JOINT STATEMENT ON THE PROPOSED CHANGES TO CONNECTICUT'S MEDICAID PROTECTED DRUG CLASSES

April 28, 2026

ADAP Advocacy and HealthHIV **stand in opposition** to changes to the Connecticut Medicaid program's Prescription Drug Policy. **Connecticut HB 5040** could jeopardize open access to life-saving therapeutics for People Living with HIV/AIDS (PLWHA) in the Nutmeg State. The legislation reflects the Governor's Health and Human Services budget recommendations but adopts a materially flawed approach for a communicable disease, like HIV, where uninterrupted access to treatment is central to individual outcomes and broader HIV prevention and care efforts. It would make antiretroviral (ARV) drugs subject to utilization management tools such as prior authorization and step therapy, also known as fail-first, which can introduce delays, limit regimen stability, and complicate lifelong care.

Connecticut's Integrated HIV Prevention and Care Plan states that 83% of newly diagnosed individuals are linked to care within one month and that viral suppression among all PLWHA remains at 74%, both below established targets. It further details ongoing efforts to expand access to treatment options and strengthen referral systems to support patients in initiating and maintaining care, including access to medications. These efforts, reflected in Goal 2, call for increased viral load suppression, improved linkage to care within one month of diagnosis, and the development of clinical provider capacity and referral mechanisms to increase access to supportive services for PLWHA. But HB 5040, Section 2, **removes** the statutory exemption for HIV ARVs from the Medicaid Preferred Drug List. And since access to HIV services can vary across regions and rural geographies, the plan's reliance on referral systems and supportive services means gaps in care coordination may affect how routinely patients are able to initiate and maintain lifelong treatment. These changes directly intersect with the same treatment access and care coordination structures identified in the plan.

About ADAP Advocacy: The ADAP Advocacy mission is to promote and enhance the AIDS Drug Assistance Programs (ADAPs) and improve access to care for persons living with HIV/AIDS.

About HealthHIV: HealthHIV is a national non-profit advancing effective prevention, care, support, and health equity in HIV, HCV, STIs, LGBTQ health, and drug user health by providing education, training, capacity building, health services research, communications, and advocacy to organizations, communities, and professionals.

In submitting these joint comments, ADAP Advocacy and HealthHIV stand at the intersection of the rights of patients being able to access the care and treatment, as prescribed by their primary or specialty care physician, and healthcare decisions not being entirely driven by payors trying to mitigate costs; however, HB 5040, as written, threatens to **undermine** the patient-provider relationship that has long been a central tenet of the American healthcare system, as well as **presenting serious challenges** to healthcare provider workforces, state agency compliance, patient access, and treatment adherence.

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ADAP Advocacy and HealthHIV specifically oppose Section 2 of the Governor's Budget Recommendations for Health and Human Services, which proposes removing the ARV exemption from the Medicaid Preferred Drug List, as we believe it compromises patient safety by weakening safeguards that guarantee ongoing, affordable, and uninterrupted access to essential treatment.

We object for the reasons enumerated herein:

Cost Containment as a "Fiscally Responsible" Measure:

Across HIV prevention and care, we see the same pattern repeat: funding debates occur in one lane, policy design in another, implementation somewhere else, and the consequences show up downstream with patients, providers, and communities. **The uncomfortable question is who ultimately absorbs the cost**—both quantitatively and qualitatively—when that chain breaks.

Cost growth is a legitimate concern. It has long been debated across ecosystems affecting HIV treatment by Prescription Drug Affordability Boards, Medicaid, provider and therapeutics committees, Medicare benefit designers, AIDS Drug Assistance Programs (ADAPs), employer-sponsored coverage, and the Affordable Care Act Marketplace.

In response, states and payers have operationalized those concerns through cost-containment mechanisms such as formulary redesign, eligibility adjustments, and increased scrutiny of high-cost antiretroviral therapies.

HB 5040, Section 2, emerges from this same cost-growth context. However, reintroducing prior authorization and step therapy for communicable disease medications—especially HIV drugs—can introduce treatment delays and administrative barriers that undermine adherence and viral suppression. Any savings analysis, including evidence-based spending and utilization patterns, should therefore account for downstream clinical and system costs, not just pharmacy spending and rebate leverage.

In practice, utilization management often shifts costs from the pharmacy benefit to care coordination, emergency coverage, and re-engagement efforts. Those costs do not disappear; they often shift elsewhere in the system and are shouldered by safety-net clinics, providers, and public health programs. In those settings, administrative delays, regimen uncertainty, and coverage churn undermine stability before it is ever achieved. HIV care coordination—medical case management (MCM) and non-medical case management supportive services (NMCM)—is not fully embedded in Connecticut's Medicaid targeted case management (TCM) structure, so changes in Medicaid drug policy can affect care without a parallel Medicaid-supported coordination system to absorb that impact. That disruption is absorbed through existing HIV care and support services, including Ryan White–funded programs and clinic-based care coordination.

Whereas research and industry analysis indicate that prior authorization does not directly transfer costs to patients by increasing their premiums or deductibles; however, it may indirectly lead to higher out-of-pocket expenses and impose financial burdens. In fact, PA costs patients over $35.8 billion annually, according to a study published in *Health Affairs*. The American Medical Association has also documented that PAs can **raise patient out-of-pocket costs** when delays or denials force them to seek more expensive treatments or repeat services.

Shifting Costs to an Already-Burdened Healthcare Workforce:

Prior authorization often **adds administrative work for providers**. PA frequently entails telephone calls, faxes, or manual form submissions, which may result in delays in care delivery, increased documentation workload, and potential denials due to incomplete information. Providers are required to collect and submit supporting medical documentation, monitor submission status, and occasionally follow up, which can divert their time from clinical responsibilities.

The burdens can be significant, requiring multiple steps, such as collecting documentation to confirm that all necessary clinical and administrative data are complete before submission. This process often requires revising incomplete or incorrect submissions while managing complex payer requirements, particularly when different forms or criteria are involved. Overall, these challenges frequently disrupt clinical workflows, especially when staff must divert from their primary duties to handle authorizations.

As a result, these programs must devote—often divert—additional staff time to care coordination, enrollment troubleshooting, and compliance management. That operational burden adds strain through burnout, retention challenges, and reduced workforce readiness, particularly when churn occurs at both the reimbursement and policy levels, including under federal requirements.

Introducing New Administrative Hurdles:

Connecticut's plan, ironically, will add costs by creating new administrative hurdles.

Cost efficiency is vital to implementing any plan for a healthy Connecticut, including for people enrolled in public assistance programs, as the Governor affirms in his budget request. However, this move appears aligned with efforts to increase rebate capture. Rebate strategies that rely on utilization management function by introducing administrative hurdles—not by changing clinical care—and those hurdles directly affect whether people remain on treatment and stay virally suppressed.

Medicaid drug rebates, paid by manufacturers to states and the federal government for outpatient drugs, are a key cost-saving tool but impose administrative burdens on states. Under the Medicaid Drug Rebate Program, manufacturers must pay rebates, and states handle invoicing and collection.

When states try to collect Medicaid drug rebates, the process is complicated and easy to get wrong. In 57 audits in 2024, the Office of Inspector General found that states did not always follow the required steps for invoicing manufacturers for certain drugs (especially physician-administered ones), and as a result, they failed to collect money they were entitled to—in some cases, adding up to hundreds of millions of dollars. This indicates that the process is error-prone and requires extensive record-keeping, coordination, and auditing.

Disrupting Patient Access to Care and Treatment:

HIV treatment does not work like a therapeutic equivalence checklist. It is individualized and requires shared clinical decision-making, as part of the equation. It does not fit neatly into short-term metrics. Short-term utilization metrics do not account for resistance history, hepatitis B co-infection, or clinically meaningful differences across integrase strand transfer inhibitor (INSTI) classes, including the higher resistance barriers and durability of second-generation INSTIs compared with earlier agents. Nor do they reflect the realities of aging with HIV, including low CD4 nadirs and the long-term durability of immune recovery. When treatment decisions intersect with comorbidities and acute stressors—such as COVID-19, influenza, or measles—disruptions over decades of care can compound treatment fatigue, adherence challenges, and cumulative harm in ways utilization controls are not designed to absorb.

Washington State's experience provides a relevant real-world test of the same assumptions underlying HB 5040 Section 2, including the expectation that utilization management can be reintroduced without destabilizing treatment or shifting costs downstream. Through a legislatively directed budget proviso, Washington required the Health Care Authority (HCA) to remove prior authorization for all FDA-approved HIV antiviral drugs under Apple Health beginning January 1, 2023, and to report annually on utilization, expenditures, and regimen switching. That proviso—adopted in SB 5092, section 118.6.a—also prompted the convening of the HIV Medication Access Workgroup (HMAW).

Through the HMAW process, stakeholders consistently documented that prior authorization, step therapy, and regimen disruption introduced administrative friction that delayed access, destabilized effective treatment, and increased churn within Medicaid HIV care. Participants emphasized that utilization management strategies intended to favor lower-cost or multi-tablet regimens did not operate in isolation, but shifted costs downstream to Ryan White providers, safety-net clinics, and public health systems tasked with mitigating treatment interruptions and re-engaging patients. In this context, "continued access" often existed on paper while continuity of care eroded in practice.

As required by the proviso, HCA published its 2024 legislative report on HIV antiviral drugs, analyzing utilization, expenditures, and available health outcomes data following the removal of prior authorization. Viral load data were available for approximately 42 percent of Apple Health clients receiving HIV treatment in 2022—more than 3,000 individuals—representing a substantial real-world Medicaid population. While HCA appropriately cautioned that this subset cannot be assumed to represent all clients, it did not characterize the data as unreliable or dismiss observed differences across regimen types.

Within this cohort, patients initiating treatment with single-tablet regimens had higher rates of viral suppression than those starting multi-tablet regimens or switching regimens. Although insufficient to establish causality, these findings establish directionality and challenge the assumption that regimen form and administrative disruption are clinically neutral—particularly in Medicaid settings shaped by utilization management, coverage churn, and administrative delay.

Preventing a single HIV infection avoids hundreds of thousands of dollars in lifetime medical costs, with some estimates exceeding one million dollars depending on treatment scenarios. Given these well-established costs, policy decisions that risk even modest reductions in adherence or viral suppression should not be evaluated solely on the basis of short-term pharmacy spending or rebate leverage.

Notably, Washington ultimately codified the policy direction reflected in the proviso and stakeholder findings. In 2025, the Legislature enacted SB 5577, requiring Medicaid coverage of all FDA-approved HIV antiviral drugs without prior authorization or step therapy for both fee-for-service and managed care enrollees, effective July 1, 2025. This statutory action reflects a legislative determination that, for HIV treatment, utilization management introduces unacceptable risk to treatment stability and system sustainability.

Conclusion:

The lack of complete outcome data warrants caution, not the reinstatement of prior authorization and step therapy based on projected savings alone. HB 5040, Section 2 assumes these controls can be reintroduced for HIV drugs without disrupting care or shifting costs outside the pharmacy benefit—an assumption that has not been supported by real-world experience. That assumption is not only incorrect, but—we feel—potentially harmful for Persons living with HIV in Connecticut.

ADAP Advocacy and HealthHIV advise that Section 2 be removed from HB 5040, or, at a minimum, be substituted with language that protects patient-provider relationships and preserves clinical decision-making by designating clear exceptions. Should these changes take effect, they risk causing harm to Connecticuters living with HIV.