ADAP Insurance Cost-effectiveness Model
Companion Document
July 2014

Through a Cooperative Agreement with HRSA, NASTAD has created a model that can be used by ADAPs to assess the cost-effectiveness of providing insurance in comparison to full-cost medications for ADAP clients. The following serves as a companion document to the ADAP Insurance Cost-effectiveness Model. Please contact Britten Pund if you have questions.

HRSA Policy Notice 07-05
Per HRSA policy notice 07-05, if deemed cost-effective, ADAPs are permitted to purchase or continue an insurance policy and pay insurance premiums, co-payments and/or deductibles for individuals eligible for ADAP. This policy notice serves as an update to the previously issued HRSA policy notice 99-01. Prior to the use of ADAP funds for the purchase of health insurance, states must provide HRSA/HAB with notification of intent annually in their Ryan White HIV/AIDS Program Part B application.

ADAPs are subject to the conditions as outlined in HRSA policy notice 07-05 below when purchasing or continuing insurance for individuals eligible for ADAP.

1. Funds must continue to be managed as part of the established ADAP Program.
2. ADAP programs must be able to account for and report on funds used to purchase and maintain insurance policies for eligible clients including covering any costs associated with these policies.
3. Funds may only be used to purchase premiums from health insurance plans that, at a minimum, includes at least one drug in each class of core antiretroviral therapeutics from the HHS Clinical Guidelines for the Treatment of HIV/AIDS as well as appropriate primary care services (provided as an update in HRSA policy clarification notice 13-05).
4. The total annual amount spent on insurance premiums cannot be greater than the annual cost of maintaining that same population on the existing ADAP program.
5. Funds may be used to cover any costs associated with the health insurance policy, including co-payments, deductibles, or premiums to purchase or maintain insurance policies.
6. Current client eligibility guidelines, set under Section 2616(b) of the Public Health Service Act, must be followed.
7. The States must maintain their contributions to their HIV/AIDS care programs as required under Section 2617(b)(7)(E).
8. Ryan White HIV/AIDS Program funds must be the payer of last resort.
9. The State must assure that ADAP funds will not be used to purchase health insurance deemed inadequate by the State in its provision of comprehensive primary care services.

The ADAP Insurance Cost-effectiveness Model is intended to assist ADAPs in meeting condition #4 above: “the total annual amount spent on insurance premiums cannot be greater than the annual cost of maintaining that same population on the existing ADAP program.”
Instructions for Using the ADAP Insurance Cost-effectiveness Model

Note: The information pre-populated in the grey boxes of the Model is used as an example and should be replaced with actual information from your state.

This tool will assist in assessing if individual insurance plans are cost-effective. Information inserted into the tool should be based on an individual insurance plan for an average client, not the total cost of providing insurance for all of your ADAP clients. Note: the cost-effectiveness model may be used and applied for any private insurance plan, including a qualified health plan (QHP) available through either a state- or federally-run Affordable Care Act (ACA) marketplace.

The tool has been built with two completion approaches:

The first sheet (HRSA guidelines) directly aligns with HRSA policy notice 07-05 and only assesses cost-effectiveness based on the cost of paying premiums vs. the cost of maintaining an individual on traditional ADAP (paying the full cost of medications). Please note that HRSA cost-effectiveness requirement is for the aggregate cost (not individual client cost) of paying for the health insurance option versus paying for the full cost for medications and other appropriate primary care services.

The second sheet (state alternative) provides a broader way to assess cost-effectiveness, taking into consideration all costs associated with purchasing insurance vs. the cost of maintaining an individual on traditional ADAP (paying the full cost of medications).

**HRSA GUIDELINES**

**Step One**

<table>
<thead>
<tr>
<th>Model for evaluating cost-effectiveness of individual insurance plans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADAP input variables = Grey cells</strong></td>
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<tr>
<td><strong>HRSA Guidelines</strong></td>
</tr>
<tr>
<td><strong>Step 1 – ADAP Cost of Drugs</strong></td>
</tr>
<tr>
<td>ADAP Average Gross Drug Cost</td>
</tr>
<tr>
<td>$500.00</td>
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<tr>
<td>Rebate Revenue (Optional)</td>
</tr>
<tr>
<td><strong>ADAP Average Monthly Net Drug Cost</strong></td>
</tr>
</tbody>
</table>

**Notes on Step 1:**

The ADAP average monthly gross drug cost should be calculated using the program's utilization data for an uninsured client. This number will automatically be multiplied by 12 months by the Model. This approach will better reflect the continuity of enrollment that can be expected for an insured individual rather than the transitional nature of enrollment for some ADAP clients.

An option is provided to allow ADAPs to consider rebate revenues received in calculating a Net Drug Cost. HRSA does not require consideration of rebate revenues.

The purpose of Step One is to calculate the ADAP average monthly gross drug cost using the program's utilization data for an uninsured client. This number will automatically be multiplied by 12 months by the Model. This approach will better reflect the continuity of enrollment that can be expected for an insured individual rather than the transitional nature of enrollment for some ADAP clients.

An option is provided to allow ADAPs to consider rebate revenues received (for a 12 month period) in calculating a net drug cost. HRSA does not require consideration of rebate revenues.
Step Two

The purpose of Step Two is to capture the costs associated with the plan you are assessing. Insert the monthly premium cost and the annual federal premium subsidy that will be available (using the link provided). The annual cost and ADAP share of the premium will be automatically calculated.

Step Three

This step will complete the actual calculation to determine if an individual plan is cost-effective in comparison to the average monthly net drug cost to ADAP (full payment of medications).

Of specific note:
- HRSA policy notice 07-05 requires only that the aggregate ADAP cost of premiums be less than the cost of drugs for an insurance plan to be cost effective.
- Using this approach an ADAP could establish an eligibility requirement that an insurance plan must cost ADAP less than the ADAP cost of drugs as calculated in Step 1.

The tool will use the information inputted to automatically calculate if an individual plan is cost-effective and will display a response of “YES” or “NO.”
**STATE ALTERNATIVE**

**Step One**

The purpose of **Step One** is to capture the costs associated with the plan you are assessing. Insert the *monthly* premium cost and the annual federal premium subsidy (if applicable) that will be available (using the link provided). The annual cost and ADAP share of the premium will be automatically calculated.

### Model for evaluating cost-effectiveness of individual insurance plans

*Alternative Model for States’ further consideration of cost-effectiveness*

<table>
<thead>
<tr>
<th>ADAP input variables = Grey cells</th>
</tr>
</thead>
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<table>
<thead>
<tr>
<th><strong>Step 1 - Cost of Insurance Premiums</strong></th>
<th>Cost/Month</th>
<th>Cost/Year</th>
<th>ADAP Cost/Year</th>
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<tbody>
<tr>
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<tr>
<td>Federal Premium Subsidy</td>
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<td>ADAP Share of Premium</td>
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<td>$1,182.00</td>
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</tr>
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</table>

**Notes on Step 1:**
The Kaiser Family Foundation has a subsidy calculator that will estimate the Federal Cost Sharing Subsidy for a Silver Plan. A link to the website is provided.

**Step Two**

If ADAP will wrap-around the insurance plan and pay for deductibles and co-payments, complete **Step Two** based on ADAPs policies on the issues listed. Insert your ADAPs cost-sharing maximum per year (for a qualified health plan, this should not exceed $6,350 but ADAPs are not required to cover that amount in its entirety), the federal subsidy for cost-sharing (if applicable, using the link provided), the annual deductible and anticipated rebate percentage, the estimated cost-sharing for medical costs (if subsidized by Part B, not ADAP), and the anticipated rebate from payment of prescription co-payments. The remaining information will be automatically calculated.

### Step 2 - Cost Sharing

If ADAP will wrap around the insurance plan and pay for deductibles and co-payments, complete **Step Two** based on ADAPs policies on the issues described below.

<table>
<thead>
<tr>
<th>Total Cost</th>
<th>ADAP Payments</th>
<th>Rebate %</th>
<th>Rebate $</th>
<th>ADAP Net Cost/Year</th>
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<tbody>
<tr>
<td>Cost-sharing Maximum/Year</td>
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<tr>
<td>Federal Subsidy for Cost-sharing</td>
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<tr>
<td>Deductible/Year</td>
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<tr>
<td>Maximum Co-payments</td>
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</tr>
<tr>
<td>Optional - Estimated cost-sharing for medical costs</td>
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<tr>
<td>Total Drug Co-payments</td>
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<td>$265.65</td>
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<tr>
<td>ADAP Cost-sharing</td>
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<td></td>
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</tbody>
</table>

Some assumptions to note:
- Annual out-of-pocket cost-sharing maximums for 2014 are set at $6,350 for an individual and $12,700 for a family of any size.
There are a range of assumptions that ADAP can use to estimate the portion of cost-sharing paid by ADAP that will be recovered by filing drug rebate claims.

- ADAPs can receive a minimum rebate of 23.1% of Average Manufacturer Price (AMP) on any brand name drugs under the 340B Drug Pricing Program.
- ADAPs receive an average rebate of 58% of AMP on HIV drugs under ADAP Crisis Task Force Agreements. By contrast, the average rebate for these same drugs under the 340B Drug Pricing Program is 44%.
- Rebates can exceed 100% of the amount paid by ADAP under the program guidance known as "full rebates for partial payments." This will occur most frequently when prescription co-payments are low.
- Optimal rebate revenue will result from a plan in which prescription co-payments are lowest, because more claims are paid by ADAP before reaching the cost-sharing maximum.

- An option is provided to allow an assumption that some portion of the cost-sharing will be on non-prescription costs and therefore not paid by ADAP.

### Step Three

This step will complete the actual calculation to determine if an individual plan is cost-effective in comparison to the average monthly net drug cost to ADAP (full payment of medications). Insert your ADAPs average monthly net drug cost and the average annual amount spent on ambulatory care by Ryan White (Part B or other Ryan White Program parts, if known) that will be avoided due to insurance coverage.

Of specific note:

- The **ADAP average monthly net drug cost** should be calculated using the program’s utilization data for an uninsured client; that number will automatically be multiplied by 12 months in the tool. This approach will better reflect the continuity of enrollment that can be expected for an insured individual rather than the transitional nature of enrollment for some ADAP clients. Rebate ADAPs should calculate the net cost after accounting for rebates.
- An option is provided to allow ADAPs to consider funds spent on ambulatory care by the Ryan White Program that will now be avoided due to insurance coverage in the cost-effectiveness calculation.

The tool will use the information inputted to automatically calculate if an individual plan is cost-effective and will display a response of “YES” or “NO.”