Our Interconnected HIV Care Financing System is Under Threat

Reductions in Medicaid and Private Insurance Coverage and Cuts to HIV Programs Will Undermine Progress Toward Ending the HIV Epidemic

Improving the health of people with HIV and reducing new cases requires maintaining and strengthening our nation's complex and interwoven systems of financing and delivering HIV prevention and care. Over time, the U.S. has expanded access to insurance coverage while retaining funding for the Ryan White HIV/AIDS Program (RWHAP) that helps people with HIV navigate and access insurance, provides cost-sharing assistance so that low-income individuals can access insurance benefits, and covers services when insurance does not. The program also provides HIV treatment and other services for people with HIV who are uninsured. Beginning in 2019 when President Trump launched the Ending the HIV Epidemic (EHE) Initiative, Congress has appropriated additional resources for both HIV prevention and care, including additional funding for the RWHAP. These policies and financial investments are driving progress. **All these elements of the U.S. HIV care system, however, are under threat due to the reorganization and elimination of key functions within the Department of Health and Human Services (HHS) and through potential cuts for both discretionary HIV programs and our major national insurance programs.**

ROBUST INSURANCE COVERAGE IS CRITICAL FOR FINANCING HIV CARE

Insurance is important not only as a source of paying for HIV services, but as a promise of coverage for a defined set of benefits, typically including inpatient and outpatient hospital care, physician and other provider visits, prescription drugs, and HIV and other prevention services. Although Medicaid always has been the largest source of financing for HIV care, eligibility was initially restricted to people with advanced HIV (i.e. AIDS) who qualified on the basis of disability. Early in the epidemic, Medicare also was a much smaller source of coverage. Moreover, people with HIV faced significant discrimination in obtaining private insurance. Unless they had access to employer sponsored coverage, it was effectively unavailable.

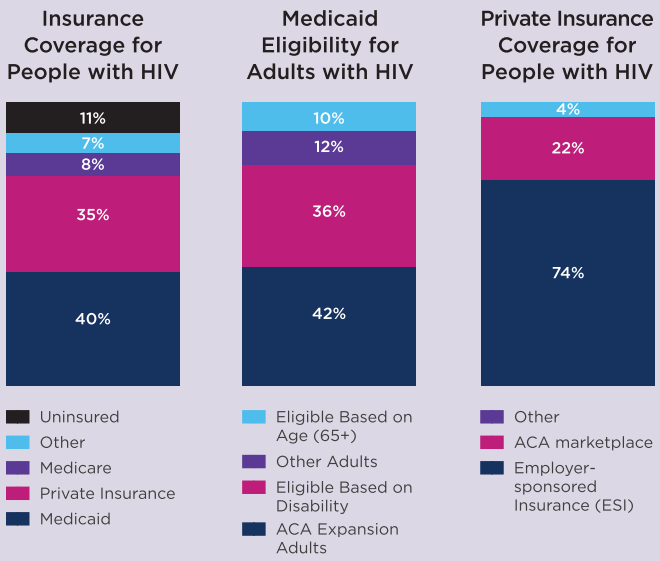
The Affordable Care Act (ACA), enacted in 2010, created the option for states to expand Medicaid to all persons with income up to 138% of poverty, greatly increasing coverage for many adults living with HIV in expansion states (40 states plus DC). The ACA also included important reforms to private insurance, including the prohibition of discrimination on the basis of health status in the invidividual insurance market coupled with subsidies to make premiums and coverage affordable to lower-income enrollees. Additionally, as the population of people with HIV ages, Medicare has become a much more significant source of HIV health coverage. Moreover, with the availibility of effective HIV treatment, more people with HIV are now employed and have employer-sponsored insurance (ESI).

THE RYAN WHITE HIV/AIDS PROGRAM IS THE GLUE THAT HOLDS THE SYSTEM TOGETHER

While private insurance, Medicaid, and Medicare greatly contribute to consistent, high-quality HIV care, many people with HIV find that standard coverage does not fully meet their needs. In 2023, of the 576,040 clients served by the RWHAP, four in five had insurance coverage. The RWHAP is the payer of last resort and cannot pay for services for which insurance or another source of coverage is available. It is critical, however, in supporting retention in care and high viral suppression by assisting with cost-sharing and providing services not covered by insurance. The RWHAP also supports the insurance system's ability to provide HIV care by conducting clinical workforce training in HIV care and continuing medical education, as well as by developing and updating HIV practice guidelines, monitoring HIV outcomes, and providing technical assistance to create integrated systems of care within local communities. **Cuts and reforms being contemplated to Medicaid and changes to the private insurance landscape would likely lead to major losses in primary health coverage or reduced benefits for people with HIV. This would shift a greater burden onto the RWHAP, which it is not equipped to bear**.

Meanwhile, proposed cuts to the RWHAP itself, including the wholesale elimination of Part F that trains providers, operates the HIV/AIDS Dental Program, and develops new models for delivering HIV care, and the recent elimination of key elements of the program such as the data monitoring team weaken the RWHAP (see our Quick Take: The Ryan White HIV/AIDS Program: The Program's Parts Work Together to Make It Effective). President Trump's

THREE IN FOUR PEOPLE WITH HIV HAVE MEDICAID OR PRIVATE INSURANCE



Sources: KFF, *5 Key Facts About Medicaid Coverage for People with HIV*, April 2025 and KFF, *Insurance Coverage and Viral Suppression Among People with HIV, 2018*, September 2020.

POTENTIAL CUTS IN THE FY 2026 FEDERAL BUDGET COULD UNRAVEL THE HIV CARE SYSTEM

Loss of Medicaid or private insurance coverage or reductions in HIV programs could dramatically weaken the financing of HIV care.

MEDICAID:

The federal-state partnership that covers 72 million beneficiaries is the largest source of HIV care covering nearly 450,000 people with HIV. As the Congress considers extending tax cuts from the first Trump Administration, the House of Representatives passed a budget resolution that, if enacted, could require up to $880 billion in cuts to Medicaid over ten years. Numerous policy options are under consideration. These include:

Work Requirements: These would require most Medicaid beneficiaries (excluding specific groups such as people receiving Supplemental Security Income, SSI) to meet work or "community engagement" requirements to receive Medicaid. Most proposals would require 20 hours of work per week. According to a 2020 KFF analysis, 13% of beneficiaries with HIV could be at risk, and remaining 87% of beneficiaries with HIV could face difficulty documenting their compliance or verifying their exempt status also jeopardizing their Medicaid coverage.

Reduced Federal Match for Medicaid Expansion and Trigger Laws: The federal government pays states between 50-83% of total spending (i.e. the federal match rate) for regular Medicaid beneficiaries (based on per capita income in the state) but pays 90% of the costs for persons covered in the Medicaid expansion group. Some policymakers have proposed to reduce the federal government's share for the expansion group. When adopting Medicaid expansion, however, twelve states passed laws that if the federal government reduced its share, it would trigger an end or require changes to the expansion. According to a February 2025 KFF analysis, if the federal share was reduced to the regular Medicaid matching rate, up to 20 million people could lose Medicaid coverage, including potentially roughly 185,000 people with HIV. As previously stated, the Ryan White HIV/AIDS Program likely would not have the capacity to serve all in need. Further, AIDSVu estimates that PrEP use in Medicaid was 1.3 times higher in Medicaid expansion versus non-expansion states.

Block Grants or Per Capita Caps: These would transform Medicaid from an open-ended financing partnership where, as costs rise due to increased enrollment and other factors, federal funding rises with state spending. In its place, a block grant would give each state a fixed amount of money. Per capita caps are a variation where each state would receive a fixed amount per beneficiary (possibly a different amount for each of several broad groups such as people with disabilities, children, etc.). Neither block grants nor per capita caps offer policy solutions to deliver care more efficiently. Instead, they represent a loss of accountability and a shift of the burden to states which would likely greatly undermine coverage and access for people with HIV.

PRIVATE INSURANCE:

Another area where federal policy could lead to a loss of HIV health care coverage is by changing various components of the Affordable Care Act (ACA) which has created a system for individuals and families to purchase coverage through health insurance marketplaces. This could include weakening the benefit standards so that coverage can be less comprehensive or allowing marketplaces to offer so-called "junk plans" that often provide inadequate coverage if a hospitalization or serious health event arises.

Reductions or Elimination of Enhanced Premium Tax Credits: In 2021, Congress enacted enhanced premium tax credits for marketplace coverage that were extended through the end of 2025. This was in recognition that the original ACA subsidies were too limited to make marketplace coverage accessible for many low-income and middle-income individuals and families. While not a cut, it would cost an additional $335 billion to extend these credits for 10 more years, yet if Congress fails to do so, the more than 24 million Americans with marketplace coverage would face significant increases in premiums. According to KFF, on average, premiums would increase by 75% and in some states, premiums could double. Up to 85,000 people with HIV could be at risk of losing marketplace coverage, with few, if any, options to find affordable alternative options for private insurance coverage.

Note: Estimates of potential coverage losses for people with HIV are based on KFF estimates of coverage by payer and an estimated 1.1 million people with diagnosed HIV in the U.S.

EHE initiative provided the first meaningful increases in the RWHAP in about fifteen years, yet the EHE initiative now also faces potential elimination. Additionally, the President's 2026 budget request would eliminate the Minority AIDS Initiative (MAI) that focuses resources on communities disproportionately impacted by HIV. The Administration already has eliminated core HIV surveillance activities at the Centers for Disease Control and Prevention (CDC) including the Medical Monitoring Project (MMP) that tracks the care experience of all people with HIV in the U.S. The budget also appears likely to eliminate much of the remaining portions of our federal investment in HIV prevention.

THE TIME IS NOW

Over time, our nation has built an increasingly effective system of financing and delivering HIV primary and specialty care for people with and at risk for HIV in the U.S. Potential changes to Medicaid and private insurance, combined with reduced support for HIV programs, would dismantle much of that system, and therefore lead the nation backward.

TO LEARN MORE

For additional background information, see:

KFF.org for a vast array of resources, including its section on HIV, as well as Medicaid, Medicare, private insurance, and the Affordable Care Act.

For hyperlinked citations, see the CHIDP link below.

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