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The Ryan White HIV/AIDS Program: The Basics

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Key Facts

- The Ryan White HIV/AIDS Program, first enacted in 1990, is the largest federal program (https://www.kff.org/global-health-policy/fact-sheet/u-s-federal-funding-for-hivaids-trends-over-time/) designed specifically for people with HIV, serving over half of all those diagnosed (https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/data/rwhap-annual-client-level-data-report-2020.pdf). It is a discretionary, grant program dependent on annual appropriations from Congress.
- It is the nation's safety net program for people with HIV, providing outpatient HIV care, treatment, and support services to those without health insurance and filling in gaps in coverage and cost for those with insurance limitations.
- Most Ryan White clients are low-income, male, people of color, and half are gay and bisexual men and other men who have sex with men.
- The program is the third largest source (https://www.kff.org/global-health-policy/fact-sheet/u-s-federal-funding-for-hivaids-trends-over-time/) of federal funding for HIV care in the U.S., following Medicare and Medicaid and is the largest source of HIV discretionary funding. Funding is distributed to states/territories, cities, and HIV organizations in the form of grants. In FY 2022, (https://www.kff.org/hivaids/slide/ryan-white-hiv-aids-program-federal-funding-fy1991-fy2022/) the Ryan White HIV/AIDS Program was funded at $2.5 billion which includes continued funding for the federal "Ending the HIV Epidemic" initiative.

Overview

The Ryan White HIV/AIDS Program (Ryan White), the largest federal program designed specifically for people with HIV in the United States, serves over half (https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/data/rwhap-annual-client-level-data-report-2020.pdf) of those in the country diagnosed with HIV. First enacted in 1990, Ryan White has played an increasingly significant role as the number of people living with HIV has grown over time and people with

HIV are living longer. It provides outpatient care and support services to individuals and families affected by the disease, functioning as the "payer of last resort," by filling the gaps for those who have no other source of coverage or face coverage limits or cost barriers. Many "parts" of the program (described below) can purchase health insurance (https://www.kff.org/hivaids/issue-brief/the-ryan-white-program-and-insurance-purchasing-in-the-aca-era/) on behalf of clients which is often less expensive than paying for drugs alone and offers broader health coverage.

The program has been reauthorized by Congress four times since it was first created (1996, 2000, 2006, and 2009) and each reauthorization has made adjustments to the program. The current authorization lapsed in FY 2013, but the program has continued to be funded through the annual appropriations process as there is no "sunset" provision or end date attached to the legislation. The program is administered by the HIV/AIDS Bureau (HAB) at the Health Resources and Services Administration (HRSA) of the Department for Health and Human Services (HHS), and programs and services are delivered by grantees and sub-grantees at the state and local levels.

HRSA is one of the lead agencies in the federal government's Ending the HIV Epidemic (EHE): A Plan for America initiative (https://www.kff.org/hivaids/issue-brief/the-u-s-ending-the-hiv-epidemic-ehe-initiative-what-you-need-to-know/), launched in 2019, and the Ryan White Program is set to play a key role in efforts to reach the goal of reducing new HIV infections by 75% in five years and by 90% in ten years. The initiative includes new federal funding, some of which has been channeled to Ryan White.

Clients

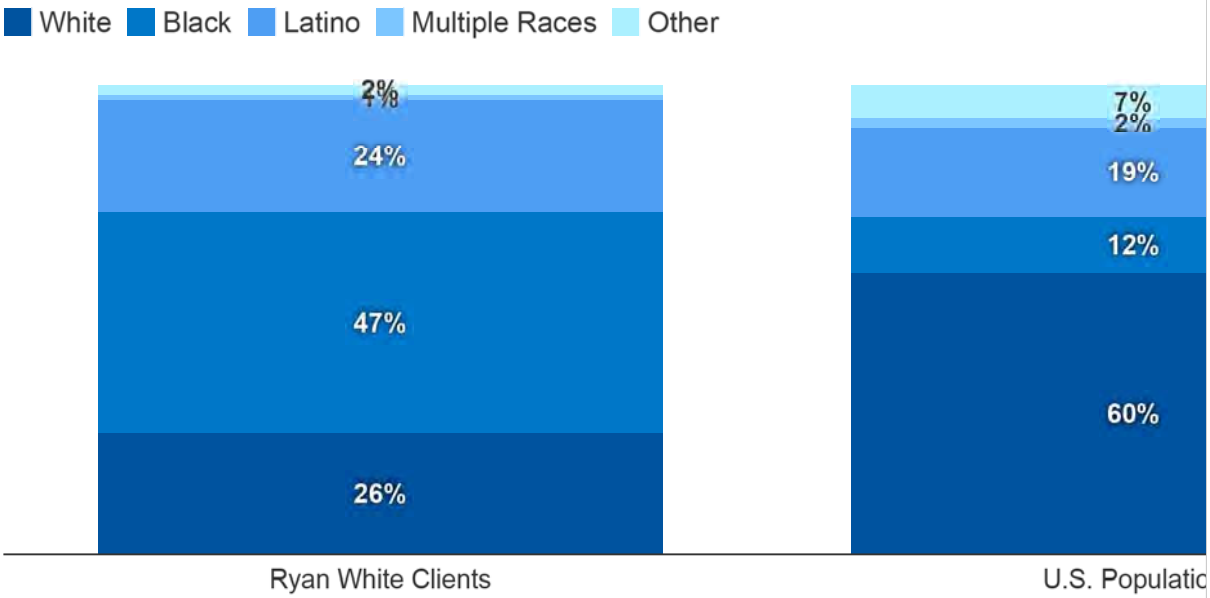
More than half a million people (https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/data/rwhap-annual-client-level-data-report-2020.pdf) receive at least one medical, health, or related support service through the program in 2020, with many clients receiving multiple types of services:

- Nearly two-thirds (61%) had incomes at or below the federal poverty level (FPL) (which in 2020 (https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references/2020-poverty-guidelines) was $12,760 for a single person or $26,200 for a family of four); 29% had incomes between 101% and 250% FPL.
- One-fifth (19%) were uninsured, a decrease from 28% in 2013, prior to enactment of the major coverage provisions under the Affordable Care Act (ACA). Most clients (80%) have some form of insurance coverage: Medicaid is the primary payer for Ryan White clients, covering 38%, including those dually eligible for Medicare. Other coverage includes: private insurance (20%), Medicare only (11%), and other or multiple sources of insurance (12%).
- Clients are largely male (72%), 26% are female and 2% are transgender. Approximately half (49%) are between the ages 45 and 64, up from 22% in 2016. More than one-third (38%) are between 25-44. Smaller shares are under 25 (4%) or over 64 (10%). Most clients are people of color (74%), including 47% who are Black and 24% who are Hispanic. Just over one-quarter of clients (26%) are White. Half (50%) are gay, bisexual men, or men who

have sex with men.

Figure 1

Ryan White Clients & U.S. Population, by Race/Ethnicity, 2020



SOURCE: Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2020. www.hab.hrsa.gov/data/data-reports . Published December 2021. AND KFF. State

Role of Ryan White in the COVID-19 Response and Other Emerging Health Threats

In early 2020, the U.S. was hit by the COVID-19 pandemic which dramatically impacted health, health coverage, and health access for all people. The Ryan White Program pivoted (https://www.kff.org/hivaids/issue-brief/delivering-hiv-care-prevention-in-the-covid-era-a-national-survey-of-ryan-white-providers/) to find new ways of providing care, seeking to ensure that people with HIV were retained in care, even when the programs that serve them were strained. Recognizing the new stresses the pandemic might mean for Ryan White, Congress appropriated emergency supplemental funding for the program through the Coronavirus AID, Relief and Economic Security (CARES) Act (https://www.kff.org/coronavirus-covid-19/issue-brief/the-coronavirus-aid-relief-and-economic-security-act-summary-of-key-health-provisions/#:~:text=The%20CARES%20Act%20contains%20a,support%20for%20the%20global%20response.) in March of 2020 (Discussed further below, see also Table 1). The one-time allocation of $90 million supported 581 existing Ryan White grantees to aid them in preventing, preparing, and responding to the coronavirus. Funding was also provided to Ryan White Part F AIDS Education and Training Center Program (AETC) for the development of educational resources, expansion of telehealth capacity and incorporation of distance-based learning.

Alongside COVID-19, Ryan White has played a role in responding to other emerging health

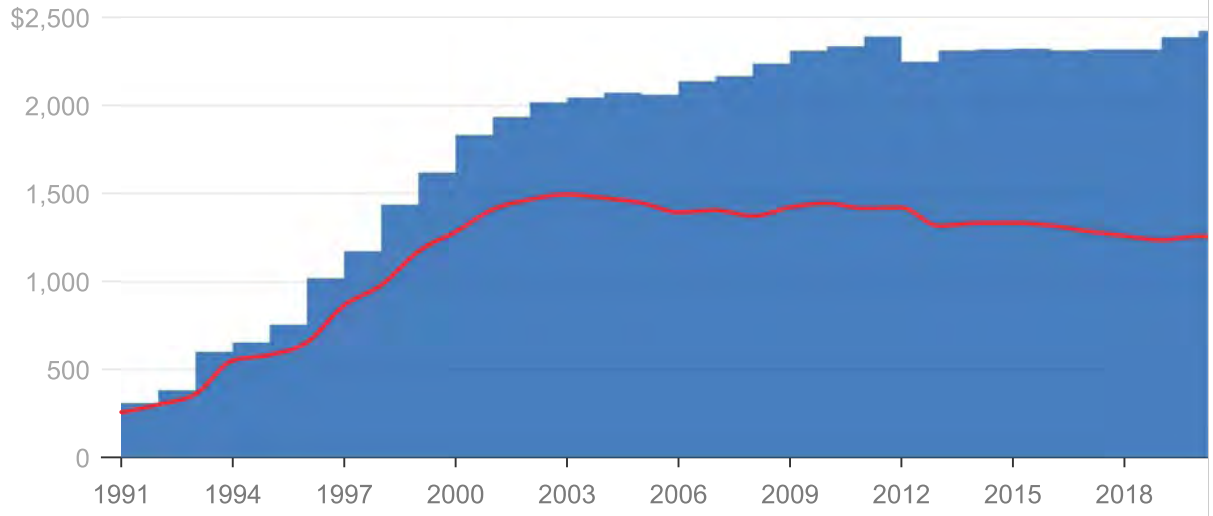
threats such as monkeypox (MPX). On August 4, 2022, the MPX outbreak (https://www.kff.org/other/issue-brief/key-questions-about-the-current-u-s-monkeypox-outbreak/) was declared a public health emergency (https://aspr.hhs.gov/legal/PHE/Pages/monkeypox-4Aug22.aspx?ACSTrackingID=DM87270-USCDC_2146&ACSTrackingLabel=Lab%20Advisory%3A%20HHS%20Declares%20Monkeypox%20a%20Public%20Health%20Emergency%20&deliveryName=DM87270-USCDC_2146) in the U.S.. Early on Ryan White provided flexibility (https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/monkeypox-guidance-dear-colleague.pdf) for grantees to use program funds to respond to the outbreak by supporting monkeypox testing, treatment and vaccination for eligible clients.

Structure and Funding

The Ryan White Program is the third largest source (https://www.kff.org/global-health-policy/fact-sheet/u-s-federal-funding-for-hivaids-trends-over-time/) of federal funding for HIV care in the U.S., after Medicare and Medicaid, totaling $2.5 billion in FY 2022. Federal funding for the program, which is appropriated by Congress annually, began in FY1991 and increased significantly in the mid-1990s (https://www.kff.org/global-health-policy/fact-sheet/u-s-federal-funding-for-hivaids-trends-over-time/), primarily after the introduction of highly active antiretroviral therapy (HAART). For many years thereafter, funding continued to increase, but at slower rates, eventually . New funding as part of the EHE Initiative (https://www.kff.org/hivaids/issue-brief/the-u-s-ending-the-hiv-epidemic-ehe-initiative-what-you-need-to-know/) ($70 million in FY 2020) marked the first significant increase to the program in many years. When adjusted for inflation, however, funding has been flat since 2001 and even on a slight decline as of 2013 despite having more clients enrolled in the program (Figure 2).

Figure 2

Federal Ryan White Funding FY1991-FY2022



NOTE: Funding adjusted using CPI-U www.bls.gov
SOURCE: KFF analysis of data from OMB, congressional budget justifications, and appropriations bills • PNG

The Ryan White HIV/AIDS Program is composed of "Parts," each with a different purpose and funded as a separate line item through annual appropriations. Funding is provided to states and territories (Part B) cities (Part A), and to providers, community-based organizations (CBOs), and other institutions (Parts C, D, and F), in the form of grants. In recognition of the varying nature of the HIV epidemic, grantees are given broad discretion to design key aspects of their programs, such as specifying client eligibility levels and service priorities. However, there are requirements, (https://www.congress.gov/bill/109th-congress/house-bill/6143) including that, unless granted a waiver, grantees must spend 75% or more of funds on "core medical services" under Parts A through C and that all state AIDS Drug Assistance Programs (ADAPs) must have a minimum formulary for medications.

Table 1: Description of the Ryan White Program, by Part, FY22		
Part	**FY22 (Funding in Millions)**	**Part Description**
Part A	$670.5	Funds provided to "eligible metropolitan areas" (EMAs), areas with 2,000+ reported AIDS cases over the past 5 years & "transitional grant areas" (TGAs), areas with 1,000-1,999 reported AIDS cases in the past 5 years. TGAs and EMAs must have a population of at least 50,000. Two-thirds of funds are distributed by formula based on area's share of living HIV (non-AIDS and AIDS) cases and the remainder is distributed via competitive supplemental grants based on "demonstrated need." EMAs must establish Planning Councils, local bodies tasked with assessing needs, developing HIV care delivery plans, and setting priorities for funding. Most TGAs are not required to have Planning Councils. *Number of Grantees: 24 EMAs; 28 TGAs.*
Part B	$1,344.2	Funds provided to states, Washington, D.C., and territories/associated jurisdictions. Grantees provide services directly, through sub-grantees and/or through Part B "Consortia" (associations set up to plan and deliver HIV care). Part B components include: • **Base & Supplemental:** Funds distributed by formula to states based on state's share of living HIV (non-AIDS and AIDS) cases, weighted to reflect the presence of EMAs/TGAs. Additional "supplemental" grants are available for states with "demonstrated need." • **Emerging Communities (ECs):** A portion of Part B base funds is set aside for grants to metropolitan areas with 500-999 cumulative reported AIDS cases over the most recent 5 years. Funding distributed via formula. *Number of grantees: 50 States, D.C., and 8 Territories/Associated Jurisdictions.*
ADAP (non-add)	*$900.3*	***ADAP & ADAP Supplemental:*** *Congress "earmarks" funds under Part B for ADAPs which provide medications and assists with costs related to insurance for people with HIV. ADAP supplemental grants (5% of earmark) available to states with "severe need".*
Part C	$205.5	Funds public and private organizations directly for: • **Early Intervention Services (EIS):** To provide comprehensive primary health care to people with HIV, including services to those newly diagnosed,

		such as HIV testing, case management, and risk reduction counseling. • **Capacity Development & Planning Grants:** To support organizations in planning for service delivery and building capacity to provide services. *Number of grantees: 348 EIS; 59 Capacity Development.*
Part D	$76.8	Funds public and private organizations to provide family-centered and community-based services to children, youth, and women living with HIV and their families, including outreach, prevention, primary and specialty medical care, and psychosocial services. Supports activities to improve access to clinical trials and research for these populations. *Number of grantees: 115.*
Part F	$34.4 (AETCs)/$13.4 (Dental)/$25 (SPRNS)	Includes the following components: • **AIDS Education and Training Centers (AETCs):** National and regional centers proving education and training for health care providers who treat people with HIV. *Number of grantees: 14.* • **Dental Programs:** The "Dental Reimbursement Program," reimburses dental schools/providers for unreimbursed oral health services; the "Community-Based Dental Partnership Program" funds dental provider education and increases access to dental care for people with HIV. *Number of grantees: 51 Reimbursement, 12 Community Partnership.* • **Minority AIDS Initiative (MAI):** MAI, created in 1998, aims to address impact of HIV on racial/ethnic minorities. Provides funding across DHHS agencies/programs, including the Ryan White HIV/AIDS Program, to strengthen organizational capacity and expand HIV services in minority communities. The Ryan White HIV/AIDS Program's (https://sgp.fas.org/crs/misc/RL33279.pdf) component of the MAI was codified (https://www.cdc.gov/niosh/topics/ryanwhite/pdfs/RyanWhiteActof2009.pdf) in the 2006 reauthorization. • **Special Projects of Regional and National Significance (SPRNS):** Funded through "set-asides" of general federal Public Health Service evaluation funding, separately from the amount appropriated by Congress for the Ryan White HIV/AIDS Program, SPNS projects address emerging needs of clients and

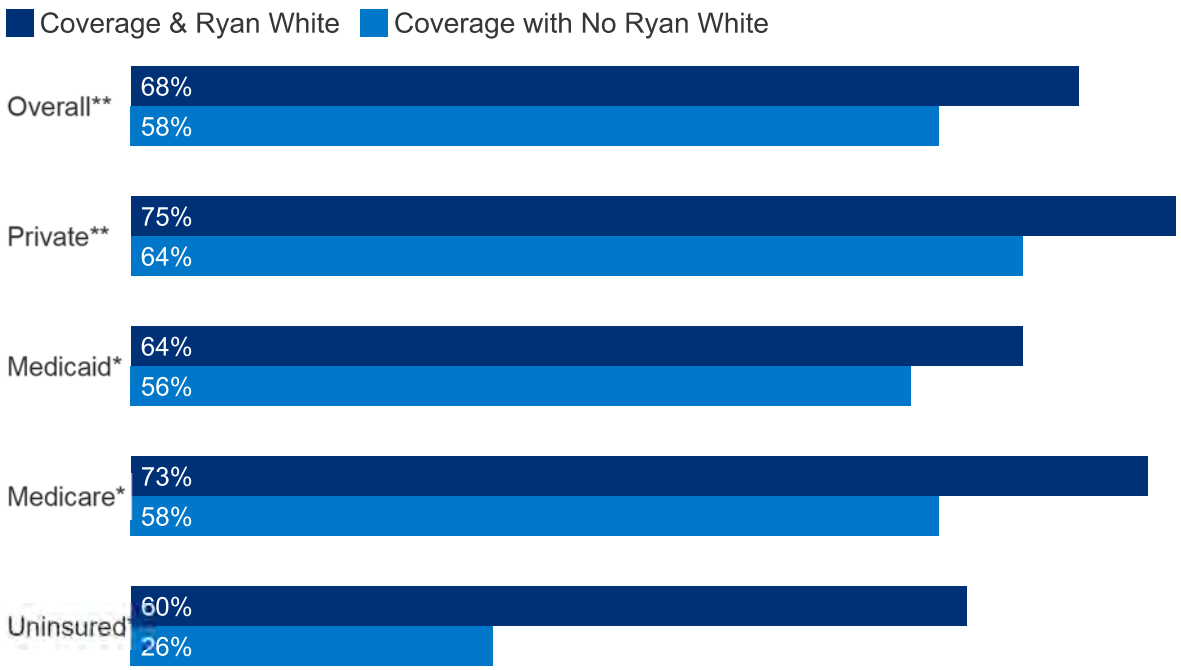
		assist in developing a standard electronic client information data system.
Ending the HIV Epidemic Initiative	$125	Dedicated funding to support the "Ending the HIV Epidemic (EHE)" initiative which aims to reduce HIV infections by 90% in ten years. Ryan White plays a key role in delivering care to people with HIV in the initiative and seen as the agency lead for the initiative's "care pillar."
Total	**$2,494.8**	

Ryan White HIV/AIDS Program and Care Outcomes

While many clients have gained coverage under the ACA, Ryan White continues to play a critical role as a safety net provider for those who remain uninsured or underinsured, helping to fill the gaps for clients with insurance, including assisting with insurance affordability and access to support services. Importantly, Ryan White clients are significantly more likely to have sustained viral suppression (https://www.kff.org/hivaids/issue-brief/insurance-coverage-and-viral-suppression-among-people-with-hiv-2018/) compared to those without (68% v. 58%) and this pattern was observed across all coverage types (see Figure 3). Viral suppression (https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/whats-new-guidelines) affords optimal health outcomes at the individual level and, because when an individual is virally suppressed they cannot transmit HIV, significant public health benefit.

Figure 3

Ryan White Support and Sustained Viral Suppression Among Adults with HIV, by Insurance Coverage



NOTE: *Rate of viral suppression significantly different between those with coverage source & Ryan White vs. those with coverage source and no Ryan White, (p<.05). **Rate of viral suppression significantly different between those with coverage source & Ryan White vs. those with coverage source and no Ryan White, (p<.001). Sustained viral suppression is defined as having an undetectable viral load over all tests in the preceding 12 months.

SOURCE: KFF/CDC Analysis of Medical Monitoring Project data, 2018 • PNG

Key Issues

First enacted as an emergency measure, the Ryan White program has grown to become a central component of HIV care in the U.S., playing a critical role in the lives of many low and moderate-income people with HIV. Looking ahead, there are several key issues facing the program that will be important to monitor, including:

- **Future funding**. As a federal grant program, funding is dependent on annual appropriations by Congress, and funding levels do not necessarily correspond to actual need (i.e. the number of people seeking services or the costs of services). As a result, not all states and communities have been able to meet the needs of people in their jurisdictions.
- **The future of the EHE initiative**, including subsequent Congressional appropriations for EHE and program flexibilities afforded through this funding stream not possible in traditional program parts.
- **Possible future program reauthorization** could impact program structure and future financing.
- **Major changes to the health policy landscape,** including the continued evolution

around state Medicaid expansion decisions; the Biden administration's approach to and enforcement of the ACA's nondiscrimination protections; the impact of a recent court decision that may impact access to preventive services including PrEP (an HIV prevention medication) and HIV testing; among other changes could affect the ability of Ryan White to meet client need.

- **The challenge of emerging health threats, including COVID-19 and Monkeypox**. Emerging health threats pose a strain on the providers and systems that serve people with HIV, including the Ryan White Program. In addition, because people with HIV need access to ongoing care and treatment and may themselves face additional challenges that could affect their health and care, these other emergencies can have significant impacts on the HIV response. With two such threats having emerged in the last few years alone, Ryan White has been required to both respond to and recover from these events while simultaneously meeting the care and support needs of people with HIV.