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AIDS Drug Assistance Programs: Managers Confront Uncertainty And Need To Adapt As The Affordable Care Act Kicks In

Erika G. Martin¹, Terence Meehan¹, Bruce R. Schackman²

¹Department of Public Administration and Policy, University at Albany, SUNY, Albany, NY

²Department of Healthcare Policy & Research, Weill Cornell Medical College, New York, NY, USA

Abstract

With the Affordable Care Act set to expand insurance coverage to millions more Americans next year, existing discretionary health programs that receive federal support might find themselves competing for funds as the health reform law is fully implemented. To assess the implications the Affordable Care Act might have on discretionary health programs, we focused on state AIDS Drug Assistance Programs, which provide free medications to low-income HIV patients. We conducted semistructured interviews with program managers from twenty-one states. Many of the managers predicted that their programs will change focus to provide “wrap-around services,” such as helping newly insured clients finance out-of-pocket expenses, including copays, deductibles, and premiums. Although program managers acknowledged that they must adapt to a changing environment, many said that they were overwhelmed by the complexity of the Affordable Care Act and some expressed fear that state AIDS Drug Assistance Programs would be eliminated entirely. To remain viable, such programs must identify and justify the need for services in the context of the Affordable Care Act and receive sufficient political support and funding.

Although the Affordable Care Act seeks to increase access to health care and strengthen consumer protections, little attention has been given to the law’s potential impact on discretionary health care programs that target specific populations. For example, the federal Health Resources and Services Administration and the Substance Abuse and Mental Health Services Administration administer a number of discretionary programs for HIV/AIDS patients, children with special needs, substance abusers, and the mentally ill. Policy makers may now perceive that there is less need for these services and in turn shift their attention toward funding various provisions of the Affordable Care Act instead.

To examine the impact the Affordable Care Act might have on existing discretionary health care programs, we interviewed managers of state AIDS Drug Assistance Programs, federally funded programs that provide drug coverage for low-income HIV patients. Because the program is up for congressional reauthorization this year, program officials and advocates are concerned about its fate. We asked AIDS Drug Assistance Program managers their views

on how the program may evolve in the near future and what challenges the program may face in adapting to a new policy environment. In this article, we report the views and potential new strategies of program managers and discuss the implications for other discretionary health programs.

AIDS Drug Assistance Programs

Less than one-third of US HIV patients have private insurance, and most rely on government payers for medical services and prescription drugs.(1) The major sources of government funding are Medicaid, Medicare, and the Ryan White HIV/AIDS Program, a federal “payer of last resort” for uninsured or underinsured HIV patients who are ineligible for other government programs or have gaps in coverage.(1)

State-administered AIDS Drug Assistance Programs receive a portion of Ryan White funds administered through the Health Resources and Services Administration. These state-administered programs primarily provide access to HIV medications, although funds may also be used for other medical and support services related to drug therapy. In fiscal year 2010, the AIDS Drug Assistance Program budget totaled \$1.79 billion, a \$200 million increase from the previous fiscal year. Federal funding for the program was \$915 million with the remainder coming from nonfederal sources, including manufacturers’ drug rebates and state supplemental funds.(2)

AIDS Drug Assistance Programs are critical for low-income, minority, and uninsured clients who do not yet meet eligibility requirements for Medicaid and Medicare.(2) Approximately one-quarter of US HIV patients in 2010 were enrolled in an AIDS Drug Assistance Program (authors’ calculation based on [2, 3]). Client enrollment in AIDS Drug Assistance Programs vary by state, ranging from ninety-six in Alaska to 41,457 in California, reflecting differences in population size, HIV prevalence, state eligibility criteria, and access to insurance.(2) Although states with less generous Medicaid programs may have a greater need for funding, states’ capacities to cover these patients is not a main driver of federal allocations.(4) Funding allocations are primarily based on case counts, and although special needs (such as disproportionate numbers of low-income or minority clients) are considered during budget allocations, the strongest predictor of states’ federal allocations is the size of their past allocations. [Reference Martin & Keenan 2009, note 4]

Eighty-five percent of AIDS Drug Assistance Program expenditures pay for prescription drugs, and another 10 percent fund insurance premiums, copayments, and deductibles.(2) States have considerable flexibility in program administration and show wide variation in the degree to which they cover medical services and nonantiretroviral drugs, such as psychotropics, and in administrative processes to purchase and distribute drugs.(2)

Despite increasing caseloads, the Ryan White HIV/AIDS Program has received no major increases or decreases in funding since 2000, leading to an environment of chronic resource scarcity.(4) In December 2011 there were over 4,000 clients on waiting lists to enroll in AIDS Drug Assistance Programs in twelve states.(5) The National Alliance of State and Territorial AIDS Directors described the programs as experiencing a “perfect storm” of state

budget cuts, limited federal funding, increased program demand because of the economic recession, and high drug costs. Other trends also threaten to increase program demand and thus exacerbate the current funding shortage. There are ongoing national efforts to increase HIV testing and then connect HIV-positive patients to medical care. At the same time, updated clinical guidelines are advocating earlier intervention of antiretroviral therapy.(2,6)

AIDS Drug Assistance Programs are a useful case study of the potential effects of the Affordable Care Act on discretionary health care grant programs. The AIDS Drug Assistance Programs rely on a network of state-level program officials and benefit low-income and chronically ill populations, features that are shared by other programs that target substance abusers, the mentally ill, and children with special needs. Although such discretionary programs have been supported by advocacy groups and the pharmaceutical industry, these actors may become less influential as Congress looks for more opportunities to cut the budget.

The Ryan White HIV/AIDS Treatment Extension Act of 2009 is up for congressional reauthorization this year, just months before the planned 2014 start of the Affordable Care Act's Medicaid expansion and insurance exchanges. The timing will force HIV/AIDS programs funded through the Ryan White Program to develop strategies to justify their continued existence.

Study Data And Methods

We conducted semistructured telephone interviews with AIDS Drug Assistance Program officials from twenty-two states (one respondent per state) from June 2011 to August 2011. We used purposeful sampling (7,8) to identify states that varied by geographic region, political orientation, health reform environment, case burden, fiscal capacity, state contributions to the program, number of clients, and presence of a waiting list. Half of the interviews were conducted after the July 2011 regional technical assistance conference of the National Alliance of State and Territorial AIDS Directors, where the health reform law was the subject of discussion. Respondents were recruited until no new concepts emerged from subsequent interviews.

Respondents were asked about program history, ways in which the Affordable Care Act is likely to affect publicly funded HIV services, unclear aspects of the law, preparations for the new health policy environment, expectations about local implementation of the health reform law, and likely results of the upcoming reauthorization of the AIDS Drug Assistance Program. Terence Meehan, University at Albany, conducted and transcribed all interviews. See the online appendix for the interview guide.(9)

We analyzed the responses using grounded theory, in which themes and concepts emerge inductively.(8) We coded interview transcripts line by line in an iterative process, with subsequent interviews used to identify and refine codes. Authors met to discuss a coding scheme, and Erika Martin, University at Albany and Nelson A. Rockefeller Institute of Government, and Meehan independently coded three interviews and compared results twice to refine the coding instrument. All interviews were subsequently coded by Martin using Atlas.ti.

Limitations—The analysis has limitations, including that the data are perceptions of program officials who may understand only some aspects of the Affordable Care Act. Sampling was not representative, and researchers may have brought biases into the analysis. As with qualitative research more generally, the output was a description of the complexity and range of observations, and findings should not be interpreted as indicating that a proportion of program managers hold specific views.

Study Results

Affordable Care Act Impact On HIV Drug Insurance Coverage

AIDS Drug Assistance Program managers predicted that for their clients the most salient provision of the Affordable Care Act is the Medicaid eligibility expansion in 2014. This will offer Medicaid coverage to all people with incomes up to 133 percent of the federal poverty level, without disability requirements. Program managers expect most of their current clients will become Medicaid eligible. As low-income clients transition to Medicaid, thereby reducing caseloads and budget pressures for AIDS Drug Assistance Programs, programs may have “a little breathing room.” State-run health insurance exchanges will also become operational in 2014, providing insurance coverage subsidies for low-income people. This, too, should also reduce demand on AIDS Drug Assistance Programs.

In the meantime, states may apply for section 1115 Medicaid waivers to move nondisabled low-income patients, many of whom are AIDS Drug Assistance Program clients, to Medicaid prior to 2014. Some states have recently received approval for these waivers. Special temporary government-run risk pools for uninsured people with pre-existing conditions have been established until these patients can gain coverage through Medicaid or insurance exchanges in 2014. Despite their low utilization to date, these temporary risk pools could help clients and administrators transition to a private insurance model and reduce program costs.

Program managers reported that, as a result of the Affordable Care Act, rebates and drug discounts for elderly and younger disabled patients are already available through Medicare Part D. In addition, under the Affordable Care Act, AIDS Drug Assistance Program payments for medications that Medicare does not cover during the Part D “donut hole” period count toward clients’ true out-of-pocket costs. Previously, if AIDS Drug Assistance Program clients who were also enrolled in Medicare Part D encountered costs that tipped them into the donut hole and the program assisted with drug costs during that period, then the program would be responsible for all subsequent costs for HIV medications. Now, under provisions of the Affordable Care Act, AIDS Drug Assistance Program clients can emerge from the donut hole and receive Medicare Part D catastrophic coverage. AIDS Drug Assistance Program managers reported that clients are generally unaware of the new rules, but program officials unanimously anticipated substantial cost savings.

New Roles For AIDS Drug Assistance Programs

As many AIDS Drug Assistance Program clients gain coverage elsewhere, program officials said they aspire to move from providing direct services to providing wrap-around services.

These services include helping newly insured clients finance out-of-pocket expenses, such as copays, deductibles, and premiums. This is important because out-of-pocket expenses may make private insurance and risk pools prohibitively expensive for low-income HIV patients, even with government subsidies(10): “A lot of health care reform plans...have large deductibles, like \$1,000, \$1,500, \$2,000, and I don’t know how these clients are going to be able to come up with that money.”

Although the Affordable Care Act contains provisions to simplify processes to enroll in public and private insurance programs, the mix of payers and eligibility rules will continue to be complex. Program managers anticipate that AIDS Drug Assistance Program case managers may have new roles as patient navigators to help clients gain coverage, which is important for clients with little health insurance experience, language barriers, limited health literacy, and other chronic health issues. Officials reported wide variation in states’ Medicaid income eligibility determinations and the scope of medical services offered.(11) Even after the Medicaid expansion, states with less generous Medicaid benefits may continue to have a greater need for the AIDS Drug Assistance Program to provide supplemental coverage for Medicaid recipients. These states may also experience the largest cost savings as clients transition to Medicaid.

In addition to providing wrap-around services, AIDS Drug Assistance Program managers expect the program to continue providing direct services to people who fall through the cracks and remain uninsured. The most visible group will be undocumented immigrants who will be ineligible for both Medicaid and health insurance exchanges. Many state AIDS Drug Assistance Programs have previously covered undocumented immigrants because the Health Resources and Services Administration does not impose citizenship requirements.

Yet, even among citizens, there is likely to be imperfect take-up. For example, temporary government-run risk pools for people with pre-existing conditions have had low utilization. As of December 2010, only 151 of 135,607 AIDS Drug Assistance Program clients nationally had enrolled in a risk pool.(2) Officials noted that consumers and providers have expressed general resistance to change along with specific fears about service reductions and the repercussions of moving from the AIDS Drug Assistance Program to managed care plans offered through insurance exchanges or to Medicaid managed care. Furthermore, AIDS Drug Assistance Program managers hypothesized that taxes and subsidies for private insurance may not be sufficient to induce enrollment.

Rationale For Continuing To Provide Services To HIV-Infected Clients

Some AIDS Drug Assistance Program managers alluded to the current discourse about the end of “HIV exceptionalism,” by which HIV is treated differently than other communicable diseases. For example, there have been special policies to protect privacy and patient autonomy, such as state regulations requiring written consent for HIV testing and ensuring privacy in the collection of HIV surveillance data.(12) Also, the original Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was established in 1990 specifically to improve access to HIV care.(13) The subsequent success of antiretroviral therapies, the shift from acute care to chronic disease management(1), and the potential benefits that early treatment may have on reducing HIV transmission(14) have led to the

elimination of some of these special protections and to efforts to move HIV testing and treatment into routine medical care.

Though there may be less dedicated funding for HIV as less care is provided by HIV specialists, AIDS Drug Assistance Program managers emphasized the importance of continuing to provide services to their clients. Maintaining clients on antiretroviral therapy may reduce future transmission through viral load suppression⁽¹⁵⁾ and is cost effective⁽¹⁶⁾. In addition, paying for ongoing medical care, either through direct provision of services or as wrap-around insurance payments, may prevent expensive hospitalizations and use of the emergency department as a usual source of HIV care.

Variation In States' Progress

There was general consensus among AIDS Drug Assistance Program managers about the program's likely new roles. However, there was considerable variation in how the managers viewed states' progress toward adapting AIDS Drug Assistance Programs to the new policy environment. Some managers anticipate a "smooth transition." In contrast, managers of AIDS Drug Assistance Programs in other states have not made major changes: "We're not really doing anything...[except]...hand wringing, fretting, worrying..."

States are in different stages of Affordable Care Act implementation. For example, Massachusetts and Hawaii previously had insurance mandates or exchanges, and New York already barred health insurers from denying coverage to people with pre-existing conditions. Consequently, other states require more preparation.

Some states must update regulations to allow AIDS Drug Assistance Programs to respond to emerging needs. One program manager explained that adaptation is relatively easy because legislative permission is not required to enact program changes in that state. In contrast, another program manager described a state law that prohibits the program from purchasing insurance, thereby preventing the provision of wrap-around insurance coverage.

This variation in states' health policy environments has contributed to differences in their progress. Some states have already obtained general or HIV-specific Medicaid waivers to allow nondisabled low-income clients to enroll in Medicaid prior to 2014. In other states, AIDS Drug Assistance Program managers are actively encouraging their state Medicaid offices to apply for such waivers. Still, program managers in some states were not optimistic about seeking a Medicaid waiver. Temporary government-run risk pools were reported to be less relevant in states with existing guaranteed-issue regulations that prohibit private insurance companies from denying coverage to people with pre-existing conditions and in states with more generous Medicaid eligibility. One state official reported a programmatic goal to enroll clients into the state's temporary risk pool, while other states are still learning about these programs.

Although AIDS Drug Assistance Program managers unanimously believed that counting program payments toward true out-of-pocket costs in Medicare Part D is a positive change, not all programs have taken advantage of these new rules. Some states previously had

similar mechanisms to assist people in the donut hole, and utilizing this new benefit was straightforward. Other states, however, have not worked out technical details.

Adapting To The New Health Policy Environment

Accepting Change

AIDS Drug Assistance Program managers reported there is a need for their respective programs to “change how we do business” and “revamp.” Managers expressed pride in the program’s historic flexibility, which has allowed it evolve over two decades in response to the HIV epidemic. This adaptability is critical to future success. Program managers anticipate making programmatic changes, such as reimbursing certain out-of-pocket costs; expanding patient navigation services; changing their drug purchasing mechanisms to take advantage of rebates; and filling gaps in services, such as laboratory testing, that are not covered by insurance or Medicaid. They expect these changes will continue not only through 2014 but also for several more years until clients successfully transition to Medicaid and private insurance.

Yet some AIDS Drug Assistance Program managers expressed reservations about the program’s ability to adapt. A few mentioned “stagnation” in the Ryan White Program caused by the efforts of “vested interests,” including advocacy groups, program staff, and elected officials who seek to maintain current funding allocations through multiple Ryan White funding streams to state, local, and community entities, even where this leads to duplicate services and inefficient uses of limited resources.⁽⁴⁾ Some program managers fear that their positions may become obsolete, but they did not openly support making programmatic changes to preserve their jobs instead of improving patient wellbeing. As one respondent said, “We should never be upset if we’re out of work because somebody gets their services.” Similarly, respondents reported past concern among program officials that the program would be eliminated entirely, although now there is consensus that it will, as one official said, have to “change its look.”

Accepting the need for change, becoming “change agents,” and being ready to reinvent the program are critical to future success, particularly in the context of the 2013 reauthorization: “[AIDS Drug Assistance Programs] need to quit their whining and drama around [possible elimination] and stand firm that what we have done for the last twenty years is valuable and that there’s still going to be clients and gaps and that we need to meet those services, and that should be the thrust behind the 2013 reauthorization. Yes, it will look different...but it doesn’t negate our presence...It just means that we may have to reinvent ourselves, which we’ve done before...We need to do it again in 2013, but we certainly are not going away because those client gaps are going to exist.”

Overwhelmed By The Affordable Care Act

AIDS Drug Assistance Program managers explained that the size, scope, and complexity of the Affordable Care Act are overwhelming. Unclear national messages make it difficult for states to understand how to adapt to upcoming changes. Although program managers were generally aware of the health reform law’s key features, there was considerable uncertainty

around technical details, such as the transition from temporary risk pools to either Medicaid or the insurance exchanges, assessment of Medicaid spend-down requirements, and mechanics of the exchanges and tax credits.

Although program managers anticipated a shift in focus from direct service provision to helping clients obtain and pay for insurance, many said there is unclear national guidance about the AIDS Drug Assistance Program's place in insurance coverage, including whether it can pay directly for insurance given its role as payer of last resort. For example, some program officials indicated that the Health Resources and Services Administration requires that programs purchasing insurance demonstrate that this is an appropriate use of funds, which is difficult to document. This confusion is further complicated by general uncertainty about the future of the Ryan White Program, its design, and funding.

Program managers said it is particularly difficult to predict local implementation of the Affordable Care Act, which in turn impedes their planning activities. One program manager asserted that the law made sense overall, but it was unclear how it would be interpreted within the state context. Another program manager discussed the importance of having a local, trained staff member to review and interpret the health care law. Local interpretation is particularly difficult for program managers in jurisdictions that are legally challenging the Affordable Care Act because it is unclear which, if any, provisions will be implemented and win political support.

It is important to note that the results reported in this paper are based on interviews with AIDS Drug Program managers that occurred one year before the June 2012 Supreme Court ruling on the Affordable Care Act. Although the Supreme Court ruling upheld most provisions except the mandatory Medicaid expansion, there continues to be substantial variation in the level of state implementation of the law's provisions. For example, some states have indicated that they will not establish their own health insurance exchanges. Other states will impose insurance rules that are more stringent than federal guidelines, such as establishing a more extensive list of essential benefits.

States need to address numerous technical details, which will be difficult given their limited resources. One program manager discussed efforts to investigate how to provide copayments for medical services because the program previously dealt only with pharmaceutical companies. Several program managers outlined the operational challenges of transitioning their clients to temporary government-run risk pools, with one concluding that this effort was not worthwhile because of the paperwork burden. Another program manager expressed concern that providers will not accept lower reimbursement rates as clients transition from AIDS Drug Assistance Programs to Medicaid.

State Financial Challenges

State budget shortfalls are a major barrier to Affordable Care Act implementation. For example, several program managers worried that the Medicaid expansion would not be financially feasible in their states. These concerns could reflect a lack of understanding about the amount of federal cost sharing, specifically that most of the Medicaid expansion will initially be federally financed. Some program managers were concerned that low

Medicaid reimbursements may cause clinic closings when clients shift to Medicaid. There was also concern among program managers that the emerging “treatment as prevention” strategy may further strain program budgets. In this context, “treatment as prevention” involves aggressive HIV screening to identify untreated patients and link them to treatment, and starting HIV patients on antiretroviral therapy earlier in their disease course to lower their viral load, making them less likely to transmit new infections.

Not surprisingly, states’ current resources will affect whether they take advantage of key provisions, such as temporary risk pools and the new rules on Medicaid Part D donut hole costs, in a timely fashion. States with limited staff because of small HIV populations or resource constraints reported difficulties planning for upcoming changes. For example, states with restricted program budgets and waiting lists have greater financial incentives to shift costs to Medicaid. Yet, because they are struggling financially, these states will have trouble hiring additional staff to assist with the long-term planning required to transition clients to Medicaid. Additionally, staff time is limited because case managers devote considerable effort toward connecting waiting list clients to charity drug assistance programs run by pharmaceutical companies. Program managers in states with waiting lists must also submit additional documentation to the Health Resources and Services Administration to show how funds are used. These issues make it disproportionately difficult for resource-constrained states to make implementing the Affordable Care Act a priority.

Ryan White Program Reauthorization

AIDS Drug Assistance Program managers described “a lot of fog out there” regarding reauthorization of the federal Ryan White Program. They were uncertain about future funding levels; allowable services; possible philosophical changes about using funds to pay for insurance premiums; and outcomes of the reauthorization, including whether the program will even continue to exist.

Program managers said the biggest challenge ahead is that national policy makers may perceive the program to be unnecessary after 2014. One official explained, “This is the [big] question going on in the HIV world right now...What do we do about reauthorization when health care reform doesn’t really kick in for another year?...Most people will have access to medical care and medications, then what is really the role of the [Ryan White] CARE Act in the new landscape?...It’s going to be a hard nut to crack on Capitol Hill to convince the legislators that there is still a need for the CARE Act [to pay] for all these support services and wrap around services when very few of their populations get this type of appropriation and coverage.” The 2012 election was expected to be important to the program’s future success because of the Obama administration’s support for the Ryan White Program.

Even if the Ryan White Program is reauthorized, AIDS Drug Assistance Program managers expect declining federal allocations. Some program managers asserted that reduced funding may be appropriate as costs shift to Medicaid and private insurance. There were common concerns, however, about maintaining current funding levels in the short term to help clients transition and to support wrap-around services and care for clients who fall through the cracks. One program manager explained, “I hope we’ll reauthorize for at least three years... [because]... people are not going to wake up January 1, 2014 and say, ‘Oh I have Blue

Cross/Blue Shield, now I'm insured.' So we have to have enough funding and I hope that funding remains relatively constant between '13 and late '16 to allow us to make sure that people select the health insurance exchanges, people get into Medicaid."

Changing Relationships With Pharmaceutical Companies

Some program managers expressed concern that their long-standing relationships with pharmaceutical companies may also change as the Affordable Care Act kicks in.

Currently, the ADAP (AIDS Drug Assistance Program) Crisis Task Force, a national advocacy group representing state programs, negotiates with pharmaceutical companies to obtain rebates, price freezes, and drug prices that are generally lower than mandatory government rates for Medicaid and the federal 340B drug pricing program. The federal 340B program requires pharmaceutical companies to provide discounts for eligible organizations serving low-income populations.

Through the task force, all states receive the same price deals, and program managers contend that these successful negotiations have been, as one put it, "a major feather in our cap." Several program managers expressed pride over their success at maximizing their states' drug rebates. Drug rebates have been a critical revenue stream for the AIDS Drug Assistance Program, representing 29 percent of the program's 2010 budget.(2) In addition to the rebates, pharmaceutical company patient assistance programs have been instrumental in providing medications to clients who are on waiting lists to enroll in an AIDS Drug Assistance Program. Pharmaceutical companies have also helped some AIDS Drug Assistance Programs lobby for state and federal funding. Because AIDS Drug Assistance Programs are major purchasers of drugs, pharmaceutical companies want them to remain viable.

Some program managers anticipate that as AIDS Drug Assistance Programs move from direct service provision to purchasing insurance and wrap-around benefits, their relationship with the pharmaceutical industry may change. And some program managers fear that if AIDS Drug Assistance Programs no longer purchase drugs directly from pharmaceutical companies, the programs may lose their negotiating power to receive special discounts. These rebates do not exist for risk pools, Medicare Part D, or private insurance.

Undocumented Immigrants—A Politically Sensitive Issue

Because undocumented immigrants are ineligible for key Affordable Care Act provisions, AIDS Drug Assistance Programs will likely remain their direct service providers. Program managers emphasized the importance of continuing to cover immigrants to prevent new infections, curb downstream health care costs, and to meet ethical standards.

However, undocumented immigrants are a politically sensitive topic, and it will be difficult for the program's coverage of this group to remain out of the public eye. One program manager explained, "I can't overemphasize the issues for the undocumented folks...it's really scary because we've all tried to keep that issue under the radar, and with the Affordable Care Act there's no way to keep the issue of who's paying for care of

undocumented folks under the radar.” Some program managers were concerned that this issue may reduce the program’s future political support.

Lessons For Other Discretionary Health Programs

Implementing the Affordable Care Act will disrupt the environment for discretionary government health programs that target specific populations. These programs may face changes in the real or perceived need for their services and compete with Affordable Care Act implementation for continued funding.

To remain viable, discretionary health programs will need to quickly evolve. Many program managers aspire to develop new roles in providing wrap-around services, such as assisting newly insured clients with out-of-pocket expenses and helping vulnerable clients obtain coverage and medical and support services. Their challenges include accepting the need for change; lack of knowledge and guidance about Affordable Care Act implementation; varying levels of state political support for their program’s mission; and, with respect to the Affordable Care Act, uncertainties about future federal funding levels and coverage of undocumented immigrants.

These findings are generalizable to other targeted discretionary programs, such as the Substance Abuse and Mental Health Services Administration’s block grant for the prevention and treatment of substance abuse and the Health Resources and Services Administration’s block grant to support maternal and child health services for low-income populations. These programs will also need to identify new gaps to address, and they will likely grapple with similar challenges.

The responses of AIDS Drug Assistance Program managers to these challenges varied from perplexity and indecision to strong but perhaps unrealistic assertions about their ability to cope with change and retain adequate funding. Similar variation likely exists among program officials for other discretionary programs. AIDS Drug Assistance Programs have the advantage, however, of a history of adapting to change and an established infrastructure for collaboration and information sharing through the National Association of State and Territorial AIDS Directors and the ADAP Crisis Task Force. Many program managers described these organizations as being important to their successful adaption to HIV policy changes in the past and going forward.

One lesson for other discretionary programs is that states’ ability to share information can accelerate adaptation and allow resource-constrained states to obtain technical assistance. Additionally, interstate collaborations can identify areas where federal policy should be clarified.

If implemented as designed, the Affordable Care Act will expand access to care, thus relieving some financial strain on discretionary health programs while allowing them to focus on providing different services for vulnerable populations. Yet a successful transition will require program managers to accept a change in strategy, identify and justify the need for services in the context of state-level Affordable Care Act implementation, and receive sufficient political support and funding. Adaptation will be difficult, particularly for states

with limited administrative capacities and no political support to expand Medicaid, but it is also an opportunity to improve population health.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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ABOUT THE AUTHORS: ERIKA G. MARTIN, TERENCE MEEHAN & BRUCE SCHACKMAN

In this month's *Health Affairs*, Erika Martin and coauthors assess the implications the Affordable Care Act might have on discretionary health programs, such as state AIDS Drug Assistance Programs, which provide free medications to low-income HIV patients.

Martin is an assistant professor of public administration and policy and an institute fellow at the Nelson A. Rockefeller Institute of Government, Rockefeller College of Public Affairs and Policy, University at Albany, the State University of New York. Her HIV policy research includes examining the fairness and flexibility of the federal allocation formula for the Ryan White HIV/AIDS Program, interstate variation in AIDS Drug Assistance Programs, and the national budget impact of expanded HIV screening. Martin has a master's degree in epidemiology from the University of Michigan and a doctorate in health policy and administration from Yale University.

Terence Meehan is a doctoral student in public administration at the Rockefeller College of Public Affairs and Policy, University at Albany, the State University of New York. In the late 1990s, he served as assistant director of An Effective Shield of Protection, an HIV prevention and outreach nongovernmental organization in Moscow, Russia. He has a master's degree in public administration from Harvard University.

Bruce Schackman is an associate professor of public health and chief of the division of health policy in the Department of Public Health at Weill Cornell Medical College. His current research projects include economic evaluations of screening and treatment for HIV, hepatitis C, and opioid dependence in the United States and treatment for HIV in Haiti. Schackman earned an MBA and a doctorate in health policy from Harvard University.

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