



JOINT STATEMENT ON THE PROPOSED CHANGES TO FLORIDA'S AIDS DRUG ASSISTANCE PROGRAM



March 2, 2026

ADAP Advocacy and HealthHIV are in opposition to the proposed changes to services for People Living with HIV/AIDS (PLWHA) as set forth in the Notice of Proposed Rule (NPR) #30517381 promulgated by the Florida Department of Health (DOH).

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.

ADAP Advocacy and HealthHIV have not previously submitted joint public comments; however, the magnitude and consequences of the proposed changes to Florida Rules 64D-4.002, 64D-4.003, and 64D-4.007 compel a unified response.

We object for the reasons enumerated herein:

Lowering the Income Eligibility Threshold:

In 2023, there were an estimated 123,279 PLWHA residing in Florida, of whom 36,834 (29.9%) were enrolled in Florida's state ADAP ([NASTAD, 2025](#)). Should DOH move forward with its plan to lower its income eligibility cap to 130%—roughly \$20,345/year for an individual—potentially up to half of patients currently enrolled (between 16,000-20,000 PLWHA) would be disenrolled.

The justification for the proposed changes is fundamentally flawed due to an inaccurate budget forecast, notably a \$62M carry-forward deficit that conflates funding sources and fails to align with federal reporting standards. HRSA and NASTAD reports indicate no deficit in the previous year. Furthermore, the FY 25/26 cost projections were developed assuming zero revenue, neglecting approximately \$160M in grant funding. Correcting just one of these errors significantly reduces the perceived shortfall. When all are addressed, the narrative of insolvency is rendered entirely unconvincing.

The proposed changes are designed not to “contain costs” but to remove people who have long been eligible for coverage from Florida's ADAP. We strongly object to the department's invocation of the “Emergency Rule” provision that allows the administration to pass emergency rules when an agency finds there's an “immediate danger to public health, safety, or welfare,” when no such emergency exists. A true emergency will arise when gaps in care occur. A 2026 study found that suboptimal adherence, defined as less than 85%, may occur in 46.7% to 53.2% of patients during the first year, with 18.8% experiencing a gap of 90 days or longer in therapy ([Lim, 2026](#)). The NPR opens the door to numerous treatment gaps.



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Periods of virologic breakthrough or high viral load increase transmission risk ([HIV.gov, 2026](https://www.hiv.gov)). New infections result in an extra \$1.12 million in lifetime treatment costs ([Cohen, 2025](#)). The NPR also opens the door to both.

Significant and Potentially Deadly Changes to the ADAP Formulary:

Federal rules require that ADAP formularies include at least one medication from each core antiviral class. The NPR eliminates this language altogether.

ADAP-eligible patients would face major restrictions on medication choices. The most popular and commonly prescribed medication to treat HIV/AIDS, Biktarvy, will be removed from the formulary. Biktarvy, a single-pill oral regimen made by Gilead Sciences, is taken by over 430,000 people living with HIV in the United States ([Gilead Sciences, 2026](#)), or 35.8% of PLWHA. Biktarvy is currently prescribed to over 60% of the Florida ADAP clients.

By removing Biktarvy from the ADAP formulary, DOH will be forcing patients to transition from current guideline-recommended single-tablet regimens to alternative regimens that may increase pill burden and clinical complexity.

Dismantling Health Insurance Premium Plus and Marketplace Premium Assistance:

Florida's plan would discontinue health insurance continuation payments for ADAP clients. Insurance continuation is a process that allows state ADAPs to pay for various aspects of private health insurance coverage, including those plans made available to patients on the Health Insurance Marketplace under the Affordable Care Act, and the vast majority of state ADAPs participate in some form of insurance continuation purchasing, be that through premium assistance, paying deductibles, and/or paying co-pays

The changes proposed significantly narrow this framework by limiting the program to medication co-pay and deductible assistance through a limited number of contracted pharmacies. If DOH's intent is to save money, its discontinuation of these plans runs contrary to this objective because insurance premium plans are widely recognized as a cost containment strategy.

The budget shortfall is described as structural, but its underlying assumptions are inflated or outdated. DOH reports a client count of 9,598 premium clients, yet enrollment has decreased to about 6,000, and the projected average premium of \$2,361/month by DOH actually averages closer to \$1,608/month, a 47% difference. DOH's math doesn't add up.

Additionally, switching to the direct-dispense model ignores the insurance model's rebate leverage—remember, premium assistance generates significantly more rebate revenue.



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Eliminating Part A information sharing:

The NPR's removal of the Ryan White Part A programs from the definition of who can issue a "Notice of Eligibility" and the elimination of the provision that such notice satisfies ADAP (Part B) eligibility requirements.

Florida's proposed change would require every Part A client to qualify separately for ADAP services, resulting in additional paperwork and administrative costs that increase the risk of lapses in coverage, administrative delays, and missed doses or treatment abandonment. Because of the nature of the HIV virus, missed doses or abandoning treatment can result in the mutation of the virus, creating drug-resistant strains. Lapsed treatment also assures that viral suppression will evaporate, increasing the risk of outbreaks of a multi-drug resistant strain of HIV.

Conclusion:

DOH is not just placing at risk the lives of PLWHA but creating the perfect circumstances for an outbreak of a multidrug-resistant strain of HIV in the general population. Much of the past decade in HIV advocacy has been dedicated to the scientific discovery that patients whose HIV is virally suppressed—meaning that the number of actively replicating HIV cells per milliliter has dropped below 50 or 20 copies/ml—are unable to transmit HIV to someone else through sexual contact. When patients lose access to the antiretroviral medications that help them achieve and sustain viral suppression and undetectability, they risk transmitting HIV with every sexual encounter, perhaps doing so with a newly multidrug-resistant strain.

The primary risk facing PLWHA is that they may lose access to treatment. While treatment cessation for any disease state can cause serious complications, the nature of the HIV retrovirus is such that it can quickly mutate to develop resistance to a treatment regimen if that regimen is suddenly halted. This can create a strain of HIV that is multidrug-resistant, making the virus more difficult and significantly costlier to treat. When PLWHA lose access to their medications, their medical expenses are considerably higher, and those costs will likely be financed by the state in other ways.

ADAP Advocacy and HealthHIV advise that DOH be accountable to its residents by providing verifiable evidence to support its rule changes. Should these changes go into effect, they will result in demonstrable harm to ADAP recipients and expose the state to significant legal and fiscal liability.