NASTAD

Federal Policy Changes and Their Impact on AIDS Drug Assistance Programs

State and territorial AIDS Drug Assistance Programs (ADAPs) are facing an unprecedented fiscal storm. A wave of federal policies threatens to unravel key pillars of the U.S. health care safety net and roll back the coverage gains that have kept people with HIV insured and in care since the passage of the Affordable Care Act (ACA).

The *One Big Beautiful Bill Act* (OBBBA), or "H.R. 1," enacted July 4, 2025, includes deep cuts to Medicaid, Medicare, and the ACA's Health Insurance Marketplaces. The Congressional Budget Office (CBO) estimates that H.R. 1, combined with the expiration of enhanced Premium Tax Credits (ePTCs) at the end of 2025, will leave 14.2 million more Americans uninsured by 2034. Another 750,000 to 1.8 million Marketplace enrollees are expected to lose coverage under the 2025 *Marketplace Integrity Rule*, finalized in June 2025. Together with proposed federal funding cuts for Fiscal Year 2026, this confluence of pressures are poised to push ADAPs past their fiscal limits.

At the same time, rising insurance premiums and drug prices are intensifying existing fiscal pressures. As health coverage becomes less affordable, more clients may shift from ADAP-supported insurance plans to direct medication assistance—an increasingly unsustainable model.

As the payer of last resort for low-income people with HIV, the Ryan White HIV/AIDS Program (RWHAP) and ADAPs will bear the burden of ensuring continued medication access when these policies take effect. This analysis outlines the major threats, their potential impact on ADAP operations, and strategies already under consideration in several states to preserve program viability and continuity of care.

UNWINDING THE SAFETY NET: MEDICAID COVERAGE LOSSES

The One Big Beautiful Bill Act (H.R. 1) is the primary driver of forthcoming cuts to Medicaid, a foundational source of coverage for many people with HIV and the largest source of public spending for HIV care in the U.S. The law's new eligibility restrictions and administrative red-tape requirements are expected to increase the number of uninsured Americans nationwide by 10 million by 2034, potentially creating an unprecedented influx of new RWHAP and ADAP clients over the next decade.

Medicaid work reporting requirements for Medicaid expansion group

Beginning January 1, 2027, most adults covered under the ACA Medicaid expansion must document at least 80 hours of "qualifying activities" each month to stay enrolled. Enrollees who fail to report compliance with work requirements (or obtain an exemption) will be terminated from Medicaid, and new applicants who are not already working will be denied enrollment. Clients who lose Medicaid because they cannot meet the new reporting rules will not qualify for Premium Tax Credits (PTCs) in the ACA Marketplaces, ultimately shifting a much larger share of their health care costs to Part B and ADAPs. The CBO estimates that H.R.1's work requirements will leave 4.8 million more people uninsured by 2034.

Medicaid work requirements have consistently failed to promote employment or reduce unemployment and often cause eligible people to lose coverage due to onerous red tape. The experience of Arkansas, which briefly implemented work requirements in 2018, is instructive: more than 18,000 people lost coverage, primarily due to confusion and difficulties with the online reporting system, and there was no positive impact on overall employment rates. Even under existing rules, roughly 10 percent of Medicaid renewals nationwide result in "procedural disenrollment" – in other words, people losing coverage for paperwork reasons despite being eligible for the program. Under H.R.1, Medicaid renewals will be *more* frequent and *more* burdensome than they are now, leading to greater risk of procedural disenrollments. Researchers estimate that at least two out of three enrollees who lose Medicaid under H.R.1's work requirements will already be working or qualify for an exemption due to a disability, student status, or other factors.

Other Medicaid eligibility restrictions and costs

Work reporting requirements are only one of several H.R. 1 provisions estimated to strip millions of Medicaid coverage and shift costs to Part B and ADAP programs. Other provisions include:

- **More frequent renewals for Medicaid expansion group:** Beginning in 2027, Medicaid enrollees will be required to renew their eligibility *at least* every 6 months. Under current rules, Medicaid coverage must be renewed annually, consistent with the commercial market. More frequent renewals create a high risk that people with HIV will lose coverage for procedural reasons and increase workloads on ADAPs and RWHAP case managers.
- **Shortened retroactive coverage:** Beginning in 2027, retroactive Medicaid coverage will be shortened to one month for Medicaid expansion enrollees and two months for other eligibility groups. Under current law, all Medicaid enrollees may receive up to three months of retroactive coverage. Cuts to retroactive coverage are proven to increase medical debt for low-income individuals and increase uncompensated care costs for hospitals and providers. This will raise costs for ADAPs that rely on retroactive coverage to reimburse medications dispensed while a client's Medicaid application is pending, especially as churn between ADAPs and Medicaid grows due to H.R. 1's broader coverage losses.
- **Cost-sharing for Medicaid expansion group:** Under H.R. 1, cost-sharing will apply to the Medicaid expansion population with incomes above 100% of the federal poverty level (FPL). The law includes exemptions for certain services and care settings, including primary care, mental health, substance use disorder (SUD) care, federally qualified health centers (FQHCs), and rural health clinics. Evidence shows that out-of-pocket costs generally have a deterrent effect, and that even small copays are associated with reduced use of care. Under H.R. 1, out-of-pocket expenses are expected to rise substantially—particularly for Medicaid expansion enrollees with chronic conditions—potentially causing Medicaid enrollees living with HIV to forego care altogether. (Medicaid rules related to prescription copays are unchanged.)

DESTABILIZING THE ACA MARKETPLACES

The Health Insurance Marketplaces face a dual shock: new enrollment barriers under H.R. 1 and the *2025 Marketplace Integrity and Affordability Final Rule*, and a looming "affordability cliff" that will make coverage prohibitively expensive when enhanced Premium Tax Credits (ePTCs) expire at the end of 2025. ADAPs will increasingly become the primary payer not only for a growing number of uninsured individuals, but also for premiums and cost-sharing that insured clients can no longer afford. This marks a reversal of the cost-effective, ACA-era model—where ADAPs leveraged federal subsidies to provide comprehensive coverage to eligible clients—and a return to the far more expensive pre-ACA "full-pay" model for a growing number of uninsured clients.

- **The *2025 Marketplace Integrity and Affordability Rule*[1]:** Finalized in June 2025, this rule is projected to cause between 725,000 and 1.8 million people to lose their health insurance in 2026 due to higher premiums and out-of-pocket costs, new red-tape administrative requirements, and reduced opportunities for enrollment.
- **Expiration of enhanced Premium Tax Credits (ePTCs):** Enacted during the pandemic, ePTCs made Marketplace coverage significantly more affordable and increased enrollment by millions. Without them, an estimated 4.2 million people are expected to lose coverage. Healthcare.gov plan premiums are set to rise an average of 26%. Unless Congress acts, monthly premium payments for currently subsidized enrollees are estimated to rise by about 114% on average. The impact will be disproportionately felt by older adults, a key demographic for ADAPs.

[1] *As of this writing, major provisions of the 2025 Marketplace Rule are paused pending litigation and will not be implemented at this time.*

COMPOUNDING PRESSURES: BROADER HIV PROGRAM FUNDING CUTS

As coverage losses mount and costs rise, federal funding cuts across the HIV care and prevention infrastructure will compound ADAPs' financial strain and weaken the entire safety net. The House of Representatives proposed flat federal funding for RWHAP Part B and ADAP, while eliminating RWHAP Parts C and D, the AIDS Education & Training Centers (AETCs), Special Projects of National Significance (SPNS), the Part F dental programs, and all support for the Ending the HIV Epidemic (EHE) initiative. Together, these eliminations would reduce RWHAP funding by $525 million in FY2026. In contrast, the Senate FY2026 bill proposed maintaining flat funding for all RWHAP components. To close any resulting shortfalls, RWHAP Part B may need to divert funds typically reserved for ADAP and core medical and support services at a time when clients need them most.

Furthermore, key HIV prevention funds from the Centers for Disease Control and Prevention (CDC) and the Substance Abuse and Mental Health Services Administration (SAMHSA) are eliminated or consolidated in the President's and House FY2026 proposals. This domino effect weakens the entire HIV safety net and raises the risk of new HIV transmissions, forcing RWHAP and ADAPs to stretch already-strained budgets and threatening to erase years of public health progress.

These federal policy challenges are particularly alarming because they layer on top of already significant growth in ADAP enrollment and spending. An analysis of NASTAD's National RWHAP Part B ADAP Monitoring Project Annual Report for calendar years 2019-2023 shows that ADAPs are already managing increased demand—total nationwide client enrollment grew by 8%, new client enrollment grew by 28%, and prescription-drug expenditures rose by 10% over this five-year period.

A REVIEW OF ADAP SUSTAINABILITY AND CLIENT PROTECTION OPTIONS

To remain sustainable, ADAPs can explore various strategies, which generally fall into two categories: proactive cost-saving opportunities that maximize available resources, and reactive cost-cutting measures that reduce expenditures. It is recommended that *cost-saving* strategies be exhausted before resorting to *cost-cutting*.

Ensuring continuity of care

Throughout any period of programmatic change, continuity of care must come first. Client-centered approaches for ADAPs include:

- **Establishing robust support systems:** This includes implementing pathways for emergency medication access (e.g., a 30-day supply), strengthening case management and peer navigation to help clients with complex eligibility requirements, and establishing rapid response teams to address sudden coverage disruptions.
- **Partnership and transparent communication:** ADAPs must communicate openly with clients, providers, and community members about anticipated changes. In a climate of fear, trusted communication can prevent clients from disengaging from care. It is also vital to enhance coordination with other safety net programs—including RWHAP Parts A, C, and D; FQHCs; and other 340B entities—to create a seamless referral system for clients who may lose ADAP eligibility.

Proactive cost-saving strategies

To address a potential budget shortfall, ADAPs can first consider a range of cost-saving measures designed to enhance efficiency and secure all available resources.

- **Sophisticated budgeting:** One key strategy is the adoption of dynamic "cost per client" methodologies that provide a more accurate forecast of fiscal pressures than traditional methods based on historical data.
- **Aggressive pursuit of funding:** Another option is to proactively explore all available federal (e.g., ADAP ERF, RWHAP Part B Supplemental Funds), state, and local funding streams, with the understanding that the demand for funding is expected to increase considerably across jurisdictions and programs, ultimately resulting in available funds becoming increasingly scarce.

- **Intensifying "Vigorous Pursuit":** Programs can maximize enrollment in other health coverage programs for every eligible client, using resources from the ACE TA Center to enhance staff expertise.
- **Strategic health care coverage selection:** The use of tools like the NASTAD Cost-Effectiveness Tool, available to ADAP staff via NASTAD's secure HIV Care Online Resources (HCORe) portal, allows for the selection of plans that are both clinically sound and financially advantageous.
- **Enhancing 340B rebate procedures:** Maximizing revenue from the 340B Drug Pricing Program is possible through the development of formal policies for monitoring, reconciliation, and dispute resolution.

Cost-cutting measures

If cost-saving measures prove insufficient, ADAPs may then be forced to consider more drastic cost-cutting measures. These decisions have a direct impact on clients and are typically approached with extreme caution.

- **Formulary management:** ADAPs can assess their formularies for potential cost reductions, such as removing non-HIV medications or implementing prior authorization for high-cost drugs. A demographic impact analysis is essential to ensure changes do not disproportionately harm specific populations.
- **Restricting eligibility:** Options include lowering income thresholds (e.g., from 500% FPL to 400% FPL)–for new clients and/or existing clients–or requiring more frequent recertification. Both carry risks of clients losing eligibility and increased administrative burden.
- **Reprioritizing RWHAP Part B services:** Programs may consider reducing or eliminating certain non-ADAP Part B services based on a careful assessment of utilization, cost, and the ability of subrecipients to secure alternative funding.
- **The last resort: initiating an ADAP waitlist:** Establishing a waitlist is the most drastic measure and requires prior approval from HRSA. It necessitates comprehensive policies addressing prioritization (e.g., clinical need vs. first-come, first-served) and referral pathways to alternative medication sources like Patient Assistance Programs (PAPs).

THE PATH FORWARD

The confluence of recent federal policies presents an immense challenge to the stability of ADAPs and the entire HIV care safety net. Navigating this crisis requires a dual approach: shrewd, proactive fiscal management and an unwavering, client-centered commitment to mitigating harm. ADAP administrators, public health officials, providers, and advocates must work in close collaboration, leveraging every available tool. The path ahead is difficult, but it is a defining moment for our community, and one we must face together.

Please contact Tim Horn or Dori Molozanov with any questions.