their ADAP; the drug distribution system of their ADAP; the existing technological infrastructure of their ADAP; and the numbers in Part D client income categories. Chart Two describes the wrap-around policies put in place by 38 states regarding their Medicare-eligible beneficiaries who do not qualify for LIS. Twenty-six states reported that they assist these clients by allowing them to return to ADAP when they hit their plan's "doughnut hole." Twenty states

⁷ The following states reported that clients must apply for the LIS: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Illinois, Iowa, Louisiana, Maine, Michigan, New Hampshire, Ohio, Oklahoma, Texas, Utah, Vermont. The following states reports that only low-income ADAP clients must apply for the LIS: Arkansas, District of Columbia, Florida, Idaho, Maryland, Missouri, New Jersey, New York, North Carolina, South Carolina, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

reported disenrolling dual-eligible clients from their ADAP; 17 ADAPs disenrolled full-subsidy clients and six states reported disenrolling clients who were eligible for the partial LIS. Four states reported that they disenrolled ADAP clients receiving the standard benefit under Medicare Part D. These states disenrolled their clients to SPAPs or another wrap-around benefits programs.

Chart Two



For a complete list of state responses and the wrap-around assistance provided to all levels of Medicare beneficiaries, please refer to Appendix 1.

Working with a Limited Number of Part D Plans

In order to ease administrative burden and provide clients with plans that better suit their needs, several ADAPs chose to coordinate with a limited number of prescription drug plans. Many ADAPs chose to coordinate with an “enhanced plan,” which usually has a greater deductible and increased cost-sharing, but does not have a “doughnut hole” for beneficiaries to fall into. Many clients who are not eligible for LIS are unable to pay the out-of-pocket costs during the doughnut hole. For ADAPs with limited infrastructure, it is difficult to coordinate with multiple plans and therefore working with one enhanced plan was an option that offered a more comprehensive benefit to clients and allowed ease of coordination. At the time of the survey, 14 states were working with enhanced plans and seven of those states required their Part D clients to sign up for the enhanced plan. The availability of these plans varied by state. In 2006, clients in all but four states had access to an enhanced plan that covered brand name and generic medications during the “coverage gap.” However, the companies providing enhanced coverage in 2006 did not continue to do so in 2007. In 2007, thirteen states were without enhanced plans that provided brand name drugs during the doughnut hole and several states experienced problems with the only plan that included brand name drugs in the coverage gap.

There are no enhanced plans covering brand name medications during the doughnut hole in the 2008 plan year. This means that the seven states that had been working exclusively with enhanced plans had to reassess their ADAP wrap-around policies and find options that were best for the clients for plan year 2008.

State Pharmaceutical Assistance Plans (SPAPs)

Under the MMA, SPAPs realized some special treatment not afforded to other public programs that provide medications to individuals. Many states had implemented SPAPs in the years before Part D to assist individuals, particularly the elderly, with obtaining their medications. SPAP expenditures count towards TrOOP, therefore saving the SPAP money by getting their beneficiaries through the coverage gap and into catastrophic coverage. While HIV/AIDS advocates have long-advocated for ADAP expenditures to count towards TrOOP, this has not yet happened. Therefore, several ADAPs have looked to SPAPs to find relief for their ADAP and to provide comprehensive coverage for their clients. This is especially the case for ADAPs that have little infrastructure to assist in providing wrap-around services to their clients, such as the payment of premium and co-pays. As of December 31, 2006, ten ADAPs reported they have an SPAP open to individuals living with HIV/AIDS in their state and six ADAPs are considering implementing a SPAP to assist in the Part D benefit wrap-around.

States had three options for utilizing a SPAP to assist their Part D clients: enroll clients into an existing SPAP that allowed disabled populations; adapt an existing SPAP to allow HIV-positive clients to enroll; or create an entirely new SPAP specifically for beneficiaries living with HIV. Several states such as Missouri and New Jersey had an existing SPAP that allowed for the transfer of ADAP clients into the SPAP. Illinois had an SPAP in their state, but it did not allow disabled clients to enroll. Local advocates worked with the legislature to adopt a new population for the SPAP that would mirror what was provided to ADAP clients. Other states such as Texas, Virginia and Colorado have recently implemented SPAPs because they had little or no mechanism to coordinate wrap-around services. Other states may be in the process of implementing or exploring the option of a SPAP.

Cost-Savings

NASTAD had hoped to receive information regarding the positive cost-savings to ADAPs due to the implementation of Medicare Part D. However, the data received only allowed for estimates to be made by NASTAD. States are still working on adapting data systems to better reflect the partial pay nature of wrapping around Medicare Part D. In order to estimate cost-savings, NASTAD used two methods. The lower estimate was reached by extrapolating self-reported cost-savings from the survey. The upper range was reached by modeling savings based upon client numbers reported in the survey. NASTAD estimates that due to Medicare Part D, ADAPs nationwide saved between \$73 and \$89 million in calendar year 2006. In addition, it is estimated that if ADAP payments were allowed to count towards TrOOP, it would save up to an additional \$25 to \$44 million for the programs.

NASTAD does not expect that this rate of savings will be duplicated for 2007 or in the future. A majority of the cost-savings was due to ADAP's ability to disenroll dual-

eligible beneficiaries and enroll them in Part D. We expect that the rate of new clients being enrolled into ADAP programs will be lower than in the past, as a portion of those individuals will now be going directly into Part D, but that there will not be the same dramatic shift in client numbers as was seen during the first year.

Part D and Administrative Burden on ADAPs

While it appears that Medicare Part D has been a financial benefit for ADAPs, it has caused enormous strain on staff resources for ADAPs. This survey asked states how many hours a week ADAP staff spend assisting clients with Part D and/or dealing with other Part D issues. Of the 30 states that answered this question, the average number of hours spent assisting clients was almost 19 hours per week. This is an enormous burden for smaller ADAPs who may only have one or two full-time employees.

Future Implications

Medicare Part D has added another benefit to the patchwork system that provides people living with HIV/AIDS medical care. While any additional benefit covering more people is welcome, it does bring added complexity of piecing together a comprehensive benefit. ADAPs continue to monitor their Part D wrap-around policies and alter them to appropriately match the needs of their clients and the fiscal status of their programs. Medicare Part D has provided financial savings for ADAPs and allowed several programs to clear waiting lists and ease other access restrictions.

With thirty ADAPs providing wrap-around services for clients, Medicaid Part D has also put stress on ADAPs to cover the cost of clients once the Medicare Part D benefit will no longer support them. As the benefit continues to change, so does the impact on ADAPs. With the absence of enhanced plans in 2008, all ADAPs will be challenged to provide coverage for clients once they reach the doughnut hole and the impact will be even greater on the seven states that had only enrolled clients in enhanced plans. As plans continue to change, the administrative burden on ADAPs related to coordination will continue, drawing resources from the ADAP that are otherwise used to directly serve clients.

With the third year of the Part D benefit underway, ADAPs continue to see a shifting landscape with plan options. Clients continue to need one-on-one counseling to adapt to changes in premium levels, plan choices and formulary changes. NASTAD will continue to monitor the effects of Medicare Part D through surveys and verification of ADAP wrap-around policies.

Appendix 1

ADAP Policies Related to Medicare Part D, May 2007

State	Pays for Part D Premiums		Pays for Part D Deductibles		Pays for Part D Co-Payments				Disenrollment from ADAP*				Provides Medications During Coverage Gap**
	Partial Subsidy Clients	Standard Clients	Partial Subsidy Clients	Standard Clients	Dually Eligible Clients	Full Subsidy Clients	Partial Subsidy Clients	Standard Clients	Dually Eligible Clients	Full Subsidy Clients	Partial Subsidy Clients	Standard Clients	
Alabama	No	Yes	NA	NA	No	No	No	Yes	Yes	Yes	Yes	Yes	No
Alaska	Yes	Yes	Yes	Yes	NA	NA	NA	Yes	NA	NA	No	No	Yes
American Samoa	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Arizona	No	No	No	No	No	No	No	No	Yes	Yes	No	No	No
Arkansas	No	No	Yes	Yes	Yes	No	Yes	Yes	No	Yes	No	No	Yes
California	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	Yes
Colorado	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No	No	Undecided
Connecticut	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Delaware	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
District of Columbia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	Yes
Florida	No	No	Yes	No	No	No	Yes	No	Yes	Yes	No	No	NA
Georgia	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Guam	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Hawaii	No	No	No	No	No	No	No	No	Yes	Yes	No	No	No
Idaho	No	No	No	No	No	No	No	No	Yes	Yes	Yes	No	Yes
Illinois	NA	NA	NA	NA	NA	NA	NA	NA	Yes	Yes	Yes	No	NA
Indiana	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Iowa	Yes	No	Yes	No	No	No	Yes	No	Yes	Yes	No	Yes	No
Kansas	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	Yes
Kentucky	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	Yes
Louisiana	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Undecided	Undecided	Undecided	Undecided	Yes
Maine	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	Yes
Marshall Islands	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Maryland	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No	No	Yes
Massachusetts	NA	Yes	NA	No	Yes	NA	NA	Yes	No	NA	NA	No	Yes
Michigan	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No	No	Yes
Minnesota	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Mississippi	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Missouri	No	No	No	No	No	No	No	No	Yes	Yes	Yes	Yes	No
Montana	No	No	No	No	No	No	No	No	Yes	Yes	Yes	No	Yes
Nebraska	Yes	Yes	NA	NA	NA	Yes	Yes	Yes	NA	NA	NA	NA	NA
Nevada	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
New Hampshire	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	Yes
New Jersey	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	Yes
New Mexico	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
New York	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No	No	Yes
North Carolina	No	No	No	No	No	No	No	No	Yes	Yes	No	No	No
North Dakota	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
N. Mariana Islands	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Ohio	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	Yes
Oklahoma	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	Yes
Oregon	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Palau	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Pennsylvania	Yes	Yes	Yes	Yes	NA	Yes	Yes	Yes	NA	No	No	No	Yes
Puerto Rico	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Rhode Island	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
South Carolina	NA	NA	NA	NA	No	No	No	No	Yes	Yes	No	No	NA
South Dakota	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Tennessee	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Texas	No	No	No	No	No	No	No	No	Yes	Yes	No	No	NA
Utah	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	No	No	Yes
Vermont	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	Yes
Virgin Islands	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Virginia	No	No	No	No	No	No	No	No	Yes	Yes	NA	No	Yes
Washington	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	Yes
West Virginia	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	Yes
Wisconsin	No	No	Yes	Yes	No	No	Yes	Yes	Yes	Yes	No	No	Yes
Wyoming	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Total Yes	17	19	25	23	16	20	25	26	20	17	6	4	26
Total No	18	17	8	11	15	15	10	11	14	17	28	32	6
Total NR	20	20	20	20	20	20	20	20	20	20	20	20	20
Total NA	3	2	5	4	4	3	3	1	3	3	3	1	3
Total Undecided	0	0	0	0	0	0	0	0	1	1	1	1	1

* Many ADAPs chose to disenroll clients receiving any portion of the Part D subsidy because the benefit provided them comprehensive care. In many instances, when standard clients were disenrolled from ADAP, they were consequently enrolled in a state pharmaceutical assistance program (SPAP).

** Once a client reaches the coverage gap (or "doughnut hole") in their Part D plan, the client will revert back to ADAP to receive all medications available through the ADAP formulary.

Note: 38 ADAPs reported data. NR indicates that the ADAP did not report its policy. NA indicated that the ADAP did not respond to this question.