

February 2017 | Fact Sheet

The Ryan White HIV/AIDS Program: The Basics

Key Facts

- The Ryan White HIV/AIDS Program, first enacted in 1990, is the largest federal program designed specifically for people with HIV, serving over half of all those diagnosed.¹
- Ryan White is the nation’s safety net for people with HIV providing outpatient HIV care and treatment to those without health insurance and filling in coverage gaps for those with insurance.
- Most Ryan White clients are low-income, male, people of color, and sexual minorities.
- The program is the third largest source of federal funding for HIV care in the U.S., following Medicare and Medicaid, funded at \$2.3 billion in FY 2016.² Funding is distributed to states/territories, cities, and HIV care and support organization in the form of grants.
- Under the Affordable Care Act (ACA), the Ryan White HIV/AIDS Program has remained a critical component of the nation’s response to HIV.

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 of those in the country diagnosed with the disease.³ First enacted in 1990, the Ryan White Program has played an increasingly critical 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.

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 can continue 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 at the Health Resources and Services Administration (HRSA) of the Department for Health and Human Services (DHHS), and programs and services are delivered by grantees at the state and local levels.

Clients

HRSA estimates that more than half a million people receive at least one medical, health, or related support service through the program each year; many clients receive multiple types of services. In 2015⁴:

- Nearly two-thirds (65%) of clients had incomes at or below the federal poverty level (FPL) (which in 2017 is \$11,880 for a single person or \$24,300 for a family of four); an additional 27% had incomes between 101% and 250% FPL.

- More than one-fifth (21%) of clients were uninsured. This is a decrease from 28% in 2013, prior to enactment of the major coverage provisions under the Affordable Care Act (ACA). However, most clients (79%) are insured – covered by Medicaid, Medicare, private insurance, and other sources - but face limits with their coverage or need help with costs.
- Reflecting the demographics of HIV in the U.S., clients are largely male (71%); between the ages 40 and 59 (55%); people of color (73%); and nearly half (48%) are gay or bisexual men.

Funding

The Ryan White Program is the third largest source of federal funding for HIV care in the U.S., after Medicare and Medicaid (see Figure 1).⁵ Federal funding for the program, which must be appropriated by Congress each year, began in FY 1991 and increased significantly in the mid-1990s, primarily after the introduction of highly active antiretroviral therapy (HAART).⁶ For many years thereafter, funding continued to increase, but at slower rates and has leveled out in recent years.⁷ The program’s federal FY 2016 funding was approximately \$2.3 billion.⁸

Federal Ryan White funding is provided to states and territories, cities, providers, community-based organizations (CBOs), and other institutions, in the form of grants. Most funding is provided to states or Part B grantees (57% in FY 2015), followed by cities or Part A grantees (29%), and the remainder directly to organizations (Part C, D, and F grantees).⁹ (See Table 1 for details on Parts and funding). Much of the funding provided to states and cities is, in turn, channeled to local providers. CBOs make up the largest single group of funded entities

serving clients (40% in 2013).¹⁰ In addition to federal funding, some states and localities provide other funding to their Ryan White programs (including through certain state matching requirements).

Structure

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 (see Table 1). 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 parameters. For instance, the 2006 reauthorization added new grantee requirements, including a requirement that 75% or more of funds be spent on “core medical services” under Parts A through C¹¹ and that all state AIDS Drug Assistance Programs (ADAPs) have a minimum formulary for medications.¹²

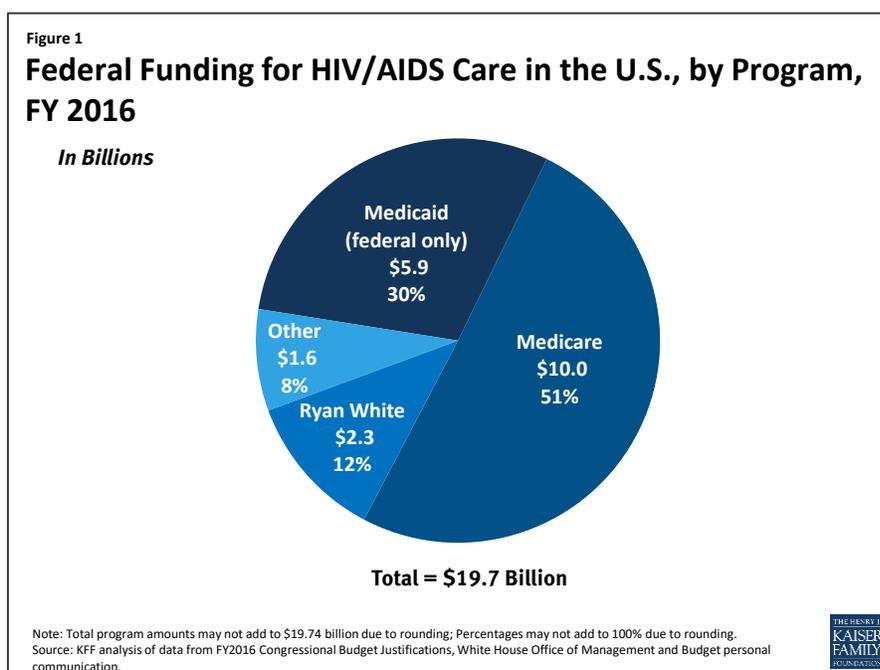


Table 1: Ryan White Program Parts and Funding¹³

Part	FY16 (Funding in Millions)	Part Description
Part A	\$655.9	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. <i>Number of Grantees: 24 EMAs; 28 TGAs.</i>
Part B	\$1,315.0	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: <ul style="list-style-type: none"> • 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. <i>Number of grantees: 50 States, D.C., and 8 Territories/Associated Jurisdictions.</i>
<i>ADAP (non-add)</i>	\$900.3	ADAP & ADAP Supplemental: Congress “earmarks” funds under Part B for ADAPs which provide medications and insurance coverage to people with HIV. ADAP supplemental grants are available to states with “severe need” (5% of earmark reserved for this purpose).
Part C	\$205.1	Funds public and private organizations directly for: <ul style="list-style-type: none"> • 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. <i>Number of grantees: 347.</i>
Part D	\$75.1	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. In recent years, the President’s budget has proposed to eliminate Part D and consolidate its funding with Part C, but this proposal has not been implemented by Congress. <i>Number of grantees: 115.</i>
Part F	\$33.6 (AETCs)/\$13.1 (Dental)	Includes the following components: <ul style="list-style-type: none"> • AIDS Education and Training Centers (AETCs): National and regional centers providing education and training for health care providers who treat people with HIV. <i>Number of grantees: 16.</i> • 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. <i>Number of grantees: 56 Reimbursement, 12 Community Partnership.</i> • 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 component of the MAI was codified in the 2006 reauthorization.^{14,15} • Special Projects of National Significance (SPNS): 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.
Total	2,322.8	

Ryan White HIV/AIDS Program & Affordable Care Act

Research has demonstrated that the Ryan White Program remains a critical component of the nation's response to HIV in the ACA era.¹⁶ The program continues to fill gaps for those with traditional insurance – such as private coverage, Medicare and Medicaid – by providing support services like case management, transportation, and nutritional support, which are critical to engaging people with HIV in care. In fact, recent Ryan White program data shows that client insurance coverage through Medicaid and private insurance increased in the ACA era while the rate of uninsurance declined.¹⁷ Additionally, its role in insurance purchasing assistance has become increasingly important under the ACA as thousands of clients gained insurance through the private market. The number of ADAP clients that received insurance purchasing assistance to help defray the cost of coverage increased by 1162% between 2002 and 2015.¹⁸ Finally, while thousands of people with HIV gained coverage under the ACA, many are still without coverage and, for them, the Ryan White HIV/AIDS Program will remain a critical safety net, providing life-saving care and treatment.

Key Issues

The Ryan White HIV/AIDS Program, first enacted as an emergency measure, has grown to become a central component of HIV care in the U.S., playing a critical role in the lives of low and moderate-income people with HIV who have little or no access through other sources. Looking ahead, there are several key issues facing the program:

- As a federal grant program, its funding depends on annual appropriations by Congress, and funding levels do not necessarily correspond to actual need including the number of people who need services or the costs of services. As a result, historically, not all states and communities have been able to meet the needs of their jurisdictions. For these reasons, monitoring appropriations allocations and any cuts enacted by Congress will be important going forward.
- It will be critical to assess how future reauthorization impact structure and financing of the program.
- If the ACA is repealed, or repealed and replaced – a policy option currently on the table – it will have significant implications for the health coverage of people with HIV, many of whom have gained coverage through the Medicaid expansion and the marketplaces, and for the Ryan White Program. In particular, it will be important to assess whether the program is able to meet the HIV care and treatment needs of those losing coverage in such an environment.

ENDNOTES

- ¹ Kaiser Family Foundation. *U.S. Federal Funding for HIV/AIDS: Trends Over Time*. June 2016. Available at: <http://kff.org/global-health-policy/fact-sheet/u-s-federal-funding-for-hivaids-trends-over-time/>.
- ² Kaiser Family Foundation. *U.S. Federal Funding for HIV/AIDS: Trends Over Time*. June 2016. Available at: <http://kff.org/global-health-policy/fact-sheet/u-s-federal-funding-for-hivaids-trends-over-time/>.
- ³ Department of Health and Human Service. Health Resources and Services Administration. Congressional Budget Justification Fy17. Available at: <https://www.hrsa.gov/about/budget/budgetjustification2017.pdf>.
- ⁴ All data in the below bullets from Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2015. December 2016. Available at: <https://hab.hrsa.gov/sites/default/files/hab/data/datareports/2015rwhapdatareport.pdf>
- ⁵ Kaiser Family Foundation. *U.S. Federal Funding for HIV/AIDS: Trends Over Time*. June 2016. Available at: <http://kff.org/global-health-policy/fact-sheet/u-s-federal-funding-for-hivaids-trends-over-time/>.
- ⁶ Personal communication with Office of Management and Budget. See also: Kaiser Family Foundation. *U.S. Federal Funding for HIV/AIDS: Trends Over Time*. June 2016. Available at: <http://kff.org/global-health-policy/fact-sheet/u-s-federal-funding-for-hivaids-trends-over-time/>.
- ⁷ KFF analysis of data provided by the Office of Management and Budget. See also: Kaiser Family Foundation. *U.S. Federal Funding for HIV/AIDS: Trends Over Time*. June 2016. Available at: <http://kff.org/global-health-policy/fact-sheet/u-s-federal-funding-for-hivaids-trends-over-time/>.
- ⁸ See also: Kaiser Family Foundation. *U.S. Federal Funding for HIV/AIDS: Trends Over Time*. June 2016. Available at: <http://kff.org/global-health-policy/fact-sheet/u-s-federal-funding-for-hivaids-trends-over-time/>.
- ⁹ Department of Health and Human Service. Health Resources and Services Administration. Congressional Budget Justification Fy17. Available at: <https://www.hrsa.gov/about/budget/budgetjustification2017.pdf>.
- ¹⁰ Health Resources and Services Administration. HIV/AIDS Bureau. Ryan White HIV/AIDS Program State. Available at: <https://hab.hrsa.gov/stateprofiles/>.
- ¹¹ Grantees may be able to get waivers from this requirement.
- ¹² Ryan White HIV/AIDS Treatment Modernization Act of 2006 (P.L. 109-415).
- ¹³ Funding data from: KFF analysis of data provided by the Office of Management and Budget. See also: Kaiser Family Foundation. *U.S. Federal Funding for HIV/AIDS: Trends Over Time*. June 2016. Available at: <http://kff.org/global-health-policy/fact-sheet/u-s-federal-funding-for-hivaids-trends-over-time/>. More information on Parts of the Ryan White Program can be found at CRS. *The Ryan White HIV/AIDS Program*; June 2011 and at <https://hab.hrsa.gov/about-ryan-white-hivaids-program/about-ryan-white-hivaids-program>.
- ¹⁴ Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87).
- ¹⁵ CRS. *The Ryan White HIV/AIDS Program*; June 2011.
- ¹⁶ Kaiser Family Foundation. *The ACA and People with HIV: An Update*. May 2016. Available at: <http://kff.org/health-reform/issue-brief/the-aca-and-people-with-hiv-an-update/>; Kaiser Family Foundation. *The Ryan White Program and Insurance Purchasing in the ACA Era: An Early Look at Five States*. April 2015. Available at: <http://kff.org/hivaids/issue-brief/the-ryan-white-program-and-insurance-purchasing-in-the-aca-era/>; Kaiser Family Foundation. *The ACA and People with HIV: Profiles from the Field*. June 2015. Available at: <http://kff.org/health-reform/issue-brief/the-aca-and-people-with-hiv-profiles-from-the-field/>; Kaiser Family Foundation. *Health Insurance Coverage for People with HIV Under the Affordable Care Act: Experiences in Five States*. December 2014. Available at: <http://kff.org/hivaids/issue-brief/health-insurance-coverage-for-people-with-hiv-under-the-affordable-care-act-experiences-in-five-states/>; Doshi, R., et al. "For Many Served By The Ryan White HIV/AIDS Program, Disparities In Viral Suppression Decreased, 2010–14." *Health Affairs*. January 2017. Vol. 36 No. 116-123.; Ryan White HIV/AIDS Program Annual Client-Level Data Report 2015. December 2016. Available at: <https://hab.hrsa.gov/sites/default/files/hab/data/datareports/2015rwhapdatareport.pdf>.
- ¹⁷ Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2015. December 2016. Available at: <https://hab.hrsa.gov/sites/default/files/hab/data/datareports/2015rwhapdatareport.pdf>
- ¹⁸ NASTAD. National ADAP Monitoring Project 2016 Annual Report. January 2016. Available at: <https://www.nastad.org/sites/default/files/2016-National-ADAP-Monitoring-Project-Annual-Report.pdf>.