Submitted by Anna K. Person, MD, FIDSA, chair of the HIV Medicine Association. Prepared for the U.S. Senate Committee on Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies regarding the FY 2027 appropriations for federal HIV and related programs.

May 19, 2026

Chairman Capito, Ranking Member Baldwin and members of the Subcommittee, my name is Anna K. Person, MD, FIDSA, chair of the HIV Medicine Association (HIVMA). I am a professor of medicine in the Division of Infectious Diseases at Vanderbilt University Medical Center in Nashville, Tennessee, and serve as director of education and faculty development in the division. I am pleased to submit this testimony in my capacity as chair of HIVMA, which represents nearly 6,000 physicians, scientists and other health care professionals on the front lines of the HIV epidemic in communities around the country. Our members provide care and treatment to people with HIV, conduct research and lead public health programs nationwide.

Nearly 45 years after HIV first emerged in the United States, we find ourselves at a defining moment, one that will determine whether decades of hard-won progress move us forward or are reversed by neglect and disinvestment. We are grateful for the Subcommittee's longstanding bipartisan commitment to HIV programs, which has helped sustain critical services for millions of Americans living with or vulnerable to HIV. As an infectious diseases specialist and a clinician dedicated to caring for people with HIV, I have seen firsthand the benefits of federal investment in HIV programs to people with HIV and vulnerable to HIV in Tennessee and beyond, and the high human and economic cost of cuts to these programs. The programs that transformed HIV from a death sentence into a manageable chronic condition have been flat funded for over a decade, even as they now provide lifesaving treatment and services to more people with or vulnerable to HIV. Merely sustaining these programs is no longer adequate. On behalf of HIVMA, I urge Congress to support and increase funding in FY 2027 for the Ryan White HIV/AIDS Program, the CDC Division of HIV Prevention, and NIH's HIV and infectious diseases research programs, and to fund the Bio-Preparedness Workforce Pilot Program.

The funding requests in my testimony reflect the consensus of the Federal AIDS Policy Partnership (FAPP), a coalition of nationwide HIV organizations. For a chart of current and historical funding levels and coalition requests for each program, please refer to FAPP's FY 2027 Appropriations for Federal HIV/AIDS Programs.

HIV/AIDS Bureau – Health Resources and Services Administration: In 2024, the Ryan White Program served a record high number of people with HIV, adding 26,830 new clients, and despite more than a decade of flat funding, it has continued to deliver extraordinary results. However, the remarkable success of this lifesaving program is now at great risk. States, localities and clinics are responding to rising costs at a time of increased demand for services by cutting services and staff. Increased funding in FY 2027 is critical to help the program ensure that people with HIV have access to the HIV treatment and services important to achieve and sustain viral suppression, meaning the virus is undetectable and untransmittable. People receiving Ryan White services achieve viral suppression at a rate of 91.4%, compared to just 67.2% nationally, making this program one of the most successful and effective federal investments. But flat

funding in the face of growing demand, rising health care costs, Medicaid cuts and surging insurance premiums is eroding the infrastructure that makes those outcomes possible. The Ryan White Program served 18,509 people with HIV in my home state of Tennessee and more than 601,000 people receiving care nationwide. The program serves more than half of the people diagnosed with HIV in the U.S., and it is vital to ensuring access to HIV treatment and services in rural areas. **HIVMA urges Congress to allocate $3.130 billion for the HIV/AIDS Bureau's Ryan White HIV/AIDS Program at Health Resources and Services Administration, an increase of $559.4 million over FY 2026, with funding for all parts of the program, including:**

- **$751.4 million for Part A**
- **$520 million for Part B: core medical services**
- **$1.075 billion for Part B: AIDS Drug Assistance Program**
- **$231 million for Part C**
- **$85 million for Part D**
- **$58.0 million for Part F: AIDS Education and Training Centers**
- **$18 million for Part F: dental programs**
- **$358.6 million for EHE initiative**

It is critical to ensure that clinics in all jurisdictions nationwide receive additional funding to increase access to HIV care to keep pace with increased demand and inflation and to help end HIV as an epidemic. Approximately half of the RWP clinics receiving Part C funding serve rural communities, making them the primary source for delivering HIV care in rural jurisdictions. Together, these program parts provide the health care infrastructure to ensure low-income people with HIV have access to care.

The urgency of increased ADAP funding is underscored by recent data from NASTAD's ADAP Watch (April 2026), which found that 19 jurisdictions are currently reporting budget deficits, driven by rising drug costs, increasing insurance premiums, and growing client enrollment. Without a significant increase in Ryan White Part B ADAP funding in FY 2027, these trends will accelerate, threatening the treatment access that keeps people with HIV virally suppressed and healthy.

Beyond the personal impact, RWP clinics not only save lives but also reduce costs. A study from the University of Alabama at Birmingham showed that people treated in the later stages of HIV required 2.6 times more health care spending than those with early treatment. I urge Congress to increase funding over FY 2026 to finally meet the demand that has long outpaced available resources.

Division of HIV Prevention – Centers for Disease Control and Prevention: CDC's Division of HIV Prevention (DHP) provides for our nation's critical HIV prevention infrastructure. Nearly 90% of CDC HIV prevention funding goes directly to state and local health departments and community-based organizations, supporting the surveillance, HIV screening, PrEP access programs and outbreak response that communities across the country depend on, services that states simply could not replace on their own if federal support is withdrawn. As a clinician, I see the downstream effects of this investment every day, in patients who learned their status through an HIV testing program and were connected to HIV care and initiated treatment, preventing the virus from damaging their immune system. I also have seen the consequences of patients not having access to HIV testing who were diagnosed late after their immune system had been

compromised, and of patients newly diagnosed with HIV after being denied access to pre-exposure prophylaxis or PrEP, which is 99% effective at preventing HIV acquisition.

Between 2018 and 2022, new HIV cases declined by 12%, saving between $5 billion and $10 billion in lifetime health care costs. Yet approximately 32,000 Americans are still diagnosed with HIV each year, and each new transmission carries a lifetime treatment cost between $500,000 and $1.1 million. PrEP remains dramatically underutilized due to persistent barriers, including access, stigma and discrimination. **Sustained investment in CDC HIV prevention programs is one of the most cost-effective tools Congress has at its disposal.**

The infrastructure CDC has built for HIV prevention also supports the response to viral hepatitis, sexually transmitted infections and tuberculosis, representing a broad public health value that would be difficult and costly to rebuild if allowed to erode. DHP and the Ryan White HIV/AIDS Program play distinct but complementary roles. CDC focuses on preventing new HIV cases at the population level, while Ryan White delivers care and treatment to individuals already living with HIV. Together, they form the foundation of the national strategy to end HIV as an epidemic. **We urge Congress to increase funding for the CDC Division of HIV Prevention and to ensure that HIV prevention programs remain housed within CDC in FY 2027. We request a total of $1.318 billion, a $304 million increase over FY 2026 levels.** Additionally, under CDC's National Center for HIV, Viral Hepatitis, STD and Tuberculosis Prevention, we request the following:

- **For CDC's opioid-related infections programs, we request an appropriation of $150 million,** a $127 million increase above the FY 2026 program.
- **For the Division of Viral Hepatitis, we request a total of $150 million,** a $104 million increase over FY 2026 levels.
- **For the Division of STD Prevention, we request a total of $322.5 million,** a $158.2 million increase over FY 2026.

Office of AIDS Research – National Institutes of Health: Few investments in medicine have generated a greater return than NIH's commitment to HIV research, producing tools that have reshaped medicine far beyond HIV. I have watched this research reach my patients in real time, including the twice-yearly injectable PrEP option, now changing what prevention looks like for the communities I serve. NIH-funded HIV science gave rise to PD-1 inhibitors that have revolutionized cancer immunotherapy, cures for hepatitis C and a deeper understanding of cardiovascular disease and frailty that benefits all Americans.

In FY 2025, NIH awarded $36.58 billion in research grants across the United States, supporting 390,863 jobs and generating $94.15 billion in new economic activity, a return of $2.57 for every dollar invested. In Tennessee alone, NIH awarded $826.3 million in grants and contracts in FY 2025, directly supporting 9,555 jobs and $2.22 billion in economic activity. Cuts to NIH do not just slow science delaying cures and treatments; they eliminate jobs, hurt local economies and dismantle the research infrastructure that takes decades to rebuild.

Funding of multiyear grants only in year one, abrupt grant cancellations and restrictions on global research partnerships are already setting back the HIV response and threatening the

pipeline of the next generation of American scientists. **To protect and advance these discoveries, we ask for $51.303 billion in overall NIH funding for FY 2027, including $3.953 billion for HIV/AIDS research. We request that the National Institute of Allergy and Infectious Diseases be funded at $7.15 billion** to support the development of vaccines, diagnostics and treatments for emerging infectious threats, including avian flu, antimicrobial-resistant pathogens and other agents categorized as posing the greatest risk to national biosecurity.

Bio-Preparedness Workforce Pilot Program – Health Resources and Services Administration: HIV care and prevention programs alone cannot deliver results without a skilled workforce to implement them. An estimated 80% of counties in 14 Southern states, where new HIV cases are concentrated, have no experienced HIV clinicians, with the greatest gaps in rural and underserved communities. Tennessee is not immune to this crisis. Nearly 20,000 people are living with HIV in the state, 892 residents were newly diagnosed in 2023 alone, and the infectious diseases and HIV workforce needed to serve them is insufficient to meet demand. At Vanderbilt University Medical Center, we aim to recruit five new ID physician trainees each year, but without meaningful financial incentives, medical students and residents burdened by debt are making career and geographic decisions that may bypass the communities that need them most.

The Bio-Preparedness Workforce Pilot Program, authorized as part of the bipartisan Consolidated Appropriations Act of 2023, would directly address this gap by offering loan repayment to health care professionals who provide ID, HIV and emergency preparedness services in health professional shortage areas, Ryan White-funded clinics, VA facilities, community health centers, and rural and tribal health facilities. **We urge Congress to provide $5 million to launch this program in FY 2027 and to fully fund the Public Health Workforce Loan Repayment Program at its $100 million authorization level**. Funding for these programs would strengthen the pipeline of HIV clinicians, support retention in underserved communities and influence the decisions of the medical students and residents choosing their career paths.

Conclusion: Decades of progress in the fight against HIV is the result of Congress's sustained commitment to science, to prevention and to ensuring people with HIV have access to HIV care and treatment. I have watched, year after year, as the programs making advancements in prevention and care do so with fewer resources, and I have seen the consequences for my patients in Tennessee. On behalf of HIVMA and the nearly 5,000 clinicians, educators and researchers we represent, I urge you to strengthen these programs in FY 2027 to sustain our progress in ending the HIV epidemic. Thank you for your support in addressing the HIV epidemic and for considering this request in the FY 2027 LHHS appropriations bill. Please contact HIVMA's associate director of public policy and advocacy, Jose A. Rodriguez, at JRodriguez@hivma.org or (703) 299-0200 with questions.