Florida’s Changes to Its AIDS Drug Assistance Program Will Cause Harm

Over 16,000 Floridians could lose HIV care through ADAP and the program no longer covers at least one effective regimen, writes IAPAC.

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The Florida Department of Health has announced abrupt, life-endangering changes to the state’s AIDS Drug Assistance Program (ADAP), shifting coverage to directly provide HIV medications only for people at or below 130% of the Federal Poverty Level (FPL). A Florida DOH official characterized the move as a transition to “a financially sustainable model to benefit the largest population of ADAP clients.” That framing obscures the reality that sustainability cannot be achieved by excluding thousands of people from lifesaving care.

According to the National Alliance of State and Territorial AIDS Directors (NASTAD), Florida ADAP served 32,248 clients in 2024: 40% at or below 100% FPL, 10% between 101-138% FPL, and 50% between 138-400% FPL. With a cutoff at 130% FPL, NASTAD estimates that more than 16,000 people will lose ADAP coverage. This means that roughly half of all Floridians currently relying on ADAP for uninterrupted access to HIV treatment are at immediate risk of treatment disruption solely due to an administrative eligibility change, not clinical need.

The policy compounds harm by allowing only a two-month transition – effective March 1, 2026 – for people to secure alternative coverage, an unrealistic timeline in a fragmented insurance market. Treatment disruption for a person living with HIV is not an administrative inconvenience; it is a clinical risk. Interruptions in antiretroviral therapy (ART) can lead to viral rebound, increased risk of drug resistance, loss of viral suppression, worsened health outcomes, and heightened risk of onward transmission. The stress and instability created by coverage loss also undermines trust in care, eroding decades of progress built on continuity, choice, and patient-centered treatment.

Equally concerning are formulary changes that move the program towards drug rationing under the banner of cost control. The removal of Biktarvy and restriction of Descovy to individuals with renal insufficiency (CrCl <60) — with a stated intention to “monitor cost closely and adjust if needed” — signals an ongoing willingness to deselect effective, well-tolerated antiretroviral regimens for budgetary reasons. While other antiretroviral drugs, including Tivicay, remain available today, the explicit caveat that additional changes may follow creates uncertainty for clinicians and patients alike. Cost stewardship is essential, but it must never override clinical judgment, individualized care, or the evidence-based standards that keep people virally

suppressed and healthy.

“We call on Florida clinicians to urgently contact their state government representatives and register their opposition to these changes, demanding an immediate reversal and a transparent, stakeholder-driven solution that preserves access and continuity of care,” said IAPAC President/CEO Dr. José M. Zuniga. “We also call on clinicians in other states, particularly in states with similar political and fiscal dynamics, to proactively engage their representatives now to make clear that ADAP exists to prevent HIV treatment interruption and policies that knowingly place thousands at risk betray that mission and must be stopped.”

This statement was originally published January 12, 2026, by the International Association of Providers of AIDS Care (IAPAC). Representing 30,000 members, IAPAC is the largest association of clinicians and allied health professionals working to end the epidemics of HIV and tuberculosis, as well as eliminating hepatitis B and C. IAPAC is also a core technical partner to the Fast-Track Cities network.
