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The Ryan White HIV/AIDS Program: Overview and Impact of the Affordable Care Act

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Summary

The Ryan White HIV/AIDS Program makes federal funds available to metropolitan areas and states to assist with health care costs and support services for individuals and families affected by the human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS). In 2012, the Ryan White Program served more than half a million low-income people with HIV/AIDS in the United States; 28% of those served were uninsured, and an additional 59% were underinsured.

The Ryan White Program is administered by the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services (HHS). Its statutory authority is Title XXVI of the Public Health Service (PHS) Act, originally enacted in 1990 and composed of four major parts and several other components. Part A provides grants to urban areas and mid-sized cities. Part B provides grants to states and territories; it also provides funds for the AIDS Drug Assistance Program (ADAP). Part C provides early intervention grants to public and private nonprofit entities. Part D provides grants to public and private nonprofit entities for family-centered care for women, infants, children, and youth with HIV/AIDS. The other components include the AIDS Dental Reimbursement (ADR) Program, the Community-Based Dental Partnership Program, the AIDS Education and Training Centers (AETCs), and the Minority AIDS Initiative (MAI). In October 2009, the 111th Congress passed and President Obama signed the Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87), which reauthorized the Ryan White Program through September 30, 2013. The program's authority is currently expired, but Congress continues to appropriate funds for the program.

The Patient Protection and Affordable Care Act of 2010 (ACA, P.L. 111-148, as amended) contains general provisions to increase access to health insurance; therefore, the ACA has the potential to increase coverage for people living with HIV/AIDS. For example, ACA includes prohibitions on the cancellation of coverage by an insurer due to a preexisting condition, elimination of lifetime caps on insurance benefits and annual limits on coverage, and eligibility for tax subsidies to help low- and middle-income individuals purchase coverage from a health insurance exchange. ACA phases out the Medicare Part D “doughnut hole” (i.e., payment gap) for HIV/AIDS individuals who are Medicare eligible, which should increase coverage of HIV/AIDS drugs. Finally, the ACA permits states to broaden Medicaid eligibility to include non-elderly adults. There could be a significant impact on Ryan White ADAP clients in states that expand their Medicaid program; specifically, about half of ADAP clients would be Medicaid-eligible in expansion states, and the remainder would likely be eligible for premium subsidies to purchase health coverage on the exchange.

The long-range impact of ACA on the Ryan White Program—in which health and treatment services provided under Ryan White are replaced by access to such services through health insurance coverage via ACA—remains to be determined. Prior to the ACA's implementation, many Ryan White patients were insured and used Ryan White funds to pay premiums and cost sharing, and this need for funds is likely to remain as some Ryan White patients transition to private insurance. In states that decide not to participate in the Medicaid expansion, the need for the full range of Ryan White services would remain. However, even if all states decide to cover the new Medicaid-eligible group, there will be gaps that the Ryan White Program could continue to fill, such as coverage of those individuals with HIV/AIDS who are undocumented immigrants, and training of health providers in HIV-related care. In addition, Ryan White provides dental care and support services, such as transportation, that may not be provided under Medicaid or private health insurance. The Ryan White Program serves a public health role by keeping people in treatment and thereby decreasing the risk of transmitting HIV to others.

For FY2016, the Obama Administration requested a total of \$2.323 billion for the Ryan White Program, an increase of \$4 million compared with FY2015; the increase would go to Part C. The FY2016 budget request proposed consolidating Part D funds into Part C; this consolidation was also proposed in the FY2015 budget request. The House appropriations bill (H.R. 3020, H.Rept. 114-195) would have provided \$2.318 billion for the Ryan White Program, the same amount as the FY2015-enacted level and without the consolidation of Parts C and D. The Senate appropriations bill (S. 1695, S.Rept. 114-74) would have provided \$2.294 billion for the Ryan White Program, \$25 million less than the FY2015-enacted level. The Senate also did not agree to the proposed consolidation of Parts C and D and did not provide \$25 million in funding for Special Projects of National Significance (SPNS). On December 17 and 18, 2015, the House and Senate passed the Consolidated Appropriations Act, 2016 (H.R. 2029, P.L. 114-113) which the President signed on December 18, 2014. The measure provides a total of \$2.323 billion for the Ryan White Program in FY2016, including the \$25 million for SPNS but did not agree to the consolidation of Parts C and D.

Contents

The Ryan White Program	2
Part A—Grants to Urban Areas	2
EMAs and TGAs.....	3
Core Medical Services vs. Support Services	4
Formula Grants, Supplemental Grants, and Number of Living HIV/AIDS Cases	5
Planning Councils	6
Unexpended Funds.....	6
Part B—Grants to States	6
Formula Grants and Number of Living HIV/AIDS Cases.....	7
Supplemental Grants.....	8
Emerging Community Grants	8
ADAP.....	8
Unexpended Funds.....	9
Part C—Early Intervention Services.....	10
Part D—Women, Infants, Children, and Youth.....	11
Part E and Part G.....	11
Part F—Demonstration and Training	12
The National HIV/AIDS Strategy	13
ACA and the Ryan White Program	14
Medicaid Expansion.....	15
Private Insurance Expansions	16
Other ACA Provisions.....	17
ACA and the Future of the Ryan White Program.....	18
Reauthorization of the Ryan White Program.....	19
Appropriations.....	19
FY2015.....	19
FY2016.....	19

Figures

Figure 1. Ryan White Funding, FY2016	2
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Tables

Table 1. Federal Funding for the Ryan White Program, FY1991-FY2016	21
Table A-1. Ryan White Program Overview	22

Appendixes

Appendix. Summary of Ryan White Program Parts.....	22
--	----

Contacts

Author Contact Information 24

The Ryan White HIV/AIDS Program makes federal funds available to metropolitan areas and states to that provide a number of health care services for HIV/AIDS patients, including medical care, drug treatments, dental care, home health care, and outpatient mental health and substance abuse treatment. In 2012, the program served more than half a million low-income people with HIV/AIDS in the United States. The Centers for Disease Control and Prevention (CDC) estimates that more than 1.2 million people have HIV/AIDS, but does not indicate the percentage of this population is low income.¹ Of the more than half million people served by the Ryan White Program, 28% were uninsured, and an additional 59% were underinsured.² In 2012, the Ryan White Program also reported that the program served about 60% of the persons diagnosed with HIV infection in the United States and retained 82.1% of them in care.³ Clinical research has demonstrated that treatment of HIV patients with anti-HIV (also called antiretroviral) medication reduces the amount of virus in the blood to very low levels (also called viral suppression), and lowers the risk of HIV transmission by 96%.⁴

The Ryan White Program was established in law in 1990 (P.L. 101-381) and reauthorized and amended in 1996 (P.L. 104-146), 2000 (P.L. 106-345), 2006 (P.L. 109-415), and 2009 (P.L. 111-87).⁵ It was enacted as Title XXVI of the Public Health Service (PHS) Act and codified as Parts A, B, C, D, E, F, and G under 42 U.S.C. §300ff-11 et seq. The program is administered by the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau. Most Ryan White funding is distributed to eligible entities based on formulas that take into account the number of people living with HIV/AIDS. Proposed FY2016 funding of \$2.3 billion is divided among the individual grant programs (Parts A, B, C, D, and F) as shown in **Figure 1**. At the end of this report, **Table 1** provides FY1991-FY2016 dollar amounts; the grant programs are summarized in the **Appendix**.

P.L. 111-87 provided specific authorization levels for Parts A, B, C, D, and F for each fiscal year through FY2013, resulting in a four-year reauthorization for the Ryan White Program. The program's authority is currently expired, but Congress continues to appropriate funds for the program. P.L. 111-87 required that the Secretary establish a national HIV/AIDS testing goal of 5 million tests annually through programs administered by HRSA and the CDC. The Secretary is required to submit an annual report to Congress on the progress made in achieving the testing goal, including any barriers to meeting the goal, the amount of funding necessary to meet the goal, and the most cost-effective strategies for identifying individuals who are unaware of their HIV status. The Secretary is also required to review each of the programs and activities conducted by CDC as part of the Domestic HIV/AIDS Prevention Activities. Other provisions of

¹ Centers for Disease Control and Prevention, HIV in the United States: At a Glance, <http://www.cdc.gov/hiv/statistics/overview/ataglance.html>.

² HRSA, *FY2016 Justification of Estimates for Appropriations Committees*, p. 278, <http://www.hrsa.gov/about/budget/budgetjustification2016.pdf>.

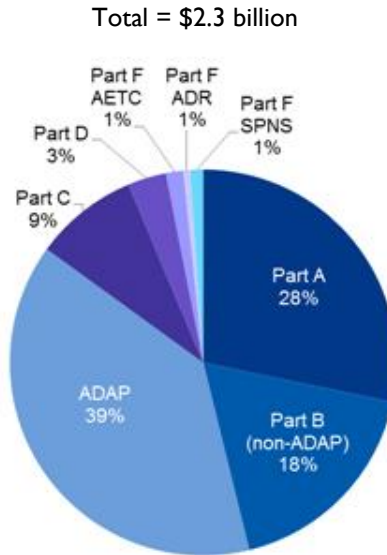
³ Ibid.

⁴ Myron S. Cohen, Ying Q. Chen, Marybeth McCauley, et al., "Prevention of HIV-1 infection with early antiretroviral therapy," *The New England Journal of Medicine*, vol. 365, no. 6 (August 11, 2011), pp. 493-505.

⁵ P.L. 109-415 had reauthorized the Ryan White Program through September 30, 2009. A provision in P.L. 109-415 (§703) would have repealed the Ryan White Program as of the start of FY2010. The FY2010 Continuing Appropriations Resolution (Division B of P.L. 111-68) extended authority for the Ryan White Program through October 31, 2009. Legislation that would reauthorize the Ryan White Program, H.R. 3792 (Pallone), the Ryan White HIV/AIDS Treatment Extension Act of 2009, was approved by the House Energy and Commerce on October 15, and a report was filed on October 20, 2009 (H.Rept. 111-305). The Ryan White HIV/AIDS Treatment Extension Act of 2009, S. 1793 (Harkin), passed the Senate by voice vote on October 19, 2009. The House passed S. 1793 on October 21, 2009, by a vote of 408-9. President Obama signed the legislation on October 30, 2009 (P.L. 111-87). P.L. 111-87 removed the sunset provision (§703 of P.L. 109-415).

P.L. 111-87 are discussed below in the sections of this report on the various parts of the Ryan White Program.

Figure I. Ryan White Funding, FY2016



Source: HRSA, FY2016 Justification of Estimates for Appropriations Committees, pp. 277-316.

Notes: ADAP= AIDS Drugs Assistance Program; ADR= AIDS Dental Reimbursement Program; AETC= AIDS Education and Training Centers; and SPNS= Special Projects of National Significance.

The Patient Protection and Affordable Care Act of 2010 (ACA, P.L. 111-148, as amended) contains general provisions to increase access to health insurance and is expected to increase coverage for people living with HIV/AIDS. These provisions include prohibitions on the cancellation of coverage by an insurer due to a preexisting condition, elimination of lifetime caps on insurance benefits and annual limits on coverage, and eligibility for tax subsidies to help low- and middle-income individuals purchase coverage from health insurance exchanges. In addition, states have the option to broaden Medicaid eligibility to include single adults. ACA phases out the Medicare Part D so-called “doughnut hole”—a gap in prescription drug coverage—for individuals who are Medicare-eligible, including individuals with HIV/AIDS.⁶

The long-range impact of the health care law on HRSA’s Ryan White Program (in which the health and treatment services provided under Ryan White are likely to be replaced to some extent by access to such services through health coverage via ACA) remains to be determined and may be of interest to policymakers given that authorization for the Ryan White Program has lapsed.

The Ryan White Program

Part A—Grants to Urban Areas

Part A provides funds for medical and support services in urban areas with high numbers of people living with HIV, as well as mid-sized cities that have emerging needs for assistance with

⁶ For description of the doughnut hole, see “Phase Out of the Coverage Gap” section in CRS Report R40611, *Medicare Part D Prescription Drug Benefit*.

their HIV-infected populations.⁷ The boundaries of the areas are based on the Metropolitan Statistical Areas of the U.S. Census Bureau and may range in size from a single city or county to multiple counties that cross state boundaries.

EMAs and TGAs

Part A provides funds to eligible metropolitan areas (EMAs) with a population of at least 50,000 that have had more than 2,000 reported AIDS cases in the prior five years. An EMA would stop being eligible if it failed for three consecutive years to have (1) a cumulative total of more than 2,000 reported cases of AIDS during the most recent five calendar years, and (2) a cumulative total of 3,000 or more *living* cases of AIDS as of December 31 of the most recent year.⁸ Part A currently provides grants to 24 EMAs.⁹

The 2006 reauthorization (P.L. 109-415) established a grant program for transitional grant areas (TGAs), defined as metropolitan areas with at least 1,000 but fewer than 2,000 cumulative AIDS cases during the most recent five calendar years.¹⁰ Unless a TGA became an EMA, it would continue to be eligible as a TGA until it failed for three years to have (1) at least 1,000 but fewer than 2,000 cumulative cases of AIDS during the most recent five calendar years, and (2) 1,500 or more living cases of AIDS as of December 31 of the most recent calendar year. P.L. 111-87 permits a metropolitan area with a cumulative total of at least 1,400 but less than 1,500 living cases of AIDS to continue to be eligible as a TGA, provided that not more than 5% of the TGA grant award is unobligated at the end of the most recent fiscal year.

Under P.L. 111-87, if a metropolitan area were to lose TGA eligibility, the state containing the TGA would receive 75% of the TGA formula grant in the first year after the loss of TGA eligibility, 50% in the second year, and 25% in the third year. The remainder in each year is made available for Part B grants, as is the entire amount of the former TGA's formula grant in the fourth year after the loss of eligibility. Part A currently provides grants to 28 TGAs.¹¹

⁷ For information about FY2015 grant awards, see U.S. Department of Health and Human Services, "HHS Awards \$2.2 billion in Grants for HIV/AIDS Care and Medication," October 21, 2015, at <http://www.hhs.gov/about/news/2015/10/21/hhs-awards-22-billion-grants-hiv-aids-care-and-medications.html>. The list of Part A grants awards is available at <http://hab.hrsa.gov/about/hab/partafy15awards.html>.

⁸ If an eligible metropolitan area (EMA) no longer qualified as an EMA for FY2007, it was treated as a transitional grant area (TGA), even if it would not otherwise qualify as a TGA. Under prior law, in FY2006 a total of 51 EMAs received funding. In FY2007 and FY2008, 22 EMAs received funding; in FY2009, 24 EMAs received funding. Nassau-Suffolk, NY, and New Haven, CT, regained EMA status due to the results of a lawsuit filed by Nassau-Suffolk against HHS. "County Executive Suozzi, Rep. Israel Declare Victory in Nassau-Suffolk Lawsuit to Save HIV/AIDS Funding," *US Fed News Service, including US State News*, April 28, 2008.

⁹ HRSA, *FY2016 Justification of Estimates for Appropriations Committees*, pp. 293-294, <http://www.hrsa.gov/about/budget/budgetjustification2016.pdf>.

¹⁰ A total of 29 areas that had been EMAs prior to the 2006 reauthorization received funding as TGAs starting in FY2007, and five metropolitan areas received funding as TGAs in FY2007 that were not previously eligible as an EMA: Indianapolis, IN; Baton Rouge, LA; Charlotte, NC; Memphis, TN; and Nashville, TN. For FY2007 and FY2008, a total of 34 TGAs received funding. For FY2009, 32 TGAs received funding; two former TGAs, New Haven, CT, and Nassau-Suffolk, NY, received an EMA grant rather than a TGA grant.

¹¹ In FY2014, Ponce, PR, was not eligible for a TGA grant; a one-time transfer of Part A funds was made to Part B. HRSA, *FY2016 Justification of Estimates for Appropriations Committees*, p. 294. In FY2013, Columbus, OH, began receiving a TGA grant. In FY2011, Caguas, PR; Dutchess County, NY; Vineland, NJ; and Santa Rosa, CA, did not receive TGA grants. Rather, Part A funds were awarded to Puerto Rico, New York, New Jersey, and California. HRSA, *FY2013 Justification of Estimates for Appropriations Committees*, pp. 249 and 252, <http://www.hrsa.gov/about/budget/budgetjustification2013.pdf>.

Core Medical Services vs. Support Services

For each Part A grant, 75% of the funds must be spent on core medical services, defined as

- outpatient and ambulatory health services,
- AIDS Drug Assistance Program (ADAP) treatments and pharmaceutical assistance,
- oral health care,
- early intervention services,
- health insurance premium and cost-sharing assistance,
- home health,
- medical nutrition therapy,
- hospice,
- home and community-based health services,
- mental health and substance abuse outpatient services, and
- medical case management.

The core services spending requirement may be waived if (1) there is no waiting list for receiving treatment (under the Part B ADAP program), and (2) core medical services were available to all individuals with HIV/AIDS who were eligible to receive such services under Part A. The remaining 25% of funds may be used for support services, such as outreach services, medical transportation, language services, respite care for persons caring for individuals with HIV/AIDS, and referrals for health care and support services.

Payments under Part A (and all other parts of the Ryan White Program) must be coordinated with other federal and nonfederal sources of funds.¹² In particular, HRSA must coordinate with Medicare and Medicaid and private health insurance because the Ryan White Program is considered to be the “payer of last resort,” meaning the program will pay only for services that cannot be provided using another funding source (see text box).

Payer of Last Resort

Ryan White Program grantees must seek payment from other sources before using Ryan White funds. The funds are intended to fill gaps in care not covered by other resources, such as Medicare, Medicaid, State Children’s Health Insurance Program (CHIP), and private insurance. Grantees must ensure that eligibility for other funding sources is consistently assessed and enrollment is vigorously pursued.

Source: Part A Manual and Part B Manual,
<http://hab.hrsa.gov/tools2/PartA/parta/ptAsec7chap5.htm>
<http://hab.hrsa.gov/manageyourgrant/files/habpartbmanual2013.pdf>.

¹² S.Rept. 106-294, which accompanied the Ryan White CARE Act Amendments of 2000 (P.L. 106-345), states “CARE Act funds should not be used to provide items or services for which payment has already been made or reasonably can be expected to be made by third-party payers, including Medicaid, Medicare, SCHIP, and or other State or local entitlement programs, prepaid health plans, or private insurance. Funds allocated by this Act shall be available to supplement services to patients who are Medicaid beneficiaries for services not covered by Medicaid. CARE Act grantees should ensure that eligible individuals are expeditiously enrolled in Medicaid and that CARE Act funds are not used to pay for any Medicaid- or SCHIP-covered services for Medicaid or SCHIP enrollees.”

Formula Grants, Supplemental Grants, and Number of Living HIV/AIDS Cases

Two-thirds of the Part A appropriation is distributed through formula grants, and the remaining one-third is distributed via competitive supplemental grants awarded on the basis of need.¹³ The awarding of supplemental Part A grants is based on weighting factors. Under P.L. 111-87, success in testing for HIV/AIDS and making individuals aware of their HIV status is counted as one-third in making such determinations.

CDC collects the statistics used in the Ryan White formula. In the past, some states reported their cases by name, while others used a code-based system to protect privacy.¹⁴ CDC initially indicated its preference for name-based reporting in 1999 in order to avoid double counting. In 2005, the agency recommended that all jurisdictions transition to name-based reporting.

In contrast to EMA and TGA eligibility definitions based on cumulative AIDS cases, grant award amounts are based on living HIV/AIDS cases. Prior to the 2006 reauthorization, formula grants had been distributed to EMAs in proportion to an estimate of the number of living AIDS cases in each EMA.¹⁵ P.L. 109-415 changed the funding distribution, basing it on the number of living HIV and AIDS cases in each EMA or TGA for states that use a name-based HIV reporting system. The requirement for name-based HIV reporting in P.L. 106-345 and P.L. 109-415 influenced states to change from code-based reporting to name-based reporting, although many states were reluctant to do so because of privacy concerns. P.L. 109-415 provided a transition period for states that did not have a fully mature name-based reporting system,¹⁶ and subsequently P.L. 111-87 provided a continuation of the transition period.¹⁷ Beginning with FY2013, only living name-based cases of HIV/AIDS are used in making Part A grant determinations.

¹³ P.L. 111-87 had a Part A hold-harmless provision (which expired in FY2014) that was intended to protect some grantees from large decreases in formula grants and was financed with Part A supplemental grant funds. GAO found that “although 17 EMAs received hold-harmless funding in FY2009, only 7 received more funding because of the hold-harmless provision than they would have received through supplemental grants in the absence of the hold-harmless provision.” GAO, Ryan White CARE Act: Effects of Certain Funding Provisions on Grant Awards, GAO-09-894, September 18, 2009, <http://www.gao.gov/new.items/d09894.pdf>.

¹⁴ Code-based reporting uses an alphanumeric code instead of a name.

¹⁵ The number of living AIDS cases was estimated from the number of reported AIDS cases over a 10-year period, with weighting factors to reflect that not all reported cases were still alive. Under the 2000 reauthorization (P.L. 106-345), statistics on HIV cases could have been used in the Ryan White grant formulas as early as FY2005 if the Secretary of HHS found that HIV incidence data were sufficiently accurate and reliable. In June 2004, the Secretary determined that HIV case reporting was incomplete and could not be used to distribute the grants.

¹⁶ The 2000 reauthorization, P.L. 106-345, did not contain a transition period for states that were moving from code-based to name-based HIV reporting as recommended by the CDC. P.L. 109-415 provided a three-year transition period for qualifying areas. For purposes of the Part A formula, states without a sufficiently accurate and reliable name-based reporting system had a reduction of 5% in the number of non-AIDS HIV cases reported for an eligible area to account for duplicate cases. P.L. 109-415 identified 33 states and two territories that had a sufficiently accurate and reliable name-based reporting system as of December 31, 2005.

¹⁷ Under P.L. 111-87, these jurisdictions incurred a 5% reduction in the number of non-AIDS HIV cases reported for the eligible area (to account for duplicate cases caused by code-based reporting) in making Part A grant determinations for fiscal years prior to FY2012 and a 6% reduction for FY2012. In addition, as was the case under P.L. 109-415, the amount of the formula grant in these areas may not exceed that of the preceding fiscal year by more than 5%. California, Washington DC, Illinois, Maryland, Massachusetts, Oregon, and Rhode Island did not have fully mature name-based HIV reporting systems, and GAO identified three territories that had not begun collecting name-based HIV case counts. GAO-09-894, p. 14. For the purpose of determining Part A grant amounts, P.L. 111-87 allowed for an increase of 3% in the number of living HIV/AIDS cases in an area for FY2010 through FY2012 if the area switched to name-based reporting in 2007 and had experienced a decrease in funding of more than 30% in FY2007 compared with FY2006.

Planning Councils

Part A grants are made to the chief elected official of the city or county in the EMA or TGA that administers the health agency providing services to the greatest number of persons with HIV. The official must establish an HIV Health Services Planning Council, which sets priorities for care delivery according to federal guidelines. Planning Councils are not mandatory for TGAs, unless the TGA was an EMA in FY2006. The council may not be directly involved in the administration of any Part A grant. Membership of the council must reflect the ethnic and racial makeup of the local HIV epidemic.

P.L. 111-87 required the Part A Planning Councils to develop a strategy for identifying individuals with HIV/AIDS who do not know their HIV status, making them aware of their status, and connecting them with health care and support services. Particular attention is given to “reducing barriers to routine testing and disparities in access and services among affected subpopulations and historically underserved communities.”¹⁸

Unexpended Funds

The 2006 reauthorization introduced restrictions on the use of unexpended funds. Starting in FY2007, if an eligible area did not obligate all *supplemental* grant funds within one year of receiving an award, the eligible area was required to return any unobligated funds. Similarly, starting in FY2007, if an eligible area did not obligate all *formula* grant funds within one year of receiving the award, the eligible area was required to return any unobligated funds. The eligible area may request a waiver of the cancellation of formula grant funds, explaining how the eligible area intends to spend the funds. If the waiver is approved, the eligible area has one additional year in which to spend the funds, called the *carryover year*. If the funds are not spent by the end of the carryover year, the eligible area is required to return the unexpended funds. Regardless of whether the waiver for carryover was granted, under the 2006 reauthorization, the eligible area’s formula grant funds would be reduced for the following year by an amount equal to the unobligated balance.

The 2009 reauthorization, however, stipulated that the amount of the reduction would not include any unobligated balance that was approved by HRSA for carryover, and the reduction in formula grant funds does not apply if the unobligated balance is 5% or less.¹⁹ Any returned grant funds are additional amounts available for Part A supplemental grants.

Part B—Grants to States

Part B provides grants to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and five jurisdictions in the Pacific.²⁰ Grant funds may be used for drug treatments, home and community-based health care, and support services or health insurance coverage for low-income persons. Congress sets aside about two-thirds of Part B funding for ADAP. The remaining one-third (non-ADAP) is used for Part B base grants and a supplemental grant program. ADAP provides drug treatments for individuals with HIV who cannot afford to

¹⁸ Sec. 6 of P.L. 111-87.

¹⁹ Under P.L. 109-415, the reduction in formula grant funds did not apply if the unobligated balance was 2% or less.

²⁰ For information about FY2015 grant awards, see U.S. Department of Health and Human Services, “HHS Awards \$2.2 billion in Grants for HIV/AIDS Care and Medication,” October 21, 2015, at <http://www.hhs.gov/about/news/2015/10/21/hhs-awards-22-billion-grants-hiv-aids-care-and-medications.html>. The list of Part B grants awards is available at <http://hab.hrsa.gov/about/partbfy15awards.html>.

pay for drugs and have limited or no coverage from private insurance, Medicaid, or Medicare Part D. ADAP funds also may be used to purchase health insurance for eligible clients or to pay for services that enhance access, adherence, and monitoring of drug treatments. As under Part A, 75% of Part B funds must be spent on core medical services, and 25% may be spent on support services (defined in “Core Medical Services vs. Support Services”).

P.L. 111-87 required that the Part B grant application provide a comprehensive plan for identifying individuals with HIV/AIDS who are unaware of their HIV/AIDS status and enabling those individuals access to medical treatment for HIV/AIDS. The comprehensive plan must include efforts to remove any legal barriers, including states laws and regulations, to routine testing.

Formula Grants and Number of Living HIV/AIDS Cases

Of the non-ADAP Part B funds, two-thirds is used for the Part B base awards, and one-third is reserved for a supplemental grant program (see “Supplemental Grants”). The Part B base award formula is based on three factors: (1) 75% of the award is based on the state’s proportion of the nation’s HIV/AIDS cases; (2) 20% is based on the state’s proportion of HIV/AIDS cases outside Part A-funded areas (EMAs and TGAs); and (3) 5% is based on the state’s proportion of HIV/AIDS cases in states with no Part A funding.²¹

Prior to the 2006 reauthorization, formula grants had been distributed to states in proportion to an estimate of the number of living AIDS cases in each state.²² Under P.L. 109-415, funding distribution is based on the number of living HIV and AIDS cases for states that use a name-based HIV reporting system. The requirement for name-based HIV reporting influenced states to change from code-based reporting to name-based reporting, however many states were reluctant to do so because of privacy concerns. P.L. 109-415 provided a transition period for states that did not have a fully mature name-based reporting system.²³ If the transition period was not extended, some grantees might not receive funding in proportion to their number of HIV/AIDS cases, “which is the intended basis of the formula grant.”²⁴ P.L. 111-87 provided a continuation of the

²¹ The formula attempts to correct a problem under a previous formula: specifically, states with EMAs received a larger amount of money, per case, than states without an EMA. GAO, *Ryan White CARE Act: Factors that Impact HIV and AIDS Funding and Client Coverage*, GAO-05-841T, June 2005, <http://www.gao.gov/new.items/d05841t.pdf>.

²² The number of living AIDS cases was estimated from the number of reported AIDS cases over a 10-year period, with weighting factors to reflect that not all reported cases were still alive. Under the 2000 reauthorization (P.L. 106-345), statistics on HIV cases would have been used in the Ryan White Program grant formulas as early as FY2005 if the Secretary of HHS found that HIV incidence data were sufficiently accurate and reliable. In June 2004, the Secretary determined that HIV case reporting was incomplete and could not be used to distribute the grants. Under P.L. 106-345, HIV case data would have been used for determining FY2007 grant amounts. However, P.L. 106-345 did not contain a transition period for states that were moving to name-based HIV reporting, as recommended by the CDC. P.L. 109-415 had a three-year transition period for qualifying areas.

²³ According to a 2009 GAO report, 47 of the 59 Part B grantees had HRSA use their name-based HIV case counts to determine FY2009 formula funding and the remaining 12 grantees had HRSA use code-based HIV case counts. Of the 12 grantees, 7 were collecting name-based HIV case counts as of December 31, 2007, and 5 were not. The seven grantees were California, Washington DC, Illinois, Maryland, Massachusetts, Oregon, and Rhode Island. All but Maryland could have had HRSA use their name-based HIV case counts to determine formula funding but instead had HRSA use their code-based counts. Maryland’s name-based HIV reporting system had not been determined to be operational and, therefore, did not have that option. The five grantees were Hawaii, Vermont, the Federated States of Micronesia, Palau, and the Republic of the Marshall Islands. Hawaii and Vermont transitioned to name-based reporting in 2008; the remaining three had not begun collecting name-based HIV case counts. GAO, *Ryan White CARE Act: Effects of Certain Funding Provisions on Grant Awards*, GAO-09-894, September 18, 2009, <http://www.gao.gov/new.items/d09894.pdf>.

²⁴ *Ibid.*, p. 16.

transition period.²⁵ Beginning with FY2013, only living name-based cases of HIV/AIDS are used in making Part B grant determinations.

Supplemental Grants

One-third of the non-ADAP Part B appropriation is reserved for a supplemental grant program.²⁶ Eligible states must have a demonstrated need for supplemental financial assistance and no cancelled grant funds or waivers permitting carryover of funds (see “Unexpended Funds”). Priority in making supplemental grants is given to states with a decline in funding under Part B due to the changes in the distribution formula. Supplemental grant funds must be used for core medical services. Not later than 45 days after awarding supplemental funds under Part B, HRSA must submit a report to Congress concerning such funds.

Emerging Community Grants

An “emerging community” is defined as a metropolitan area with cumulative total of at least 500 and fewer than 1,000 reported cases of AIDS during the most recent five calendar years.²⁷ The metropolitan area continues as an emerging community until it fails for three consecutive fiscal years (1) to have the required number of AIDS cases and (2) to have a cumulative total of 750 or more living cases of AIDS as of December 31 of the most recent calendar year. The grant amount is determined by the amount set aside by the Secretary (authorized at \$5 million) and by the proportion of the total number of living cases of HIV/AIDS in emerging communities in the state to the total number of living cases of HIV/AIDS in emerging communities nationwide.

ADAP

In 2012, about 60% of HIV-positive people in care in the United States received their medications through state ADAPs.²⁸ ADAP funds are distributed via a formula based on each state’s proportion of living HIV and AIDS cases.²⁹ P.L. 111-87 provided a continuation of the transition period for states that did not have a fully mature name-based HIV reporting system.³⁰ Beginning with FY2013, only living name-based cases of HIV/AIDS are used in making ADAP grant determinations.

²⁵ Under P.L. 111-87, these jurisdictions incurred a 5% reduction in the number of non-AIDS HIV cases reported for the eligible area (to account for duplicate cases caused by code-based reporting) in making Part B grant determinations for fiscal years prior to FY2012 and a 6% reduction for FY2012. For the purpose of determining Part B grant amounts, P.L. 111-87 would allow an increase of 3% in the number of living HIV/AIDS cases in an area for FY2010 through FY2012 if the area switched to name-based reporting in 2007 and had experienced a decrease in funding of more than 30% in FY2007 compared with FY2006.

²⁶ P.L. 111-87 contained a hold-harmless provision for Part B that protected grantees from large decreases in funding. The hold-harmless provision was funded by reducing the amount reserved for the Part B supplemental grant program and by any unobligated funds repaid by the states. The hold harmless provision expired in FY2014.

²⁷ PHS Act, Sec. 2621(d).

²⁸ HRSA, *FY2016 Justification of Estimates for Appropriations Committees*, p. 282, <http://www.hrsa.gov/about/budget/budgetjustification2016.pdf>.

²⁹ ADAP operates in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, and the Republic of Palau.

³⁰ Under P.L. 111-87, these jurisdictions incurred a 5% reduction in the number of non-AIDS HIV cases reported for the eligible area (to account for duplicate cases caused by code-based reporting) in making ADAP grant determinations for fiscal years prior to FY2012 and a 6% reduction for FY2012.

Five percent of the ADAP appropriation is set aside for ADAP supplemental grants.³¹ States are eligible for these grants if they demonstrate a severe need to increase the availability of HIV/AIDS drugs. There is a state-match requirement (\$1 state for every \$4 federal) for ADAP supplemental grants that may be waived under certain circumstances. The 2006 reauthorization established a formulary, a list of HIV/AIDS therapeutics that all ADAPs must provide. The list is based on the clinical practice guidelines for use of HIV/AIDS drugs issued by HHS.³²

According to a May 2015 report produced by the National Alliance of State and Territorial AIDS Directors (NASTAD), in FY2014 federal funds provided 43% of the national ADAP budget, state contributions provided 11%, and drug rebates provided another 43%.³³ In the past, many states had to implement cost containment measures—such as waiting lists, lowered income eligibility criteria, reduced formulary, capped enrollment, monthly or annual expenditure cap, client cost sharing—because of insufficient ADAP funds. The George W. Bush Administration and Barack Obama Administration provided supplemental ADAP grants to help alleviate this problem.³⁴

ADAP is the payer of last resort for HIV/AIDS drugs. As such, it coordinates with other programs available to pay for HIV/AIDS drugs and helps people enroll in other programs (including private insurance) that could be used to pay for HIV/AIDS drugs. In particular, the ADAP programs coordinate with state Medicaid programs and seek to enroll people in Medicaid when eligible. It also retroactively bills Medicaid for services provided to people who obtain Medicaid eligibility retroactively.³⁵

Unexpended Funds

Starting in FY2007, states were required to obligate grant funds by the end of the grant year for Part B formula grants, supplemental grants, emerging communities grants, ADAP grants, and supplemental ADAP grants. For supplemental ADAP grants, supplemental grants, and emerging communities grants, if there is an unobligated balance at the end of the grant year, states must return the amount and the funds will be used for additional supplemental grants.

³¹ Like Part A and Part B formula grants, ADAP formula grants also had a hold-harmless provision, which expired in FY2014. Its purpose was to protect some grantees from large decreases in formula grants, and it was financed with ADAP supplemental grant funds.

³² Guidelines are available at <http://aidsinfo.nih.gov/Guidelines/Default.aspx?MenuItem=Guidelines>.

³³ The remaining 3% consisted of other state or federal funds. NASTAD, National ADAP Monitoring Project, 2015 Annual Report, May 2015, p. 22, at <http://www.nastad.org>. As covered entities under the Public Health Service Act (PHSA) Sec. 340B Drug Pricing Program, ADAPs qualify for rebates on drug purchases made on behalf of their patients. For more information on the PHSA Sec. 340B program, see <http://www.hrsa.gov/opa/eligibilityandregistration/ryanwhite/index.html>.

³⁴ On September 18, 2007, the George W. Bush Administration announced supplemental ADAP grants totaling \$39.5 million to 14 states (Alabama, Alaska, Georgia, Indiana, Iowa, Montana, North Carolina, Oklahoma, Oregon, South Carolina, Texas, Utah, Virginia, and Wisconsin), the Virgin Islands, and Puerto Rico. On June 23, 2004, the George W. Bush Administration announced what it described as a one-time \$20 million initiative for 10 states with ADAP waiting lists (Alabama, Alaska, Colorado, Idaho, Iowa, Kentucky, Montana, North Carolina, South Dakota, and West Virginia). In July 2010, HHS Secretary Kathleen Sebelius announced the reallocation of \$25 million in funds from dozens of programs throughout HHS for ADAP. The additional funds were targeted for states with ADAP waiting lists or other cost containment strategies. On July 19, 2012, HHS Secretary Kathleen Sebelius announced that \$69 million would be sent to 23 states (Alabama, Alaska, Arizona, California, Colorado, Florida, Georgia, Idaho, Illinois, Iowa, Kentucky, Louisiana, Montana, Nebraska, New Jersey, North Carolina, North Dakota, South Dakota, Tennessee, Utah, Virginia, Washington, and Wisconsin) Puerto Rico and the Virgin Islands through Ryan White ADAP to eliminate waiting lists.

³⁵ Letter from Cindy Mann, Director, Center for Medicaid and CHIP Services, and Mary Wakefield, Administration, Health Resources and Services Administration, “Coordination Between Medicaid and Ryan White HIV/AIDS Programs,” May 1, 2013, <http://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-01-2013.pdf>.

For Part B formula grants and ADAP grants, if there is an unobligated balance, states must either return the unexpended funds or apply for a waiver to use the funds in the next year. If the waiver is approved, the funds would be available for one more year, called the carryover year. If a state fails to use the funds in the carryover year, the state must return the funds, which will be used for supplemental grants.

For states with an unobligated balance for their Part B formula grant or an ADAP grant, the amount of the grant for the next year would be reduced by the amount of the unobligated balance. The 2009 reauthorization allowed that the amount of the reduction would not include any unobligated balance that was approved by HRSA for carryover; if the amount of the unobligated balance was 5% or less, the grant reduction would not apply.³⁶ The funds from grant reduction are used for supplemental grants.

Drug rebates are received by Part B grantees from pharmaceutical manufacturers following the purchase of drugs for the ADAP program. There is a federal requirement that drug rebate funds be spent before federal funds are obligated. Because states may receive the rebates late in the year, some states may incur an unobligated balance penalty. In September 2009 GAO reported that both grantees and HRSA found that the requirement to spend drug rebate funds before obligating federal funds makes it more difficult to avoid unobligated balances.³⁷ According to GAO, HRSA tried to address this problem by asking HHS for an exemption from the relevant regulations for grantees using drug rebates, but the request was denied.³⁸ Under P.L. 111-87, if an expenditure of ADAP rebate funds triggered a penalty, the Secretary may deem a state's unobligated balance to be reduced by the amount of the rebate. Any unobligated amount returned to the Secretary would be used for ADAP supplemental grants or Part B supplemental grants.

Part C—Early Intervention Services

Part C grants provide medical services to uninsured people living with HIV/AIDS in rural and frontier communities.³⁹ Part C “provides grants directly to community and faith based primary health clinics and public health providers in 49 states, Puerto Rico, the District of Columbia and the U.S. Virgin Islands.”⁴⁰ Under current law, 75% of a Part C grant must be used for core medical services, and not less than 50% of a grant must be used for early intervention services. Part C grants are awarded to facilities that focus on underserved populations, including federally qualified health centers, family planning clinics, hemophilia centers, rural health clinics, Indian Health Service facilities, and certain health facilities and community-based organizations that

³⁶ Under P.L. 109-415, the reduction in formula grant funds did not apply if the unobligated balance was 2% or less.

³⁷ GAO, *Ryan White CARE Act: Effects of Certain Funding Provisions on Grant Awards*, GAO-09-894, September 18, 2009, p. 24, <http://www.gao.gov/new.items/d09894.pdf>. GAO found that nine states and seven territories received reduced Part B grant amounts in the 2009 grant year because they had unobligated balances over 2% in the 2007 grant year. “Part B base funding penalties ranged from \$6,433 in Palau to \$1,493,935 in Ohio. ADAP base funding penalties ranged from \$26,233 in Maine to \$12,670,248 in Pennsylvania.” Almost half of the grantees interviewed by GAO said the 2% threshold was too low, and some suggested that 5% would be more reasonable. However, GAO noted that “only 2 of the 16 Part B grantees that received penalties for unobligated balances had unobligated balances of less than 5%.”

³⁸ *Ibid.*, pp. 30-31.

³⁹ The FY2015 grant awards for Part C were announced on October 21, 2015; the grant award announcement is available at <http://www.hhs.gov/about/news/2015/10/21/hhs-awards-22-billion-grants-hiv-aids-care-and-medications.html>. The list of Part C Early Intervention Services (EIS) grants awards is available at <http://hab.hrsa.gov/about/hab/partceisyf15awards.html>. The list of Part C Capacity Development grant awards is available at <http://hab.hrsa.gov/about/hab/partccapacityf15awards.html>.

⁴⁰ HRSA, *FY2016 Justification of Estimates for Appropriations Committees*, p. 303, <http://www.hrsa.gov/about/budget/budgetjustification2016.pdf>.

provide early intervention services to people infected with HIV/AIDS through intravenous drug use. Part C services include counseling, HIV testing, referrals, clinical and diagnostic services regarding HIV/AIDS, and drug treatments under ADAP. A small portion of Part C funds are used for capacity development grants.

Part D—Women, Infants, Children, and Youth

Part D provides grants to public and nonprofit entities for family-centered care for women, infants, children, and youth with HIV/AIDS.⁴¹ Such individuals are provided outpatient health care, case management, referrals, and other services to enable participation in the program, including services designed to recruit and retain youth with HIV. Grantees must coordinate with programs promoting the reduction and elimination of risk of HIV/AIDS for youth. P.L. 111-87 clarified that Part D should be the payer of last resort when Part D clients have access to other forms of health care coverage, such as Medicaid and the Children’s Health Insurance Program. The FY2015 and FY2016 Obama Administration budget requests proposed consolidating Part D with Part C in order to “expand the focus on women, infants, children and youth across all the funded grantees, increase points of access for these populations and reduce duplication of effort and reporting/administrative burden among co-funded grantees.”⁴² The House and the Senate rejected the consolidation proposal in FY2015 and in FY2016.

Part E and Part G

In the past, Part E authorized grants for emergency response employees and established procedures for notifications of infectious diseases exposure; Part E was never funded. The 2006 reauthorization (P.L. 109-415) deleted the sections of Part E on emergency response and inserted into Part E several sections, with some text changes, from Part D (on coordination, audits, definitions, and a prohibition on promotion of intravenous drug use or sexual activity) and two new sections on public health emergencies and certain privacy protections.

P.L. 109-415 inadvertently deleted language on “procedures for the notification of occupational infectious diseases exposure” from Part E of Ryan White. This was a matter of some concern for the emergency response community, and reinstatement of the relevant language was requested.⁴³ P.L. 111-87 reinserted the deleted language on “procedures for the notification of occupational infectious diseases exposure” into a new Part G of Title XXVI of the PHS Act, including a change from the original language that would permit the Secretary to suspend the requirements in a public health emergency.

⁴¹ The FY2015 grant awards for Part D were announced on October 21, 2015; the grant award announcement is available at <http://www.hhs.gov/about/news/2015/10/21/hhs-awards-22-billion-grants-hiv-aids-care-and-medications.html>. The list of Part D grants awards is available at <http://hab.hrsa.gov/about/hab/partdfy15awards.html>.

⁴² HRSA, *FY2016 Justification of Estimates for Appropriations Committees*, p. 308.

⁴³ Katherine West, “Ryan White Notification Law for Emergency Response Employees Deleted: 10 Reasons Why We Need it Back,” *EMS Magazine*, October 2008, at [http://www.emsresponder.com/print/EMS-Magazine/Ryan-White-Notification-Law-for-Emergency-Response-Employees-Deleted—10-Reasons-Why-We-Need-It-Back/1\\$8394](http://www.emsresponder.com/print/EMS-Magazine/Ryan-White-Notification-Law-for-Emergency-Response-Employees-Deleted—10-Reasons-Why-We-Need-It-Back/1$8394); James R. Cross, JD, “Ryan White Notification Law Repealed: The Deletion of Emergency Response Provisions Demands Attention,” *Journal of Emergency Medical Services*, March 2008, pp. 136-137; and National Association of State EMS Officials, “NASEMSO Issue Brief on the Repeal of Emergency-Response Provisions Contained in the Ryan White CARE Act,” March 2008, at <http://www.nasemsd.org/Advocacy/PositionsResolutions/documents/RyanWhiteIssueBrief032508.pdf>.

Part F—Demonstration and Training

Part F provides support for the AIDS Dental Reimbursement (ADR) Program, the Community-Based Dental Partnership Program, the AIDS Education and Training Centers (AETCs), the Special Projects of National Significance (SPNS) Program, and the Minority AIDS Initiative (MAI).⁴⁴ The two dental programs reimburse dental schools and community-based entities for their treatment of HIV/AIDS patients.⁴⁵ The AETC program provides specialized clinical education and consultation for health providers on HIV transmission, treatment, and prevention.⁴⁶

The SPNS program awards grants to support the development of innovative models of HIV treatment.⁴⁷ Under statute, the SPNS program is to be funded, up to \$25 million, from amounts appropriated for Parts A, B, C, and D; this was not changed by reauthorization. However, from FY2003 through FY2014, each Labor-HHS appropriations bill provided \$25 million for the SPNS program via a funding mechanism known as the “PHS evaluation tap.”⁴⁸ The FY2015 appropriation, FY2016 request, and FY2016 House appropriation bill include funding for SPNS directly via budget authority rather than through the PHS evaluation tap. The Senate did not propose funding for SPNS in FY2016.⁴⁹ The Continuing Appropriations Act, 2016 (P.L. 114-53, H.R. 719), provides funding for the Ryan White Program, through December 11, 2015, at the same level as in the FY2015 Consolidated and Further Continuing Appropriations Act (P.L. 113-235), minus an across-the-board reduction of 0.2108%. Ryan White FY2016 funding provided by P.L. 114-53 is subject to the same authority and conditions as in FY2015.

P.L. 109-415 codified MAI as part of the Ryan White Program under Part F of Title XXVI of the PHS Act.⁵⁰ Under P.L. 109-415, MAI provided funding for competitive grants (via Parts A, B, C, D, and F-AETC) that evaluate and address the disproportionate impact of HIV/AIDS on racial and ethnic minorities. P.L. 111-87 directed HRSA to develop a formula for awarding MAI grants under Part A and Part B “that ensures that funding is provided based on the distribution of populations disproportionately impacted by HIV/AIDS.”⁵¹ The law directed HRSA to

⁴⁴ Both the dental and the AETC programs were transferred legislatively from Title VII of the PHS Act.

⁴⁵ The FY2015 grant awards for Part F were announced on October 21, 2015; the grant award announcement is available at <http://www.hhs.gov/about/news/2015/10/21/hhs-awards-22-billion-grants-hiv-aids-care-and-medications.html>. The list of Part F Dental Reimbursement Program and Community-Based Dental Partnership Program grants awards is available at <http://hab.hrsa.gov/about/partffy15awards.html>.

⁴⁶ The FY2015 grant awards for Part F were announced on October 21, 2015; the grant award announcement is available at <http://www.hhs.gov/about/news/2015/10/21/hhs-awards-22-billion-grants-hiv-aids-care-and-medications.html>. The list of Part F AETC grant awards is available at <http://hab.hrsa.gov/about/aetcfy15awards.html>.

⁴⁷ For a list of current SPNS initiatives, see <http://hab.hrsa.gov/about/partfspns.html>.

⁴⁸ The tap, authorized under §241 of the PHS Act, transfers money among PHS agencies for particular activities as specified by the appropriators. For further information, see CRS Report R43304, *Public Health Service Agencies: Overview and Funding (FY2010-FY2016)*.

⁴⁹ S.Rept. 114-74, pp. 50-51, and 228-229.

⁵⁰ The MAI began in 1998 with the White House announcement of a series of initiatives targeting appropriated funds for HIV/AIDS prevention and treatment programs in minority communities. The Congressional Black Caucus worked with the Clinton Administration to formulate the approach. MAI activities are supported by the following agencies and offices in HHS: HRSA; CDC; National Institutes of Health; Substance Abuse and Mental Health Services Administration; Minority Communities Fund; Office of Minority Health; and Office of Women’s Health. GAO was required by P.L. 109-415 to provide a report on a variety of issues related to MAI: U.S. Government Accountability Office, *Ryan White CARE Act: Implementation of the New Minority AIDS Initiative Provisions*, GAO-09-315, March 27, 2009, <http://www.gao.gov/new.items/d09315.pdf>.

⁵¹ Previously under P.L. 109-415, a competitive grant system was used to award Part A and Part B MAI grants.

synchronize the schedule of application submissions and funding of MAI grants with the schedule of the corresponding Ryan White part.

P.L. 111-87 required GAO to provide a report for Congress within one year of enactment that describes MAI activities across HHS. The GAO report found that MAI grantees were providing mostly support services similar to the support services (community outreach and education, staff/provider training) the grantees provided with core HIV/AIDS funding from HRSA.⁵² GAO found that the multiple funding streams “carried separate administrative requirements that caused administrative challenges” for the grantees.⁵³ The use of multiple funding streams “raises the possibility of inefficiencies and requires unnecessarily duplicative application and reporting requirements of grantees that could otherwise be using their resources to provide needed services.”⁵⁴ GAO recommended that MAI funding should be consolidated into core HIV/AIDS funding, and HHS stated that this would “align with the National HIV/AIDS Strategy and federal program accountability goals.”⁵⁵ P.L. 111-87 also required, within six months of publication of the GAO report, that HHS submit to Congress a departmental plan for using MAI funds, taking into consideration the best practices described in the GAO report.⁵⁶

The National HIV/AIDS Strategy

The National HIV/AIDS Strategy (NHAS) is a five-year plan detailing the “principles, priorities, and actions” to guide the “collective national response to the HIV epidemic.”⁵⁷ The NHAS was first released in July 2010 and updated in July 2015.⁵⁸ The current NHAS goals are as follows:

1. Reduce new infections.
2. Increase access to care and improve health outcomes for people living with HIV.
3. Reduce HIV-related health disparities and health inequities.
4. Achieve a more coordinated national response to the HIV epidemic.

The NHAS cites the Ryan White Program as a critical source of lifesaving care and treatment for individuals living with HIV. Moreover, providing such treatment “not only improves the health outcomes for individuals with HIV, it serves the public health benefit of helping to prevent HIV transmission.”⁵⁹ Clinical research has demonstrated that early treatment of HIV patients with antiretroviral medication results in viral suppression and reduces the risk of HIV transmission by 96%.⁶⁰ However, CDC data indicate that in 2012, only 30% of people living with HIV were virally suppressed.⁶¹ According to HRSA, the Ryan White Program grant awards, by supporting

⁵² U.S. Government Accountability Office, *Minority AIDS Initiative: Consolidation of Fragmented HIV/AIDS Funding Could Reduce Administrative Challenges*, GAO-14-84, November 22, 2013, p. 12, <http://www.gao.gov/assets/660/659216.pdf>.

⁵³ Ibid.

⁵⁴ Ibid., p. 23.

⁵⁵ Ibid., pp. 23-24.

⁵⁶ HHS states that this report is in the HHS clearance process.

⁵⁷ <https://www.aids.gov/federal-resources/national-hiv-aids-strategy/overview/>.

⁵⁸ <https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf>.

⁵⁹ The White House, “Fact Sheet: The National HIV/AIDS Strategy Updated to 2020,” press release, July 30, 2015, <https://www.whitehouse.gov/the-press-office/2015/07/30/fact-sheet-national-hiv-aids-strategy-updated-2020>.

⁶⁰ Myron S. Cohen, Ying Q. Chen, Marybeth McCauley, et al., “Prevention of HIV-1 infection with early antiretroviral therapy,” *The New England Journal of Medicine*, vol. 365, no. 6 (August 11, 2011), pp. 493-505.

⁶¹ CDC, “Monitoring selected national HIV prevention and care objectives by using HIV surveillance data – United (continued...)”

cities, states, and communities in the treatment of HIV patients, will allow the goals of the updated NHAS to be achieved.⁶²

ACA and the Ryan White Program

Prior to the implementation of the ACA (P.L. 111-148, as amended), obtaining private health insurance was difficult for individuals with HIV/AIDS and others living with serious preexisting medical conditions.⁶³ A 2011 Institute of Medicine (IOM) report estimated that in urban areas, only about 13% of HIV patients in 2010 had private health insurance; most HIV patients were covered by Medicaid (36%), Medicare (12%), or a combination of these two programs (6%).⁶⁴ The remaining individuals were either uninsured and obtained services through the Ryan White Program (24%), or their insurance coverage information was missing or unknown (8%).⁶⁵ In 2012, the Ryan White Program served more than a half million low-income individuals with HIV/AIDS in the United States, of whom 28% were uninsured and 59% were underinsured.⁶⁶ The CDC estimates that more than 1.2 million people have HIV/AIDS, but does not indicate the percentage of this population that is low income.⁶⁷ Among those who were underinsured, Ryan White Program funds were used to supplement insurance gaps.⁶⁸

The ACA expanded insurance coverage through a number of different provisions. Specifically, it expanded public coverage for low-income individuals through the Medicaid program.⁶⁹ It also made a number of changes to the private insurance market, created a standardized marketplace for individuals to purchase insurance coverage and premium subsidies for individuals whose incomes were too high for Medicaid, but were otherwise unable to afford private insurance coverage.⁷⁰

(...continued)

States and 6 dependent areas – 2013,” *HIV Surveillance Supplemental Report*, vol. 20, no. 2 (July 2015), <http://www.cdc.gov/hiv/library/reports/surveillance/>.

⁶² HRSA, “HHS awards \$2.2 billion in grants for HIV/AIDS care and medications,” press release, October 21, 2015, <http://www.hhs.gov/about/news/2015/10/21/hhs-awards-22-billion-grants-hiv-aids-care-and-medications.html>.

⁶³ Jeffrey S. Crowley and Connie Garner, *Reimagining the Ryan White HIV/AIDS Program: Aligning The Ryan White HIV/AIDS Program with Insurance Coverage*, O’Neill Institute for National & Global Health Law, Issue Brief no. 1, Washington, DC, June 2015, <https://www.law.georgetown.edu/oneillinstitute/research/documents/AligningwithInsurance1.pdf>.

⁶⁴ According to the IOM report, “there are no recent national estimates of health coverage of individuals with HIV. The HIV Cost and Service Utilization Study (HCSUS), for example, the only nationally representative study of people with HIV/AIDS in care, was conducted from 1994 to 2000. A more recent analysis of data from a convenience sample involving 12 medical sites located in urban cities throughout the United States showed that the majority of patients were covered under Medicaid (42%, including those dually eligible for Medicare) and the Ryan White Program (24%). These data likely do not represent the national picture of health coverage of individuals with HIV, however, such as those in non-urban areas.” IOM (Institute of Medicine), 2011, *HIV Screening and Access to Care: Exploring the Impact of Policies on Access to and Provision of HIV Care*, Washington, DC: The National Academies Press, pp. 7-8.

⁶⁵ Ibid.

⁶⁶ HRSA, FY2016 Justification of Estimates for Appropriations Committees, p. 278.

⁶⁷ Centers for Disease Control and Prevention, HIV in the United States: At a Glance, <http://www.cdc.gov/hiv/statistics/overview/ataglance.html>.

⁶⁸ Jennifer Kates et al., *Health Insurance Coverage for People with HIV Under the Affordable Care Act Experiences in Five States*, The Kaiser Family Foundation, Issue Brief, Washington, DC, December 2014.

⁶⁹ Medicaid is a federal-state matching entitlement program; the federal portion currently varies from 50% in relatively affluent states to almost 80% in less affluent states.

⁷⁰ CRS Report R42069, *Private Health Insurance Market Reforms in the Affordable Care Act (ACA)*.

The ACA may affect the need for, and use of, certain services provided by the Ryan White Program. For example, about half of ADAP clients would be Medicaid-eligible in expansion states, and the remainder would likely be eligible for premium subsidies to purchase health coverage on the exchange.⁷¹ This section describes the ACA changes that are relevant to the Ryan White Program and its service population. The section also highlights some of the services provided under the Ryan White Program that are not covered by the ACA.

Medicaid Expansion

Beginning January 2014, states have the option to expand Medicaid coverage for adults under the age of 65 with incomes up to 133% of the federal poverty level (FPL).⁷² This expansion, where implemented, is a significant change for the Medicaid program, which generally requires individuals to belong to a categorically eligible group: children, pregnant women, parents of dependent children, the elderly, or the disabled.⁷³ Some states elected to implement the Medicaid expansion prior to January 2014; these states include California, Colorado, Connecticut, District of Columbia, Minnesota, New Jersey, and Washington State.⁷⁴ As of November 2015, more than half of all states (including the District of Columbia) have adopted the Medicaid expansion.⁷⁵

The Medicaid expansion may have a significant impact on the Ryan White ADAP program. NASTAD indicates that about half of ADAP clients would be Medicaid-eligible in expansion states.⁷⁶ HRSA is examining the effects of Medicaid expansion on the ADAP program. So far, HRSA has found that Medicaid expansion states reduced their number of ADAP clients; in contrast, non-expansion states saw an increase in ADAP clients.⁷⁷ In expansion states ADAP funds may still be used to supplement Medicaid coverage. For example, ADAP funds can be used to assist people with Medicaid cost sharing and to pay for monthly prescriptions because some states limit the number of monthly prescriptions its Medicaid program will pay for.

HRSA predicts that the Medicaid expansion will have minimal effects on the non-ADAP parts of the Ryan White Program, primarily because data show that, prior to the ACA, Medicaid beneficiaries accessed Ryan White primary medical care services.⁷⁸ HRSA predicts that the use of these services by Medicaid beneficiaries will continue. HRSA also found that most non-ADAP clients are insured (either publicly or privately).⁷⁹ In addition, the Ryan White Program provides

⁷¹ *National ADAP Monitoring Project Annual Report: 2015 Annual Report*, National Alliance of State and Territorial AIDS Directors, Washington, DC, May 2015, Chart 17, p. 27, <https://www.nastad.org/resource/national-adap-monitoring-project-2015-annual-report>.

⁷² For the new eligibility group, the federal government will pay 100% of the costs for 2014-2016; the federal share will gradually be reduced to 90% by 2020. See CRS Report R43564, *The ACA Medicaid Expansion*, by Alison Mitchell.

⁷³ In 2011, less than 1% of Medicaid enrollees had HIV. Prior to ACA, most individual with HIV who were on Medicaid qualified for the program because they were disabled. Jen Kates, *Medicaid and HIV: A National Analysis*, The Henry J. Kaiser Family Foundation, Washington, DC, October 2011, pp. 5 and 8.

⁷⁴ CRS Report R43357, *Medicaid: An Overview*.

⁷⁵ The Henry J. Kaiser Family Foundation, *Status of State Action on the Medicaid Expansion Decision*, <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicare-under-the-affordable-care-act/>.

⁷⁶ *National ADAP Monitoring Project Annual Report: 2015 Annual Report*, National Alliance of State and Territorial AIDS Directors, Washington, DC, May 2015, Chart 17, p. 27, <https://www.nastad.org/resource/national-adap-monitoring-project-2015-annual-report>.

⁷⁷ Personal communication, Health Resources and Services Administration, Office of Legislation, April 24, 2015.

⁷⁸ *Ibid.*

⁷⁹ *Ibid.*

certain services, such as dental care, that not all state Medicaid programs provide to adults. As such, even in states that have expanded their Medicaid program, there may be services that the Ryan White Program can provide.

Private Insurance Expansions

Private health insurance is generally of two types: group (e.g., employer sponsored) and non-group. The ACA generally made changes to non-group coverage in ways that may increase access to health insurance for the U.S. population as well as coverage for people living with HIV/AIDS.⁸⁰ Specifically, the ACA prohibits the cancellation of coverage by an insurer due to a preexisting condition, and eliminates the lifetime caps on insurance benefits.⁸¹ Individuals with HIV/AIDS may have been at risk for either policy cancellation or of reaching lifetime caps. It is expected that these ACA changes will benefit the HIV/AIDS population.⁸²

The ACA required that U.S. citizens and legal residents have qualifying health insurance or pay a penalty. Private insurance plans are considered to be qualifying health insurance if they cover certain “essential health benefits,” which are 10 broad benefit categories, such as outpatient and ambulatory care and prescription drugs.⁸³ Although a number of essential health benefit categories overlap with the services that the Ryan White Program can provide, the overlap is not complete. For example, the Ryan White Program provides case management, oral health care, hospice services, and home and community-based services, among others, that are not required to be covered in exchange plans. Conversely, exchange plans are required to cover some services—such as inpatient hospital care—that the Ryan White Program cannot.⁸⁴

As noted, the ACA required that U.S. citizens and legal residents have qualifying health insurance or pay a penalty. To help people meet this requirement, the ACA created health insurance exchanges—marketplaces—and provided subsidies to individuals with incomes between 100% and 400% of the federal poverty level.⁸⁵ NASTAD indicates that about half of ADAP clients would be eligible for premium subsidies to purchase health coverage on the exchange.⁸⁶

⁸⁰ See description in CRS Report R42069, *Private Health Insurance Market Reforms in the Affordable Care Act (ACA)*.

⁸¹ *Ibid.*

⁸² Sean R. Cahill, Kenneth H. Mayer, and Stephen L. Boswell, “The Ryan White HIV/AIDS Program in the Age of Health Care Reform,” *American Journal of Public Health*, vol. 105, no. 6 (June 2015), pp. 1078-1085. Prior to ACA’s 2014 implementation, some individuals with HIV may have obtained health insurance coverage under the Pre-Existing Condition Insurance Plan, or PCIP created in Sec. 1101 of the ACA. This was a temporary (July 1, 2010, through December 31, 2013) state or federally administered program that served as a “bridge for people with pre-existing conditions who cannot obtain health insurance coverage in today’s private insurance market.” PCIPs were phased out as of January 2014. Although some ADAPs reported barriers in coordination with PCIPs, as of December 2011, 24 ADAPs had enrolled 2,393 clients in PCIPs. See National Alliance of State and Territorial AIDS Directors, *ADAP Coordination with Pre-Existing Condition Insurance Plans (PCIPs)*, December 2011, http://www.nastad.org/Docs/103359_ADAP%20and%20PCIPs%20-%20December%202011.pdf.

⁸³ CRS Report R44163, *The Patient Protection and Affordable Care Act’s Essential Health Benefits (EHB)*.

⁸⁴ Jeffrey S. Crowley and Connie Garner, *Reimagining the Ryan White HIV/AIDS Program: Aligning The Ryan White HIV/AIDS Program with Insurance Coverage*, O’Neill Institute for National & Global Health Law, Issue Brief no. 1, Washington, DC, June 2015, <https://www.law.georgetown.edu/oneillinstitute/research/documents/AligningwithInsurance1.pdf>.

⁸⁵ CRS Report R44065, *Overview of Health Insurance Exchanges*, coordinated by Namrata K. Uberoi. In states that did not expand Medicaid, some individuals may have too little income to qualify for insurance subsidies, but may not be eligible for Medicaid because they do not belong to a categorical eligibility group (e.g., they are a childless adult).

⁸⁶ *National ADAP Monitoring Project Annual Report: 2015 Annual Report*, National Alliance of State and Territorial AIDS Directors, Washington, DC, May 2015, Chart 17, p. 27, [https://www.nastad.org/resource/national-adap-\(continued...\)](https://www.nastad.org/resource/national-adap-(continued...))

Ryan White Program funds may also be used to pay premiums or cost sharing for individuals who enroll in private insurance plans, including plans offered on an exchange. The Ryan White Program continues to be the payer of last resort; as such, the use of funds for insurance coverage is and has been a goal of the program. HRSA and others note that Ryan White funds are increasingly being used for insurance premiums and cost sharing.⁸⁷

A 2014 study by the Kaiser Family Foundation looked at ACA implementation in five states, examining the use of Ryan White Program funds and challenges that individuals faced.⁸⁸ This study suggests that Ryan White Program funds were being increasingly used to help people enroll in exchange plans and then to educate people about how to use insurance coverage. This was particularly a challenge, as some Ryan White clients had little experience with the use of health insurance. In some cases, this lack of experience resulted in individuals enrolling in a high-deductible plan, which would pay only after the deductible had been met. As such, some could not afford to meet this deductible and continued to rely on the ADAP program for their medication.⁸⁹ The Kaiser study found that the ACA changes to insurance coverage has enabled some Ryan White clients to better manage their non-HIV related medical conditions.

HRSA notes that there have been challenges with coverage of HIV medication under exchange plans.⁹⁰ Other studies have also found that some individuals who transitioned from the Ryan White Program to an exchange plan have experienced difficulty obtaining their HIV medication. Specifically, there was large variation in cost of HIV drugs depending on the plan design; certain insurance plans placed all HIV drugs in the most expensive tier, resulting in greater out of pocket spending (an estimated \$3,000 annually),⁹¹ or causing individuals to rely on Ryan White funds to pay their drug costs. Some contend that, as a result, Ryan White funds are being used for expenses that could be covered by insurance plans.⁹²

Other ACA Provisions

Because ACA expands insurance coverage to those previously uninsured, the law also includes provisions that support changes to physician training, compensation, and practice.⁹³ These changes are intended to increase the size of the medical workforce, alter its composition (more primary care providers or other specialties in shortage), and incentivize practice in rural or other underserved areas.

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⁸⁷ Personal communication, Health Resources and Services Administration, Office of Legislation, April 24, 2015; Jennifer Kates et al., *Health Insurance Coverage for People with HIV Under the Affordable Care Act Experiences in Five States*, The Kaiser Family Foundation, Issue Brief, Washington, DC, December 2014.

⁸⁸ Jennifer Kates et al., *Health Insurance Coverage for People with HIV Under the Affordable Care Act Experiences in Five States*, The Kaiser Family Foundation, Issue Brief, Washington, DC, December 2014.

⁸⁹ Ibid.

⁹⁰ Personal communication, Health Resources and Services Administration, Office of Legislation, April 24, 2015.

⁹¹ Douglas B. Jacobs and Benjamin D. Sommers, "Using Drugs to Discriminate--Adverse Selection in the Insurance Marketplace," *The New England Journal of Medicine*, vol. 372, no. 5 (January 29, 2015), pp. 399-402.

⁹² Jeffrey S. Crowley and Connie Garner, *Reimagining the Ryan White HIV/AIDS Program: Aligning The Ryan White HIV/AIDS Program with Insurance Coverage*, O'Neill Institute for National & Global Health Law, Issue Brief no. 1, Washington, DC, June 2015, <https://www.law.georgetown.edu/oneillinstitute/research/documents/AligningwithInsurance1.pdf>.

⁹³ CRS Report R42029, *Physician Supply and the Affordable Care Act*.

The ACA includes a number of sections that aim to incentivize changes to the delivery of health care services. Specifically, the ACA supports models of care that are patient-centered with an emphasis on improved care coordination, the integrated delivery of health care services, and an increased emphasis on primary and preventive care. For example, the law creates the option for states to establish “health homes” for individuals with chronic conditions, including behavioral health disorders, in the Medicaid program.⁹⁴

ACA also permanently authorized the federal health center program administered by HRSA and created the Community Health Center Fund, including \$9.5 billion to be appropriated for health center operations in FY2011 through FY2015.⁹⁵ Although these funds were initially intended to expand the health center program, they have been partially used to supplement its annual appropriation. Despite this, the overall funding, the number of health centers available, and the services they provide have increased during this period.⁹⁶ Health centers receive Ryan White Program funds to provide health services, including HIV testing.

ACA and the Future of the Ryan White Program

The long-range impact of ACA on the Ryan White Program—in which health and treatment services provided under the Ryan White Program are replaced by access to such services through health coverage via ACA—remains to be determined. In those states that do not participate in the Medicaid expansion, the need for the full range of services under Ryan White would remain. However, even if all states decide to cover the new Medicaid-eligible group provided under ACA, there will be gaps that the Ryan White Program could continue to fill, such as coverage of those individuals with HIV/AIDS who are undocumented immigrants or legal immigrants within the five-year Medicaid ban.⁹⁷ Ryan White also provides dental care and support services, such as transportation, that may not be provided under Medicaid or private health insurance. Some analysts expect that the need for Ryan White funds to pay premiums and out of pocket expenses for individuals who are able to obtain private health insurance coverage on an exchange should continue and may grow. Such expenses may be significant if individuals enroll in high-deductible plans or for those who are on long-term medication.⁹⁸

Ryan White Program funds are also used to train health care providers. The ACA, by expanding coverage, could increase the need for such training. Although this issue is debated, some analysts have voiced concerns about whether enough physicians will be available to care for individuals who were previously uninsured.⁹⁹ There may also be shortages in particular geographical areas or certain specialists, such as primary care or those who are knowledgeable about HIV/AIDS.¹⁰⁰

⁹⁴ Section 2703(a) of ACA defines “health home” as “a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services.”

⁹⁵ CRS Report R43911, *The Community Health Center Fund: In Brief*. This funding was extended until FY2017 in the Medicare Access and CHIP Reauthorization Act of 2015; see CRS Report R43962, *The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10)*.

⁹⁶ CRS Report R43911, *The Community Health Center Fund: In Brief*; see Figure 1.

⁹⁷ For further information about the five year ban, see Office of the Assistant Secretary for Planning and Evaluation, *ASPE Issue Brief: Overview of Immigrants’ Eligibility for SNAP, TANF, Medicaid, and CHIP*, March 2012, <http://aspe.hhs.gov/hsp/11/ImmigrantAccess/Eligibility/ib.shtml>.

⁹⁸ CRS Legal Sidebar WSLG886, *Can Third Parties Pay Health Insurance Premiums in the Exchanges?*, by Jennifer A. Staman.

⁹⁹ CRS Report R42029, *Physician Supply and the Affordable Care Act*.

¹⁰⁰ During July 2012, HRSA conducted a series of four listening sessions to allow stakeholders, including Ryan White (continued...)

Advocates for the Ryan White Program also note that the program plays a public health role by providing health education and seeking to increase treatment compliance as a way of reducing HIV transmission thereby seeking to prevent the infection of other individuals.¹⁰¹ This public health role differs from the role of payers, who generally do not focus on public health initiatives. In addition, much of the work to retain people in treatment is accomplished by the Ryan White Program's case management services, which are less likely to be duplicated by the coverage that insurance programs provide under the ACA.¹⁰²

Reauthorization of the Ryan White Program

P.L. 111-87 provided authority for the Ryan White Program through FY2013. Section 2(a) of P.L. 111-87 removed the sunset provision that had been included in the 2006 reauthorization (§703 of P.L. 109-415). The Ryan White Program continues to operate under general authority (Title III) of the PHS Act. As noted above ("ACA and the Ryan White Program"), the role of the Ryan White Program has been and may continue to be altered by the ACA, particularly state decisions on Medicaid expansion. Such changes may be taken into consideration should Congress undertake another reauthorization of the Ryan White Program or consider making changes to the ACA.

Appropriations

FY2015

For FY2015, the Obama Administration requested a total of \$2.323 billion for the Ryan White Program, an increase of \$4 million compared with FY2014. The FY2015 budget request proposed consolidating Part D funds into Part C, and the increased funding was requested for Part C. Congress provided a total of \$2.319 billion for the Ryan White Program, without the consolidation of Parts C and D, in Division G of P.L. 113-235, the Consolidated and Further Continuing Appropriations Act, 2015.¹⁰³

FY2016

For FY2016, the Obama Administration requested a total of \$2.323 billion for the Ryan White Program, an increase of \$4 million compared with FY2015; the increase would go to Part C. As in FY2015, the FY2016 budget request again proposed consolidating Part D funds into Part C.

The House Appropriations Committee reported H.R. 3020, the FY2016 Labor/HHS/Education bill on June 24, 2015 (H.Rept. 114-195). The House bill would have provided \$2.319 billion for

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grantees, advocacy organizations, state and local administrators, and others to provide comments on all aspects of the Ryan White Program in preparation for possible reauthorization. HRSA, Ryan White HIV/AIDS Program Reauthorization, Recorded Listening Sessions, available at <http://hab.hrsa.gov/reauthorization/index.html>.

¹⁰¹ Jeffrey S. Crowley and Connie Garner, *Reimagining the Ryan White HIV/AIDS Program: Aligning The Ryan White HIV/AIDS Program with Insurance Coverage*, O'Neill Institute for National & Global Health Law, Issue Brief no. 1, Washington, DC, June 2015, <https://www.law.georgetown.edu/oneillinstitute/research/documents/AligningwithInsurance1.pdf>.

¹⁰² Ibid.

¹⁰³ The FY2015 appropriation included \$25 million in funding for SPNS directly via budget authority rather than through the PHS evaluation tap. See **Table 1**.

the Ryan White Program, the same as the FY2015-enacted level, without the consolidation of Parts C and D. The Senate Appropriations Committee reported S. 1695 on June 25, 2015 (S.Rept. 114-74). The Senate bill would have provided \$2.294 billion for the Ryan White Program, \$25 million less than the FY2015-enacted level. The Senate bill did not agree to the proposed consolidation of Parts C and D and did not provide \$25 million in funding for SPNS.

On September 30, 2015, the President signed into law the Continuing Appropriations Act, 2016 (P.L. 114-53, H.R. 719), which provided funding for the Ryan White Program through December 11, 2015, at the same level as in the FY2015 Consolidated and Further Continuing Appropriations Act (P.L. 113-235), minus an across-the-board reduction of 0.2108%. The Further Continuing Appropriations Act, 2016, (H.R. 2250, P.L. 114-96) provided funding through December 16, 2015, under the same conditions and funding rate as P.L. 114-53. On December 17 and 18, 2015, the House and Senate passed the Consolidated Appropriations Act, 2016 (H.R. 2029, P.L. 114-113) which the President signed on December 18, 2014. The measure provides a total of \$2.323 billion for the Ryan White Program in FY2016, including the \$25 million for SPNS but did not agree to the consolidation of Parts C and D.

Table I. Federal Funding for the Ryan White Program, FY1991-FY2016
(\$ in millions)

Fiscal Year	Part A	Part B	(ADAP) (non-add)	Part C	Part D	Part F AETC	Part F ADR	SPNS	Total
FY1991	87.8	87.8	—	44.9	19.5	17.0	—		257.0
FY1992	120.5	106.6	—	48.7	19.3	16.9	—		312.0
FY1993	184.8	115.3	—	48.0	20.9	16.4	—		385.4
FY1994	325.5	183.9	—	48.0	22.0	16.4	7.0		602.8
FY1995	356.5	198.1	—	52.3	26.0	16.3	6.9		656.2
FY1996	391.7	260.8	(52)	56.9	29.0	12.0	6.9		757.4
FY1997	449.8	417.0	(167)	69.6	36.0	16.3	7.5		996.3
FY1998	464.7	542.8	(285.5)	76.2	40.8	17.2	7.8		1,150.2
FY1999	505.0	737.8	(461.0)	94.3	46.0	20.0	7.8		1,410.9
FY2000	546.3	823.8	(528.0)	138.4	51.0	26.6	8.0		1,594.2
FY2001	604.2	910.9	(589.0)	185.9	65.0	31.6	10.0		1,807.6
FY2002	619.4	977.2	(639.0)	193.8	71.0	35.3	13.5		1,910.2
FY2003	618.7	1,053.4	(714.3)	198.4	73.6	35.6	13.4		1,993.0
FY2004	615.0	1,085.9	(748.9)	197.2	73.1	35.3	13.3		2,019.9
FY2005	610.1	1,121.8	(787.5)	195.6	72.5	35.1	13.2		2,048.3
FY2006	603.6	1,119.7	(789.0)	193.5	71.7	34.6	13.1		2,036.3
FY2007	604.0	1,195.5	(789.5)	193.7	71.8	34.7	13.1		2,112.8
FY2008	627.1	1,195.2	(794.4)	198.8	73.7	34.1	12.9		2,141.8
FY2009	663.1	1,223.8	(815.0)	201.9	76.8	34.4	13.4		2,213.4
FY2010	678.1	1,276.8	(860.0)	206.4	77.6	34.7	13.6		2,290.2
FY2011	672.5	1,308.1	(885.0)	205.6	77.3	34.6	13.5		2,311.7
FY2012	666.1	1,360.8	(933.3)	215.1	77.2	34.5	13.5		2,367.2
FY2013	624.3	1,287.5	(886.3)	194.4	72.3	32.4	12.6		2,223.6
FY2014	649.4	1,314.4	(900.3)	205.5	72.4	33.2	13.0		2,288.0
FY2015	655.9	1,315.0	(900.3)	201.1	75.1	33.6	13.1	25	2,318.8
FY2016	655.9	1,315.0	(900.3)	205.1	75.1	33.6	13.1	25	2,322.8

Sources: Amounts for FY2016 are found in the detailed tables of the explanatory statement accompanying H.R. 2029, (P.L. 114-113). Amounts for FY2014 and FY2015 are found in HRSA, *FY2016 Justification of Estimates for Appropriations Committees*, pp. 277-312, <http://www.hrsa.gov/about/budget/budgetjustification2016.pdf>. Amounts for earlier years are from prior HRSA Justification documents.

Notes: Totals for FY2002 through FY2014 do not include \$25 million for the Special Projects of National Significance (SPNS) provided via the PHS program evaluation tap (§241 of the PHS Act). FY2015 and FY2016 appropriations include funding for SPNS via budget authority. Totals may not add due to rounding.

Appendix. Summary of Ryan White Program Parts

Table A-1. Ryan White Program Overview

Program Part	Eligibility	Allocation Method	Uses of Funds
Part A—Grants to Urban Areas: Eligible Metropolitan Area (EMA) grants and Transitional Grant Areas (TGA)	EMAs have a population of at least 50,000 and more than 2,000 reported AIDS cases in the prior five years. TGAs have a population of at least 50,000 and at least 1,000, but fewer than 2,000 cumulative reported AIDS cases in the prior five years.	2/3 of funds are distributed as formula grants based on reported living cases of HIV/AIDS. The remaining 1/3 are competitive supplemental grants distributed on the basis of need and other factors, such as an area’s success in HIV/AIDS testing.	75% of funds must be used for core medical services (outpatient and home health services, ADAP treatments and case management). 25% of funds may be used for support services (outreach, medical transportation, language services, and respite care).
Part B—Base Grants to States	All 50 states, DC, Puerto Rico, and territories.	2/3 of funds are distributed as formula grants based on reported living cases of HIV/AIDS and other factors. Remaining 1/3 are supplemental grants distributed competitively on the basis of need.	75% of funds must be used for core medical services (outpatient and home health services, ADAP treatments and case management). 25% of funds may be used for support services (outreach, medical transportation, language services, and respite care)
Part B—AIDS Drug Assistance Program (ADAP)	All 50 states, DC, Puerto Rico, and territories.	Formula grants based on reported living cases of HIV/AIDS; 5% is set aside for ADAP supplemental grants distributed based on need.	Administration of state ADAP programs, primarily to provide HIV drugs, insurance continuation, drug co-pays and deductibles.
Part B—Emerging Communities Grants	Grants to states that have a metropolitan area with a population of at least 50,000 and a cumulative total of at least 500 but fewer than 1,000 reported cases of AIDS during the most recent five calendar years.	Formula grants based on reported living cases of HIV/AIDS.	Grants for core medical services and support services.
Part B—Emergency Relief Funds	States and territories.	Grants distributed based on need.	Grants to help states prevent, reduce, eliminate ADAP waitlists or cost-containment measures.
Part C—Early Intervention Services (EIS)	Health care entities that serve underserved populations (federally qualified health centers, family planning clinics, and hemophilia centers).	Competitive grants, cooperative agreements, and contracts.	75% of a grant must be used for core medical services, and not less than 50% must be used for EIS (counseling and HIV testing).

Program Part	Eligibility	Allocation Method	Uses of Funds
Part C—Capacity Development Grants	Public and non-profit entities that are or intend to become HIV providers. Entities that currently provide Ryan White Program services are also eligible.	Competitive grants, cooperative agreements, and contracts.	Grants to improve the infrastructure and capacity of eligible entities to enable facilities to provide comprehensive HIV/AIDS services. Examples include management systems to track financial and health care information of HIV patients, and service delivery system improvement.
Part D—Women, Infants, Children, and Youth	Public and nonprofit entities that provide primary medical care to HIV positive women, infants, and children. State and local governments, Indian Tribes, Tribal Organizations, and faith and community based organizations are also eligible.	Competitive grants, cooperative agreements, and contracts.	Grants for family-centered care for women, infants, children, and youth with HIV/AIDS. Outpatient health care, case management, referrals, and other services to enable participation in the program, including services designed to recruit and retain youth with HIV.
Part F—AIDS Dental Reimbursement (ADR) Program	Accredited dental schools, post-doctoral dental education programs, and dental hygiene education programs.	Competitive grants.	Reimbursement for dental services provided to individuals with HIV/AIDS.
Part F—Community-Based Dental Partnership Program	Partnerships of dental education programs and community based organizations.	Competitive grants, cooperative agreements, and contracts.	Grants to support collaborations between dental education programs and community-based partners to deliver oral health services in community settings while training students and residents enrolled in accredited dental education programs.
Part F—AIDS Education and Training Centers (AETCs),	Grants support 11 regional centers and more than 130 locally associated sites.	Competitive grants, cooperative agreements, and contracts.	Specialized clinical education and consultation for health providers on HIV transmission, treatment, and prevention.
Part F—Special Projects of National Significance (SPNS) Program	Entities that have received Ryan White program funds.	Competitive grants.	Grants to quickly respond to emerging needs.
Minority AIDS Initiative (MAI)	Entities that have received Ryan White program funds.	Formula and competitive grants.	Activities such as education and outreach to improve minority access to the services available through the Ryan White Program.

Source: CRS analysis of HRSA Budget Justification, agency program documents, and program statute.

Note: Part E/G is not included in the table because this program has never been funded.

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