State Strategies to Sustain HIV Prevention, Care and Treatment

The U.S. has spent more than four decades building one of the most effective HIV care systems in the world, and this has underpinned the progress the nation has made at curbing the impact of the HIV epidemic. The Ryan White HIV/AIDS Program (RWHAP), including its largest component, the AIDS Drug Assistance Program (ADAP), creates a multi-faceted nationwide system of clinical and non-clinical care. This provides a public health safety net for uninsured people with HIV and supplements public and private insurance for insured people with HIV to yield impressively high rates of viral suppression.[1] It depends on a network of critical partners that includes frontline clinical providers, local health departments, community-based organizations (CBOs), university-based researchers, people with HIV, and others. States and territories receive funding under Part B to operate their own ADAPs and utilize Part B base funding to support quality improvement, providers and medical support, and monitoring activities to support sustained engagement in care. In some cases, states also contribute general fund revenues to support their ADAPs and Part B programs. Some states also have maximized opportunities and provided premium assistance to generate revenue from pharmaceutical rebates that were used to expand ADAP's capacity for service delivery.

That system is now threatened by eroded funding in light of inflation, rising costs, and increased need for RWHAP services due in significant part to policy changes enacted as part of the One Big Beautiful Bill Act (OBBBA) of 2025. This is shifting major cost burdens onto states, causing many of them to restrict access to ADAP.[2] Since 2005, federal funding for ADAPs has lost 31% of its real purchasing power while enrollment has grown by nearly a third.[2] The OBBBA is projected to leave 14.2 million more Americans uninsured by 2034, pushing people with HIV toward a safety net that does not have the capacity to absorb them.[3] The OBBBA did not extend the enhanced premium tax credits, which provided sliding-scale subsidies in marketplace health plans for people with income above 400% of poverty ($63,830 for a single individual in 2026) and eliminated the premium cap of 8.5% of income for all income levels for a silver plan (medium tier level of coverage). Starting in 2027, the OBBBA requires Medicaid programs to impose work requirements for persons covered under

POLICY ACTION TO SUSTAIN HIV PREVENTION, CARE AND TREATMENT

Immediate policy interventions can help to preserve access to critical HIV services as states respond to a multi-pronged, growing crisis. HIV stakeholders have a critical role to play in highlighting the threats to continuity of HIV care.

STABILIZING ADAPs AND THE HIV SAFETY NET

- Federal investment in ADAPs must be increased to meet growing enrollment demand, rising drug and premium costs, and the erosion of 340B rebate revenue.
- Increase transparency, coordination, and accountability for 340B revenues.
- Braided financing can help to preserve access to HIV services.

PROTECTING COVERAGE CONTINUITY

- States should pursue every available pathway to exclude people with HIV from Medicaid work requirements.
- Data use agreements between state RWHAP programs and Medicaid agencies are needed to identify and prevent coverage losses.
- States should ensure no-cost coverage, free from prior authorization, for all FDA-approved antiretroviral medications, independent of federal USPSTF action.

PROVIDING HIV SUPPORT TO BROADER CONSUMER COALITIONS

- State HIV advocacy must center the lived experience of people with HIV.
- Establish rapid-response funds to mobilize communities and educate policymakers on budget and policy changes that impact HIV prevention and care.
- Broad coalition-building across health, housing, immigration, and chronic disease advocacy is essential to sustain political and fiscal support for HIV systems under simultaneous attack.

the Medicaid expansion option. This will lead to greater strain on the RWHAP and ADAPs. With 19 states already implementing active ADAP cost-containment measures and many others considering them, the current changes threaten access to HIV medications and care, as some states impose tighter eligibility rules, benefit reductions, or waiting lists.[4]

1. STABILIZING ADAPs AND THE HIV SAFETY NET

State ADAPs provide a critical last resort for access to ART for uninsured people with HIV. For those with insurance, they ensure that monthly premiums and medication cost-sharing do not create barriers to sustained ART. Premium assistance through ADAPs, however, is not offered in all states. HRSA reports that between 2011 and 2024, viral suppression among RWHAP clients increased from 74% to 91.4%, which is much higher than the national average of 67% in 2024 among all people with diagnosed HIV in the U.S.[5] That success is now at risk.

The previously described fiscal pressures are converging simultaneously. The RWHAP, by law, is the payer of last resort. It only pays for services when insurance or another payer is not available, yet a major role of the program is to provide wraparound coverage, when needed, to supplement the limits of an individual's insurance coverage. While all parts of the RWHAP work together to support sustained engagement in care and access to ART, ADAPs often shoulder the largest financial responsibility due to the central role and high cost of medications. Prescription drug spending across ADAPs rose 6.4% in 2024 alone and 17% from 2022 to 2024.[6] When it is cost-effective compared to purchasing medication alone, ADAP funds are used to purchase insurance coverage that gives clients access to a broader range of medicines and enables ADAPs to generate revenue from the 340B Drug Pricing Program, allowing them to serve more people. In 2024, insurance purchasing costs averaged $6,377 per client, or over $530 per month. These costs could rise and ADAPs could stop insurance purchasing because the practice no longer meets the RWHAP cost-effectiveness test.[2] Additionally, shrinking marketplace options in many states pose an additional challenge for ADAPs seeking to purchase affordable insurance for their clients.

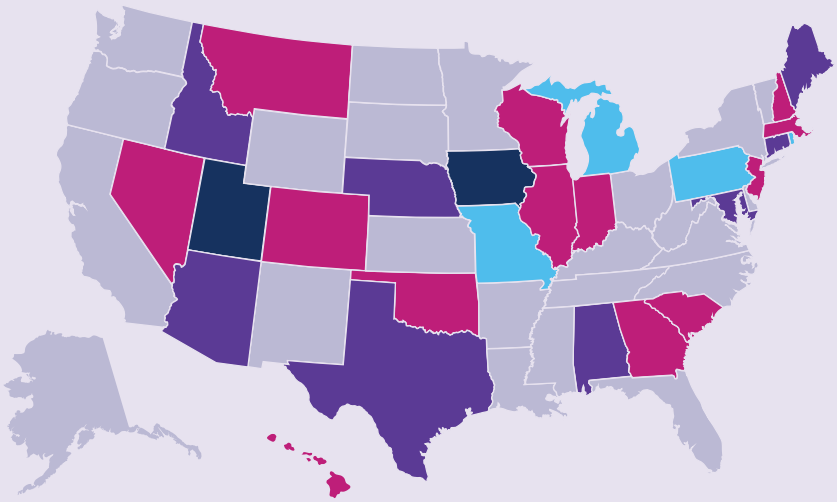
The results are already visible. ADAPs are implementing cost-containment measures with numerous jurisdictions actively considering additional restrictions, including reductions in Part B funding, premium assistance, more restrictive formularies, expenditure caps, and other operational changes. These proposed measures underscore the continued financial vulnerability of state ADAPs and the risk that additional barriers to HIV care may emerge in the absence of sustained federal investment and policy interventions.

Iowa and Utah have ADAP waiting lists.[5] Two other states have already reduced ADAP income eligibility. Florida initially slashed eligibility from 400% to 130% FPL, removing an estimated 16,000 people from coverage, imposing new prior authorization requirements, and eliminating a critical single tablet regimen from its formulary.[7] The state also proposed to eliminate its premium assistance program, which not only causes individuals to lose insurance coverage

ADAP PROGRAMS ARE UNDER GROWING STRESS

2026 ADAP State Stress Map

State-level AIDS Drug Assistance Program cost-containment actions as of July 2026



2 STATES
HAVE ACTIVE WAITING LISTS
Iowa (1,035 people) • Utah (48 people)

19 STATES
WITH ACTIVE MEASURES
Waiting list, eligibility / formulary, or other cost-containment restrictions

15 ADAPs
ADAPs FORECASTING DEFICITS
Currently Ryan White FY ending March 2027 (down from 19 in April 2026)

Source: NASTAD ADAP Watch (July 2026). Reporting jurisdiction RFI July 6-24, 2026. State colors reflect the most severe active measure reported. Guam and Puerto Rico also have active cost-containment measures (not shown). Florida did not respond; not colored.

but can also cause a significant drop in revenue for the ADAP program. In Florida's case, the state went from approximately $200M in rebates when providing premium assistance to approximately $60M in rebates when it terminated premium assistance.[8] Where states have found room to maneuver, doing so has required braided financing from sources beyond Ryan White such as Medicaid, opioid settlement funds, and rural health transformation grants.[9,10,11] These strategies are necessary but insufficient without increased federal investment. The financing architecture of the HIV care system is under strain, and states must find every lever they can pull to ensure people continue receiving coverage.

POLICY ACTION:

Federal investment in ADAPs must be increased to meet growing enrollment demand, rising drug and premium costs, and the erosion of 340B rebate revenue.

When it appropriates funds for the RWHAP, Congress creates a specific earmark dedicating the amount of funds that are allocated to ADAP. The federal ADAP earmark has been set at approximately $900 million since fiscal year 2014, effectively flat for over a decade. Meanwhile, ADAPs are serving more people than ever: enrollment grew 30% between 2022 and 2024, with new client enrollment surging 23% in a single year as people fell off Medicaid during post-COVID unwinding. Compounding this, changes to Medicare Part D under the Inflation Reduction Act reduced cost-sharing payments, triggering a corresponding drop in rebate revenue that ADAPs depend on.[12] The OBBBA, with its Medicaid changes and the expiration of enhanced premium tax credits, will leave more Americans uninsured, pushing a new wave of people with HIV toward ADAPs as the payer of last resort. To avoid lost progress in increasing viral suppression and to avoid more HIV transmissions, Congress should take emergency action and increase federal funding to ADAP base appropriations and ADAP emergency funds. Some stakeholders have estimated that the minimum level of investment needed to prevent significant harm is a dedicated increase of at least $175 million for ADAPs, including $100 million for the ADAP Emergency Relief Fund (ERF).[13] The ERF is a discretionary, supplemental funding stream managed by the Administration to act as a financial safety net to prevent or reduce ADAP client waiting lists and resolve sudden budget shortfalls. This fund currently stands at a fixed $75 million that is diluted as more states apply.

POLICY ACTION:

Increase transparency, coordination, and accountability for 340B revenues.

The 340B Drug Pricing Program has become the financial backbone of state ADAPs. Rebates provided by the 340B Program and manufacturers now represent 52% of total ADAP budgets nationally, up from 37% just five years ago.[13] The federal earmark now accounts for only 29% of ADAP budgets and state general fund contributions account for 4% of aggregate state ADAP budgets.[13] Many funding entities in the RWHAP receive 340B revenue, and while the legislation requires grant recipients to reinvest all 340B revenue back into allowable services, the coordination and prioritization of how the revenue is spent are currently lacking.

Nineteen states have adopted cost-cutting changes to their ADAP programs. Given that 340B rebate revenue now accounts for more than half of ADAP budgets, jurisdictions should convene all RWHAP stakeholders, including planning councils and consortia that set service priorities for the program, to share program income data, establish reinvestment priorities under conditions of scarcity, and ensure that 340B revenue generated by the HIV care system flows back to the people with HIV whom the system was built to serve.[14]

POLICY ACTION:

Braided financing can help to preserve access to HIV services.

Federal and state funding for HIV programs is under pressure from multiple directions: the House FY2027 appropriations bill proposed eliminating Ryan White Parts C, D, and F entirely, while the Trump administration's FY2026 and FY2027 budgets called for eliminating all CDC HIV prevention programs.[15] While Congress did not adopt the President's request for the current budget year, and next year's budget is unresolved, these proposals highlight the threat of significantly reduced federal funding to states, a threat that demands immediate planning and efforts to make services less vulnerable to federal cutbacks.

With no single funding stream that is sufficient to fill these gaps, states must turn to alternative sources. In some cases, such sources already exist and are being underutilized. Opioid settlement dollars represent one of the most immediate opportunities. States and localities received over $6.5 billion in opioid settlement funds in 2024 alone. The syndemic overlap between HIV, hepatitis C, and substance use disorder means these funds are directly applicable to HIV testing, PrEP navigation and access, case management, syringe service programs, and medical care for patients with co-occurring substance use and HIV. Braiding settlement dollars with other sources of state revenue could help to continue essential services, particularly for an underserved part of the HIV community: persons at risk for and with substance use disorders (SUD).

Some states are already finding creative paths to generate revenue for HIV services. Texas has leveraged its 1115 Medicaid Transformation Waiver uncompensated care pool to channel hospital funds toward HIV services for uninsured patients, while Alabama maintains a dedicated 1115 waiver for home and community-based services for people with HIV. Furthermore, the Rural Health Transformation Program (RHTP) could be leveraged to support HIV prevention and treatment, strengthening the rural HIV and STI workforce and expanding low-barrier testing and treatment access.[16,17,11] These efforts can help to sustain HIV infrastructure where federal support is shrinking. States that are not actively pursuing these streams are leaving critical resources on the table at exactly the moment they can least afford to.[18]

2. PROTECTING COVERAGE CONTINUITY

Medicaid is the largest health insurer for people with HIV in the United States, covering more than 40% of all people with diagnosed HIV.[19] That coverage is now under direct political assault. The OBBBA requires states to implement semi-annual eligibility redeterminations for all adults covered by Medicaid expansion and enforce 80 hours per month of work or community engagement requirements, with individuals who lose coverage due to non-compliance also barred from subsidized marketplace coverage.[20] The Urban Institute projects that these two provisions together will reduce Medicaid expansion enrollment by 3 to 8 million people in 2028, with the overwhelming majority losing coverage not because they are ineligible, but because they cannot navigate the paperwork and administrative requirements.[21] For people with HIV, this is not an abstract policy risk. 44% of adult Medicaid enrollees with HIV have a substance use disorder (SUD) or mental health diagnosis, and 73% have some other chronic condition, compounding the barriers they already face. Stable Medicaid coverage directly reduces ADAP reliance, and each Medicaid redetermination cycle produces measurable ADAP enrollment spikes.[22,23,24] The post-COVID Medicaid unwind showed this in real time with ADAP enrollment surging 30% between 2022 and 2024 as people lost continuous Medicaid coverage and fell back on ADAPs.[6] Semi-annual redeterminations and work documentation requirements, layered on top of an already strained ADAP system, threaten to repeat that cycle at scale. For people with HIV, gaps in coverage mean gaps in antiretroviral therapy, which would translate into declining viral suppression and likely increase HIV transmission.

More than four in ten Medicaid enrollees with HIV nationwide qualify for the program as part of the Medicaid expansion option. In Medicaid expansion states (40 states plus DC), 51% of Medicaid enrollees with HIV qualify as part of the Medicaid expansion. Medicaid enrollees who gained coverage through the expansion are now subject to work requirements. Further, even though individuals losing Medicaid would have a special enrollment period permitting them to purchase a Marketplace health plan, the OBBBA makes people who lose Medicaid due to the work requirement ineligible for Marketplace premium and cost-sharing subsidies, eliminating the only remaining alternative.[25]

POLICY ACTION:

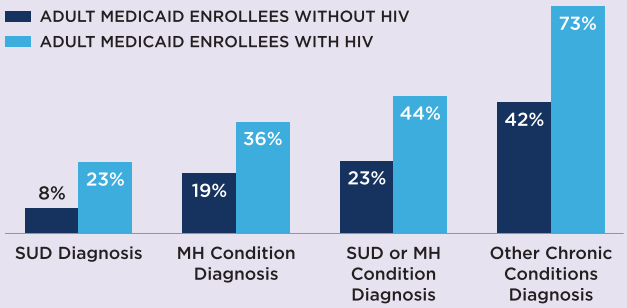
States should pursue every available pathway to exclude people with HIV from Medicaid work requirements.

States should explore every possible avenue for excluding people with HIV from the work requirements to ensure continuity of care and to maximize sustained viral suppression. The OBBBA creates several exclusion categories that can protect some people with HIV, including persons with SUD, persons with a disabling mental condition, and persons with a serious and complex medical condition. Indeed, many states were planning to automatically exclude people with HIV because it is a serious and complex medical condition. In June 2026, however, CMS issued an interim final rule (IFR) that prohibits categorical exclusion for people with HIV. Instead, it ties exclusion to documenting that the condition's severity significantly impairs an individual's ability to meet the work requirement. The IFR permits self-attestation that an enrollee meets these criteria in 2027, but documented evidence will be required starting in 2028. Eligibility for Medicaid also must be redetermined at least every six months. A person with HIV who is stable on treatment and technically

HIGH RATES OF CHRONIC CONDITIONS CREATE BARRIERS TO NAVIGATING WORK DOCUMENTATION REQUIREMENTS

Adult Medicaid Enrollees with HIV are More Likely Than Those Without HIV to Have Substance Use Disorder, a Mental Health Condition, and Other Chronic Conditions.

Rate of chronic conditions among adult Medicaid enrollees, by HIV status, 2021



Source: KFF analysis of the T-MSIS Research Identifiable Files, 2021.
Note: SUD = Substance Use Disorder. MH = Mental Health condition. This analysis reflects enrollees 18 and older who had no Medicare coverage in 2021 (260,000 enrollees with HIV and 46.3 million without HIV).

able to work has no guaranteed exclusion from work requirement reporting, risking treatment interruption, viral rebound, and onward transmission. States must work with partners, clinicians, case managers, and people with HIV to educate providers and clients on navigating work rules. Notably, the Congressional Budget Office (CBO) previously examined Medicaid work requirements in Arkansas and found that they had a negligible impact on employment.[26]

HIV stakeholders should continue to seek ways to exclude as many people with HIV as possible from the work requirement. In the same month that CMS published its IFR, 23 states, two governors, and the District of Columbia sued the Department of Health and Human Services and CMS in federal court seeking a preliminary injunction against the IFR and seeking to have it vacated.[27] This also includes submitting amicus briefs in support of states' efforts to have the courts enjoin enforcement of the IFR. Further, the IFR permits states to develop their own list of health conditions, and states should list HIV in it. Some states are already taking the lead. Nebraska has released an index of diagnosis and procedure codes, including HIV, and is using claims data to auto-exclude individuals where possible, offering a replicable model. Michigan has already formally submitted a request to exclude all people with HIV from work requirements. States should move immediately to operationalize HIV as a qualifying condition for medical frailty exclusion and develop ways to document the severity of one's condition in the electronic medical record.

Longer-term solutions include having states develop registry-based matching between HIV surveillance data and Medicaid enrollment systems, as self-attestation eligibility lapses beginning in 2028.[28] States and RWHAPs will require the resources and support to implement this. Case managers and navigators will require more support to assist clients in tracking qualifying hours, understanding reporting deadlines, and avoiding coverage loss due to bureaucratic failures rather than actual ineligibility. Investing in this capacity now is essential to ensure administrative barriers do not drive people off coverage and onto ADAPs; investment should include training, quality improvement, tracking and forecasting, relationship building, and webinars.

POLICY ACTION:

Data use agreements between state RWHAP programs and Medicaid agencies are needed to identify and prevent coverage losses.

States cannot protect coverage for people with HIV they cannot identify as being at risk. At a moment when Medicaid churn (cycling in and out of Medicaid coverage) is accelerating, formal data use agreements between RWHAP grantees and state Medicaid agencies are the foundational infrastructure required to respond and minimize coverage gaps. Without these agreements, states cannot proactively identify which people with HIV are at risk of losing Medicaid, cannot flag them for outreach before a gap in coverage occurs, and cannot verify work requirement exclusions through registry matching rather than requiring self-disclosure.[18] Many states have developed data sharing models with Medicaid. For example, Michigan's model, in which Medicaid shares its full enrollment file with the state HIV program via a master person index tool, which runs the matches internally against the HIV registry and returns only results without transmitting HIV data back to Medicaid, is the standard every state should be working toward.[18] Critically, the HIV program aims to share minimal data with Medicaid and vice versa to address patient privacy and confidentiality concerns while also supporting shared clinical and quality resources that can assist clients in achieving the best possible health outcomes. The state HIV program does the matching and never sends HIV data outward,

MASSACHUSETTS LAW OFFERS A MODEL FOR STATE PrEP PROTECTIONS

Extending access to PrEP and ensuring persistent use is critical to national efforts to end the HIV epidemic. The stability of current USPSTF protections has been called into question, however, by recent federal policy actions, as well as uncertainty over coverage of newer PrEP options as they receive approval from the Food and Drug Administration (FDA).

Massachusetts' FY27 budget, signed into law in July 2026, establishes a replicable model for other states to adopt. The law requires state employee health plans, Medicaid, commercial insurers, and HMOs to cover all FDA-approved PrEP drugs and related HIV prevention services for anyone with a covered plan in Massachusetts. It also mandates HIV prevention support for people leaving state and county correctional facilities.

- Coverage must also include all FDA-approved HIV pre-exposure prophylaxis (PrEP) medications without co-pays, deductibles, or prior authorization.
- Insurers must cover PrEP and related services like office visits, lab work, and counseling without co-pays, deductibles, prior authorization, or other barriers that could delay treatment.
- Law requires insurers to accept prescriptions for PrEP from any health care practitioner licensed to prescribe medications.
- Before release, state and county correctional facilities must offer PrEP to people at risk for HIV, including administration of a long-acting injectable form that provides six months of protection.

protecting patient privacy and shielding people from harm. These agreements ensure patient privacy and safety are prioritized, and states that have not started sharing data across programs must begin immediately.

POLICY ACTION:

States should ensure no-cost coverage, free from prior authorization, for all FDA-approved antiretroviral medications, independent of federal USPSTF action.

In addition to state actions needed to protect access to HIV treatment, state action is also needed to protect access to critical prevention services. State laws should establish durable protections covering all FDA-approved antiretroviral therapies for HIV treatment and prevention without cost-sharing or prior authorization regardless of future federal action on United States Preventive Services Task Force (USPSTF) recommendations. The Supreme Court's June 2025 ruling in *Kennedy v. Braidwood* preserved the ACA requirement that most private insurers cover USPSTF-recommended preventive services, including PrEP, at no cost. But the same ruling confirmed that the HHS Secretary can remove USPSTF members at will and block recommendations before they take effect.[29] If states accept that only specifically enumerated drugs in the USPSTF recommendation must be covered, every new PrEP agent will face years of delay before achieving no-cost access, exactly when HIV prevention technology holds its greatest promise. The model in Massachusetts is replicable (see text box on page 5). Massachusetts' FY27 budget, signed into law in July 2026, requires coverage of all FDA-approved HIV pre-exposure prophylaxis (PrEP) without cost-sharing or prior authorization, allowing Massachusetts to outpace federal rollbacks while retaining flexibility to add new regimens, including longer-acting options.[30] In DC, PrEP legislation includes explicit coverage requirements for all FDA-approved medications.

3. PROVIDING HIV SUPPORT TO BROADER CONSUMER COALITIONS

The HIV response was built by people with HIV. The Denver Principles, adopted in 1983 at the beginning of the HIV crisis, established that people with HIV are primary actors with the right to set their own agenda and be fully involved in every decision affecting their lives and care.[31] After the Denver Principles, the Greater Involvement of People Living with HIV/AIDS (GIPA) was formally recognized at the 1994 Paris AIDS Summit to empower people with HIV, shifting them from passive care recipients into active, recognized partners across all levels of the HIV response. Meaningful Involvement of People with HIV/AIDS (MIPA) advances this goal by ensuring that inclusion translates into genuine decision-making power, leadership, and shared governance rather than mere token representation. Forty years later, the HIV community demonstrated again that community mobilization works, leading to Congress ultimately blocking nearly $2 billion in proposed HIV program cuts.[32] But support for state-level advocacy is far more limited. Often state policymakers and legislators determine who keeps medication access, whether waiting lists are necessary, and who loses Medicaid coverage.[2] In some cases, states can make changes to ADAP without legislative action. The people best positioned to make that case are the ones directly impacted by administrative changes. Agencies often treat people with HIV as patients to be served rather than as active partners to be engaged. This can change when people with HIV are centered in advocacy. States can integrate lived experience into the public health workforce by creating funded peer-navigator career pathways. Additionally, states can enforce accountability by requiring grant sub-recipients to demonstrate meaningful community involvement and prioritizing funding for peer-led organizations.

POLICY ACTION:

State HIV advocacy must center the lived experience of people with HIV.

Florida showed that the messenger matters as much as the message. Legislators across the aisle responded when advocates and members of the community raised their concerns. Scaled and well-resourced advocacy can accomplish a great deal at the state and federal levels if invested in, and if advocates reflect the communities most affected. Florida's provisional restoration of ADAP eligibility through sustained community advocacy, legislative relationship-building, and direct engagement with legislators across the aisle is a model other states should accelerate now, before a crisis forces reaction. By the time a state health department announces cuts, the window to respond might be too short, and legislators who have never heard of ADAP, Ryan White, or viral suppression are not going to become allies overnight.

POLICY ACTION:

Establish rapid-response funds to mobilize communities and educate policymakers on budget and policy changes that impact HIV prevention and care.

The community response to Florida's ADAP crisis and Idaho's House Bill 135 demonstrates both what rapid advocacy can accomplish and what its absence costs.[33] In Idaho, where state legislation explicitly named the RWHAP and ADAP as programs requiring immigration status verification, an HIV physician and five immigrant clients filed suit within weeks, securing a federal preliminary injunction that preserved HIV

treatment access for all immigrant Idahoans while litigation continues.[34] In Florida, sustained community advocacy led by a person with HIV at personal risk of retribution helped to push the legislature to unanimously pass emergency legislation restoring ADAP eligibility to 400% FPL and appropriating $30.9 million in bridge funding through June 30, 2026, giving more than 12,000 Floridians who had lost access a temporary path back to their antiretroviral medications.[35] Subsequent state action provided a longer-term restoration of funding and ensured that the most-prescribed HIV regimen (a single-tablet treatment) was added back to the state's formulary.[36] Advocates can work with state legislators to develop ADAP-specific questions for use during health department budget hearings or other hearings on topics related to HIV.[37] Community voices, when resources are available to support their timely education and mobilization, can have similar impacts in other states to protect HIV prevention and care. ADAP formulary committees and community planning bodies should have real decision-making power and greater impact. While some organizations spend large amounts of funds on lobbyists, ADAP clients are often left out of these processes. Communities of people with HIV/AIDS should be embedded in decision-making processes.

Private and corporate funders should develop the capacity to award rapid-response funds to frontline organizations to ensure that affected communities can weigh in before legislative or administrative policy changes are enacted or implemented. This could include various models such as awarding funds to a national organization that can provide sub-awards when an emergency response is needed. Alternatively, it could include pre-approval for foundations or grantmaking programs to award discretionary funds in the face of a legislative or administrative crisis requiring urgent action.

POLICY ACTION:

Broad coalition-building across health, housing, immigration, and chronic disease advocacy is essential to sustain political and fiscal support for HIV systems under simultaneous attack.

For the first forty years of this epidemic, HIV advocates could often appeal to policymakers' concern for people with HIV; today, those same communities are being directly targeted by federal funding cuts and political retrenchment. Our policy recommendations must therefore make clear that protecting the HIV care system also means protecting rural communities and people living below the federal poverty level—however that threshold is defined. The communities most affected by HIV cuts are often the same communities losing SNAP benefits, Medicaid coverage, housing assistance, and immigrant protections under the current federal policy environment. To achieve the best outcomes for the communities in which individuals live, HIV advocates should embed their HIV messages and priorities into a broader ask for policies to support these communities as a whole. Helping people with HIV helps everyone, because none of us lives in isolation from the health of our neighbors, our communities, or the systems that care for us. The COVID-19 pandemic made this unmistakable: when we strengthen care for populations that carry more than their share of disease burden, we build a healthier society and improve outcomes for all of us. Our ability to respond effectively to the unexpected was shaped in no small part by the HIV care network; cutting resources from that network weakens not only HIV care, but also our nation's broader public-health readiness. The current public health and social services funding crisis is one that cannot be solved by the HIV community alone. State policymakers should also work alongside these groups. Whether acting at the national, state, or local level, coalition building across immigrant access to healthcare, food assistance, and housing is critical to success. Opponents of broad-based funding for HIV prevention and care and other critical services often benefit from advocates who compete with each other. Legislators who are unmoved by a single program may become movable when they hear from multiple communities working together.[38] Building those relationships before and during a crisis is what determines whether a coalition can respond rapidly between announcement and implementation of a policy change. This is ever more evident in the South. With more than 200 anti-immigrant bills targeting public benefit programs moving across state legislative chambers simultaneously, and ADAP eligibility cuts moving from announcement to implementation in as few as 52 days, multi-front coalitions are essential to respond quickly.[39,40] The Ryan White HIV/AIDS Program, ADAPs, and the broader HIV care network are not isolated services whose value begins and ends with

THE TIME IS NOW

As federal and state funding crises deepen, urgent and creative solutions are needed to ensure state-level advocates can respond effectively and protect continuity of care for people with and at risk for HIV. This requires a broad coalition approach that centers community voices to push for greater federal investment, while simultaneously advancing state-level action to codify protections for critical HIV prevention and treatment medications, modernize data-sharing frameworks and agreements, and safeguard the privacy and legal status of people with HIV.

an HIV diagnosis. They sustain clinics, pharmacies, case-management systems, workforce capacity, referral pathways, and community partnerships that strengthen care for underserved communities, including people with low incomes and people in rural areas who may not have HIV or be at risk for it. When we invest in this infrastructure, we preserve a durable community-health foundation that benefits far more people than the program's immediate clients.

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O'NEILL INSTITUTE
GEORGETOWN LAW
CENTER FOR HIV & INFECTIOUS DISEASE POLICY

AUGUST 2026

This brief is a product of the **Center for HIV and Infectious Disease Policy (CHIDP)** of the **O'Neill Institute for National and Global Health Law. It was developed with support from and in partnership with Gilead Sciences**. It was informed by a stakeholder consultation held in April 2026.

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