WHAT’S HAPPENED AND WHAT TO EXPECT IN 2020
Federal Policy Update

Supplemental Funding

CARES Act (enacted)\(^1\)
- $95 million for Ryan White Programs (all parts)
- $65 million for HOPWA

HEROES Act (proposed)\(^2\)
- $10 million for Ryan White Programs (all parts)
- $15 million for HOPWA


CARES Act (enacted)
- Allows up to 3 month fills and refills of Medicare Part Drugs
- Eliminates Medicare Part B cost-sharing for COVID-19 vaccine
- Expansion of covered telehealth services
- Ensures certain uninsured individuals can receive COVID-19 testing with no cost-sharing

HEROES Act (proposed)
- Eliminates cost sharing for Medicaid beneficiaries for COVID-19 treatment and vaccines during the COVID-19 public health emergency
- Ensures that uninsured individuals whom states opt to cover through the new Medicaid eligibility pathway will be able to receive treatment for COVID-19 without cost-sharing during the COVID-19 public health emergency
- Establishes zero cost-sharing (out-of-pocket costs) for COVID-19 treatment under Medicare Parts A and B during the COVID-19 public health emergency
- Requires coverage under Medicare PDPs and MA-PDPs without cost-sharing or Utilization Management Requirements for drugs intended to treat COVID-19 during the COVID-19 public health emergency
- Makes the requirement for free coverage of COVID-19 testing retroactive to the beginning of the COVID-19 public health emergency
- Provides for a two-month open enrollment period to allow individuals who are uninsured, for whatever reason, to enroll in coverage
- Requires group and individual market health plans to notify consumers if their plan permits advance prescription drug refills during an emergency period

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\(^1\) The Coronavirus Aid, Relief, and Economic Security Act (H.R. 748) was signed into law on March 27\(^{th}\)

\(^2\) The Health and Economic Recovery Omnibus Emergency Solutions Act (H.R. 6800) passed the House on May 15\(^{th}\), but there has been no further action taken in the Senate
<table>
<thead>
<tr>
<th></th>
<th>Private Insurance</th>
<th>Medicaid</th>
<th>Medicare</th>
</tr>
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<tbody>
<tr>
<td>Eliminate COVID-19 testing and</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>treatment cost sharing</td>
<td></td>
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<tr>
<td>Waive deadlines for premium</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>payments</td>
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<tr>
<td>Expand telehealth services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Relax prescription drug restrictions:</td>
<td></td>
<td></td>
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<tr>
<td>Early refills</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Extended supply/quantity</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Waive Prior Authorization</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Allow Special Enrollment Periods</td>
<td>✓ ¹</td>
<td>Medicaid enrollment is open on a rolling basis</td>
<td>✓</td>
</tr>
</tbody>
</table>

1) Many State-based marketplaces opened up the enrollment system during the COVID-19 crisis. However, all marketplaces, including the Federally-facilitated marketplace allows for special enrollment periods when an individual loses their job or health insurance.

2) CMS permitted states to apply for Disaster Relief State Plan Amendments which allowed changes to their plans. However, it varies greatly by state: Florida applied for changes that permitted early refills, extended supply/quantities of prescriptions, and telehealth.

For more detailed information here are additional resources:

- [https://www.medicare.gov/medicare-coronavirus#400](https://www.medicare.gov/medicare-coronavirus#400)
WHAT YOU NEED TO KNOW ABOUT
Congressional Coronavirus Aid

BY ELEANOR MUELLER AND TAYLOR MILLER THOMAS

HOW WE GOT HERE

When the House passed the first coronavirus response package, there were 11 confirmed deaths in the U.S. from Covid-19. The death toll is now approaching 100,000. The growing health and economic crisis hit public and private entities in all sectors hard, and the federal government continues to face pressure to mitigate the damage.

Other entities like the Federal Reserve can and have taken steps to aid Americans. But much of the attention is on Congress, which has responded by almost literally throwing money at the problem. These packages are long, of record-breaking size, and have been thrown together quickly: Stimulus checks have been sent to the deceased, and large companies have received small business aid.

Some in Congress are calling to enact a fifth package immediately, while others say everyone should take a step back and assess what fixes should be made and what is essential going forward. Lawmakers will need to reach a consensus, and convince President Donald Trump to sign it, all while navigating partisan divides and acting fast enough to keep the U.S. out of an inescapable hole.

HERE'S WHAT'S IN THE FOUR ENACTED BILLS AND THE RECENT HOUSE-PASSED PROPOSAL

The first package funneled cash to federal, state and local health agencies to respond to the coronavirus. The bulk of H.R. 6074’s funding went to HHS.

The second package provided for some paid leave, tax credits and free testing, expanded funding for food and unemployment aid and increased Medicaid funding. H.R. 6201 is often referred to by its short title, the Families First Coronavirus Response Act.

PRO POINTS

- The first package sent $8.3B to federal, state and local health agencies. H.R. 6074 became law March 6.
- The second package, which cost $192B, expanded food aid and unemployment benefits, and mandated paid sick leave, among other things. H.R. 6201 became law March 18.
- The third package allocated $1.7T for a dramatic expansion of unemployment insurance, a rescue fund for state and local governments, immediate cash for hospitals and a huge pool of grants and loans for small businesses, along with checks to many Americans. H.R. 748 became law March 27.
- The fourth package spent $484B to replenish the Paycheck Protection Program and provide more cash for health care providers, testing and other things. H.R. 266 became law April 24.
- House Democrats’ proposal for the fifth package would spend $3T on state and local governments, additional checks to Americans, extend Pandemic Unemployment Assistance, expand paid leave and more. H.R. 6800 passed the House on May 15.
The third package, or CARES Act, sent money to airlines, hospitals and other health care providers, and state and local governments, among others. H.R. 748 also created Pandemic Unemployment Assistance to expand unemployment benefits, established the Paycheck Protection Program to provide loans and grants to small businesses and sent $1,200 checks to most Americans.

The fourth package, termed the PPP and Health Care Enhancement Act, was seen by many lawmakers as an interim package. H.R. 266 replenished PPP and another Small Business Administration loan program, Economic Injury Disaster Loans. It also sent money to hospitals and set aside cash for testing.

House Democrats’ proposed fifth package, or The Heroes Act, would send nearly $1 trillion to state and local governments, hand more cash to hospitals, expand paid leave, extend PUA and provide another $1,200 check to many Americans, among other things. Senate Republicans say they won’t take up H.R. 6800, but Democrats say it was important for them to lay down a marker before negotiations begin on the next package.

WHAT’S NEXT

Even before the House passed H.R. 6800, Republicans in both chambers panned it as partisan, unrealistic and premature. Senate Majority Leader Mitch McConnell said that although another package would likely be necessary, it was too soon after enactment of the fourth bill to determine how much and what kind of aid was needed. The GOP also holds out hope that shuttered businesses will soon reopen and the economy will begin to recover without Congress further breaking the bank.

 Congressional coronavirus aid packages
TOTAL FUNDING PROVIDED AND DATE ENACTED*

$192B
H.R. 6201
3/18/20

$1.7T
H.R. 748
3/27/20

$484B
H.R. 266
4/24/20

$3T
H.R. 6800
PASSED HOUSE
ON 5/15/20

$8.3B
H.R. 6074
3/6/20

*All measures shown enacted but for H.R. 6800
Source: U.S. Congress
But the Federal Reserve wants more aid to the economy, and Democrats want a lot more aid to the economy. The House, for its part, will return a few days after Memorial Day to follow up passage of the $3 trillion package with consideration of a bipartisan bill to overhaul the PPP, amid growing concern it’s become unworkable for many employers. Similar talks are underway in the Senate. That’s a notable shift in strategy for Speaker Nancy Pelosi that could indicate a willingness to pass additional aid in smaller, more narrow bills rather than via another multi-trillion-dollar package. And it could reduce the sense of urgency some in Congress have to pass another big relief measure.

Possible flashpoints in the next round of negotiations include: enhanced unemployment benefits, which Democrats want extended but McConnell on May 20 assured House Republicans “will not be in the next bill;” funding for states and localities, along with whether to grant states flexibility over how they use funds allocated under the CARES Act; and whether to include liability protections, which McConnell has insisted be included in the next round of legislation to minimize lawsuits, but Democrats oppose.

Regardless, more than 30 million Americans lost their jobs in two months, and they all won’t be getting hired back quickly. Nobody knows how many of the job losses will be temporary. Investors are counting on the government filling the gap; otherwise the reality of Depression-era unemployment levels will take a toll. A failure to maintain government aid could smack voters just months before the election. Republican Sen. Cory Gardner, facing a tough reelection race in Colorado, articulated that concern May 20, and others may follow suit, putting pressure on McConnell to return to negotiations on the next package.

### POWER PLAYERS

**House Speaker Nancy Pelosi and Senate Majority Leader Mitch McConnell**

The two congressional leaders hold the keys here. Nothing will pass in the House without Pelosi’s support, and nothing will pass in the Senate without McConnell’s.

**Treasury Secretary Steven Mnuchin**

As far as negotiations between lawmakers and the White House, Mnuchin had a heavy hand in the enacted packages, and likely will again. “There is a strong likelihood we will need another bill,” he said May 21.

**President Donald Trump**

Trump, of course, has veto power over it all, and so whatever the trio agree on will have to pass muster in the Oval Office.
### FY2021 Appropriations for Federal HIV/AIDS Programs

April 30, 2020  
*(Increases/decreases from previous fiscal years are shown in parenthesis.)*

<table>
<thead>
<tr>
<th>HHS PROGRAM</th>
<th>FY2019 Final</th>
<th>FY2020 Final</th>
<th>FY2021 President’s Request</th>
<th>FY2021 Coalition Request¹</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total – HIV, Hep, STD, TB line</strong></td>
<td>$1.132 b (+$5.0 m)</td>
<td>$1.274 b (+$141.3 m)</td>
<td>$1.553 (+$279 m)</td>
<td>$1.921 b (+$647 m)</td>
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<tr>
<td><strong>Division of HIV/AIDS Prevention</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$788.7 m (+$0.0 m)</td>
<td>$928.7 m (+$140.0 m)</td>
<td>$1.160 b (+$231 m)</td>
<td>$1.293 b (+$365 m)</td>
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<tr>
<td><strong>HIV Prevention</strong></td>
<td>$755.6 m (+$0.0 m)</td>
<td>$755.6 m (+$0.0 m)</td>
<td>$755.6 m (+$0.0 m)</td>
<td>$822.7 m (+$67.1 m)</td>
</tr>
<tr>
<td><strong>Ending the Epidemic Plan</strong></td>
<td>N/A</td>
<td>$371 m (+$231 m)</td>
<td>$371 m (+$231 m)</td>
<td></td>
</tr>
<tr>
<td><strong>School Health</strong></td>
<td>$33.1 m (+$0.0 m)</td>
<td>$33.1 m (+$0.0 m)</td>
<td>$33.1 m (+$0.0 m)</td>
<td>$100.0 m (+$66.9 m)</td>
</tr>
<tr>
<td><strong>Viral Hepatitis</strong></td>
<td>$39.0 m (+$0.0 m)</td>
<td>$39.0 m (+$0.0 m)</td>
<td>$39.0 m (+$0.0 m)</td>
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<tr>
<td><strong>STD Prevention</strong></td>
<td>$157.3 m (+$0.0 m)</td>
<td>$160.8 m (+$3.5 m)</td>
<td>$160.8 m (+$0.0 m)</td>
<td>$240.8 m (+$80 m)</td>
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<tr>
<td><strong>TB Elimination</strong></td>
<td>$142.2 m (+$0.0 m)</td>
<td>$135.0 m (-$7.2 m)²</td>
<td>$135.0 m (+$0.0 m)</td>
<td>$195.7 m (+$60.7 m)</td>
</tr>
<tr>
<td><strong>Opioid Related Infectious Diseases</strong></td>
<td>$5.0 m (+$0.0 m)</td>
<td>$10.0 m (+$5.0 m)</td>
<td>$58.0 m (+$48.0 m)</td>
<td>$58.0 m (+$48.0 m)</td>
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<tr>
<td><strong>Ryan White Program Total</strong></td>
<td>$2.319 b (+$0.0)</td>
<td>$2.389 b (+$70.0)</td>
<td>$2.483 b (+$94 m)</td>
<td>$2.652 b (+$263 m)</td>
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<tr>
<td><strong>Part A</strong></td>
<td>$655.9 m (+$0.0 m)</td>
<td>$655.9 m (+$0.0 m)</td>
<td>$655.9 m (+$0.0 m)</td>
<td>$686.7 m (+$30.8 m)</td>
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<tr>
<td><strong>Part B: Care</strong></td>
<td>$414.7 m (+$0.0 m)</td>
<td>$414.7 m (+$0.0 m)</td>
<td>$414.7 m (+$0.0 m)</td>
<td>$437.0 m (+$22.3 m)</td>
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<tr>
<td><strong>Part B: ADAP</strong></td>
<td>$900.3 m (+$0.0 m)</td>
<td>$900.3 m (+$0.0 m)</td>
<td>$900.3 m (+$0.0 m)</td>
<td>$943.3 m (+$43.0 m)</td>
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<tr>
<td><strong>Part C</strong></td>
<td>$201.1 m (+$0.0 m)</td>
<td>$201.1 m (+$0.0 m)</td>
<td>$201.1 m (+$0.0 m)</td>
<td>$225.1 m (+$24.0 m)</td>
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<tr>
<td><strong>Part D</strong></td>
<td>$75.1 m (+$0.0 m)</td>
<td>$75.1 m (+$0.0 m)</td>
<td>$75.1 m (+$0.0 m)</td>
<td>$85.0 m (+$9.9 m)</td>
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<tr>
<td><strong>Part F: AETCs</strong></td>
<td>$33.6 m (+$0.0 m)</td>
<td>$33.6 m (+$0.0 m)</td>
<td>$33.6 m (+$0.0 m)</td>
<td>$58.0 m (+$24.4 m)</td>
</tr>
<tr>
<td><strong>Part F: Dental</strong></td>
<td>$13.1 m (+$0.0 m)</td>
<td>$13.1 m (+$0.0 m)</td>
<td>$13.1 m (+$0.0 m)</td>
<td>$18.0 m (+$4.9 m)</td>
</tr>
<tr>
<td><strong>Part F: SPNS</strong></td>
<td>$25.0 m (+$0.0 m)</td>
<td>$25.0 m (+$0.0 m)</td>
<td>$25.0 m (+$0.0 m)</td>
<td>$34.0 m (+$9.0 m)</td>
</tr>
<tr>
<td><strong>Ending the Epidemic Plan</strong></td>
<td>N/A</td>
<td>$165 m (+$95 m)</td>
<td>$165 m (+$95 m)</td>
<td></td>
</tr>
</tbody>
</table>

¹ Coalition requests, calculated from the FY2020 funding levels, do not reflect the true need for each program and the people they serve. The second year requests for the End the HIV Epidemic (EtE) initiative are based on the Administration’s proposed FY2021 budget, and will need to be new funds and increased over the years to achieve its goals.
### FY2021 Appropriations for Federal HIV/AIDS Programs

April 30, 2020

(Increases/decreases from previous fiscal years are shown in parenthesis.)

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<tr>
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</thead>
<tbody>
<tr>
<td><strong>HRSA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Community Health Centers(^2)</td>
<td>$5.6 b (+$300.0 m)</td>
<td>$5.6 b (+$0.0 m)</td>
<td>$5.7 b (+$102.0 m)</td>
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<tr>
<td>Ending the Epidemic Plan</td>
<td>N/A</td>
<td>+$50.0 m</td>
<td>$137 m (+$87 m)</td>
<td>$137 m (+$87 m)</td>
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<tr>
<td>Office of Population Affairs</td>
<td>$286.5 m (+$0.0 m)</td>
<td>$286.5 m (+$0.0 m)</td>
<td>$286.5 m (+$0.0 m)</td>
<td>$400.0 m (+$113.5 m)</td>
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<tr>
<td><strong>NIH</strong></td>
<td></td>
<td></td>
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<tr>
<td>Total AIDS Research</td>
<td>$39.1 b (+$2.0 b)</td>
<td>$41.7 b (+$2.6 b)</td>
<td>$38.7 b (-$3.0 b)</td>
<td>TBD</td>
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<tr>
<td><strong>ACF</strong></td>
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<tr>
<td>”Sexual Risk Avoidance” Abstinence-Only Program</td>
<td>$35.0 m (+$10.0 m)</td>
<td>$35.0 m (+$0.0 m)</td>
<td>$0.0 m (-$35.0 m)</td>
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<tr>
<td>Office of Adolescent Health</td>
<td>$101.0 m (+$0.0 m)</td>
<td>$101.0 m (+$0.0 m)</td>
<td>$0.0 m (-$101.0 m)</td>
<td>$101.0 m (+$0.0 m)</td>
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<tr>
<td><strong>SAMHSA</strong></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Total</td>
<td>$5.74 b (+$583.5 m)</td>
<td>$5.88 b (+$140.0 m)</td>
<td>$5.74 b (-$142 m)</td>
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<tr>
<td>Minority AIDS Initiative</td>
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<td>TBD</td>
<td>$610.0 m (+$183.7)</td>
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<td>Minority HIV/AIDS Fund</td>
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<td>$53.9 m (+$0.0 m)</td>
<td>$53.9 m (+$0.0 m)</td>
<td>$105.0 m (+$51.1 m)</td>
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<td>SAMHSA Minority AIDS</td>
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<td>$116.0 m (+$0.0 m)</td>
<td>$116.0 m (+$0.0 m)</td>
<td>$160.0 m (+$44.0 m)</td>
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<tr>
<td>Indian Health Services(^5)</td>
<td>N/A</td>
<td>$0.0 m</td>
<td>+$27 m</td>
<td>+$27.0 m</td>
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<tr>
<td>Ending the Epidemic Plan</td>
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#### HUD PROGRAM

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</thead>
<tbody>
<tr>
<td><strong>HOPWA</strong></td>
<td>$393.0 m (+$18.0 m)</td>
<td>$410.0 m (+$17.0 m)</td>
<td>$330.0 m (-$80.0 m)</td>
<td>$430.0 m (+$20.0 m)</td>
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</tbody>
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The AIDS Budget and Appropriations Coalition (ABAC) is a working group of the Federal AIDS Policy Partnership, a coalition of 180 national and community-based HIV/AIDS and public health organizations that represent people living with HIV/AIDS, HIV medical providers and researchers, and advocates, as well as community organizations that provide critical HIV related health care and support services. ABAC advocates for the necessary resources for domestic HIV/AIDS programs across the federal government.

For more information, please contact ABAC Co-chairs Nick Armstrong, The AIDS Institute, narmstrong@taimail.org, Carl Baloney Jr., AIDS United, cbaloney@aidsunited.org, or Emily McCloskey, NASTAD, emccloskey@nastad.org.

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\(^2\) These numbers include discretionary appropriations as well as $4 b in mandatory funding for FY2019 and FY2020. The President’s FY21 Budget Request assumes that FY21 mandatory funding is reauthorized at $4b.

\(^3\) Based on FY2020 Trans-NIH HIV/AIDS Professional Judgment Budget.

\(^4\) Total MAI funding is distributed through multiple programs and, in most instances, is included in the funding requests for those programs.

\(^5\) Indian Health Services funding is appropriated through the Interior, Environment and Related Agencies appropriations bill.
Dear Chairman Blunt and Members of the Subcommittee:

The AIDS Institute, a national public policy, research, advocacy, and education organization, is pleased to offer testimony in support of domestic HIV and hepatitis programs in the FY2021 Department of Health and Human Services Appropriations. Last year, you and your colleagues showed incredible leadership by increasing funding for domestic HIV programs by over $300 million. This funding will allow jurisdictions across the United States to begin planning the Ending the HIV Epidemic Initiative (ETE Initiative). We urge you to fully fund the request for year two of the Initiative so that these jurisdictions can transition from planning to implementation. We also request that core public health programs that provide essential HIV prevention and treatment services are adequately funded, and we request significant new funding for viral hepatitis programs in order to combat the skyrocketing cases of viral hepatitis in the country. Finally, we urge you to provide immediate supplemental funding for HIV and hepatitis programs in order to mitigate the impact COVID-19 has on people living with and at risk of HIV and hepatitis.

**HIV in the United States**

There are currently over 1.1 million people living with HIV in the United States. Since the height of the epidemic, there have been tremendous advancements in HIV treatment and prevention. A person living with HIV on treatment can expect to live a near full life, and if they achieve an undetectable viral load, are unable to pass HIV on to a partner. The toolbox for HIV prevention is ever expanding, with pre-exposure prophylaxis (PrEP) now available in addition to traditional prevention techniques like condoms and syringe service programs. Despite these advancements, new cases of HIV have been stagnant at around 39,000 cases a year since 2013, although we are concerned that the disruption of in-person outreach and care caused by COVID-19 may result in HIV outbreaks. Ending the HIV epidemic will require increased federal investments in the public health infrastructure that serves people living with and at risk of HIV.

**Ending the HIV Epidemic Initiative**

In last year’s State of the Union Address, the president announced the Ending the HIV Epidemic Initiative. This initiative has the goal of reducing new HIV infections by 75% in the first five years and 90% by the tenth year. To do so, the Initiative focuses on 57 jurisdictions across the nation that have the highest burden of new infections. We thank your Subcommittee for leading Congressional action last year which resulted in $261 million for the first year of this Initiative. Jurisdictions across the nation have been eagerly developing plans to combat the HIV epidemics that cater to the unique needs of their populations. A significant increase in funding is
necessary for year two of the EHE Initiative so that these jurisdictions can transition from planning to implementation, directing resources to areas at most need.

We urge you to fund year two of the EHE Initiative at the administration’s requested levels: $371 million for the CDC Division of HIV/AIDS Prevention to do targeted testing, connection to treatment, and robust surveillance; $165 million for the Ryan White HIV/AIDS Program to increase access to high-quality HIV care and treatment; $137 million for HRSA’s Community Health Center program to provide prevention services emphasizing PrEP; $16 million for NIH’s Centers for AIDS Research to provide best practices to guide the plan; and $27 million for the Indian Health Service to provide HIV prevention, treatment, education, and hepatitis C (HCV) elimination in Indian Country.

**CDC HIV Prevention**

CDC’s Division of HIV/AIDS Prevention focuses resources on those populations and communities most affected by investing in high-impact prevention. One in seven people living with HIV in the United States are unaware of their status, and many people newly diagnosed with HIV have been living with HIV for many years. There is no single way to prevent HIV, but jurisdictions use a combination of effective evidence-based approaches including testing, linkage to care, education, condoms, syringe service programs, and PrEP. We urge the Subcommittee to fund CDC’s HIV Prevention program at $1.293 billion, which includes $100 million for school-based HIV prevention efforts and $371 million for the Ending the HIV Epidemic Plan.

**The Ryan White HIV/AIDS Program**

The Ryan White HIV/AIDS Program provides medications, medical care, and essential coverage completion services to almost half of all people living with HIV in the United States, many of whom are uninsured or underinsured. With people living longer and continued new diagnoses, the demands on the program continue to grow. The Ryan White Program successfully engages individuals in care and treatment, increases access to HIV medications, and helps over 86 percent of clients achieve viral suppression. Science has proven that if a person achieves viral suppression, they cannot transmit HIV to another person, making the Ryan White Program also integral for preventing new HIV infections. The AIDS Drug Assistance Program (ADAP), provides people access to lifesaving medications by helping clients afford insurance premiums, deductibles, and high cost-sharing of their medications, and is an important component in the successful health outcomes for Ryan White clients.

The AIDS Institute requests that the Subcommittee fund the Ryan White HIV/AIDS Program at a total of $2.652 billion in FY2020, distributed in the following manner:

Part A at $686.7 million; Part B (Care) at $437 million; Part B (ADAP) at $943.3 million; Part C at $225.1 million; Part D at $85 million; Part F/AETC at $35.5 million; Part F/Dental at $18 million; and Part F/SPNS at $34 million; Ending the HIV Epidemic Plan at $165 million.

**Minority AIDS Initiative**

As racial and ethnic minorities in the U.S. are disproportionately impacted by HIV/AIDS, it is critical that the Subcommittee continue to fund the Minority HIV/AIDS Fund and Minority AIDS
programs at SAMHSA. We urge the Subcommittee to appropriate $105 million for the Minority HIV/AIDS Fund; and $160 million for SAMHSA’s Minority AIDS Initiative Program.

**Viral Hepatitis in the U.S**

Over the past decade, there has been a resurgence of viral hepatitis in the United States, largely driven by the opioid epidemic. CDC data modeling suggests that approximately 3.2 million people are currently living with HBV or HCV. However, because of insufficient funding for testing and surveillance, only about half of those individuals are aware of their infection. Annual diagnoses have increased substantially, with a more than 400 percent increase in new infections of HCV from 2010 to 2018. The CDC estimates that over 70 percent of the approximately 44,000 new cases identified in 2018 alone were the result of injection drug use. Despite the availability of a highly effective vaccine for HAV and HBV, there have been recent HAV outbreaks in multiple states across the country, and an increase in HBV cases nationwide, which are also related to the opioid epidemic. Despite the availability of a cure for HCV, some 2.4 million people are currently living with the disease. Left untreated, HBV and HCV can cause liver damage, cirrhosis, and liver cancer. The federal government must invest in testing, surveillance, and linkage to treatment in order to staunch the viral hepatitis epidemics.

**Infectious Disease Impact of the Opioid Crisis**

The clear link between viral hepatitis, HIV, and opioid use indicate that there should be better coordination between programs designed to combat opioid use and to address the HIV and viral hepatitis epidemics.

Starting in FY2019, Congress allocated new funds to enhance the nation’s efforts to prevent and treat infectious diseases commonly associated with injection drug use. That legislation also authorizes CDC to expand surveillance for those diseases, which includes viral hepatitis and HIV. The AIDS Institute supports the administration’s proposed $58 million for CDC’s infectious diseases and opioid epidemic efforts. This new funding would allow CDC to work collaboratively with state and local health departments to improve knowledge of the full scope and burden of these infectious diseases.

**CDC Viral Hepatitis Program**

Despite the large increase in the number of cases, the CDC’s Viral Hepatitis program is only funded at $39 million in FY2020, which is a far cry from the $393 million the CDC estimated it would need for a national program focused on decreasing mortality and reducing the spread of the disease.1 Unfortunately, the administration did not request an increase in its FY2021 budget proposal. We cannot begin to address the rise in viral hepatitis and combat the impact of the opioid crisis without a significant increase in funding commensurate with the importance of eradicating the epidemic. The AIDS Institute recommends $134 million for CDC viral hepatitis prevention activities.

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1 Centers for Disease Control and Prevention’s Pathway to Eliminating Hepatitis B and Hepatitis C and Professional Judgment Budget, Fiscal Year 2018-Fiscal Year 2027
**Syringe Service Programs**

Syringe service programs (SSPs) are an important tool in the fight to end the opioid, HIV, and hepatitis epidemics because they have been proven to reduce the incidence of new HIV and viral hepatitis among people who inject drugs: The presence of SSPs has been associated with a 50 percent decline in new HIV and viral hepatitis incidence. When these SSPs are combined with medication-assisted treatment, there is a two-thirds reduction in HIV and HCV transmission. In order to ensure that local jurisdictions have the capacity and flexibility to expand SSPs in areas that could benefit from these services, Congress must remove the restrictions on the use of federal funds for the purchase of sterile syringes. Sterile syringes are a large part of SSPs budgets and removing this ban will encourage state and local governments to expand these life-saving and effective programs.

One of our nation’s most effective tools in fighting opioid-related infectious diseases is syringe service programs. We urge your Subcommittee to remove all restrictions on federal funding for syringe service programs, including for the purchase of sterile syringes.

**HIV, Hepatitis, and the Impact of COVID-19**

The COVID-19 pandemic has significantly impacted the public health infrastructure in the United States. Public health programs have had to reckon with scarce resources, reassigned staff, and disruption of in-person outreach and provision of services in order to protect their staff and clients from the spread of COVID-19. Experts in HIV and viral hepatitis are worried that these disruptions are resulting in new HIV and hepatitis outbreaks because people are not able to access effective preventive services during the pandemic. We urge your Subcommittee to provide supplemental funding for these programs immediately to enable them to grapple more effectively with these challenges and minimize the damage to people in vulnerable communities and to our nation’s effort to eliminate these epidemics.

We urge you to provide $500 million in supplemental funding for the Ryan White HIV/AIDS Program to meet the pressing needs of Ryan White clients during the COVID-19 pandemic. Ryan White programs have been simultaneously shifting their service delivery model to incorporate telehealth services, increase case management, cover new costs for their existing clients, and ensure that they have the capacity to care for the many new clients they are likely to see as a result of the economic downturn. Demand for Ryan White services, including the AIDS Drug and Assistance Program (ADAP), will increase in the next year because millions of people have lost their jobs and their job-based health insurance; additional funding is needed immediately to ensure continued access to care and uninterrupted HIV treatment.

HIV prevention programs across the United States have had to reduce or suspend in-person testing, reassign staff to COVID-19 response, suspend PrEP initiations, and transition to telehealth prevention models. In order for these programs to continue to provide HIV prevention services, and to reach the goals of the Ending the HIV Epidemic Initiative, we urge your Subcommittee to provide $100 million in supplemental funding to the CDC’s Division of HIV/AIDS Prevention, so that HIV prevention programs can expand the infrastructure needed to provide telehealth prevention services including at-home testing, and backfill gaps in programming that have occurred because resources and personnel have been reassigned to COVID-19 response.
April 8, 2020

The Honorable Mitch McConnell  The Honorable Nancy Pelosi
Majority Leader  Speaker
United States Senate  United States House of Representatives

Dear Leader McConnell and Speaker Pelosi:

The Partnership to End HIV, STDs, and Hepatitis, a coalition of five of the nation’s leading organizations focused on ending the HIV, STD, and viral hepatitis epidemics in the United States, is writing to urge you to invest in public health infrastructure and to increase access to care for people who are impacted by the COVID-19 Pandemic. We appreciate the work Congress has accomplished thus far and encourage Congress to continue addressing the many implications of the COVID-19 Pandemic.

It is critical to fund public health infrastructure, with the greatest flexibility possible, during this pandemic, especially with the increasing burden on screening, surveillance, and data systems. As state and local health departments focus solely on COVID-19, important work to prevent other infectious diseases can not happen. Congress should immediately take the following actions:

1. **Increase funding by $95 million to CDC’s viral hepatitis infrastructure to ensure the critical work on viral hepatitis continues.** Many of the viral hepatitis and other infectious disease programs nationwide have had to shift their staff and efforts to COVID-19 response, leaving a gap in the public health network used to prevent new cases of viral hepatitis via education and vaccination, test and surveil existing cases, and link individuals to treatment. These programs are also important to support COVID-19 response, including infectious disease surveillance and immunization information systems. While swiftly and fully responding to the current COVID-19 pandemic is essential, we must also ensure we are not exacerbating another public health emergency in its wake.

2. **Increase funding by $40 million to syringe service programs via CDC’s infectious disease and opioid programs.** Many individuals, including those with a substance use disorder or underlying mental health issues, rely on a range of services that address basic needs such as food, transportation, first aid, and shelter. In numerous communities across the country, these services have been disrupted or are at-risk because of COVID-19. This disruption is in part due to closure of “non-essential” services, including syringe service programs (SSPs), which the American Medical Association has recommended be labeled an essential service. SSPs are providing important front-line services, helping relieve burdens on emergency rooms and keeping communities safe. Congress should ensure SSPs have the resources they need to do their work safely.

3. **Increase funding by $700 million to CDC’s STD prevention program.** State local and tribal Sexually Transmitted Disease (STD) clinics require $500 million of this funding as this significant service network transitions to coronavirus testing sites. Disease Intervention Specialists (DIS) are key public health professionals on the frontlines of our nation’s COVID-19 response. Disease Intervention Specialists under CDC’s STD program require $200 million to
conduct contact tracing. An essential part of the public health STD prevention system, DIS play a critical role in conducting contact tracing to respond to every day outbreaks and public health emergencies.

4. **Increase funding to CDC HIV Prevention by $100 million.** As HIV Prevention and Surveillance staff are shifted to work on the COVID-19 response, it is important the infrastructure of HIV prevention is not impacted. Data modernization and increased surveillance are both critical to the COVID-19 response as well as the HIV response. HIV Prevention programs will need an investment to set up at home HIV testing programs. In addition, HIV Prevention programs will need to increase data to care efforts in order to ensure that people who have fallen out of care are able to receive HIV treatment.

5. **Increase funding to the Ryan White HIV/AIDS Program by $500 million.** As noted in the HHS Interim Guidance for COVID-19 and Persons with HIV, people who are living with HIV and are virally suppressed are not at significant risk for complications related to COVID-19. This means that access to care for people living with HIV is more important than ever. Antiretroviral therapy must be continued and the Ryan White Program must be provided with infrastructure funding to scale up telehealth. In addition, the Ryan White Program will face significant burden to all parts of the program due to the economic downturn and changes in employment-sponsored insurance. All parts of the Program, including Part F, must be funded to properly address the issues from the COVID-19 pandemic. There are already funding gaps in Ryan White clinics for staff salaries due to the COVID-19 pandemic and the Ryan White Program will have to cover new costs related to COVID-19 including testing, treatment, and eventually vaccines. We are very appreciative of the $90 million included in the CARES Act, but substantial further investment is required to serve people living with HIV.

6. **Increase funding by $65 million to Housing Opportunities for Persons with AIDS (HOPWA) Program.** As the COVID-19 epidemic is worsening and people are losing their jobs, we expect that the need for housing rental assistance to drastically increase. Further, viruses spread quickly among the homeless community and we fear that those living with HIV who are homeless will face dire realities if they are unable to access shelter.

7. **Remove the ban on syringes and other restrictions for using federal funds.** SSPs need the ability to spend federal funds for all aspects of their program, including the purchase of syringes, and to do so without restrictive policies like 1:1 exchange or barriers to accessing take-home kits.

We also urge Congress to include the following provisions to remove barriers and support improved access to care for our most vulnerable populations:

- COVID-19 Special Enrollment Period for anyone who is uninsured in all ACA Marketplaces
- Early refills in Medicaid and other health coverage programs
- 90-day refills in Medicaid and other health coverage programs
- No copays for telehealth in Medicaid and other health coverage programs
- Ensure flexibility for patients to use mail order pharmacies, including out of state mail order pharmacies and other home delivery methods without increased copays,
- Relax requirements for in-person visits for refills, including allowing visits through telehealth
- Eliminate in-person application and recertification requirements for Medicaid, Ryan White, and other means-tested/income support programs
- Prevent the overcrowding of public institutions. Many correctional institutions are still ill-equipped to properly handle the medical needs of their inmates, especially during a pandemic. We advocate for reduced admissions and the decarceration of those people in jails, prisons, and detention centers who are most vulnerable to COVID-19 and are serving due to non-violent offenses..
- Waive prior authorization, utilization management, and medication-assisted treatment (MAT) restrictions.

In addition, without financial support, non-profits nationwide may not stay open through the pandemic, and the result could be millions of Americans who already have lost so much losing their local safety nets. We strongly urge Congress to provide funding accessible to well-established health-focused non-profits providing services and support to Americans across the country.

These crucial public healthcare programs have the tools and expertise necessary to effectively respond to COVID-19, but due to being underfunded for years resources are stretched thin. Funding these programs sufficiently to support their services is needed now more than ever. Please contact Emily McCloskey at emccloskey@nastad.org with any questions or concerns. Thank you for your leadership during this time.

Sincerely,

Jesse Milan, Jr
President and CEO
AIDS United
jmilan@aidsunited.org

Stephen Lee
Executive Director
NASTAD
slee@nastad.org

David Harvey
Executive Director
National Coalition of STD Directors (NCSD)
dharvey@NCSDDC.org

Paul Kawata
Executive Director
NMAC
pkawata@NMAC.org

Michael Ruppal
Executive Director
The AIDS Institute
mruppal@theaidsinstitute.org
<table>
<thead>
<tr>
<th>Agency/Dept.</th>
<th>Grant Name</th>
<th>Number of Grantees</th>
<th>Grant Total (in millions)</th>
<th>Application Deadline</th>
<th>Award Date</th>
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<tr>
<td>HHS/ IHS</td>
<td>Jumpstart Pilot Funding</td>
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<td>CDC</td>
<td>Strategic Partnerships &amp; Planning to Support EHE in the U.S.¹</td>
<td>33 (32 to local jurisdictions &amp; 1 national organization for capacity building)</td>
<td>$14</td>
<td>July 12, 2019</td>
<td>Oct. 2, 2019</td>
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<tr>
<td>HRSA/HAB</td>
<td>Building Capacity for HIV Elimination in Ryan White HIV/AIDS Program Part A Jurisdiction</td>
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<td>NIH</td>
<td>CFAR/ARC EHE Supplement Awards</td>
<td>23 (17 CFARs and 6 ARCs)</td>
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<td>IHS</td>
<td>EHE Funding for Tribal Epidemiology Centers for diagnosis, treatment and response to HIV, hepatitis C and STIs</td>
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<td>HRSA/HAB</td>
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<td>HRSA</td>
<td>FY 2020 Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Awards</td>
<td>195</td>
<td>$53.71</td>
<td>Dec. 16, 2019</td>
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<td>CDC</td>
<td>Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic in the United States</td>
<td>48 anticipated</td>
<td>$109 anticipated</td>
<td>May 1, 2020 (Originally March 25, 2020)</td>
<td>Aug. 1, 2020 anticipated (Originally June 1, 2020)</td>
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¹Note that final jurisdictional plans funded through Component B of PS19-1906 were originally due September, 2020, but the deadline has been revised to December 31, 2020 to accommodate for COVID-19 response
### Ending the HIV Epidemic Initiative: FY 2019 Funding for Phase 1 Counties

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Total</th>
<th>CDC Strategic Partnerships &amp; Planning</th>
<th>HRSA/HAB Ryan White Part A</th>
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<td>Florida</td>
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<tr>
<td>Ft. Lauderdale EMA</td>
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<tr>
<td>Broward County</td>
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<td>Jacksonville TGA</td>
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<td>Duval County</td>
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<tr>
<td>Tampa-St. Petersburg EMA</td>
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<td>Hillsborough County</td>
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<td>Pinellas County</td>
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<tr>
<td>Miami EMA</td>
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<td>Miami-Dade County</td>
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<tr>
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<td>Palm Beach County</td>
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### Ending the HIV Epidemic Initiative: FY 2020 Funding for Phase 1 Counties

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Total</th>
<th>Ryan White HIV/AIDS Program Parts A &amp; B EHE Awards</th>
<th>EHE -Primary Care HIV Prevention (PCHP) Awards (Provided to Health Centers)</th>
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<tbody>
<tr>
<td>Florida</td>
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<td>Duval County</td>
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<td>Hillsborough County</td>
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<tr>
<td>Palm Beach County</td>
<td>$545,167</td>
<td>$560,605</td>
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2020 Passed Florida Legislative Bills

APRN Scope of Practice Expansion – HB 607

HB 607 by Rep. Cary Pigman (R-Avon Park) allows advanced practice registered nurses (APRN) to engage in independent primary care practice, including family medicine, general pediatrics, and general internal medicine. The bill allows APRNs to provide a signature, certification, stamp, verification, affidavit, or other endorsement currently required to be provided by a physician, and certify a cause of death and sign, correct, and file death certificates. HB 607 also allows certified nurse midwives to work autonomously.

Consultant Pharmacists – HB 599

HB 599 by Rep. Ana Maria Rodriquez (R-Doral) allows consultant pharmacists to provide medication management services, order and evaluate laboratory or clinical tests, and conduct patient assessments under a collaborative practice agreement in a health care facility. The legislation authorizes a consultant pharmacist to enter into a written collaborative practice agreement (CPA) with a medical director or a Florida-licensed physician, podiatrist, or dentist who is authorized to prescribe medication. The bill also defines a health care facility to include:

- Ambulatory surgery center;
- Inpatient hospice;
- Hospital;
- Alcohol or chemical dependency center;
- Ambulatory care center; or
- Nursing home component of a continuing care facility.

DOH Legislative Package – HB 713

HB 713 by Rep. Ana Maria Rodriguez (R-Doral) updates numerous provisions relating to health care practitioners and facilities regulated by the Department of Health (DOH), Division of Medical Quality Assurance (MQA). The bill:

- Provides that the Statewide Medical Director for Child Protection reports directly to the department’s deputy secretary in charge of the state’s Children’s Medical Services Program and the medical director of each child protection teams reports directly to the statewide medical director.
- Substitutes the term "human immunodeficiency virus" (HIV) in place of "acquired immune deficiency syndrome" (AIDS) to broaden the scope of the department’s regional patient care networks for persons with AIDS to also include persons with HIV;
- Grants rulemaking authority to DOH establish guidelines to implement the federal Conrad 30 Waiver Program and to encourage qualified physicians to relocate to Florida and practice in medically underserved and rural areas;
- For UF Shands, increases the period of time a cancer center may participate as a Tier 3 cancer center, and is authorized to pursue a National Cancer Institute designation as a cancer center or a comprehensive cancer, from a maximum of six years to until June 30, 2024;
- Requires the applicant’s date of birth on health care professional licensure applications;
- Revises the department’s health care practitioner licensing provisions to permit the department to issue a temporary license, that expires in 60 days, instead of 30 days, to a nonresident or non-citizen physician who has accepted a residency, internship, or fellowship in Florida and has not yet received a social security number;
- Deletes a health care practitioner’s failure to repay student loans, as grounds for discipline by the department;
- Authorizes the department to issue medical faculty certificates, without examination, to fulltime faculty at Nova Southeastern University or Lake Erie College of Osteopathic Medicine;
- Updates the osteopathic internship and residency accrediting agencies to include the Accreditation Council for Graduate Medical Education (ACGME) and repeals the Board of Osteopathic Medicine’s (BOOM) authority to approve other internship programs upon showing of good cause;
- Changes the physician/physician assistant makeup of the Council on Physician Assistants; and
- Extends the requirement for the Florida Center for Nursing (FCN) to provide an implementation study and annual report on the availability of nursing programs and production of quality nurses to the Governor, the President of the Senate, and the Speaker of the House of Representatives until January 30, 2025.

**Prescription Drug Donation Repository Program – HB 177**

HB 177 by Reps. Clay Yarborough (R-Jacksonville and Nick Duran (D-Miami) creates the “Prescription Drug Donation Repository Program Act” within the DOH and authorizes the department or third-party contractor to establish, maintain, and publish a registry of participating local repositories and available donated prescription drugs and supplies. The legislation also authorizes the Governor to waive the program’s patient eligibility requirements during a declared state of emergency in Florida.
March 23, 2020

David Altmaier
Commissioner
Office of Insurance Regulation
J. Edwin Larson Building
200 E. Gaines Street, Room 101A
Tallahassee, Florida 32399-0305

Dear Commissioner Altmaier:

Thank you for all that you are doing to ensure the health and safety of the residents of Florida, and for your quick action following Governor DeSantis’ declaration of a state emergency. In this time of national public health crisis, health insurance provides a critical gateway to regular, ongoing health care as well as testing and treatment for people who contract coronavirus (COVID-19). We know that by issuing Memorandum OIR-20-01M you have ensured that insurance plans are working intently to offer the full range of benefits, coverage, and accurate information that people will need over the next several weeks and months. To that end, The AIDS Institute is particularly concerned about the welfare of people with compromised immune systems who may be at greater risk should they contract COVID-19. Our organization, headquartered in Tampa, is dedicated to supporting and protecting health care access for people living with HIV and hepatitis who need to maintain an ongoing treatment regimen while also protecting themselves from contracting this new virus. We urge you to take speedy steps to ensure that insurance plans under your purview are maximizing flexibility for patients with serious, chronic illness to maintain access to care.

The Centers for Disease Control and Prevention (CDC) has issued recommendations encouraging those who have serious chronic medical conditions to take additional precautions to reduce their risk of infection in the event of an outbreak in their community. To prepare for an extended period of social distancing and avoid potential exposure, patients are advised to request extra necessary medications from their providers, and to minimize the frequency and amount of time they spend in public places, such as pharmacies and doctor’s offices. We urge you to adopt the strongest possible language to urge issuers under your purview to take the following steps:

- Waive refill restrictions enabling people with serious, chronic conditions to get early refills of necessary medications, and to get quantities that allow more time between refills.
- Ensure coverage of telehealth appointments with copays less than or equivalent to in-person appointments.

As part of their utilization management strategies, insurance plans often have rigid rules dictating when a prescription may be refilled. **We urge you to encourage health insurance issuers to take the necessary steps to prevent disruptions in drug access during this public health emergency.** Issuers can allow for early refills and overrides of medication quantity limits. Arming patients with an extended supply of their medications during this time of uncertainty can stand to have multiple safeguard effects:
promoting treatment adherence and reducing the risk of exposing a potentially vulnerable population to COVID-19. This is especially important for people living with and at risk for HIV.

Telehealth is a critical tool under normal circumstances for people who live long distances from health care providers, are otherwise home-bound, do not have paid sick leave, or are otherwise constrained from seeking care at a provider’s office. In this time of public health crisis, HIV clinics are temporarily adjusting their clinic protocols to limit in-person medical visits for people with HIV to reduce the spread of COVID-19 and to fully leverage severely strained clinical and public health workforce capacity. We recommend guiding issuers to promote telemedicine appointments for a broad range of providers – those providing HIV- or hepatitis-related services as well as other providers – at the same level of cost-sharing, or less, for an in-person visit. Last week, the Centers for Medicaid and Medicare Services announced this critical step for Medicare enrollees. We urge you to take the next step to protect people with other health insurance in your states.

The AIDS Institute has identified these simple solutions as having a big impact on patient access to health care. We appreciate the work you and the other Florida state officials are doing to develop quick and coordinated responses to this emerging issue. We congratulate Florida for being the first state to be approved by CMS for an 1135 waiver to adapt the state’s public programs to expand access to needed services. However, as our collective attention has turned to optimizing testing, treatment, and containment of COVID-19, we want to make sure that strategies to keep patients with high-risk, chronic conditions healthy are intertwined with the overarching efforts.

Thank you for your commitment to health care access for Floridians living with, and at risk for, HIV and hepatitis. As we continue to monitor this ever-changing issue and states’ responses, we would greatly appreciate hearing about actions your office has taken to address these specific measures. Please feel free to reach me at RKlein@taimail.org with any questions.

Sincerely,

Lab (no labs for april may June) recert relaxation – doesn’t address this in the medication access task force

Rachel Klein
Deputy Executive Director
The AIDS Institute
February 21, 2020

Mr. James Dunn  
Director, Life and Health Product Review  
Office of Insurance Regulation  
J. Edwin Larson Building  
200 E. Gaines Street, Room 101A  
Tallahassee, Florida 32399-0305

Re: Recommendations for the Update of HIV Drugs for Florida Safe Harbor Guidelines 2021

Dear Mr. Dunn,

The AIDS Institute appreciates the opportunity to provide input to the Florida Office of Insurance Regulation (FLOIR) regarding the 2021 Safe Harbor Guidelines for HIV/AIDS Drugs. We are encouraged that the FLOIR will continue to enforce the guidelines as part of the plan certification process overseen by your office, ensuring patients are protected from discriminatory benefit designs. In response to your inquiry, The AIDS Institute has reviewed and compared the current list of drugs and newly approved treatments by the Food and Drug Administration (FDA) and offer two recommendations for the upcoming plan year.

The AIDS Institute was pleased that the FLOIR included nearly all of the newly approved drugs we recommended in the 2020 Safe Harbor Guidelines for HIV/AIDS Drugs. Additionally, last year we noted that several drugs are no longer considered in best practice protocols for the treatment of people living with HIV by medical specialists. However, we felt it was important that the FLOIR maintain these drugs in the guidelines to protect any patients who continue to utilize these drugs in their regimen. We appreciate that the FLOIR recognizes the individualized nature of HIV treatment and preserved these drugs as part of the guidelines.

Considering the sensitivity of HIV treatment, and the common occurrence of drug resistance, we recommend Trogarzo be added to the 2021 Safe Harbor Guidelines for HIV/AIDS Drugs. This injectable treatment was approved by the FDA in March 2018 and was developed specifically for people whose virus is resistant to other currently approved antiretrovirals. This drug is considered to be the only prescription in a new class of anti-retrovirals called monoclonal antibodies. It is important to ensure people living with HIV have access to a broad array of prescription treatment options not only to improve their individual health but to protect the public’s health by reducing the possibility of spreading the disease.

Our second recommendation stems from an update from the United States Preventive Services Task Force (USPSTF), an independent agency that makes evidence-based recommendations about the effectiveness of specific preventive care services for patients. In June 2019, USPSTF issued a final “Grade A” for pre-exposure prophylaxis for the prevention of HIV (PrEP). This Grade A triggers a key provision of the Affordable Care Act (ACA) with statutory coverage requirements for health plans. With the exception of grandfathered plans, all private plans, including employer plans, must offer PrEP free of cost-sharing to patients.
beginning in 2021. At this time, two drugs, Truvada and Descovy, have been approved by the FDA as PrEP, with generic versions of Truvada (tenofovir disoproxil fumarate/emtricitabine) expected to enter the market in September 2020. We anticipate that the requirement that PrEP be covered by insurance at no cost to the patient will necessitate a new Safe Harbor Guidelines preventive cost-share tier.

In November 2019, the HIV Health Care Access Working Group, a coalition of national and community-based HIV services organizations, sent a letter to Commissioner Altmaier informing him of this update and of the role state departments of insurance will play in implementing this coverage requirement. We hope to partner with you and the Commissioner to look to the FLOIR to establish guidelines for insurance plans and enforce compliance with ACA preventive services requirements.

The AIDS Institute’s Director of State Policy & Advocacy, Donna Sabatino, will be meeting with Ms. Hess Sitte from your office on Tuesday, February 25, 2020 at 1:30pm to further discuss these recommendations and other issues of importance with the Florida Office of Insurance Regulation.

We appreciate this opportunity to collaborate and provide feedback. Your commitment to updating the guidelines annually ensures patients in Florida have broad access to lifesaving HIV drugs at a price that they can afford. If you have any questions, please feel free to reach out me at (813) 505-1946 or mruppal@taimail.org.

Sincerely,

Michael Ruppal, Executive Director

cc: Rachel Klein, Deputy Executive Director, The AIDS Institute
    Allison Hess Sitte, Director of Government Affairs, Florida Office of Insurance Regulation
Dear PrEP Providers and Prescribers:

In light of the ongoing COVID-19 response, the Department of Health and Human Services (HHS) is adapting the Ready, Set, PrEP program to help ensure patient retention in ongoing PrEP care and adherence to PrEP HIV prevention medications, and reduce the burden on the nation’s health care providers and health care systems. Below are the program updates, which will be/are effective immediately:

- Through September 30, 2020, an override request has been implemented for patients enrolled in the Ready, Set, PrEP program to receive up to a 90-day fill of their PrEP medication on an as-needed, case-by-case basis. While this change aligns with the U.S. Public Health Service PrEP Clinical Guidelines and a recent Centers for Disease Control and Prevention Dear Colleague letter “PrEP During COVID-19,” the determination of how many days’ worth of PrEP medication are included in a prescription is ultimately a patient-provider decision. To request the override, the pharmacy or provider must call the program.

- Ready, Set, PrEP program enrollees whose eligibility will expire between June 1, 2020 and September 29, 2020 will have their program eligibility automatically extended through September 30, 2020. This update will be communicated to enrolled patients with an expiration date during this period, and no further action is required for continued access to medication.

HHS will continue to monitor the ongoing COVID-19 response and re-assess the situation as needed.

The nationwide HHS Ready, Set, PrEP continues providing PrEP medications at no cost to individuals who qualify, raising awareness about PrEP, reducing new HIV infections, and bringing the nation one step closer to ending the HIV epidemic in the United States.

Health care providers are encouraged to continue talking with patients about PrEP options and, as appropriate, connecting them to the Ready, Set, PrEP program or other programs and resources that can help them access this safe and effective HIV prevention option. For additional information about PrEP, visit the CDC’s HIV Nexus Clinician Resources or visit the Clinician Consultation Center’s PrEP page or contact their warmline at (855) 448-7737 or (855) HIV-PrEP from Monday–Friday between 9 a.m.–8 p.m. ET. To learn more about the Ending the HIV Epidemic: A Plan for America initiative and the HHS Ready, Set, PrEP program visit www.hiv.gov. If you have any questions about the Ready, Set, PrEP program, contact us via email at ReadySetPrEP@hhs.gov.

If you have any questions regarding these changes, call 855.447.8410

Sincerely,

The Ready, Set, PrEP Enrollment Center
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Section 2: Florida's Opportunity to Expand Medicaid

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SECTION 1:
Understanding Florida's Medicaid Program Today
What is Medicaid?

• Medicaid is a public health insurance program for low-income people. It was started in 1965. In Florida, Medicaid insurance covers mostly children, pregnant women, parents, seniors over age 65 and people with disabilities.

• In Florida, nearly 4 million people have health coverage through Medicaid.

• Medicaid is jointly funded through federal and state dollars and administered by the state. Every $1 Florida spends on Medicaid is matched by $1.56 in federal funds.
Florida Medicaid plays an important role in health coverage.

- 1 in 9 adults, ages 19-64
- 3 in 7 children
- 4 in 7 nursing home residents
- 1 in 3 people with disabilities
- 1 in 5 Medicare beneficiaries
LARGEST SHARE OF FLORIDA MEDICAID ENROLLEES ARE CHILDREN

- **Children***: 61.6%
- **Adults**: 19.7%
- **People who are blind and people w/disabilities**: 11.3%
- **Seniors 65+**: 7.5%

*Adults and children who do not have a disability*
Who qualifies for Medicaid in Florida?

- Coverage categories and income eligibility levels determine who can receive coverage.

- Each of the coverage groups have varying income eligibility thresholds based on the poverty level set forth by the U.S. Department of Health and Human Services.
UNDERSTANDING FLORIDA’S MEDICAID PROGRAM

FLORIDA’S MEDICAID INCOME ELIGIBILITY LIMIT AS A SHARE OF THE FPL

Thresholds based on 100% of the poverty level. In 2020 for a family of three, that is $21,720.

- **Parents/Caretakers**: 31% $6,924
- **Pregnant Women**: 196% $42,588
- **Children (6-18)**: 138% $29,988
- **Children (1-5)**: 145% $31,512
- **Children (0-1)**: 211% $45,840

Note: Eligibility for children, parents, and pregnant women include Modified Adjusted Gross Income (MAGI)-converted income standards and a disregard equal to 5 percentage points of the FPL. In determining eligibility for pregnant women, household size includes each anticipated unborn child.

Thresholds based on 100% of the poverty level. In 2020, for a single person, that is $12,768.

- **Seniors and People with Disabilities**: 88% $11,472 222% $28,188

[Long-term services and support]
Florida has very restrictive Medicaid eligibility

Low Income Parents:

- Only five states in the nation make it harder for working parents to get Medicaid. If a family of three lives in Florida and has annual income above $6,924, the parents are ineligible for Medicaid.

- Maintaining eligibility is a high-wire act. Just a little overtime or a promotion with a slightly higher salary could make them ineligible, even when an employer doesn't offer health insurance coverage.

Adults without children:

- No matter how low their income, these adults are not eligible for Florida Medicaid.
Medicaid is a lifeline for families when the economy is down. Lessons learned from the Great Recession between 2008 and 2009:

- # jobs decreased from 8.4M to 8.1M
  - 330,000 jobs

- # of residents covered by employer-sponsored health insurance decreased from 9.4M to 8.9M
  - 500,000 people

- Medicaid/Children’s Health Insurance Program enrollment increased from 2.3M to 2.6M
  - 300,000 people

- # of uninsured people increased from 3.5M to 4M
  - 500,000 people
Medicaid controls costs

• Since 1999, the cost of Medicaid per enrollee has grown much slower than the cost of Medicare and private insurance per enrollee. There are even times when Medicaid’s growth in spending per enrollee has been negative. Cost-containment measures in Medicaid have kept growth in spending per enrollee low.
GROWTH IN SPENDING PER MEDICAID ENROLLEE HAS BEEN COMPARABLE TO, OR LOWER THAN THAT FOR, PRIVATE INSURANCE

Spending growth (%)
SECTION 2:
Florida’s Opportunity to Expand Medicaid
Coverage gap

- Prior to COVID-19, there were 391,000 Floridians in the coverage gap. Due to job loss since the pandemic, it's projected that an additional 351,000 Floridians will fall into the gap. (Total: 742,000) They cannot meet Florida's very restrictive Medicaid eligibility requirements, but their income is below the poverty level, so they do not qualify for tax credits to help them buy coverage in the marketplace.

- Those in the gap include adults without children, parents/caretakers and people with disabilities (see next page).
FLORIDA’S OPPORTUNITY TO EXPAND MEDICAID

Eligible for Medicaid

Adults without Children
Income < $12,767

Parents/Caretakers
$6,925 - $21,720*

People with Disabilities
$11,472 - $12,760

Qualifies for Marketplace Subsidies

COVERAGE GAP

*family of 3
Closing the gap and expanding Medicaid coverage

- Florida lawmakers could close the coverage gap by increasing Medicaid income eligibility for all adults (18-64) with income up to 138 percent of the poverty level. This is equal to an annual income of $17,604 for an individual and $29,976 for parents in a family of three in 2020.

- As of April 2020, 37 states, including D.C., have adopted Medicaid expansion. This includes Louisiana, Arkansas, Kentucky, Virginia and West Virginia.
### Florida’s Opportunity to Expand Medicaid

*WHO WOULD BENEFIT FROM MEDICAID EXPANSION?*

<table>
<thead>
<tr>
<th>Category</th>
<th>Newly eligible</th>
<th>Currently eligible</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults without Children</td>
<td></td>
<td></td>
<td>138%</td>
</tr>
<tr>
<td>Parents</td>
<td>31%</td>
<td></td>
<td>138%</td>
</tr>
<tr>
<td>Adults with Disabilities</td>
<td></td>
<td>88%</td>
<td>138%</td>
</tr>
</tbody>
</table>

*Income as a percentage of poverty level*

Source: [floridapolicy.org](http://www.floridapolicy.org)
Who would benefit? Low-income uninsured Floridians

Medicaid expansion would significantly reduce the number of adult Floridians without health care coverage. Projections for 2021, which include newly uninsured Floridians due to loss of employer-sponsored insurance (ages 19-64) who fall into the coverage gap:

• 1.2 million Floridians could gain coverage.**

• 29% reduction in the number of uninsured Floridians

**This number includes newly uninsured adults in the coverage gap (below poverty), and uninsured adults prior to the pandemic with income up to 138% of poverty. It also includes 42,000 adults who are currently eligible for Medicaid but are not enrolled.

For a county-by-county breakdown of the uninsured up to 100% of the poverty level, see: https://www.cbpp.org/research/health/fact-sheet-who-are-the-remaining-uninsured#states:12
FLORIDA’S OPPORTUNITY TO EXPAND MEDICAID

Who would benefit?

Florida parents and children

- Low-income, uninsured parents would gain coverage. Children are more likely to be insured and get preventive health care when their parents are covered. And the entire family would have financial protection against large medical debt and bankruptcy.

Florida women

- There are more than 184,000 Florida women in the coverage gap. (This figure does not include projections of newly uninsured due to 2020 job loss). When insured, women are more likely to get needed preventative, primary and specialty care services, like mammograms, Pap tests, timely blood pressure checks, maternity care and mental health services.
FLORIDA’S OPPORTUNITY TO EXPAND MEDICAID

Who would benefit? Florida veterans

About 105,000 Florida veterans live below the poverty level. Those with or without VA benefits would be eligible for expanded Medicaid.

- Providing coverage for poor veterans dramatically improves health care for all veterans, reducing hospital days by 5% and outpatient clinic appointments by 10%.

- These reductions would open more VA health care resources for use by VA-eligible veterans of all ages.
Who would benefit?

Florida communities of color

- More than 50% of adults left in the coverage gap because of Florida's refusal to expand Medicaid are also people of color.

- Nationally, 27% of poor, uninsured Hispanic adults and 14% of poor, uninsured Black adults live in Florida.

Florida workers

- Workers losing their employed sponsored coverage, working adults who are not offered coverage through their jobs or cannot afford it. Medicaid coverage makes it easier for workers to keep a job or search for one.
DISTRIBUTION OF POOR NONELDERLY UNINSURED ADULTS IN THE COVERAGE GAP BY RACE/ETHNICITY

**White**
- FL: 18%
- TX: 19%
- NC: 9%
- GA: 6%
- Other: 48%

**Black**
- TX: 16%
- FL: 14%
- LA: 11%
- GA: 19%
- Other: 39%

**Hispanic**
- FL: 27%
- TX: 52%
- Other: 22%

Total: 1.4 million
Total: 900,000
Total: 700,000
Who would benefit? Rural communities

While Medicaid expansion would reduce the uninsured rate for residents across the entire state, the most dramatic improvements would likely be felt in small towns and rural areas of Florida.

- The uninsured rate for low-income Floridians in these areas is 13 percentage points higher than metro areas (37% vs. 24%). In some Florida counties, like Columbia and Jackson, the rates are even higher (40 - 42% range).

- Rural hospitals would also be substantially more financially secure, preventing closures and the loss of a major local employer.
NON-METRO AREAS IN FLORIDA HAVE A GREATER SHARE OF UNINSURED RESIDENTS

- Non-metro: 37%
- Metro: 24%
Who would benefit? People with mental illness and substance use disorders (SUDs) and victims of the opioid epidemic

- Expansion states have experienced dramatic declines in uninsured hospitalizations for mental illness and SUD, as well as significant increases in medication assistance treatment for opioid addition and other SUD treatment services.
- 513,00 adult Floridians with mental illness are uninsured. Florida ranks 45th in the country for adults with mental illness not receiving treatment.
- Expansion would provide these Floridians access to a comprehensive continuum of physical and behavioral health care, essential for their recovery.
ABOUT US

► The Florida Policy Institute is committed to advancing state policies and budgets that improve the economic mobility and quality of life for all Floridians.

► Stay up to date on the latest news from the Florida Policy Institute:

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REFERENCES


REFERENCES


REFERENCES

SLIDE 22: Ibid (Artiga et al.)


PPACA Guidance to Insurers:
At least one form of each drug must be offered if no specific dosage is listed below. Any additional anti-retroviral medications beyond those listed should be tiered according to cost, and not according to the medical diagnosis or condition being treated. Preauthorization should not be required except in cases of suspected fraud. Drug quantities should never be limited to less than a thirty (30) day supply and any refills authorized by the treating physician. Step therapy should not be required for the administration of any of these drugs.

Compliance with the safe harbor guidelines is not mandatory. However, the Office is prohibited from certifying a plan to be included on the Federal Health Insurance Marketplace if the Office knows that the plan employs a drug formulary discriminatory in benefit design, benefit implementation or medical management techniques. Additionally, the Office will disapprove any plan it finds violates Sections 627.429, 641.3007, or 641.31(3)(c)6., Florida Statutes.

Lowest Generic Tier
Exclusive of tiers comprised solely of preventive and value based generics
Maximum cost sharing per 30-day supply: $40

- abacavir (20 mg/mL oral solution, 300 mg oral tablet)
- abacavir/lamivudine (600 mg/300 mg oral tablet)
- abacavir/lamivudine/zidovudine (300 mg/150 mg/300 mg oral tablet)
- atazanavir (150 mg, 200 mg, 300 mg oral capsule)
- didanosine (125 mg, 200 mg, 250 mg, 400 mg delayed release oral capsule)
- efavirenz (50 mg, 200 mg oral capsule, 600 mg oral tablet)
- fosamprenavir (700 mg tablet)
- lamivudine (10 mg/mL oral solution, 150 mg, 300 mg oral tablet)
- lamivudine/zidovudine (150 mg/300 mg oral tablet)
- lopinavir/ritonavir (80 mg/20 mg/mL oral solution)
- nevirapine (10 mg/mL oral solution, 200 mg oral tablet)
- nevirapine XR (100 mg, 400 mg extended release oral tablet)
- ritonavir (100 mg oral tablet)
- stavudine (15 mg, 20 mg, 30 mg, 40 mg oral capsule)
- tenofovir disoproxil fumarate (300 mg oral tablet)
- zidovudine (10 mg/ml oral syrup, 100 mg oral capsule, 300 mg oral tablet)

Preferred Brand
No generic available
Maximum cost sharing per 30-day supply: $70

- APTIVUS (tipranavir 100 mg/mL oral solution, 250 mg oral capsule)
- ATRIPLA (efavirenz/emtricitabine/tenofovir disoproxil fumarate 600 mg/200 mg/300 mg oral tablet)
- BIKTARVY (bictegravir/emtricitabine/tenofovir alafenamide 50 mg/200 mg/25 mg oral tablet)
- CIMDUO (lamivudine/tenofovir disoproxil fumarate 300 mg/300 mg oral tablet)
- COMPLERA (emtricitabine/rilpivirine/tenofovir disoproxil fumarate 200 mg/25 mg/300 mg oral tablet)
- CRIXIVAN (indinavir 200 mg, 400 mg oral capsule)
• DELSTRIGO (doravirine/lamivudine/tenofovir disoproxil fumarate 100 mg/300 mg/300 mg oral tablet)
• DESCOVY (emtricitabine/tenofovir alafenamide 200 mg/25 mg oral tablet)
• DOVATO (dolutegravir/lamivudine 50 mg/300 mg oral tablet)
• EDURANT (rilpivirine 25 mg oral tablet)
• EMTRIVA (emtricitabine 10 mg/mL oral solution, 200 mg oral capsule)
• EVOTAZ (atazanavir/cobicistat 300 mg/150 mg oral tablet)
• GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide 150 mg/150 mg/200 mg/10 mg oral tablet)
• INTELENCE (etravirine 25 mg, 100 mg and 200 mg oral tablet)
• INVIRASE (saquinavir mesylate 200 mg oral capsule, 500 mg oral tablet)
• ISENTRESS (raltegravir 25 mg, 100 mg chewable tablet, 400 mg oral tablet, 100 mg oral packet)
• ISENTRESS HD (raltegravir 600 mg oral tablet)
• JULUCA (dolutegravir/rilpivirine 50 mg/25 mg oral tablet)
• KALETRA (lopinavir/ritonavir 100 mg/25 mg, 200 mg/50 mg oral tablet)
• LEXIVA (fosamprenavir 50 mg/mL oral suspension)
• NORVIR (ritonavir 80 mg/mL oral solution, 100 mg oral capsule, 100 mg oral packet)
• ODEFSEY (emtricitabine/rilpivirine/tenofovir alafenamide 200 mg/25 mg/25 mg oral tablet)
• PIFELTRO (doravirine 100 mg oral tablet)
• PREZCOBIX (darunavir/cobicistat 800 mg/150 mg oral tablet)
• PREZISTA (darunavir 100 mg/mL oral suspension, 75 mg, 150 mg, 600 mg, 800 mg oral tablet)
• RESCRIPTOR (delavirdine 100 mg, 200 mg oral tablet)
• REYATAZ (atazanavir 50 mg oral powder packet)
• SELZENTRY (maraviroc 20 mg/mL oral solution, 25 mg, 75 mg, 150 mg, 300 mg oral tablet)
• STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate 150 mg/150 mg/200 mg/300 mg oral tablet)
• SYMFI (efavirenz/lamivudine/tenofovir disoproxil fumarate 600 mg/300 mg/300 mg oral tablet)
• SYMFI LO (efavirenz/lamivudine/tenofovir disoproxil fumarate 400 mg/300 mg/300 mg oral tablet)
• SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir alafenamide 800 mg/150 mg/200 mg/10 mg oral tablet)
• TIVICAY (dolutegravir 10 mg, 25 mg, 50 mg oral tablet)
• TRIUMEQ (abacavir/dolutegravir/lamivudine 600 mg/50 mg/300 mg oral tablet)
• TRUVADA (emtricitabine/tenofovir disoproxil fumarate 100 mg/150 mg, 133 mg/200 mg, 167 mg/250 mg, 200 mg/300 mg oral tablet)
• TYBOST (cobicistat 150 mg oral tablet)
• VIDEX (didanosine 2 g, 4 g powder for oral solution)
• VIRACEPT (nelfinavir 250 mg, 625 mg oral tablet)
• VIREAD (tenofovir disoproxil fumarate 40 mg/g oral powder, 150 mg, 200 mg, 250 mg oral tablet)

Non-Preferred Brand
For use only when generic is available
Maximum cost sharing per 30-day supply: $150

• COMBIVIR (lamivudine/zidovudine 150 mg/300 mg oral tablet)
• EPIVIR (lamivudine 10 mg/mL oral solution, 150 mg, 300 mg oral tablet)
• EPZICOM (abacavir/lamivudine 600 mg/300 mg oral tablet)
• KALETRA (lopinavir/ritonavir 80 mg/20 mg/mL oral solution)
• LEXIVA (fosamprenavir 700 mg oral tablet)
• NORVIR (ritonavir 100 mg tablet)
- RETROVIR (zidovudine 10 mg/mL oral solution, 100 mg oral tablet)
- REYATAZ (atazanavir 150 mg, 200 mg, 300 mg oral capsule)
- SUSTIVA (efavirenz 50 mg, 200 mg oral capsule, 600 mg oral tablet)
- TRIZIVIR (abacavir/lamivudine/zidovudine 300 mg/150 mg/300 mg oral tablet)
- VIDEK EX (didanosine 125 mg, 200 mg, 250 mg, 400 mg delayed release oral capsule)
- VIRAMUNE (nevirapine 10 mg/mL oral solution, 200 mg oral tablet)
- VIRAMUNE XR (nevirapine 100 mg, 400 mg extended release oral tablet)
- VIREAD (tenofovir disoproxil fumarate 300 mg oral tablet)
- ZIAGEN (abacavir 20 mg/mL oral solution, 300 mg oral tablet)

**Specialty Drugs**
Maximum cost sharing per 30-day supply: $200

- FUZEON (enfuvirtide 90 mg injectable solution)

Florida Office of Insurance Regulation
200 East Gaines St.
Tallahassee, FL 32399
www.floir.com
The Classroom May Be Empty, but Our Kids Still Need You More Than Ever

REPORTING ABUSE DURING COVID-19

While students are not in school, you still play a vital role in ensuring their safety during these trying times. As members of the education community and as mandated reporters, remember that by making a report, you are not only ensuring the child’s safety, you are also providing help and support to the family. Remain a supportive, caring adult in their lives.

You May Be the Only Person to Act. If it does not look safe, sound safe, or feel safe – Report.

“Abuse” means any willful or threatened act that results in any physical, mental, or sexual abuse, injury, or harm that causes or is likely to cause the child’s physical, mental, or emotional health to be significantly impaired. Within the context of the definition of “harm,” the term “neglects the child” means that the parent or other person responsible for the child’s welfare fails to supply the child with adequate food, clothing, shelter, or health care, although financially able to do so or although offered financial or other means to do so. (F.S. 39.01)

How to Report Abuse

Be prepared to provide specific descriptions of the incident(s) or circumstances contributing to the risk of harm.

Call

800-962-2873
Florida Relay 711
TTY: 800-955-8771

Report Online
https://reportabuse.dcf.state.fl.us

Areas of Concerns

• Lack of attendance on virtual sessions
• Avoidance/lack of contact after numerous attempts to reach the family
• If a child communicates they feel unsafe
• A child in a dangerous environment
• Significant change in a mood/behavior

What you can do

• Check in with children regularly
• Encourage children to ask questions
• Take notice of changes in the child’s behavior and appearance
• Report concerns
Uninsured During the COVID-19 Pandemic: The Urgent Need to Build on Florida's Medicaid Program

Anne Swerlick
April 2020

Executive Summary

Thousands of Floridians have been infected with the COVID-19 virus and the numbers continue to rise. Nearly half of the state's adults are at higher risk of serious illness if infected. More so now than ever, there is an urgent need to increase access to health care services for all Floridians, including access to COVID-19 testing and treatment.

Yet, even before the pandemic and ensuing massive job losses, 2.7 million Floridians were uninsured. Research shows that under normal circumstances the uninsured have much greater challenges accessing care. These disparities are exacerbated during a health crisis.

Scaling up the Florida Medicaid program is the most efficient and economical way to meet the needs of the uninsured, particularly in this time of crisis. If the state opted to expand its Medicaid program to cover adults (19-64) with income up to 138 percent of the federal poverty level, more than 800,000 Floridians would gain coverage. In addition, program administrative changes are needed to make it easier for people to enroll and keep coverage. Ensuring health care access for all Floridians will save lives and is vital to protecting the overall public health.

Introduction: The Landscape Before and During the Pandemic

Even before the pandemic, the state faced multiple challenges in providing Floridians access to affordable, quality health care. This is reflected in the state's ongoing low national rankings on multiple health care measures. Florida ranks:

- 49th in avoidable hospitalizations for adults 18-64;
- 47th in access and affordability; and
- 44th in receipt of prevention and treatment services.¹

These challenges are significantly compounded during a public health emergency and economic downturn.

EMILY'S STORY*

Her brother Peter died from an ear infection in March 2020. He was afraid to seek care because he had an outstanding hospital bill (~$40k). He thought the hospital and urgent care facilities would demand he pay the bill before they would provide treatment.

*Real accounts from people in Florida’s health care “coverage gap” can be found throughout this policy brief. To learn more visit medicaidmattersflorida.org

Anne Swerlick
April 2020
Florida’s high uninsured rate

Research shows that having insurance is vital for people to access health care. The uninsured, fearing medical debt, are more likely to delay or avoid seeking care. (See Emily’s Story.) Yet, Florida has been woefully behind the rest of the nation in helping its residents obtain health insurance coverage. According to the latest Census data, the Sunshine State has the fourth highest rate of uninsured residents (13 percent) in the nation, with 2.7 million Floridians uncovered.³

It is projected that by July 2020, more than 1.3 million jobs will be eliminated in Florida as a result of the pandemic.⁴ Loss of jobs also means substantial loss of employer-based coverage, which will inevitably contribute to even higher uninsured rates.

Florida’s private employment sector includes a very high proportion of workers paid low wages — more than 20 percent — predominantly in the leisure and hospitality industry, followed by retail.⁵ Economists predict that a recession is likely to disproportionately affect low wage jobs.⁶

While thousands have already lost employment, many low-wage workers, such as cashiers, grocery store employees, and delivery drivers, have kept their jobs. They are on the frontlines, having daily interaction with the public. Many are uninsured and lack paid sick leave. Thus, they are more likely to avoid or delay getting COVID-19 testing and treatment while facing potential exposure daily. This jeopardizes their own health and may increase the spread of the virus as a result of their ongoing employment-related public contact (See Christina’s Story).

Growing population of older Floridians and people with disabilities

More than 20 percent of Floridians, 4.3 million, are aged 65+-- the second largest percentage of older residents in the country.⁷ Further, growth of the state’s Supplemental Security Income (SSI) population, which covers very low-income people with severe disabilities, has been significantly higher than the national average.⁸ Florida also has more than 84,000 nursing home beds and more than 106,000 assisted living beds.⁹ These are precisely the groups at greatest risk of serious illness if infected with the virus.¹⁰

Florida’s large immigrant population

One in five residents in Florida is an immigrant, making up more than one-fourth of Florida’s labor force.¹¹ With the economic downturn many will be losing employment and in need of help from safety net programs. However, there is great fear in this community of using public benefits, including medical assistance, due to changes in the federal public charge rule.¹² Use of some public benefits by specific groups of immigrants will now be considered a negative factor when they seek citizenship. Although the federal government has said that testing and treatment of COVID-19 are exempt from public charge considerations, they are having a
“chilling effect” on all. Thousands of these Floridians are likely deterred from getting coverage and/or seeking necessary medical care. This chilling effect is even more consequential during a pandemic, when coverage and access to care for all is vital for the overall public health.

Florida’s history of deep cuts to public health services

Despite the growing need for safety net health care services, over the past decade, there have been deep cuts to the state’s public health system. Notably, between 2010 and 2018, Florida cut county health department funding by 10 percent and health department staff shrank from 12,800 to 9,300.13 The state has fewer epidemiologists per resident than most of the country.14 These experts and other public health workers are critical to controlling disease outbreaks. Even with recent smaller disease outbreaks in Florida including Zika, Hepatitis A, and tuberculosis, the deficiencies in Florida's public health infrastructure have been starkly evident and well-documented.15 These cuts have placed an even greater uncompensated care burden on hospitals, which already exceeded $2.5 billion per year before the pandemic.16

State’s failure to expand Medicaid

Notwithstanding its persistently high rate of uninsured, Florida is one of just 14 states that has refused to expand Medicaid to cover Floridians aged 19 to 64 with income at or below 138 percent of the poverty level ($17,608 for a one-person household, $29,273 for a family of three).17 Because of this policy choice, an estimated 846,000 low-income uninsured Floridians are currently excluded from coverage.18 This includes very low-income parents with minor children, and people with disabilities and chronic health conditions who do not meet Social Security’s strict disability criteria.19 (See Christine’s Story.) This number is undoubtedly increasing since thousands of Floridians are losing jobs, income, and employer-sponsored health insurance at the very moment when access to health care is critical for themselves and their families.

Lawmakers’ refusal to expand Medicaid is having life-and-death consequences. Even before the pandemic, experts projected that from 2014-2017, 2,776 older Floridians (aged 55-64) died prematurely due to the state’s failure to expand Medicaid.20

Nearly 400,000 of the 846,000 Floridians eligible for Medicaid expansion are adults living below the poverty level. They are caught in the “coverage gap.” They cannot meet the Florida Medicaid program’s very stringent eligibility criteria, but they are too poor to qualify for federal premium subsidies that would help them buy private insurance through the federal marketplace.21

CHRISTINE’S STORY

Christine is uninsured and contracted Shingles in her eye in 2018 - Ocular Shingles. It left her nearly blind AND she’s not immune to catching it again. To add insult to injury, she’s not 50 yet so she can’t get the Shingles vaccine at a low cost “from her local pharmacy.” Vaccine shots will cost her $1,300. She applied for SSD and was denied. She finally hired an attorney to appeal the decision.
People of color represent nearly half of the Floridians caught in the coverage gap. People of color are more likely to be uninsured, lack a usual source of care, and have underlying medical conditions such as diabetes and asthma which make them more susceptible to serious illness due to COVID-19. (See Deborah’s Story.) Early data emerging from Florida and other states show a disproportionately high death rate from the virus among Black residents.

The failure to expand Medicaid also negatively impacts Florida's budget and economy. It is a significant factor in a recent study ranking Florida in the bottom 10 states for recession preparedness.

**Steps Florida Has Taken to Date to Address the COVID-19 Crisis**

**Section 1135 Waiver Changes — Agency for Health Care Administration**

On March 16, 2020, the Agency for Health Care Administration (AHCA), Florida’s lead state Medicaid agency, issued a provider alert announcing multiple program modifications in response to the pandemic. Many of these changes were based on an 1135 public health emergency federal waiver.

The provider alert specifies that Medicaid will cover “all medically necessary services required to facilitate testing and treatment of COVID-19.” In addition, for the duration of the emergency, multiple requirements have been lifted to ease the administrative burdens on providers and facilitate the delivery of care to beneficiaries, such as waiver of prior authorization and copayment requirements.

**Cessation of Medicaid Terminations and Other Changes — Department of Children & Families**

Under the Families First Coronavirus Response Act (FCRA), Florida is receiving an enhanced federal Medicaid match (6.2% increase). As a condition, the state is prohibited from terminating Medicaid coverage for beneficiaries covered as of March 18, 2020 and going forward through the end of the public health emergency. Exceptions are individuals who are no longer state residents or voluntarily terminate their coverage.

After passage of the new federal law, the Department of Children and Families (DCF), the state agency responsible for Medicaid eligibility determinations, posted the following message on its website:

“We will maintain Medicaid eligibility for current recipients through the last day of the month of the state of emergency. This means no Medicaid recipient will lose Medicaid eligibility during the state of emergency (emphasis added). We are working on notifying recipients who may have received a termination notice in the month of March that their benefits will continue.”

The agency has also implemented a six-month extension for individuals and families scheduled to recertify in April or May. Additionally, beginning with applications received in February 2020, DCF is extending the timeframe for individuals to submit any necessary paperwork to 120 days from the date the application was submitted.
received. If the Medicaid application is approved, the individual’s Medicaid eligibility effective date will be the first day of the month that the initial application was received. While DCF has extended the time for people to submit their verification up to 120 days, it’s important to note that during this time the applicant is not enrolled in Medicaid and will most likely be required to pay out of pocket in order to obtain needed services. While these initial steps are helpful, far more is needed to support Floridians through this unprecedented crisis.

Notably, none of these actions extend coverage to the uninsured.

**Covering the Uninsured: The Need for Medicaid Expansion is Urgent**

Do recently passed federal relief laws extend coverage to the uninsured?

Congress has so far passed three COVID-19 relief laws. The first was the Coronavirus Preparedness and Response Supplemental Appropriations Act, signed into law on March 6; followed by the Families First Coronavirus Response Act (FFCRA), signed into law on March 18; and the Coronavirus Aid, Relief, and Economic Security (CARES) Act, which was signed into law on March 27, 2020. Only FFCRA provides some (very limited) coverage for the uninsured. It provides states the option to tap into 100 percent federal funding for free COVID-19 testing of the uninsured. Florida officials have not yet publicly announced whether the state will accept this funding or not. Testing of uninsured individuals is crucial to ensure people who experience symptoms or have been exposed to the virus do not avoid getting tested for fear of the costs, which can exceed $1,000 per test.

While FFCRA provides coverage for testing uninsured people **it does not cover treatment.** An estimated 20 percent of people with COVID-19 experience complications and require treatment including intensive and expensive hospital care. Coverage of testing but not treatment is inadequate to reduce the spread of infection and protect Floridians from this pandemic.

**Medicaid expansion is necessary to protect Floridians’ health and financial security and will be a boost for the state budget**

Medicaid covers both COVID-19 testing and any needed treatment. It also provides a full range of services people need in this crisis, including coverage of behavioral health services, prescriptions, and treatment of underlying conditions to help people stay healthy and out of the hospital.

A substantial body of research based on experience of the 37 expansion states (including D.C.) shows that these states' residents are experiencing better health outcomes, more financial security, and less medical debt compared to non-expansion states. In addition, expansion has brought more funding to support financially threatened rural hospitals at risk of having to close their doors and decreased uncompensated care for hospitals.
People covered by Medicaid are more likely to have a consistent source of care compared to those who are uninsured. Thus, expansion would help divert demand away from already-stretched safety net providers trying to serve a growing number of uninsured during this public health emergency.

Expansion would also bring billions of new federal dollars into the state at a time when they are desperately needed. The federal government pays 90 percent of the costs for people with Medicaid expansion coverage. This means that for every dollar a state spends on coverage for this population, it will bring in an additional nine dollars in federal matching funds.

Experts have projected that expansion would bring $14.3 billion in new federal dollars to the state from 2020 to 2024. If, as expected, the public health emergency leads to a severe recession, this infusion of federal dollars will be a substantial boost to the state economy. This additional funding is one of the most rapid, proven-effective ways to deliver fiscal relief to states during an economic downturn.

Expansion would also provide significant relief for Florida's state budget. The New England Journal of Medicine recently published the results of a 50-state analysis to determine the financial impact of Medicaid expansion on state budgets. It finds that increased Medicaid spending in expansion states was subsidized entirely by increased federal funding and did not force states to cut back on other priorities, such as education. Moreover, the new federal dollars offset other state costs, including health care for people involved in the criminal justice system and state-funded behavioral health services. This is consistent with the findings of other researchers that have projected Florida savings in the range of $198.9 million annually to $385 million over a five-year period.

If the Legislature and governor authorized expansion, implementation could happen swiftly. State officials would merely have to file three Medicaid state plan amendments (SPAs). It is the federal government's practice to apply these amendments retroactively to the beginning of the current quarter. Thus, an amendment filed prior to June 30, 2020, could be effective April 1. When Louisiana expanded Medicaid in 2016, it took the federal government only three weeks to approve Louisiana's SPAs.

More State Action is Needed to Facilitate Medicaid Enrollment and Help People Keep Coverage

Getting people health coverage is an essential strategy for fighting this pandemic. Yet currently there are enormous demands on Florida’s safety net — including Medicaid and the staff administering this program. Plus, there are significantly more challenges for people desperately trying to access these benefits. Indeed, the state has closed off public access to all DCF storefront offices and lobbies and is steering more people to apply online. However, this is difficult, if not impossible, for thousands of Floridians without internet access.
Particularly hard hit are seniors and people with disabilities at very high risk of infection, trying to stay at home and isolate from family and friends who might otherwise be available to help them apply.

There are key administrative steps the state could take to streamline the Medicaid application process and help people keep their coverage:

- **Simplify the Medicaid application.** The state already has experience using a simplified application for enrolling children, as well as low income Medicare beneficiaries.

- **Increase capacities to accept applications by telephone.** While Florida rules and DCF’s website indicate that telephone applications are accepted, even before the pandemic, DCF’s customer service line was not equipped to handle these requests.

- **Enroll applicants based on the information on their applications.** This will allow people to enroll based on their self-attestation of the accuracy of information on their applications. Then they can get covered quickly in order to access care. Needed verification can be obtained after enrollment.

- **Maximize the use of presumptive eligibility (PE).** PE allows “qualified entities” designated by the state to temporarily enroll people who appear to meet eligibility criteria at the time they seek assistance. Currently, only pregnant women and children can get PE and only certain hospitals and county health departments have been designated as qualified entities. It is particularly critical at this moment in time that PE be expanded to seniors and person with disabilities. Further, the types of providers who could do PE determinations need to be broadened to include, for example, state workers, DCF community partners, and other social services agencies.

- **Cease redeterminations and periodic income checks.** During the public health emergency it makes no sense for the state to be using scarce caseworker resources to do Medicaid redeterminations or periodic income checks. Even if there are changes in income or other household circumstances that might affect eligibility have changed, the state is currently barred from terminating coverage through the duration of the public health emergency.

**Conclusion**

Medicaid expansion is urgently needed in Florida to help reduce the spread of the COVID-19 virus and protect the health of both essential low wage workers and the state's overall public health. It would also provide a substantial boost to the state budget and economy during what is likely to be a severe recession.

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1 Commonwealth Fund, “Florida 2019 Scorecard on State Health Performance, [https://scorecard.commonwealthfund.org/state/florida](https://scorecard.commonwealthfund.org/state/florida)


Florida Policy Institute
primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-care/

3 Kaiser Family Foundation, “State Health Facts - Florida,” 2018, https://www.kff.org/other/state-indicator/total-population/?dataView=1&currentTimeframe=0&selectedRows=%7B%22states%22:[%7B%22florida%22:{%7B%22%7B%7D%7D%7D&sortModel=%7B%22collId%22:%22Location%22, %22sort2%22:%22asc%22%7D


15 N. Bedi, et al., 2020


28. Agency for Health Care Administration, 2020
29. Families First Coronavirus Response Act, Public Law No. 116-94
35. M. Guth, et al., 2020
38. J. Sullivan, 2020


We wanted to share some new resources with you. The first two are related to the federal EHE initiative and will be updated over time, as necessary.

An EHE “explainer”: This resource provides an overview of the federal “Ending the HIV Epidemic” initiative and explores issues that might mitigate or facilitate its success.

An EHE funding tracker. This tracker provides up-to-date data on federal EHE funding, including an overview of funding mechanisms by year, agency, grant mechanism, and jurisdiction.

We have also posted an overview of domestic HIV Funding in the FY2021 Budget Request.
Hepatitis Resources
Hepatitis A in the United States

Reported Number of HAV Cases in the U.S. - 2011-2017

HAV Rate by State - 2017

HAV Cases in the U.S. by Age - 2017

Percentage of children aged 19–35 months who received ≥2 doses of HAV vaccine
Hepatitis B in the United States

Chronic HBV Infection in the U.S. - 2011

- **1.4-2.0M**
- **400,000-600,000**
- **350,000-500,000**
- **200,000-300,000**
- **50,000**


Acute HBV Rate by State - 2017

- **729%** increase in ME from ‘15–17
- **114%** increase in KY, TN, WV from ‘09–’13
- **56%** increase in NC from ‘14–’16
- **78%** increase in southeastern MA in 2017

HBV Infant Immunization Coverage in the U.S. - 2002-2016

<table>
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<tr>
<th>Year</th>
<th>% infants vaccinated with birth dose of Hep B</th>
<th>% infants vaccinated with 3 doses of Hep B</th>
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World Health Organization

Hepatitis B Vaccine Coverage (≥3 doses)
Among Adults Aged ≥19 years* in the U.S. - NHIS 2016

<table>
<thead>
<tr>
<th>Group</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Overall</td>
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<tr>
<td>Travelers</td>
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<tr>
<td>Chronic liver conditions</td>
<td>30.3</td>
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<td>Healthcare personnel</td>
<td>61.4</td>
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<tr>
<td>Diabetes (19-59yrs)</td>
<td>26.2</td>
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<tr>
<td>Diabetes (60+yrs)</td>
<td>12.4</td>
</tr>
</tbody>
</table>

*19-59yrs and 60+yrs for adults with diabetes

National Foundation for Infectious Diseases
Hepatitis C in the United States

HCV Care Cascade in the U.S. 2011 vs. 2018

- Living with HCV: 4.58M to 4.23M
- Aware of Status: 1.88M to 2.24M
- Entered into Treatment: 0.82M to 1.58M
- Cured: 0.55M to 1.58M

Centers for Disease Control and Prevention


HCV Incidence and Prevalence in the U.S. - 2015

- Incidence: 45.8% People Who Inject Drugs, 64.2% Others
- Prevalence: 23.4% Baby Boomers, 76.6% All Others

Centers for Disease Control and Prevention

Estimated Number of HCV Cases in the U.S. - 2006-2017

- 374% Increase from 2010 - 2017

Centers for Disease Control and Prevention

Annual deaths from HCV and all 60 other nationally notifiable infectious conditions in the U.S - 2003-2013

Centers for Disease Control and Prevention