The Importance of Federal, State, and Local Investments Toward Ending the HIV Epidemic

State and local investments in HIV interventions, in conjunction with Federal programs and funding, can provide comprehensive support for HIV treatment and prevention towards ending the HIV epidemic.

Since the beginning of the HIV epidemic, historic bipartisan investments have been critical, laying the groundwork for monumental gains in addressing the crisis. While an effective national strategy and federal resources are central to ending the HIV epidemic, success requires commitment by state and local health officials, community organizations, healthcare providers, people living with HIV, and others from communities overrepresented in the epidemic.

However, funding for HIV treatment and prevention across the board has seen only minor increases and most accounts have not kept pace with inflation over the last decade (**source**). Continuing and increasing federal, state, and local investments will be crucial in achieving our 2030 goals for preventing and ending the HIV epidemic.

Bipartisan Success

Our nation's investments in the HIV epidemic thus far have paid off.

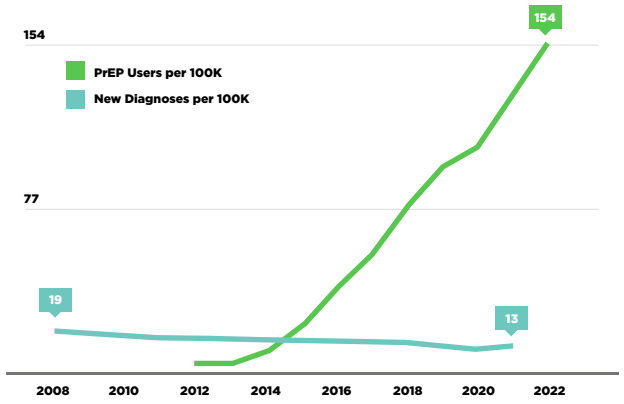
Awareness of HIV status has increased. It is estimated that 1.2 million people in the U.S. were living with diagnosed and undiagnosed HIV at the end of 2022. More people with HIV were aware of their status in 2022 than in 2018, with a slight increase from 86% to 87%. Knowledge of HIV status increased among those aged 13-24 years, Asian people, Black people, Hispanic/Latino people, people in the South, and among males with infections attributed to male-to-male sexual contact (MMSC) (**source**).

Nine in 10 people in the Ryan White HIV/AIDS Program (RWHAP) were virally suppressed in 2022, meaning they have effectively no risk of passing HIV to others through sex. Notably, the percentage of Black/African American clients, Hispanic/Latino clients, and youth and young adult clients receiving care through RWHAP and achieving viral suppression all far exceed overall national viral suppression rates (**source**).

The yearly number of **new HIV diagnoses continues to fall** (**source**).

Use of PrEP (pre-exposure prophylaxis), which can protect people from acquiring HIV, **has increased 52% each year** on average across the U.S. (**source**).

Annual PrEP Usage Rates vs New Diagnoses Rates (per 100K), 2008-2022



$850,557 in lifetime healthcare cost savings

Avoiding one new HIV infection can result in an average of $850,557 in lifetime healthcare cost savings. Average annual and cumulative healthcare costs were up to seven times higher for people living with HIV compared to those without HIV (**source**).

In the early years of the epidemic, people who were diagnosed with HIV could expect to live only one to two years. Now thanks to concerted efforts and resourcing, as well as improvements in antiretroviral therapy (ART), **people living with HIV can live long and healthy lives**.

Other federal efforts like **Minority HIV/AIDS Initiative** — funding designed to strengthen organizational capacity and expand HIV-related services in minority communities — has supported 31 projects in 40 states, DC, Puerto Rico, and Guam, involving 200+ health departments, health centers, and community organizations in essential tooling and resourcing to address inequities in HIV care. Meanwhile **Ending the HIV Epidemic: A Plan for America** (EHE) aims to end the HIV epidemic in the U.S. by 2030 by reducing the number of new HIV infections in the U.S. by 75% by 2025, and then by at least 90% by 2030, for an estimated 250,000 total HIV infections averted.

Proven Methods to End the Epidemic

PrEP works. An increase in PrEP coverage is followed by a decrease in new HIV diagnoses (**source**).

States with a **higher coverage of PrEP among people who needed it experienced steeper declines in new HIV diagnoses** in the past decade. Conversely, from 2012 to 2021, states with the **lowest levels of PrEP coverage saw an annual increase in new HIV diagnoses**.

Investing in and expanding PrEP use at the federal, state, and local levels is vital in ending the HIV epidemic.

> The bottom line is that we know PrEP works. Clinical trials have long told us that PrEP works to prevent HIV infection at an individual level, and now we know PrEP is making a difference at a population level.
>
> Our study shows that when states increase their PrEP coverage, they see a decrease in new HIV diagnoses.

DR. PATRICK SULLIVAN
AIDSVu Principal Scientist,
and Emory University Professor

PERCENTAGE OF POPULATION
Living in Poverty:

12.6% of people in the U.S.

13.9% of people in the South

PERCENTAGE OF POPULATION
Lacking Health Insurance:

10.3% of people in the U.S.

14.1% of people in the South

Median Household Income:

National: **$69,021**

People in the South: **$63,524**

More to Ending the Epidemic

HIV has always had a disproportionate impact on certain populations. For example, Black individuals make up 40% of new HIV diagnoses each year across the U.S. That's eight times more per population than white individuals. Other groups with higher levels of HIV include young people, sexual and gender identity minorities, — and people in the South.

The South experiences a higher burden of HIV compared to other regions across the country, especially among communities of color. **In 2021, the South represented over half (52%) of new HIV diagnoses, but only comprised 38% of the U.S. population. Further, Black people accounted for nearly half of all new HIV diagnoses in the South (49%), despite accounting for only 19% of the Southern population**.

The heavy burden of HIV in the South is driven in part by socioeconomic factors like poverty and unemployment. The South has the highest poverty rate and lowest median household income compared to other regions of the U.S. Both factors are associated with poorer health outcomes and may contribute to a higher concentration of HIV and other chronic diseases like diabetes in the region.

People in the South face several access barriers that can prevent them from receiving adequate HIV and other health care services. Nearly half of all Americans without health insurance live in the South. Medicaid is the largest source of coverage for people with HIV in the U.S., but as of 2022, nine of 17 states in the South have not expanded Medicaid.

Other barriers for people living with HIV in the South include:

- Healthcare access in rural areas
- Cultural factors like stigma
- Lagging prevention and care outcomes like knowledge of HIV status, linkage to care, and viral suppression
- Application of key technologies like tests that can detect HIV in its early stages — when it is most easily transmitted

Preventing and ending the HIV epidemic will require multisectoral and bipartisan support, funding, and programs at all societal levels that prioritize those most impacted.

The Epidemic Without Funding

Not investing or reducing resources in HIV could result in negative outcomes and reverse the hard-earned progress of concerted efforts thus far. **Without intervention, another 400,000 Americans will be newly diagnosed with HIV over the next 10 years**.

Funding is needed to benefit individuals and communities. Without adequate funding:

SOCIETY LEVEL	IMPACT
HIV NEGATIVE INDIVIDUALS	• Significantly reduced access to PrEP or other prevention
HIV POSITIVE INDIVIDUALS	• Significantly reduced access to healthcare • Worsening health outcomes • Increased health costs • Higher risk of transmitted HIV to others due to less viral suppression
POPULATION LEVEL	• Increased HIV transmission rates • Increased healthcare system costs • Increased economic costs and loss of productivity

Action to End the Epidemic

Ending the HIV epidemic requires a multisectoral and bipartisan approach with Governors, state legislators, and Mayors, alongside federal programs, having a key role in addressing the HIV epidemic.

Together, community and advocacy organizations, local and state governments, and federal initiatives should:

- Continue bipartisan support and action for HIV funding
- Prevent barriers to care such as prior authorization and step therapy, and ensure open and unrestricted access to antiretrovirals (ARVs) within state Medicaid programs and commercial plans
- Increase essential federal discretionary HIV funding; flat funding is, essentially, a cut
- Sustain state and federal investments to enable multisectoral investment approaches
- Not consider HIV when looking for budget to cut as progress made thus far could be lost
- Support rapid start initiation of ARVs to ensure immediate linkage to care and a pathway toward viral suppression for those who test positive for HIV, and comprehensive prevention services like PrEP for those who test negative for HIV
- Routinize HIV screening in a number of different clinical settings (emergency departments, FQHCs, hospitals, etc)