Testimony for the Record
House Appropriations Subcommittee on Labor, HHS, Education, and Related Agencies
Fiscal Year 2026 Appropriations for HIV and Hepatitis Programs
Carl Schmid, Executive Director, HIV+Hepatitis Policy Institute
April 9, 2025

The HIV+Hepatitis Policy Institute respectfully submits this testimony in support of increased funding for domestic HIV and hepatitis programs in the FY 2026 Labor, HHS spending bill. Specifically, this testimony is in support of funding for the following initiatives, programs and divisions at the Department of Health and Human Services: **Ending the HIV Epidemic Initiative** - $395 million for the CDC Division of HIV/AIDS Prevention, $358.6 million for the HRSA Ryan White HIV/AIDS Program, $207.3 million for the HRSA Community Health Centers, and $52 million for the Indian Health Service; **Ryan White HIV/AIDS Program -** $3.024 billion; **CDC Division of HIV Prevention -** $822.7 million; **CDC Division of Viral Hepatitis -** $150 million; and the **HHS Office of Infectious Disease and HIV/AIDS Policy -** $20 million**.** The HIV+Hepatitis Policy Institute also supports maintaining and funding **CDC's Eliminating Opioid-Related Infectious Diseases Program and Division of School and Adolescent Health; the Minority HIV/AIDS Initiative; AIDS Research 2 at the NIH; the Title X Family Planning Program; the Teen Pregnancy Prevention Program; and the SAMHSA HIV Block Grant.**

Testimony

In 2019, President Trump announced the Ending the HIV Epidemic initiative (EHE) which set the goal of reducing new HIV cases by 90% by 2030. EHE has demonstrated that the existing CDC and HRSA infrastructure can be scaled to significantly reduce HIV transmission in areas of high HIV prevalence. We already have the tools and programs to reach the goal, but it is clear that more funding is required. Now is the time for our nation to take advantage of advancements in prevention and treatment protocols to not only reach EHE's intended goal but to go further and eliminate HIV. Our funding request supports the goal of improving our nation's ability to implement the effective surveillance, education, prevention, care and treatment that will lead to a comprehensive approach to eliminating the syndemic of HIV and viral hepatitis.

It must be pointed out that the recent elimination of staff at the HHS Office of Infectious Diseases and HIV Policy, as well the elimination of staff at CDC's HIV prevention offices, including entire offices conducting public health communication campaigns, modeling and behavioral surveillance, capacity building, and non-lab research, has put national HIV prevention programs at serious risk. Policy development and coordination is essential to a coordinated approach, led by the federal government and implemented by states, counties, cities and community-based organizations, to mitigate chronic disease.

We are also concerned about the recently announced reorganization at HHS that has not been approved by Congress through authorization or appropriations legislation. We all support efficiency and the fight against fraud, waste and abuse, but this massive reorganization should be considered only through a lens of technical and clinical expertise and only with the consent of Congress. Accordingly, the administration should not unilaterally be eliminating critical

prevention, treatment and research grant funding that Congress has appropriated and that states, local governments, and community-based organizations rely upon to carry out their public health responsibilities to address HIV and other infectious diseases.

Increased investment – ***and certainly not cuts*** – in surveillance, education, prevention, and care and treatment will lead to further progress in reducing HIV and viral hepatitis.

Ending the HIV Epidemic

Congress has supported EHE through appropriations that have enhanced prevention programs at CDC and treatment programs at HRSA with the goal of reducing new HIV cases to less than 3,000 per year. The initiative, which is currently focused on jurisdictions representing about 50% of HIV diagnoses, has shown success by targeting funding to areas of higher HIV prevalence, supporting increased testing, expanding access to prevention medication and linking people with HIV to appropriate medical care.

EHE's impact on HIV in this country has been noteworthy. From 2017 to 2022, in jurisdictions receiving EHE funding, new HIV cases decreased 21%, compared to a 6% decrease in non-EHE jurisdictions, largely due to increased access to pre-exposure prophylaxis medication known as PrEP. Between 2021-2023, more than 61,000 people were prescribed PrEP in the CDC EHE-funded programs, and HRSA-supported community health centers provided PrEP services to 183,000 patients. Also under EHE, the Ryan White HIV/AIDS Program supported more than 22,000 clients new to care and re-engaged 19,000 clients, with 79.2% of those new to treatment achieving viral suppression in 2022. With EHE funding, 406 community health centers conducted a cumulative 7.2 million HIV tests, substantially increasing the proportion of their patients aware of their HIV status. Also, Indian Health Service EHE-supported sites have performed over 20,000 HIV tests.

Notwithstanding EHE's demonstrated successes, without an infusion of new resources to accelerate our efforts, we will continue to fall short of the intended goals even though we have the tools to achieve them. We simply need Congress to provide the resources. **For FY 26, we urge Congress to fund EHE activities at the levels outlined below to accelerate our efforts to end HIV in the prioritized jurisdictions:**

- **$395 million for the CDC Division of HIV/AIDS Prevention** for testing, linkage to care, and prevention services, including PrEP (+$175.0 million);
- **$358.6 million for the HRSA Ryan White HIV/AIDS Program** to expand comprehensive care and treatment for people living with HIV (+$193.6 million);
- **$207.3 million for the HRSA Community Health Centers** to increase access to prevention services, particularly PrEP (+$50.0 million); and
- **$52.0 million for the Indian Health Service** to address the disparate impact of HIV and hepatitis C on American Indian/Alaska Native populations (+ $47.0 million).

HIV

HRSA's Ryan White HIV/AIDS Program (Ryan White), is the payer of last resort for people living with HIV, providing medications, medical care, and essential support services to more than 576,000 low-income, uninsured, and/or underinsured individuals. More than 60% of Ryan

White clients are living at or below 100% of the Federal Poverty Level. The program continues to be a critical pillar in the federal response to HIV, providing treatment and care to more than 50% of people diagnosed with HIV in the U.S. More than 90% of Ryan White clients have achieved viral suppression, compared to just 65% of all people diagnosed with HIV nationwide.

People living with HIV who are in care and on treatment are far more likely to be virally suppressed, leading to reduced transmission of the virus. This program is especially important in many states, particularly in the South where there are large healthcare coverage gaps because they have not expanded Medicaid. There are approximately 400,000 people living with HIV in the U.S. who are not engaged in care and treatment. Ryan White can play a large role in bringing this population into care and treatment. Despite this progress, approximately 40% of people with HIV in the U.S. are either undiagnosed or not receiving regular care, contributing to most new HIV cases. Addressing these gaps is essential to achieving the goal of ending the epidemic, and Ryan White plays a pivotal role in supporting communities most severely affected by HIV through its distribution of funds to grantees.
We urge Congress to fund the Ryan White HIV/AIDS Program at a total of $3.024 billion in FY26, an increase of $453.4 million over FY25 (+$193.6 million for the EHE initiative and +$68 million for AIDS Drug Assistance Programs).

Prevention
HIV prevention methods, including PrEP, HIV testing and linkage to care, are more effective than ever. **CDC's Division of HIV Prevention** leads federal efforts in developing innovative prevention strategies, working closely with state, local, and community-based organizations to meet the disease prevention needs of their populations. Spearheaded by CDC's prevention programs, between 2012 and 2022, 27,900 HIV cases were prevented which saved an estimated $15.1 billion in lifetime medical costs. This confirms that HIV prevention efforts are clinically and fiscally impactful. Increasing funding for high-impact, community-focused HIV prevention services through the CDC's Division of HIV Prevention remains a priority and results in a strong return on investment. **We urge you to support the CDC Division of HIV Prevention at $822.7 million in FY26 (+ $67.1 million).**

PrEP
Increasing access to PrEP is the key to ending the HIV epidemic in the U.S. Long-acting PrEP options, including a six-month injectable expected to be approved by the FDA later this year, are expected to improve uptake and compliance, further advancing prevention objectives. However, only two in five people at risk of acquiring HIV have access to PrEP. Expanding access to PrEP nationwide is imperative. Increasing CDC's base HIV prevention and EHE funding, along with HRSA's EHE funding for community health centers will help ensure PrEP activities can be expanded, particularly for the uninsured.

SAMHSA HIV Block Grant
We urge the Subcommittee to include language that would modernize the way in which states qualify to be eligible for the HIV set-aside of the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG). Instead of using the outdated measurement of *AIDS* cases for a state to qualify for the 5% HIV set-aside, the number of *HIV* cases should be

used. Due to the current language, only three states and the District of Columbia now qualify. With the update, up to 20 would be eligible.

Related Programs

A holistic response to the HIV epidemic also depends on **maintaining and funding** other priority programs at HHS, including the **CDC's Eliminating Opioid-Related Infectious Diseases Program and Division of School and Adolescent Health, the Minority HIV/AIDS Initiative, AIDS Research 2 at the NIH, the Title X Family Planning Program, and the Teen Pregnancy Prevention Program (TPPP).**

Viral Hepatitis

We urge the Subcommittee to provide increased funding for viral hepatitis programs at CDC, which estimates that nearly 5 million people in the United States live with hepatitis B (HBV) or hepatitis C (HCV), and as many as 65% are unaware they are living with the disease. Left untreated, viral hepatitis results in significant costs to public health programs due to liver cancer and liver transplants. Liver transplants were estimated at over $800,000 per procedure in 2021, so, with approximately 1,500 liver transplants annually due to HCV, $1.2 billion avoidable medical costs are being incurred. The opioid epidemic continues to lead to an increase in new viral hepatitis cases. There are several curative treatments available for HCV, but individuals must have access to screening and linkage to care.

The viral hepatitis programs at the CDC are severely underfunded, receiving only $43 million, far short of what is needed to build and strengthen our public health response to all forms of hepatitis. Increased investment would allow the CDC and the states to enhance testing and screening programs, conduct additional provider education, enhance clinical services specific to hepatitis at sites serving vulnerable populations, and increase services related to hepatitis outbreaks and injection drug use. **We urge you to provide the CDC Division of Viral Hepatitis with $150 million, an increase of $107 million over FY25 enacted levels.**

Federal HIV & Hepatitis Coordination

Two important offices which coordinate the implementation of the NHAS, EHE and viral hepatitis activities need resources to bolster their ability to coordinate HIV and viral hepatitis activities across the federal government. **We urge you to restore the HHS Office of Infectious Disease and HIV/AIDS Policy at $20 million (+$12 million) and provide $3 million for the White House Office of National AIDS Policy in FY26.**

While we recognize that many in Congress are looking to reduce government spending across the board, we urge you to consider that focused investment in public health programs provides long-term savings by addressing chronic disease and keeping people healthy. We respectfully urge the committee to continue its investment in our nation's public health infrastructure specifically as it relates to addressing the ongoing HIV and hepatitis epidemics.