Evidence and Lessons on the Effectiveness of Place-Based Federal Health Funding from the Fight against HIV/AIDS*

Marcus Dillender†

February 2021

Abstract

HIV/AIDS has been one of the largest public health crises in recent history, and the U.S. federal government has spent hundreds of billions of dollars fighting the disease. This study examines the impact of federal funding allocated to U.S. cities through the largest program for combating HIV/AIDS in the United States. The findings indicate that the cost to avoid an HIV/AIDS death through this city-level funding is roughly $314,000, that the program has saved approximately 60,000 lives through 2018, and that funding disparities are responsible for the uneven progress in combating HIV/AIDS across the United States.

Key Words: government spending, HIV/AIDS, mortality, health disparities

JEL Codes: H51, I14, I18

****This is a preliminary draft. Please do not cite or distribute.****

*I thank Shila Azodi, Kitt Carpenter, Joy Getzenberg, Lisa Powell and seminar participants at the LGBTQ+ Econ Seminar and Vanderbilt University for helpful discussions and comments.

†University of Illinois at Chicago, School of Public Health, Division of Health Policy and Administration and NBER, modillen@uic.edu.

1 Introduction

A common tool of the U.S. federal government for addressing public health issues is to allocate federal funds to support local responses. This approach has been used in public health campaigns against specific diseases, including HIV/AIDS, diabetes, opioid addiction, COVID-19, and heart disease, and in addressing broader issues related to access to care for underserved areas and people. Understanding the impacts of allocating federal funds to local areas for the purpose of improving public health is important for forming optimal policy to address public health issues, but few estimates of the effect of federal spending to support local public health responses exist.

This paper examines the impact of the federal government providing funding to U.S. cities to address the HIV/AIDS epidemic, which has been one of the largest public health crises in recent history[1] and has claimed the lives of tens of millions of people worldwide. While the burden of HIV/AIDS in the United States has fallen hardest on gay men and intravenous drug users—two groups that make up a relatively small share of the U.S. population—the impact of HIV/AIDS on these groups has been so devastating that HIV/AIDS has been a major factor in aggregate health statistics. For example, from 1993 to 1995 HIV/AIDS was the leading cause of death among all people ages 25 to 44 in the United States. Though treatment emerged in 1996 that could drastically lengthen the lives of people with HIV/AIDS, no cure for HIV exists, and nearly 40 million people currently live with HIV worldwide. While HIV/AIDS death rates have fallen in the United States over the past few decades, the progress in combating HIV/AIDS has been uneven across the country, with large cities that were the early epicenters of HIV/AIDS having experienced much larger reductions in HIV/AIDS death and case rates since the height of the AIDS crisis than many other parts of the country have. The slow progress in certain parts of the country has contributed to concerns that the U.S. response to HIV/AIDS is failing.[2]

[1] While comparing the overall impacts of various public health crises would require aggregating across different metrics, HIV/AIDS stands out both for the large number of people that it has affected and for its persistence as a public health concern. Having killed over 700,000 Americans, HIV/AIDS has resulted in the deaths of more Americans than World War I, World War II, the Korean War, and the Vietnam War combined. All recent presidents have emphasized the importance of fighting HIV/AIDS for their administrations, and public health leaders and policymakers often assess the importance of emerging public health crises by comparing their possible impacts to the impact of HIV/AIDS (e.g., Benjamin 2020; Joint Economic Committee 2017).

[2] Refer to El-Sadr, Mayer, and Hodder (2010) and El-Sadr et al. (2019). See also the comments from Tom Frieden, then-director of the Centers for Disease Control and Prevention, in "U.S. Still in Danger of Losing War on AIDS, C.D.C. Director Says," which was published in *The New York Times* on December 1, 2015.

As HIV/AIDS treatment is expensive and lifelong, many resources have been spent treating the disease. Because an untreated HIV/AIDS infection can impose negative externalities by increasing the spread of HIV and because many people in the United States who have contracted HIV or are at risk of contracting HIV are socioeconomically disadvantaged, the U.S. federal government has had a large role in funding HIV/AIDS treatment. In 2019 alone, the U.S. federal government spent $34.8 billion on HIV/AIDS, with most of that funding spent on treating and limiting the spread of HIV/AIDS domestically (Kaiser Family Foundation 2019a).[3] HIV/AIDS funding levels have been controversial. Some observers have argued that too many resources have been spent combating HIV/AIDS (England 2007), and even though the U.S. federal government has the ambitious goal of eliminating the HIV/AIDS epidemic in the United States by 2030 (Fauci et al. 2019), policymakers often target HIV/AIDS funding for budget cuts (Hatcher 2020).

Despite HIV/AIDS having been one of the largest public health crises in modern history and despite the federal government having spent hundreds of billions of dollars to combat the disease, little is known about the impact of federal funding to combat HIV/AIDS or about the role that the large amounts of federal funding have played in the trajectory of the HIV/AIDS epidemic in the United States. More generally, little is known about the ability of allocating funds to local areas to support flexible public health responses to improve population health. The lack of research into the U.S. government's response to HIV/AIDS stands in contrast to economics research into the health impacts of other U.S. public health campaigns (e.g., Anderson et al. 2019, Anderson, Charles, and Rees 2020; Bleakley 2010; Bleakley 2007) and of various federal safety net programs (e.g., Almond, Hoynes, and Schanzenbach 2011; Goodman-Bacon 2018a; Hoynes, Miller, and Simon 2015; Miller et al. 2019).

The goal of this study is to understand the impact of federal funds allocated to cities to combat HIV/AIDS and the role that this funding has had in the course of the HIV/AIDS epidemic in the United States. Specifically, I examine the impact of funding from the first title of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. Since its passage in 1990, the Ryan White CARE Act has been the U.S. government's main mechanism for combating HIV/AIDS

[3]Note that this amount of annual spending is more than the federal government spends on many important safety net programs, including Head Start, the Children's Health Insurance Program, Temporary Assistance for Needy Families, and the Federal Pell Grant Program. Refer to Center for Poverty and Inequality Research (2020) for a discussion of federal spending levels for these programs.

in the United States. Unlike many other federal programs, the Ryan White program does not provide benefits directly to the targeted population. Instead, the Ryan White CARE Act provides funding directly to cities and states to support local efforts to develop, coordinate, and operate systems to provide health care and support services to low-income individuals with HIV/AIDS (Institute of Medicine 2004). Through its first title, which is the title that allocates funding to cities and is the focus of this study, the Ryan White CARE Act has allocated over 20 billion dollars (in 2018 dollars) to 52 U.S. cities through 2020.

A challenge in studying the impact of federal funding is that funding mechanisms are often set so that funding is allocated to areas with the most need. In the case of HIV/AIDS, targeted funding means that places with greater HIV/AIDS burdens generally receive more federal funding to combat HIV/AIDS than other places. Thus, naive ordinary least squares regressions of HIV/AIDS outcomes on HIV/AIDS funding would suggest that increased funding leads to worse HIV/AIDS outcomes.

To identify the impact of Ryan White funding, this paper implements a difference-in-differences research design that uses variation in eligibility for Title 1 funds that comes from two aspects of the Ryan White CARE Act. The first driver of the variation in Title 1 eligibility studied in this paper comes from the staggered timing of cities gaining Title 1 status that resulted from the original Ryan White legislation granting cities Title 1 status only after they had at least 2,000 AIDS cases. The second driver of the variation in Title 1 status studied in this paper comes from a 1996 rule change that stipulated that a new AIDS case would only count towards eligibility for five years and was implemented along with a grandfather clause that allowed cities that had obtained Title 1 status under the original rules by March 31 of 1995 to maintain Title 1 status even if they did not meet this new standard. Immediately after these changes were made, treatment was discovered that could prevent people with HIV from developing AIDS. The interaction of the simultaneous occurrence of the rule change, the grandfather clause, and the emergence of treatment resulted in the de facto criteria for receiving Title 1 funding in the coming years largely being that cities had to have had at least 2,000 AIDS cases by March 31 of 1995 and led to cities that originally had similar HIV/AIDS burdens and that were initially on parallel HIV/AIDS trajectories receiving dramatically different amounts of federal funding to combat HIV/AIDS.

Using variation in Title 1 eligibility that arises for these reasons, I identify the impact of Title 1 status by estimating how the difference in HIV/AIDS outcomes between Title 1 cities and other

cities changed after Title 1 cities obtained Title 1 status. To keep the treatment and control groups comparable, the main sample includes the final 25 cities to clear the threshold for Title 1 status under the original eligibility rules as the treatment cities and the 25 cities with the most AIDS cases through 1995 not qualifying for Title 1 status under the original rules as the control cities. In essence, cities that were near but not quite at 2,000 AIDS cases ever reported by March 31 of 1995, like Birmingham, Cincinnati, Providence, and Richmond, serve as the control group for cities that had just reached 2,000 cases March 31 of 1995, like Cleveland, Fort Worth, Hartford, and Sacramento.

The main outcome studied in this paper is cities' annual HIV/AIDS death rates from 1990 to 2018 calculated from the restricted-use Vital Statistics Multiple Cause of Death Files. Estimating difference-in-differences models indicates that a city obtaining Title 1 status reduced the city's annual HIV/AIDS death rates by about 17 percent on average. The composition of lives saved generally corresponds to HIV/AIDS prevalence rates across demographic groups with prime-aged adult males accounting for most of the lives saved. The estimates imply that one HIV/AIDS death has been avoided for every $314,000 dollars allocated through Title 1 and that Title 1 has saved approximately 60,000 lives through 2018. In addition to estimating the impact of Title 1 status on HIV/AIDS deaths, I also estimate the impact of Title 1 status on rates of new AIDS cases and find that a city obtaining Title 1 status reduced the city's annual rates of new AIDS cases by 19 to 21 percent on average.

Descriptive analysis of long differences in HIV/AIDS measures from 1990 through 2018 highlights the role that Title 1 funding disparities have had in the disparities in HIV/AIDS progress across cities. Even with changes in both the Ryan White CARE Act and the U.S. health care system in recent years that would be expected to alleviate cross-city differences in HIV/AIDS progress caused by Title 1 disparities, cities that obtained Title 1 status under the original Ryan White rules experienced a 24 percent larger reduction in AIDS death rates from 1990 to 2018 than cities that did not obtain Title 1 status under the original rules.

The significant health impacts of this funding speak to the promise of providing targeted federal funding to local areas to improve health. Assuming a value of a statistical life of $10 million, the estimates imply that the $19 billion allocated to cities from 1991 to 2018 has produced over $600 billion dollars of value in terms of lives saved. Title 1 funds yielding a benefit-cost ratio above 30 is especially notable in light of studies that find negligible health gains from marginal

health care spending (e.g., Doyle 2011; Doyle et al. 2015; Einav, Finkelstein, and Mahoney 2018). However, the role that disparities in federal funding have had in establishing the disparities in HIV/AIDS progress highlights the importance of funding mechanisms' allocation rules and points to issues that can arise from place-based funding. The analysis presented in this paper indicates that place-based disparities in federal HIV/AIDS funding are a key driver of the disparities in progress combating HIV/AIDS across the country.

The paper proceeds as follows. The next section provides a brief overview of HIV/AIDS in the United States and of the Ryan White CARE Act and discusses the expected effects of federal funding to combat HIV/AIDS. Section 3 describes the eligibility rules for Title 1 funding in more detail and discusses the empirical approach and data sources used in the study. Section 4 presents the results, and Section 5 concludes.

2 Background

This section first provides background information on the HIV/AIDS epidemic in the United States. Since the timing and nature of the HIV/AIDS treatment that emerged in the mid-1990s played a role in establishing the large disparities in federal funding studied in this paper, this discussion includes a brief summary of the search for effective HIV/AIDS treatment. The section then discusses the Ryan White CARE Act and describes the potential impact of HIV/AIDS funding.

2.1 HIV/AIDS in the United States and the Search for Effective Treatment

Human immunodeficiency virus (HIV) is a retrovirus that can be spread through unprotected sex, needle sharing, blood transfusions, and from mother to child during pregnancy, delivery, or breastfeeding. HIV harms infected people by lowering their white blood cell counts and thus weakening their immune systems. While HIV is a virus, acquired immunodeficiency syndrome (AIDS) is a set of symptoms that people with HIV develop after HIV has caused significant damage to their immune systems. People with AIDS are susceptible to opportunistic infections and cancers that a healthy immune system could typically combat but that aggressively take hold in someone with AIDS. Infections that lead to diseases like pneumocystis carinii pneumonia, Kaposi's sarcoma, and cytomegalovirus, which can be easily controlled by healthy immune systems, have been common killers of people with AIDS. Without treatment, HIV usually pro-

gresses to AIDS within 8 to 10 years. Life expectancy for people with untreated AIDS is 1.5 years. Though deaths from AIDS occurred earlier, AIDS was first recognized in 1981. Annual deaths from AIDS in the United States rose from 451 in 1981 to their height of over 50,000 in 1995.

Prior to 1987, the care that HIV/AIDS patients received was largely palliative and aimed at treating the opportunistic infections that developed as a result of HIV/AIDS. In 1987, the Food and Drug Administration (FDA) approved zidovudine (AZT, formerly azidovudine) as the first medicine to treat HIV/AIDS. Originally developed in the 1960s to be a form of chemotherapy, AZT received FDA approval to treat HIV/AIDS after it was shown to temporarily increase white blood cell counts in people with HIV/AIDS. Despite early excitement about AZT, its side effects proved to be unbearable for many people, and whether the transient increase in white blood cell counts induced by AZT was meaningful remained an open question (Hamilton et al. 1992).

In the early 1990s, the outlook for the HIV/AIDS epidemic looked bleak. AIDS had become the leading cause of death for prime-aged adults in the United States, and the rapid rise in AIDS cases and deaths showed no signs of slowing. The search for effective treatment was proving elusive. Frustrated by a lack of progress and a perceived lack of research attention, HIV/AIDS activists staged thousands of demonstrations between 1987 and 1996, including ones at the National Institutes of Health and FDA campuses in the 1990s. At these demonstrations, protestors staged die-ins, held signs that read "NIH–Nothing Is Happening" and "Federal Death Administration", and set up mock graveyards with tombstone epithets stating "Dead from a Lack of Drugs" and "Poisoned from AZT".[4]

In 1996, however, a breakthrough in HIV/AIDS treatment emerged that would alter the course of the fight against HIV/AIDS. Antiretroviral treatments were introduced that could prevent HIV from replicating in the body and could reduce HIV's damage to the immune system. While the full effects and implications of these drug cocktails were not understood immediately, studies would eventually show that within 30 days of treatment initiation, these drugs could lead to HIV being undetectable in the blood of a person with an HIV infection as long as treatment was maintained and could prevent people with HIV from developing AIDS. Research would also eventually show that these new antiretrovirals drastically reduce the likelihood that a person with an HIV infection transmits the infection to others.

[4]Refer to Fernández, Parsa, and Viarengo (2019) and Mansour, Rees, and Reeves (2020) for discussions and studies about the organizational efforts of AIDS activists.

The first of these new antiretrovirals was approved by the FDA in December of 1995 under an accelerated approval process that allows drugs to be used before their effectiveness has been established. After being disappointed by several drugs that initially seemed promising only to eventually turn out to be ineffective against HIV/AIDS, HIV/AIDS patients and physicians were at first skeptical about the likely effectiveness of these new drugs. However, reports of emaciated and demented HIV/AIDS patients whose deaths seemed imminent quickly returning to health after taking these antiretrovirals would soon become common, and HIV/AIDS communities soon realized that these new antiretrovirals marked a turning point in the search for effective HIV/AIDS treatment. In *How to Survive a Plague*, a book about the search for effective HIV/AIDS treatment that was the basis for the Oscar-nominated documentary of the same name, David France describes the moment that many people realized that these new antiretrovirals were a momentous advance in HIV/AIDS treatment. At a 1996 event about the new treatment held at the New York University Medical Center, a scientist interrupted his otherwise technical presentation about a study showing the dramatic effect of the antiretrovirals on HIV/AIDS survival rates to tell a room full of disoriented HIV/AIDS activists, researchers, and health care providers the following:

> Maybe you are not understanding what I am saying. This is the biggest news ever in this epidemic...This is what we've been working for all these years. They're not a cure. We don't know what they are, in effect. But this is the first major piece of good news we have had in all these years. They're calling it the Lazarus effect. People who were in hospitals on their last breath are getting up and going back to work. We've never seen anything like it. (France 2016)

The use of antiretroviral treatment accelerated throughout 1996 and became the standard treatment for HIV/AIDS by the start of 1997. As a result of these new antiretrovirals, deaths from HIV/AIDS began a major decline in 1996. The number of HIV/AIDS deaths fell by over 20 percent from 1995 to 1996 and by nearly 50 percent from 1996 to 1997, which has been the largest single-year decline for a major cause of death ever recorded (Centers for Disease Control and Prevention 1998). The life expectancy of a young adult who begins antiretrovial treatment immediately after contracting HIV is now near the life expectancy of a similar person without HIV

(Marcus et al. 2020). While research into HIV/AIDS treatments has continued[5], the emergence of effective treatment ushered in a new chapter in the fight against HIV/AIDS: How to ensure that people with HIV/AIDS have access to these effective but expensive treatments and how to maximize the impact of these new drugs in the fight against HIV/AIDS.

Though progress has been made in the HIV/AIDS pandemic, the United States still faces many issues related to HIV/AIDS.[6] Despite initial speculation that antiretroviral therapy was a cure for HIV, it was soon realized that the antiretrovirals suppress HIV only for as long as they are taken. Though the antiretrovirals cause HIV to be undetectable in the blood, the HIV virus lies dormant in a small number of cells and will take hold again if a person discontinues the antiretrovirals. In the United States, over 700,000 people have died of HIV/AIDS, and approximately 1.2 million people are currently infected. Half of all people with HIV infections in the United States do not have their infections suppressed through antiretroviral therapy and can therefore still spread the infections to others, which contributes to the number of HIV infections continuing to climb (Centers for Disease Control and Prevention 2017). Large disparities in HIV/AIDS burden by race and socioeconomic status exist in the United States, with low-income and Black people accounting for disproportionately large shares of HIV/AIDS cases and deaths (Rubin, Colen, and Link 2010).

2.2 The Ryan White CARE Act

The cost to treat a patient with the new antiretroviral drugs in 1996 was high at a mean annual cost of $20,300 (in 1996 dollars) (Bozzette et al. 2001), but even before the emergence of the effective antiretroviral drugs, treating HIV/AIDS was expensive.[7] Exacerbating access issues arising from the cost of treatment are the facts that many people with HIV/AIDS have below-

[5]In addition to there being improvements in antiretrovirals since 1996, another major advance in HIV/AIDS prevention occurred in 2012 with the emergence of pre-exposure prophylaxis as a daily pill that can prevent people from developing an HIV infection after exposure to HIV. Along with the vast medical and public health literatures studying HIV/AIDS treatments, several economics papers have examined aspects of these drugs. Using observational data, Duggan and Evans (2008) provide evidence that the use of the effective antiretrovirals reduces mortality rates for people with HIV infections in non-experimental settings. Lakdawalla, Sood, and Goldman (2006) show that by reducing the cost and likelihood of HIV infections, access to effective HIV treatment increases risky sexual behavior of gay men. Chan, Hamilton, and Papageorge (2016) develop a framework to measure the value of a medical innovation to combat an infectious disease and apply the framework to HIV treatment.

[6]While this paper focuses on HIV/AIDS in the United States, HIV/AIDS is a global issue and remains a leading cause of death worldwide. Sub-Saharan Africa has been hit particularly hard. In 2017, HIV/AIDS accounted for over a quarter of all deaths in South Africa and Botswana (Roser and Ritchie 2018).

[7]Treating HIV/AIDS remains expensive and continues to cost around $20,000 per year (Gebo et al. 2010).

average incomes and that people with AIDS are often unable to work for health reasons and have often reported employment discrimination when they try to work.[8] All of these challenges resulted in many people with HIV/AIDS having difficulties accessing and paying for health care.

In response to growing pressure to provide financial resources to address the HIV/AIDS epidemic, Congress passed the Ryan White CARE Act on August 18, 1990.[9] As the largest federally funded program in the United States for people living with HIV/AIDS, the Ryan White program is the backbone of the federal government's strategy to address the HIV/AIDS epidemic in the United States and has a goal of improving access to health care for low-income, uninsured, and under-insured people affected by HIV/AIDS who could not otherwise access treatment. According to the Health Resources and Services Administration (HRSA), the branch of the Department of Health and Human Services that administers the Ryan White program, over half of people with HIV/AIDS receive care through the Ryan White program, a majority of whom have incomes at or below the federal poverty level (Health Resources and Services Administration 2019). Since Ryan White funds are discretionary, the Ryan White CARE Act must be periodically reauthorized and has been reauthorized in 1996, 2000, 2006, and 2009. With each reauthorization, Congress has made changes to the Ryan White program.[10] The amount appropriated to the program has grown from $260 million in 1991 to $2.5 billion in 2020.

While Congress recognized the need for providing funding to combat HIV/AIDS, some members of Congress were concerned about creating a new federal entitlement program. Thus, Congress opted not to provide support directly to people with HIV/AIDS. Congress also chose not to have the federal government directly provide HIV/AIDS treatment or to commit to reimbursing providers for HIV/AIDS treatments. Instead, the Ryan White CARE Act provides

[8]Prior to the passage of the Affordable Care Act, people with HIV have also had difficulties accessing health insurance coverage through the individual market. By requiring insurers in the individual market to accept all who apply for coverage and by expanding Medicaid coverage for childless adults, the Affordable Care Act expanded health insurance coverage for people with HIV/AIDS. Refer to Goldman et al. (2014) and Sood et al. (2014) for discussions of the potential implications of the ACA for the Ryan White CARE Act.

[9]The Ryan White CARE Act is named in honor of Ryan White, a hemophiliac who contracted HIV through a blood transfusion and became an advocate for HIV/AIDS awareness and research before dying in his teens from HIV/AIDS.

[10]I summarize the Ryan White CARE Act and discuss the provisions that have led to the large funding disparities analyzed in this study, as well as aspects of the Ryan White CARE Act that are relevant to interpreting the results. The Ryan White CARE Act is a complex piece of legislation with many policy parameters and formulas that have changed over time. Refer to Health Resources and Services Administration (2013), Institute of Medicine (2004), and Kaiser Family Foundation (2019b) for additional information on the Ryan White CARE Act.

financial support to state and local governments to support local responses to HIV/AIDS. Ryan White funds are administered through five programs, though most of the funding—nearly 90 percent—is allocated through its first two titles. Title 1 administers funds directly to eligible cities, while Title 2 administers funds directly to states. The remaining Ryan White funds are allocated to community-based organizations to provide primary health care to people living with HIV, to AIDS education centers, and for dental care for people with HIV.

The focus of this paper is on Title 1 funds. Title 1 funds are administered directly to mayors, who then typically direct the funds to health departments (Health Resources and Services Administration 2013). Cities receiving Title 1 funds are required to establish HIV Health Services Planning Councils that set local priorities for HIV/AIDS care delivery. The majority of funds must be used for core medical care, which includes outpatient services, early intervention services, and case management.[11] Nearly half of Title 1 funds go to services classified as outpatient care and case management, while the rest of the funds are spread over many different types of services (Health Resources and Services Administration 2020). The rules for obtaining Title 1 status and for allocating Title 1 funds are crucial to the empirical approach of this study and are discussed in detail in Section 3.

Title 2 funds are allocated to states to support planning and coordinating of HIV/AIDS care and can be used for similar services as Title 1 funds. The Title 2 allocation rules are complex, but most of the Title 2 funds are allocated independently of Title 1 funds. The partial double counting of cases in Title 1 cities for Title 1 and Title 2 funding has led to disparities in total Ryan White CARE Act funds relative to HIV/AIDS burdens across states. I briefly summarize the Title 2 funding rules as they relate to Title 1 funding. Refer to Health Resources and Services Administration (2013), Institute of Medicine (2004), and Kaiser Family Foundation (2019b) for additional details about Title 2 funding. While Title 2 funding initially did not take into account Title 1 funds, the 1996 reauthorization set aside approximately 5 percent of Title 2 funds to be allocated based on a state's share of national AIDS cases that occur outside of Title 1 cities. Since 2000, Title 2 also includes a separate category of funds that provides a small amount of additional funding to states with non-Title-1 cities with high AIDS burdens. As discussed in more detail in

[11] Examples of outpatients services include medication and office visits. Examples of early intervention services include testing and contact tracing. Examples of case management include services for medication adherence and care retention. Refer to Health Resources and Services Administration (2020) for detailed expenditures in 2018.

Section 3, these city-directed Title 2 funds are much much lower than the funding provided by Title 1. Through 2020, Title 2 has allocated 33 billion dollars (in 2018 dollars) to states.

Throughout its history, the Ryan White CARE Act has been the subject of contentious disagreements. Although the initial bill received bipartisan support, politicians have expressed opposition to the Ryan White CARE Act for both moral and fiscal reasons. For instance, Congressman Jesse Helms objected to the bill based on his view that "deliberate, disgusting, revolting conduct" was responsible for people contracting HIV, while then-Congressman Mike Pence argued for directing Ryan White funds to organizations "which provide assistance to those seeking to change their sexual behavior." Facing the threat of a veto, President George H. Bush signed the Ryan White CARE Act into law, but the White House had initially expressed its opposition to the bill, stating that "The bill's narrow approach, dealing with a specific disease, sets a dangerous precedent, inviting treatment of other diseases through similar arrangements." Throughout the Ryan White program's history, Title 1 cities have fought efforts to allocate Ryan White funds more equitably. For example, in 2005, areas struggling to address HIV/AIDS that received low Ryan White funding relative to their HIV/AIDS burdens argued for implementing rules to distribute Ryan White funds more equitably in the 2006 reauthorization. In response to these calls for changes in funding, *The New York Times*—a newspaper from a city that had received over 1 billion dollars in Title 1 funds through 2005—published an editorial arguing that the lack of relative progress in addressing HIV/AIDS in much of the country was the result of those areas not caring about the plight of people with HIV/AIDS rather than from disparities in Ryan White funds. The editorial argued that the progress that Title 1 cities had made in addressing HIV/AIDS relative to other cities justified future funding disparities, seemingly ignoring the possibility that wide funding disparities up to that point could have played a role in the disparities in HIV/AIDS outcomes that had emerged by the mid 2000s.[12]

2.3 The Expected Effects of Federal Funding to Combat HIV/AIDS

The effect of federal HIV/AIDS funding on HIV/AIDS deaths depends on the health care paid for by the funds as well as on the health care that patients would have received absent the funds. Since the Ryan White program is supposed to be the last payer for treatment, the

[12]See "Guarding the Fight Against AIDS", which was written by *The New York Times* editorial board and published on August 18, 2005.

care paid for with Ryan White funds should in principle be care that people would not have otherwise received. In practice, though, Ryan White funds have the potential to displace care paid for by other sources. If patients receiving treatment paid for by Ryan White funds could have accessed their desired health care absent the Ryan White program, the funding's health impacts would be minimal. Similarly, if the productivity of additional health care provided by Ryan White funds is low or if health departments use the funds inefficiently, HIV/AIDS funding could have no health impacts.

At the other extreme, Ryan White funds could briefly provide life-saving treatment to people with HIV/AIDS while those people find other ways to access and pay for treatment. In this case, small amounts of federal funding could have large impacts on HIV/AIDS deaths. Moreover, some of the services that health departments use Ryan White funds for, such as HIV/AIDS outreach and contact tracing, could have large health impacts even though they would typically not be provided by the private market. If Ryan White funds lead to lower transmission rates of HIV, the effects of the funding on health measures may grow over time and would likely persist even if funds were discontinued.

The main outcome of interest for the study is HIV/AIDS deaths. By reducing the spread of HIV and by preventing or slowing the development of AIDS in HIV-positive people, federal funding to combat HIV/AIDS would be expected to decrease HIV/AIDS deaths.

While data on HIV rates and prevalence were not widely tracked in the 1990s and are therefore not assessed empirically in this study, federal funding would be expected to reduce new HIV transmission rates. By reducing HIV transmission rates and by reducing the likelihood that HIV leads to AIDS, federal funds would also be expected to reduce rates of new AIDS diagnoses.

The sign of the expected effect of federal funding on HIV prevalence and on AIDS prevalence is unclear. By reducing HIV transmissions and by limiting the progression of HIV to AIDS, HIV/AIDS funding could reduce a city's prevalence of both HIV and AIDS. However, by reducing HIV/AIDS deaths, federal funding also has the potential to increase the numbers of people living with HIV and AIDS.

3 Empirical Approach and Data Sources

This section discusses the rules for becoming a Title 1 city and how these rules led to vast differences in Ryan White funds across cities. The section then discusses the empirical approach

and the data sources used to implement the study.

3.1 The Rules for Becoming a Title 1 City and the Empirical Approach

As explained in more detail in the following paragraphs, the variation in Title 1 status examined in this study comes from the three following aspects of the Ryan White CARE Act: 1) The original rules for Title 1 eligibility did not prioritize recent changes in AIDS cases and used a sharp cutoff for determining eligibility that led to cities with similar AIDS burdens having different Title 1 statuses, 2) Once cities obtain Title 1 status, they do no lose it even if they no longer meet the current eligibility criteria, and 3) The 1996 reauthorization changed the Title 1 eligibility rules in a way that made obtaining Title 1 status much more difficult. The eligibility rules being changed immediately prior to effective treatment emerging led to large differences in HIV/AIDS funding across cities that were orthogonal to cities' initial HIV/AIDS trajectories.

According to the original 1990 Ryan White legislation, cities that had reported a cumulative total of 2,000 AIDS cases to the Centers for Disease Control and Prevention (CDC) by March 31 of a particular year became eligible for Title 1 funding in the following fiscal year. Prior to reaching the 2,000-case threshold, cities received no Title 1 funds. Under the initial rules, a reported AIDS case would still count towards eligibility and funding levels even after the person with AIDS had died. In an April 1995 report to Congress, the General Accounting Office (GAO, later renamed the Government Accountability Office) argued that using a more contemporaneous measure of AIDS severity would more effectively direct funds based on need (General Accounting Office 1995). When the Senate first passed its Ryan White reauthoration in June 1995, it incorporated the GAO's recommendation by changing the Title 1 funding rules so that a city had to have at least 2,000 AIDS cases reported in the last five years to be designated as a Title 1 city. This change remained in the final bill that Bill Clinton signed into law in May 1996. At the time the eligibility rule was changed, many cities that had qualified to be Title 1 cities under the original rules did not have 2,000 AIDS cases reported in the last five years. To prevent current Title 1 cities from experiencing large funding drops because of the new rules, the 1996 Ryan White CARE Act reauthorization instituted provisions to maintain funding levels and allowed cities that qualified under the original Ryan White rules by March 31 of 1995 to maintain their eligibility for Title 1 funds even if they had fewer than 2,000 AIDS cases reported in the past five years.

As AIDS cases were rising sharply in 1995 when the GAO originally recommended the switch

to using a more contemporaneous measure of AIDS cases, many cities would have cleared the new threshold within the next few years if the AIDS trends of the early 1990s had continued past 1995. However, treatment that could prevent AIDS but not cure HIV emerging immediately after the eligibility rules changed meant that cities that had not qualified for Title 1 status under the original rules would obtain Title 1 status only if they were experiencing HIV/AIDS outbreaks that were outliers in severity relative to other cities. Thus, immediately prior to effective but expensive treatment for HIV/AIDS finally emerging, Congress implemented funding rules that would provide some cities with billions more dollars for combating HIV/AIDS in the coming years than other cities.

Before the initial eligibility rules were changed, 44 cities became eligible for Title 1 funding. If Congress had not changed the rules and effective treatment had not emerged, approximately 50 cities would have achieved Title 1 status by 2006, assuming the growth in AIDS cases in 1995 continued through 2006. With the new rule Congress put in place in 1996, approximately 35 cities would have obtained Title 1 status by the end of 2006 if effective treatment had not emerged. Even with effective treatment emerging, approximately 35 cities would also have still achieved Title 1 status by 2006 if Congress had not changed the eligibility rules. With the combination of the rule change and effective treatment emerging, however, only two additional cities gained Title 1 status from 1996 to 2006.

Within a few years of the 1996 rule change, several cities that were not eligible for Title 1 funding had worse HIV/AIDS outcomes than Title 1 cities, and yet the cities without Title 1 status did not directly receive any Ryan White funds. In response to the slow progress in addressing HIV/AIDS in cities without Title 1 status, the 2000 Ryan White CARE Act reauthorization implemented a new provision that would provide additional Title 2 funds to states with non-Title 1 cities that had reported 500 to 1,999 AIDS cases in the previous five years. Even with these additional city-directed Title 2 funds, though, the large disparities in HIV/AIDS funding across cities persisted. In 2004, Title 1 cities received a mean funding per AIDS case through Title 1 of 2,380 dollars, while states qualifying for the city-directed Title 2 funds from the 2000 reauthorization were allocated an extra 414 dollars per AIDS case in those cities on average. Throughout the early 2000s, the allocation of funds became increasingly unaligned with HIV/AIDS burdens. By 2006, some non-Title-1 cities had rates of new AIDS cases that were several times the rate of the Title 1 city with the lowest rate.

To provide the non-Title-1 cities that were on the worst HIV/AIDS trajectories with additional funding, Congress changed the eligibility rules in the 2006 Ryan White CARE Act reauthorization to allow cities with at least 1,000 AIDS cases reported in the previous five years to become eligible for Title 1 status.[13] Five cities obtained Title 1 status immediately after this rule change went into effect in 2007, and one other city has obtained Title 1 status since 2007. Even with the 2006 reauthorization allowing some of the cities on the worst HIV/AIDS trajectories to gain Title 1 status, large disparities in federal funding that stem from the 1996 reauthorization rules still exist today.

In effect, the 1996 Ryan White CARE Act reauthorization resulted in cities with similar HIV/AIDS burdens and on parallel HIV/AIDS tracks receiving drastically different amounts of federal funding to combat HIV/AIDS, particularly from 1996 to 2006. This study estimates the effect of Title 1 funds by comparing how the difference in HIV/AIDS outcomes between Title 1 cities and other cities changed after Title 1 cities gain Title 1 status. Because the 1996 reauthorization led to cities needing to have substantially worse HIV/AIDS trajectories relative to other cities to obtain Title 1 status, I consider cities to be treated only if they achieved Title 1 status under the original rules, meaning that they had at least 2,000 cases by the March 31, 1995. I typically refer to these cities as Title 1 cities, even though some other cities eventually obtained Title 1 status.[14]

To keep the control and treatment groups comparable, the main analysis sample focuses on cities that were closest to the original threshold of 2,000 AIDS cases ever reported by March 31, 1995. For the baseline analysis, I set the control cities to be the 25 cities with the highest number of AIDS cases less than 2,000 reported by March 31, 1995 and the treatment cities to be the 25

[13]The 2006 reauthorization created two different categories of Title 1 cities. Eligible Metropolitan Areas, which was a label previously applied to all Title 1 cities, are those that have reported at least 2,000 AIDS cases in the past five years. Transitional Grant Areas are cities that have reported 1,000 to 1,999 AIDS cases in the past five years or that qualified for Title 1 status under an earlier set of rules. The main difference between the two designations is that Eligible Metropolitan Areas have had hold harmless provisions that keep them from losing funds, while Transitional Grant Areas do not have to set up planning councils. Transitional Grant Areas can also lose Title 1 status if they cease to have a cumulative total of 1,500 or more people living with HIV infection ever classified as AIDS. In practice, no city has come close to losing Title 1 status.

[14]Appendix B examines the impact of Title 1 status on the cities gaining Title 1 status in 2007. The analysis first verifies that, in contrast to cities gaining Title 1 status under the original Ryan White CARE Act rules, cities gaining Title 1 status in 2007 experienced rising HIV/AIDS deaths relative to other cities in the years before they obtained Title 1 status, which means that the parallel trends assumption required for difference-in-differences estimation is not satisfied for these cities. Appendix B then shows that the estimated impact of Title 1 status from a specification that accounts for these pre-existing trends by supplementing the estimation with a city-specific linear time trend indicates that Title 1 status reduced HIV/AIDS death rates in cities obtaining Title 1 status under the new eligibility rules put in place by the 2006 reauthorization, which corroborates the findings from the main analysis.

cities with the lowest number of AIDS cases greater than 2,000 reported by March 31, 1995. In Appendix Table A.3, I show that the results are robust to using different sets of treatment and control cities. Appendix Table A.1 contains the full list of control cities and of Title 1 cities.

Title 1 cities receive both formula-based funds and supplemental funds. The formula funds made up half of Title 1 funding in the original legislation and make up two-thirds of Title 1 funding as of 2007. While the formula for the non-supplemental funding was initially based on a city's share of AIDS cases ever reported by Title 1 cities, the 1996 reauthorization changed the formula to instead use estimates of a city's share of people living with AIDS in Title 1 cities. The 2006 reauthorization changed the formula to include HIV cases. The supplemental funding is allocated by the Secretary of Health and Human Services based on cities' reported need for additional HIV/AIDS funding. Throughout the Ryan White CARE Act's history, policymakers have included hold-harmless provisions to prevent cities from experiencing large drops in their Title 1 funds.

While Title 1 funding varies across Title 1 cities, the funding differences per eligible AIDS case among Title 1 cities tend to be small. In 2004, for instance, the fifth and ninety-fifth percentiles of Title 1 funding per AIDS case among Title 1 cities were 2,361 dollars and 2,492 dollars. Rather than attempt to identify the impact of these small, endogenous funding differences among Title 1 cities, the approach of this study is to estimate the impact of a binary treatment variable for a city having Title 1 status. After estimating the reduction in HIV/AIDS deaths from Title 1 status, I then use information on Title 1 funding amounts to produce an estimate of the amount of Title 1 funding spent for each HIV/AIDS death avoided.

The basic model that I estimate is as follows:

$$y_{jt} = \gamma_j + \delta_t + X_{jt}\alpha_t + Title1_{jt}\beta + \epsilon_{jt}, \tag{1}$$

where j indexes the city, t indexes the year, y represents the various measures of HIV/AIDS, γ is a vector of city fixed effects, t is a vector of fiscal year fixed effects, X is a vector of control variables, and $Title1$ is an indicator variable equal to 1 if the city is a Title 1 city in year t. The baseline set of control variables is the share of the population that is male, younger than 18, older than 64, Black, and Hispanic with the coefficients on these controls being allowed to vary before and after the emergence of effective treatment in 1996.

Interpreting the Title 1 coefficient in Equation (1) as an estimate of the causal impact of Title 1 status requires the assumption that, absent the differences in Ryan White Title 1 status, HIV/AIDS outcomes in Title 1 cities would have trended in parallel to the cities that did not receive Title 1 status under the original rules for Title 1 eligibility. As I have explained in this section, the institutional environment supports the plausibility of this assumption. However, given how central this assumption is for the analysis, I take additional steps to assess the validity of the assumption and to relax it. These steps include estimating event-study specifications of the effect of Title 1 status, varying the control and treatment groups, and incorporating additional time-varying controls.

As has been noted elsewhere, the concurrent emergence of effective treatment for HIV/AIDS is a central part of why the 1996 rule change for obtaining Title 1 status largely locked Title 1 statuses in place for the next decade. The independent effects of advances in HIV/AIDS treatment are captured by the year fixed effects in Equation (1), but it is important to remember that the expected impact of federal funding depends on the productivity of available treatment. I estimate a specification of Equation (1) that allows for separate effects of Title 1 status before and after 1996, but most of the wide differences in funding between Title 1 cities and other cities occurred during a period for which effective treatment is available, meaning the estimates presented in this paper are of the effect of federal funding to combat HIV/AIDS when effective treatment exists.

I estimate Equation (1) for two time periods. Because the 2006 reauthorization made several changes to the Ryan White program, one specification focuses only on years 1990 to 2006. However, as the 2006 reauthorization left large funding disparities in place and because large infusions of funding to combat an infectious disease likely have persistent effects, I also estimate specifications that include years 1990 to 2018.

3.2 Data

This study draws on several data sources to implement the research design. As described in the previous section, the sample is selected based on the number of AIDS cases that cities had reported by March 31 of 1995. For information on reported AIDS cases, I use the AIDS Public Information Data Set (Department of Health and Human Services 2005), which the CDC created from AIDS case reports submitted by state and local health departments. The AIDS Public In-

formation Data Set contains annual counts of AIDS cases through 2002 for each city that had at least 500,000 people as of the 2000 Census.[15] I impute AIDS cases reported as of March 31 of 1995 by adding 25 percent of cities' AIDS cases reported in 1995 to the number of AIDS cases reported by the end of 1994.

Figure 1 plots the log of AIDS cases reported through March 31 of 1995 for all cities in the AIDS Public Information Data Set, ranked according to cities' cases reported by March 31 of 1995. Cities to the right of the solid vertical line in Figure 1 had reported more than 2,000 AIDS cases by March 31, 1995, and thus gained Title 1 status under the original Ryan White rules. Cities to the left of the line had reported fewer than 2,000 AIDS cases by March 31, 1995, and thus did not qualify for Title 1 status under the original eligibility rules. The blue diamonds in Figure 1 represent the two cities that eventually became eligible for Title 1 funding under the 1996 reauthorization rules. The red squares in Figure 1 represent cities that have become Title 1 cities under the rules that were put in place starting in fiscal year 2007. The cities between the right dashed line and the solid line are the treatment cities, while cities between the left dashed line and the solid line are the control cities.

The number of HIV/AIDS deaths from fiscal years 1990 to 2018 come from restricted-use Vital Statistics Multiple Cause of Death Files, which have information on the universe of civilian deaths in the United States. In addition to containing basic demographic information on decedents and the underlying Internal Classification Diagnosis Code for each death, the restricted-use files contain information on the decedent's county. To have a consistent mapping from counties to cities over time, I attribute HIV/AIDS deaths to cities based on the city definitions in place in 1990, which are the city definitions used in the AIDS Public Information Data Set. I use annual data on county-level populations from SEER (2019) to calculate HIV/AIDS deaths per 100,000 people and to calculate the demographic controls.

Appendix Table A.2 compares HIV/AIDS deaths to other deaths over the sample period. Relative to their share of non-HIV/AIDS deaths, Black people account for a disproportionately high share of HIV/AIDS deaths (45 percent compared to 12 percent). Men also account for dispropor-

[15]The analysis excludes cities from Puerto Rico. Because the information used to create the control variables is not available for all years of the sample for Honolulu, Honolulu is also excluded from the analysis. Appendix Table A.1 contains the full list of remaining cities in the AIDS Public Information Data Set and indicates which cities are in the main sample. Appendix Figure A.1 displays a map that indicates cities in the AIDS Public Information Data Set.

tionately more HIV/AIDS deaths when compared to their share of non-HIV/AIDS deaths (80 percent compared to 50 percent). The mean age at death from HIV/AIDS was approximately 30 years younger than the mean age for non-HIV/AIDS deaths from 1990 to 2018 (42 years compared to 72 years). Finally, 83 percent of HIV/AIDS deaths occurred in cities in the AIDS Public Information Data Set compared to 61 percent of non-HIV/AIDS deaths.

Death rates from HIV/AIDS are the main outcome of interest because, in addition to being an important outcome, deaths from HIV/AIDS are consistently measured across cities and can be computed for each year from 1990 to 2018. In contrast, widespread collection of HIV data began relatively recently, and HIV cases are underreported since the effects of HIV's immune system suppression do not manifest immediately. In addition, the AIDS Public Information Data Set, which has information on AIDS cases that correspond to the city definitions used in the main analysis, does not have information past 2002. However, despite these issues with measuring AIDS rates, understanding how Title 1 affects the spread and progression of the disease is important and and can help in interpreting the analysis of HIV/AIDS death rates. Therefore, I also consider the effect of Title 1 status on several different measures of AIDS diagnoses. Information on AIDS cases from 1990 to 2002 come from the AIDS Public Information Data Set and have information for all cities in the sample. To have years that correspond to the years of HIV/AIDS deaths, I also use data on city-level AIDS cases each year from 1990 through 2018 that were received from a special request to the CDC. The city definitions in the data from the CDC do not perfectly correspond to the city definitions used in the main analysis[16], but these data have a major advantage in that they span 1990 to 2018.

Data on Ryan White Title 1 allocations come from multiple sources. Information on recent years of Title 1 allocations come from the Tracking Accountability in Government Grants System and the HRSA website. Information on earlier years of Title 1 allocations come from Government Accountability Office reports, Office of Inspector General reports, HRSA budget justifications, and HRSA press releases. Through these sources, I have been able to assemble a data set with

[16]Some cities in the AIDS Public Information Data Set are not in the CDC data or are reported combined with other cities. For this reason, the main sample for the CDC analysis includes 46 rather than 50 cities. Also note that while HIV/AIDS deaths are aggregated to fiscal years to match the Title 1 funding timing, AIDS cases are reported for calendar years. Title 1 treatment definitions for the analysis of AIDS cases are therefore based on calendar years as well. As part of the request process to obtain these data, I have agreed to treat the data as confidential, but researchers interested in these data can contact the HIV Incidence and Case Surveillance Branch of the CDC to request access.

information on 96 percent of Ryan White Title 1 allocations from 1991 to 2018.[17] Years 1994 to 1996 of this assembled data set have incomplete funding information, and information is sporadically missing for a few city-year combinations throughout the data. For the observations with missing or incomplete information, I impute missing values for a city in year t using the city's funding in year $t+1$ assuming that the change in total Title 1 funding from year t to year $t+1$ was distributed proportionally based on the city's year t Title 1 funding.

Descriptive statistics for the baseline sample are shown separately for the treatment and control cities in Table 1. As would be expected based on the original rules for Title 1 eligibility, the mean of HIV/AIDS death rates per 100,000 people is higher for the treatment cities. However, the mean percent change in the death rate from 1990 to 1991 is 17 percent for both the treatment and control cities. In Section 4, I show that HIV/AIDS death rates continue to trend in parallel between the two sets of cities until the treatment cities gain their Title 1 status. Despite similar trends in HIV/AIDS deaths in the early 1990s, the differences in Title 1 funding between the two sets of cities in subsequent years have been large. From 1996 to 2006, cities that did not qualify for Title 1 status under the original Ryan White CARE Act rules received $3,852,918 on average, while cities that qualified under the original rules received a mean funding of $68,864,959. Through 2018, the treatment cities received approximately $3.15 billion more in Title 1 funding than the control cities did.

4 The Effect of Federal Funding to Combat HIV/AIDS

The results presented in this section indicate that a city obtaining Title 1 status under the original Ryan White CARE Act rules led to dramatically fewer HIV/AIDS deaths in the city in subsequent years. The section begins by estimating the impact of Title 1 status on HIV/AIDS deaths. I then test for heterogeneous effects of Title 1 status on HIV/AIDS deaths for different sub-groups and estimate the impact of Title 1 status on AIDS cases. Finally, I assess the implications of the effect of Title 1 status by estimating the total lives saved by Title 1 and by using estimates of the value of a statistical life to produce an estimate of the benefit-cost ratio of Title 1 funds.

[17] I contacted HRSA to inquire about obtaining its information on Ryan White allocations through an open records request, but HRSA unfortunately does not maintain complete records on Ryan White allocations, which is why data had to be collected from these different sources.

The Impact of Title 1 Status on HIV/AIDS Death Rates

Figure 2 plots coefficients and 95-percent confidence intervals from a single regression of Equation (1) where the Title 1 status coefficient is allowed to vary flexibly with time. The coefficients indicate that the log of HIV/AIDS death rates trended similarly prior to cities obtaining Title 1 status. Once cities obtained Title 1 status, HIV/AIDS death rates began falling in those cities relative to cities that did not achieve Title 1 status under the original Ryan White CARE Act rules.

Table 2 displays estimates of the effect of Title 1 status on HIV/AIDS death rates. The first column of Table 2 shows estimates of the average effect of Title 1 using data from 1990 to 2006. The estimate suggests that Title 1 status lowered annual HIV/AIDS death rates by 17.0 percent on average. Because the disparities in funding between the two sets of cities are sharpest through 2006, specification 1 provides the cleanest estimates of the effect of Title 1 status. However, large funding disparities remain in effect after 2006, and the effect of funding to halt an infectious disease is likely to persist. To consider the effect of Title 1 funding through more recent years, the remaining columns in Table 2 show results from specifications that include data through 2018. Column 2 shows the baseline estimated effect of Title 1 status using data through 2018. The estimate is similar to the estimate from column 1 at -16.8 percent.

These baseline estimates average the effects of Title 1 status across time. However, the productivity of HIV/AIDS treatment rising dramatically in 1996 could lead to differential effects of Title 1 status after 1996. To test for differential effects of Title 1 status before and after 1996, column 3 presents estimates from a specification that replaces the single Title 1 status coefficient with one indicator for Title 1 status prior to 1996 and with a second indicator for Title 1 status beginning in 1996. The estimated impact of Title 1 status on HIV/AIDS deaths is a statistically insignificant 1.4 percent reduction before 1996 and a statistically significant 22.4 percent reduction beginning in 1996. These results are consistent with Title 1 status having larger impacts after effective treatment emerged, though it's also important to note that these estimates are also consistent with the effect of Title 1 status growing with Title 1 duration.

Column 4 presents an estimate of the effect of Title 1 status from a regression weighted by cities' populations. The estimated effect is similar to the estimate in column 2. Finally, column 5 expands the sample to include all cities in the AIDS Public Information Data Set in the sample.

When all cities are included, the estimated effect of Title 1 status is an 18.3 percent reduction in HIV/AIDS death rates.

Table 3 assess the robustness of the estimates from columns 1 and 2 of Table 2 to various alternative specifications. Columns 1 and 2 of Panel A of Table 3 show the baseline estimates. The remaining specifications in Panel A supplement Equation (1) with additional controls. Columns 3 and 4 supplement Equation (1) with controls for city-level unemployment rates since economic conditions have been shown to be related to health and also affect health insurance access (Ruhm 2000). Columns 5 and 6 control for same-sex marriage being legal in the state, since same-sex marriage is associated with increased health insurance and health care access for gay men and women (Carpenter et al. 2018). Columns 7 and 8 supplement Equation (1) with year-by-Census-region fixed effects to account for the possibility of region-specific trends in HIV/AIDS deaths that are correlated with Title 1 status. The estimates across these additional specifications are similar to the main estimates.

Panel B of Table 3 assesses the robustness of the results to alternative dependent variables. Columns 1 and 2 of Panel B of Table 3 show estimated effects on the log of age-adjusted HIV/AIDS mortality rates per 100,000 people.[18] Columns 3 and 4 use the log of HIV/AIDS deaths as the dependent variable instead of the log of HIV/AIDS death rates per 100,000 people. Assuming major population changes correlated with Title 1 status have not occurred, the estimates should be similar regardless of whether the dependent variable is based on rates or counts. The estimates in columns 1 through 4 are similar to the baseline estimates.

Columns 5 and 6 show estimates of the impact of Title 1 status on non-HIV/AIDS deaths per 100,000 people. Title 1 status has the potential to increase or decrease non-HIV/AIDS deaths. By reducing HIV/AIDS deaths, Title 1 status could increase non-HIV/AIDS deaths since some of the people not dying from HIV/AIDS will eventually die from other causes, but large amounts of funding to fight HIV/AIDS could also allow cities to spend money they would have spent on HIV/AIDS on other types of health initiatives. Similarly, Title 1 funds have the potential to build public health infrastructure that can be used more broadly. Despite these potential mechanisms for how Title 1 status could affect non-HIV/AIDS deaths, finding similarly sized effects on non-HIV/AIDS deaths would raise concerns about the validity of the empirical approach for identifying the impact of Title 1 status on HIV/AIDS outcomes. The estimates in columns 5 and

[18] I calculate age-adjusted mortality rates using the 2000 age distribution from the SEER data.

6 do not indicate that Title 1 status is associated with changes in non-HIV/AIDS death rates.

Appendix Table A.3 further assesses the robustness of the analysis by showing estimates from broadening and narrowing the set of cities included in the sample. Specifically, Appendix Table A.3 considers the robustness of the results to including the 10, 20, and 30 cities on either side of the original threshold of AIDS cases for Title 1 eligibility through 1995 that were closest to the threshold. Appendix Table A.3 also assess robustness to excluding the five cities that were closest to the threshold on either side of the original threshold, which removes from the sample the two cities that eventually qualified for Title 1 status under the new rules put in place in 1996. Finally, Appendix Table A.3 shows estimates from a specification that limits the set of treated cities to those that obtained Title 1 status from 1994 to 1996.[19] While the standard errors rise as fewer cities are included in the regressions, the point estimates of the effect of Title 1 status do not vary dramatically.

The estimates presented so far suggest that the large amounts of federal funding allocated to combat HIV/AIDS through Title 1 of the Ryan White CARE Act were transformative for the cities receiving the funds. Figure 3 provides descriptive evidence that supports this finding by showing how both Title 1 funding and reductions in HIV/AIDS death rates differ for cities that reached 2,000 AIDS cases by March 31, 1995, and for cities that did not. Graph A plots means of Title 1 funds received from 1996 to 2006 per AIDS case reported by March 31, 1995, for cities in the AIDS Public Information Data Set grouped based on their rank order in AIDS cases reported through 1995 relative to the original Title 1 threshold. While cities crossing the 2,000 case threshold received roughly $22,500 in Title 1 funding per AIDS case reported through 1995, cities with fewer than 2,000 AIDS cases received less than $900 in Title 1 funding per AIDS cases reported through 1995. Note that the funding differences between the two sets of cities would be even larger if the denominator were based on the estimated number of people living with AIDS in 1995 rather than on the number of AIDS cases ever reported.

Graph B of Figure 3 plots the mean change in HIV/AIDS death rates from 1990 to 2006 for

[19] As explained in Goodman-Bacon (2018b) and de Chaisemartin and d'Haultfoeuille (2019), models with two-way fixed effects can produce estimates of treatment effects that are biased towards zero when treatment timing varies across groups and when treatment effects evolve with treatment duration. As most of the treated cities in the sample obtained Title 1 status within a few years of each other, differential treatment timing is arguably unlikely to lead to major bias in this setting. The results in Appendix Table A.3 support this idea by showing that the estimated effects are similar when the set of treated cities is limited to cities that obtained Title 1 status within three years of each other.

the same grouping of cities. As the estimated effects from Table 2 suggest would be the case, cities that qualified for Title 1 status under the original Ryan White CARE Act rules experienced dramatically greater declines in HIV/AIDS death rates between 1990 and 2006 than the cities that did not. The average decrease in HIV/AIDS death rates from 1990 to 2006 is 60 percent for cities obtaining Title 1 status under the original rules and 36 percent for other cities. Graph C shows differences in HIV/AIDS death rates from 1990 to 2012 and from 1990 to 2018. Even with the broader changes in health care and health insurance occurring in recent years and even with subsequent changes to the Ryan White CARE Act to partially offset funding disparities put in place by the 1996 reauthorization, disparities in progress reducing HIV/AIDS death rates between cities that qualified for Title 1 status under the original rules and those that did not still exist through 2018.[20]

Heterogeneity by Sex, Age, and Race

Table 4 explores heterogeneous effects of Title 1 status by sex, age, and race. For these regressions, I compute death rates and controls separately for each demographic group. Because some of the groups have no HIV/AIDS deaths in certain years, I use the inverse hyperbolic sine transformation rather than the log transformation. Panel A estimates separate effects for men and women, Panel B estimates separate effects for people younger than 19, people 18 to 64, and people 65 or older, and Panel C estimates separate effects for Black people, White people, and people of other races. Column 1 displays estimated effects for 1990 to 2006, while column 2 displays estimated effects using data from 1990 to 2018. To assess the implications of the heterogeneity estimates taking into account the demographics of Title 1 cities, I calculate the implied number of deaths avoided for each demographic group assuming that the estimate in column 2 represents the effect of Title 1 status on the group's HIV/AIDS death rates in all Title 1 cities and then calculate each group's share of deaths avoided out of the total implied number of deaths

[20] As Figure 3 suggests, regression discontinuity and regression discontinuity difference-in-differences designs are alternative approaches to studying the impact of Title 1 status. The difference-in-differences approach employed in this study is preferred over these alternatives because of the staggered treatment timing and because cities just under the original threshold are more likely to eventually receive some Title 1 funding relative to other non-original-Title-1 cities. However, I have explored the sensitivity of the findings to using these alternative approaches. Estimates from regression discontinuity and regression discontinuity difference-in-differences tend to vary across modeling choices more than the estimates from difference-in-differences models, but as would be expected based on Figure 3, estimates from the discontinuity-based research designs corroborate the findings from the difference-in-differences analysis.

avoided for the panel.[21] Column 3 displays this calculation.

The first two panels of Table 4 consider heterogeneity by sex and by age. The estimates indicate that Title 1 primarily reduced HIV/AIDS deaths of males and of people ages 18 to 64, though the means in Table 4 also highlight that men and people aged 18 to 64 account for disproportionate shares of HIV/AIDS deaths. Likely because of the lower baseline numbers of deaths for non-prime-aged adults and for women, the estimates of the effects on women, people younger than 18, and people 65 and older are less precise than the estimates for men and people ages 18 to 64.

To assess statistical significance of the differences in estimates, I draw 1,000 bootstrap samples with replacement and then replicate the analysis in Table 4 with the bootstrap samples. A t-test based on these bootstrap estimates does not allow for rejecting the null hypothesis that the effect of Title 1 status on HIV/AIDS death rates for people ages 18 to 64 is the same in percent terms as the effect for people ages 0 to 17 (t-statistic=0.8 for column 2 estimates) or the effect for people age 65 and older (t-statistic=0.1). The evidence of a differential effect on male death rates is stronger but still not conclusive (t-statistic=1.5). However, the estimates provide strong evidence that Title 1 has saved the lives of more males than females (t-statistic=3.8) and the lives of more people ages 18 to 64 than people of other ages (t-statistic=3.5).

The final panel of Table 4 shows estimates separately for Black people, White people, and people of other races. Since Black people are less likely to have health insurance coverage than people of other races, Title 1 status has the potential to have disproportionately large effects on Black HIV/AIDS death rates. However, given other hurdles that Black people often face in accessing care, such as lower levels of trust for doctors (Alsan and Wanamaker 2018), Title 1 also has the potential to have smaller impacts on Black people than on people of other races. The estimates in Table 4 indicate that Title 1 led to large decreases in Black and White HIV/AIDS death rates. The point estimate of the effect on Black people in Table 4 is larger in magnitude in both columns than the point estimate for white people. The t-statistic for the difference between the estimates for White and Black people from the bootstrap analysis is 2.1 for the estimates in column 1 and 0.9 for the estimates in column 2. The difference in Black and White lives saved

[21] Note that my preferred approach for estimating the total number of HIV/AIDS deaths avoided by Title 1 of the Ryan White program, which I discuss later, accounts for the Title 1 funds received by the control group. The approach and calculations are summarized in Table 6.

based on the column 2 estimates is statistically insignificant (t-statistic=0.6).

The Impact of Title 1 Status on AIDS Case Rates

Figure 4 shows duration-specific estimates of the effect of Title 1 status on measures of rates of AIDS cases reported and diagnosed. The black line shows estimates from a single regression that uses 1990 to 2002 data on AIDS cases reported from the AIDS Public Information Data Set. The blue line shows estimates from a single regression that uses 1990 to 2006 measures of AIDS diagnosis rates based on the data received directly from the CDC. As with the HIV/AIDS death rates, rates of new AIDS cases trend similarly for both the treated and untreated cities until the treated cities obtain Title 1 status. Once cities obtain Title 1 status, their rates of new AIDS cases reported and diagnosed fall relative to other cities.

Table 5 shows estimates of the average effect of Title 1 status on AIDS cases. Column 1 shows the estimated effect of Title 1 status using data on new AIDS cases reported from the AIDS Public Information Data Set. This specification includes data from years 1990 to 2002 for the 50 cities in the main analysis. The next three columns show the estimated effect using data on AIDS diagnoses received directly from the CDC. The second column is from a regression using data from years 1990 to 2002 to show how the estimate compares to the estimate from column 1. The regression in column 3 is from a specification that uses data from 1990 to 2006. The regression in column 4 is from a specification that uses data from 1990 to 2018. The estimates in columns 1 through 4 of Table 5 are similar across specifications and indicate that Title 1 status reduced annual rates of new AIDS cases by an average of 19.2 to 21.3 percent on average. Column 5 of Table 5 shows results from a specification that allows for separate effects of Title 1 status before and after 1996. Unlike with HIV/AIDS death rates, Title 1 status reduces HIV/AIDS diagnosis rates before 1996, but as with HIV/AIDS death rates, the effect appears to grow over time.

Figure 5 shows how AIDS diagnosis and prevalence rates have changed since 1990 for cities in the AIDS Public Information Data Set grouped by their rank order in AIDS cases reported through the end of 1995 relative to the original threshold for Title 1 eligibility. Graphs A and B show diagnosis rates and mirror the equivalent analysis for HIV/AIDS death rates in Figure 3. From 1990 to 2006, AIDS diagnosis rates fell by 46 percent in cities that qualified for Title 1 status under the original Ryan White CARE Act rules and by 16 percent in cities that had fewer than 2,000 AIDS cases reported by the end of the eligibility window for the original rules.

The reductions in HIV/AIDS deaths along with continued spread of HIV have led to HIV prevalence growing each year in the United States. Even with effective treatment lowering the likelihood that HIV leads to AIDS over time, the number of people alive who have ever been diagnosed as having AIDS (indicated as AIDS prevalence in Figure 5) has also risen over time. As of 2018, the United States has its highest number of people alive who have had ever had AIDS. From 1990 to 2006, the share of the U.S. population that has ever had AIDS increased more than four-fold. As shown in Graph C of Figure 5, however, growth in AIDS prevalence was much lower for cities that qualified for Title 1 status under the original Ryan White rules. In contrast to Title 1 cities, which experienced a 315 percent increase in AIDS prevalence on average through 2006, non-Title 1 cities experienced a 473 percent increase in AIDS prevalence through 2006. The differential changes in AIDS prevalence continue through 2012 and 2018 as well.

Spending per Live Saved, Total Lives Saved, and Cost-Benefit Analysis

I now further assess the implications of the estimated impact of Title 1 by calculating the implied cost to avoid an HIV/AIDS death and the implied number of lives saved by Title 1. Table 6 summarizes the analysis.

Using the coefficient estimate from column 2 of Table 2, I first estimate the number of lives saved for each treated city in the sample from 1991 to 2018. I then sum those annual city-level estimates across years and cities to get an estimate of total lives saved across time for the treated cities in the sample. The estimated number of lives saved by Title 1 status for the treated cities in the sample is 10,024. An alternative approach to estimating the number of lives saved for the treated cities in the sample is to allow the effect of Title 1 in Equation (1) to vary with the duration that each city received Title 1 funds and then to use these duration-specific estimates to calculate the number of lives saved.[22] Calculating lives saved with duration-specific estimates implies that Title 1 status saved 10,118 lives in the treated cities. Because the analysis with the duration-specific estimates is similar to the baseline analysis, I focus the remaining discussion on the estimate of the average effect, but column 2 of panel B of Table 6 displays calculations that use the duration-specific estimates.

Relative to cities that did not qualify for Title 1 status under the original eligibility rules,

[22]This specification is similar to the specification shown in Figure 2, though the specification for the calculation presented in Table 6 uses data from 1990 to 2018 and allows separate effects for each Title 1 duration rather than combining some years of duration.

cities in the sample that qualified for Title 1 status under the original eligibility rules received an additional $3.15 billion in Title 1 funding through 2018. This difference in funding along with the estimated number of lives saved implies that Title 1 reduced one HIV/AIDS death for every $314,000 spent. This estimated spending per life saved applies to cities in the sample that received Title 1 funds and is not necessarily the same amount of Title 1 spending that would be required to avoid an HIV/AIDS death in non-Title-1 cities. However, given the arbitrariness of Title 1 status for cities in the baseline sample, the assumption that the impact of Title 1 funding on control cities would have been similar to the impact on the treatment cities is plausible. The plausibility of this assumption is further supported by the graphical analysis in Figure 3 and by analysis in Appendix B that suggests that the effect of Title 1 status on cities gaining Title 1 status in 2007 is similar to the effect estimated in the baseline analysis after accounting for the differential pre-Title-1 trends for the 2007 Title 1 cities. The assumption that the marginal effect of Title 1 funding is the same as the average effect on the treatment cities allows for making two equivalent statements about Title 1 funding decisions that are relevant given debates about levels of HIV/AIDS funding. First, if the federal government valued the lives that could be saved by Title 1 at at least $314,000, it should have allocated more money through Title 1 than it did. Second, Title 1 funding levels from 1991 to 2018 implicitly value the lives that could be saved through Title 1 of the Ryan White CARE Act at $314,000 per life.

The estimated impact of Title 1 on HIV/AIDS death rates from the specification in Table 2 that includes data from all Title 1 cities is similar to the baseline estimate from the main analysis sample, which suggests that the treatment effect of Title 1 status does not vary widely for Title 1 cities in the baseline sample and for Title 1 cities not included in the baseline sample. Under the assumption that the effect of Title 1 is the same across Title 1 cities, the estimate of spending per life saved implies that the $19 billion allocated through Title 1 saved 60,359 lives through the end of 2018. As noted above, the estimates from this study can be used to calculate the government's implied valuation of the lives that could be saved by Title 1 funding. However, to the extent that Title 1 funding levels have been set for idiosyncratic reasons, the estimates also allow for calculating the implied value of Title 1 spending under different assumptions about the value of a statistical life. Under the assumption that the value of a statistical life is $10 million, the estimates from this study imply that the $19 billion allocated through Title 1 of the Ryan White

CARE Act through 2018 resulted in a value of $604 billion and had a benefit-cost ratio of 32.[23] Note that the only benefit from Title 1 included in this calculation is its reduction in HIV/AIDS deaths. As Title 1 reduces HIV/AIDS morbidity and likely improves the lives of people with HIV/AIDS in other ways, such as by reducing out-of-pocket costs, meaningful benefits are not reflected in this benefit-cost ratio.

As was previously discussed, the Title 2 funding rules include provisions that partially offset the Title 1 funding disparities. Specifically, the formula used to allocate 20-25 percent of part of Title 2's funds excludes HIV/AIDS cases from Title 1 cities, and the 2000 Ryan White reauthorization provides additional Title 2 funds to states with non-Title-1 cities that have high numbers of AIDS cases. If states direct less Title 2 funding to Title 1 cities in response to the effect of Title 1 funds on Title 2 funds, then the amount of federal spending required to avoid an HIV/AIDS death would be less than $314,000. To produce a rough estimate of the impact of a city receiving one dollar of Title 1 funding on state Title 2 funding, I first create a state-year level data set from 2000 to 2018 that contains information on each state's AIDS cases, Title 1 funding, and Title 2 funding. I then regress Title 2 funding on year fixed effects, each state's share of AIDS cases out of all AIDS cases each year, and the total Title 1 funding that cities in each state received each year to produce an estimate of the relationship between Title 1 and Title 2 funding after accounting for states' relative AIDS burdens.[24] The coefficient on Title 1 funding from this regression indicates that cities in a state receiving an extra dollar of Title 1 funding is associated with a reduction in Title 2 funding of $0.23 after accounting for states' AIDS cases. Assuming that Title 1 cities receive $0.23 less in Title 2 funds for each dollar they receive in Title 1 funds implies that Title 1 avoided an HIV/AIDS death for every $242,000 spent in federal funding and that the benefit-cost ratio of Title 1 is 41.

[23] Estimates of the value of a statistical life vary widely. The value of a statistical life of $10 million is in line with recent evidence and with values of a statistical life used by federal agencies (Lee and Taylor 2019).

[24] In principle, if one had complete information on all parameters used to determine Title 2 allocations, it would be possible to calculate the impact of Title 1 funds on Title 2 funds using the Title 2 allocation rules. However, because Title 2 has different categories of funds, numerous inputs, a mixture of formula and discretionary funding, changes to both formula structures and input definitions over time, and hold harmless provisions, the allocation of Title 2 funds is complex, and assessing the impact of an additional dollar of Title 1 funding on Title 2 funds through the allocation rules is challenging. For this reason, I opt to produce an empirical estimate of the offset rather than to attempt to collect data on Title 2 inputs and then calculate an estimate of the offset using the allocation rules. For a discussion of how Title 2's complex allocation rules complicate efforts to determine the impact of Title 1 funding on Title 2 funds using the allocation rules, refer to HRSA administrator Elizabeth Duke's 2006 Congressional testimony about double counting in the Ryan White CARE Act (U.S. Congress Senate Committee on Health, Education, Labor, and Pensions 2006).

5 Conclusion

HIV/AIDS has claimed over 700,000 lives in the United States and tens of millions of lives worldwide, and the U.S. federal government spends billions of dollars each year to treat HIV/AIDS. This paper examined the impact of federal funding to combat HIV/AIDS provided to cities through the largest federal program aimed at addressing HIV/AIDS in the United States. The results indicate that the federal funding allocated to cities has had large impacts on the cities receiving the funds. The estimates imply that Title 1 of the Ryan White CARE Act alone has saved approximately 60,000 lives as of 2018 and reduced an AIDS death for each $314,000 spent. This amount of spending to save a life is far less than typical estimates of the value of a statistical life. Assuming a value of a statistical life of $10 million, these estimates imply a benefit-cost ratio of 32. Given that the benefits in this calculation do not take into account the reduced morbidity from Title 1 or the fact that Title 1 funds have likely displaced private payments or other governmental payments for treatment, this estimate of the benefit-cost ratio is likely conservative.

In opting to address HIV/AIDS by allocating federal funds to support local responses rather than by establishing a federal entitlement program, Congress set up the Ryan White CARE Act as a place-based funding mechanism. Place-based funding has advantages over other ways of structuring funding, including that the federal government can allocate funding to places most in need and that flexible funding can allow local officials to tailor the use of funds to their specific communities and to engage in proactive strategies. In part for these reasons, people often advocate for increasing the use of place-based funding and policies in a number of domains, including in health, education, economic development, and infrastructure (Shambaugh and Nunn 2018). This study provides evidence that allocating federal funding to local areas can have large health impacts. However, the results from this study also highlight the importance of funding rules and indicate that place-based funding can lead to disparities across places, especially if funding is allocated using sharp, arbitrary cutoffs. In the case of HIV/AIDS, many years of large funding disparities have resulted in divergent progress in combating HIV/AIDS across U.S. cities.

References

Almond, Douglas, Hilary W Hoynes, and Diane Whitmore Schanzenbach. 2011. "Inside the War on Poverty: The Impact of Food Stamps on Birth Outcomes." *The Review of Economics and Statistics*, 93(2): 387–403.

Alsan, Marcella and Marianne Wanamaker. 2018. "Tuskegee and the Health of Black Men." *The Quarterly Journal of Economics*, 133(1): 407–455.

Anderson, D Mark, Kerwin Kofi Charles, and Daniel I Rees. 2020. "Re-Examining the Contribution of Public Health Efforts to the Decline in Urban Mortality." *American Economic Journal: Applied Economics*.

Anderson, D Mark, Kerwin Kofi Charles, Claudio Las Heras Olivares, and Daniel I Rees. 2019. "Was the First Public Health Campaign Successful?" *American Economic Journal: Applied Economics*, 11(2): 143–75.

Benjamin, Georges C. 2020. "Celebrating Public Health in a Time of Crisis." *Association of State and Territorial Health Officials*.

Bleakley, Hoyt. 2007. "Disease and Development: Evidence from Hookworm Eradication in the American South." *The Quarterly Journal of Economics*, 122(1): 73–117.

Bleakley, Hoyt. 2010. "Malaria Eradication in the Americas: A Retrospective Analysis of Childhood Exposure." *American Economic Journal: Applied Economics*, 2(2): 1–45.

Bozzette, Samuel A, Geoffrey Joyce, Daniel F McCaffrey, Arleen A Leibowitz, Sally C Morton, Sandra H Berry, Afshin Rastegar, David Timberlake, Martin F Shapiro, and Dana P Goldman. 2001. "Expenditures for the Care of HIV-Infected Patients in the Era of Highly Active Antiretroviral Therapy." *New England Journal of Medicine*, 344(11): 817–823.

Carpenter, Christopher, Samuel T Eppink, Gilbert Gonzales Jr, and Tara McKay. 2018. "Effects of Access to Legal Same-Sex Marriage on Marriage and Health: Evidence from BRFSS." National Bureau of Economic Research.

Center for Poverty and Inequality Research. 2020. "What Are the Major Federal Safety Net Programs in the U.S.?" *https://poverty.ucdavis.edu/article/war-poverty-and-todays-safety-net-0*.

Centers for Disease Control and Prevention. 1998. "Aids Falls from Top Ten Causes of Death; Teen Births, Infant Mortality, Homicide All Decline."

Centers for Disease Control and Prevention. 2017. "More People with HIV Have the Virus under Control."

Chan, Tat Y, Barton H Hamilton, and Nicholas W Papageorge. 2016. "Health, Risky Behaviour and the Value of Medical Innovation for Infectious Disease." *The Review of Economic Studies*, 83(4): 1465–1510.

de Chaisemartin, Clément and Xavier d'Haultfoeuille. 2019. "Two-Way Fixed Effects Estimators with Heterogeneous Treatment Effects." National Bureau of Economic Research.

Department of Health and Human Services. 2005. "Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, AIDS Public Information Data Set US Surveillance Data for 1981-2002." *CDC WONDER On-line Database*.

Doyle, Joseph J. 2011. "Returns to Local-Area Health Care Spending: Evidence from Health Shocks to Patients Far from Home." *American Economic Journal: Applied Economics*, 3(3): 221–43.

Doyle, Joseph J, John A Graves, Jonathan Gruber, and Samuel A Kleiner. 2015. "Measuring Returns to Hospital Care: Evidence from Ambulance Referral Patterns." *Journal of Political Economy*, 123(1): 170–214.

Duggan, Mark G and William N Evans. 2008. "Estimating the Impact of Medical Innovation: A Case Study of HIV Antiretroviral Treatments." In *Forum for Health Economics & Policy*. Vol. 11. De Gruyter.

Einav, Liran, Amy Finkelstein, and Neale Mahoney. 2018. "Provider Incentives and Healthcare Costs: Evidence From Long-Term Care Hospitals." *Econometrica*, 86(6): 2161–2219.

El-Sadr, Wafaa M, Kenneth H Mayer, and Sally L Hodder. 2010. "AIDS in America—Forgotten But Not Gone." *New England Journal of Medicine*, 362(11): 967.

El-Sadr, Wafaa M, Kenneth H Mayer, Miriam Rabkin, and Sally L Hodder. 2019. "AIDS in America—Back in the Headlines at Long Last." *New England Journal of Medicine*, 380(21): 1985–1987.

England, Roger. 2007. "Are We Spending Too Much on HIV?" *BMJ*, 334(7589): 344–344.

Fauci, Anthony S, Robert R Redfield, George Sigounas, Michael D Weahkee, and Brett P Giroir. 2019. "Ending the HIV epidemic: A Plan for the United States." *JAMA*, 321(9): 844–845.

Fernández, Raquel, Sahar Parsa, and Martina Viarengo. 2019. "Coming Out in America: AIDS, Politics, and Cultural Change." National Bureau of Economic Research.

France, David. 2016. *How to Survive a Plague: The Story of How Activists and Scientists Tamed AIDS*. Pan Macmillan.

Gebo, Kelly A, John A Fleishman, Richard Conviser, James Hellinger, Fred J Hellinger, Joshua S Josephs, Philip Keiser, Paul Gaist, and Richard D Moore. 2010. "Contemporary Costs of HIV Health Care in the HAART Era." *AIDS (London, England)*, 24(17): 2705.

General Accounting Office. 1995. "Ryan White CARE Act of 1990: Opportunities to Enhance Funding Equity."

Goldman, Dana P, Timothy Juday, Mark T Linthicum, Lisa Rosenblatt, and Daniel Seekins. 2014. "The Prospect Of A Generation Free Of HIV May Be Within Reach If The Right Policy Decisions Are Made." *Health Affairs*, 33(3): 428–433.

Goodman-Bacon, Andrew. 2018a. "Public Insurance and Mortality: Evidence from Medicaid Implementation." *Journal of Political Economy*, 126(1): 216–262.

Goodman-Bacon, Andrew. 2018b. "Difference-in-Differences with Variation in Treatment Timing." National Bureau of Economic Research.

Hamilton, John D, Pamela M Hartigan, Michael S Simberkoff, Philip L Day, Gigi R Diamond, Gordon M Dickinson, George L Drusano, Merrill J Egorin, W Lance George, Fred M Gordin, et al. 1992. "A Controlled Trial of Early versus Late Treatment with Zidovudine in Symptomatic Human Immunodeficiency Virus Infection." *New England Journal of Medicine*, 326(7): 437–443.

Hatcher, William. 2020. "The Ryan White Program Is Vital to End the HIV Epidemic." *American Journal of Public Health*, 110(1): 51–52.

Health Resources and Services Administration. 2013. "Ryan White HIV/AIDS Program: Part A Manual."

Health Resources and Services Administration. 2019. "HRSA's Ryan White HIV/AIDS Program: Program Overview."

Health Resources and Services Administration. 2020. "RWHAP Allocation Reports."

Hoynes, Hilary, Doug Miller, and David Simon. 2015. "Income, the Earned Income Tax Credit, and Infant Health." *American Economic Journal: Economic Policy*, 7(1): 172–211.

Institute of Medicine. 2004. *Measuring What Matters: Allocation, Planning, and Quality Assessment for the Ryan White CARE Act.* National Academies Press.

Joint Economic Committee. 2017. "The Rise in Opioid Overdose Deaths."

Kaiser Family Foundation. 2019a. "U.S. Federal Funding for HIV/AIDS: Trends Over Time."

Kaiser Family Foundation. 2019b. "The Ryan White HIV/AIDS Program: The Basics."

Lakdawalla, Darius, Neeraj Sood, and Dana Goldman. 2006. "HIV Breakthroughs and Risky Sexual Behavior." *The Quarterly Journal of Economics*, 121(3): 1063–1102.

Lee, Jonathan M. and Laura O. Taylor. 2019. "Randomized Safety Inspections and Risk Exposure on the Job: Quasi-experimental Estimates of the Value of a Statistical Life." *American Economic Journal: Economic Policy*, 11(4): 350–74.

Mansour, Hani, Daniel I Rees, and James M Reeves. 2020. "Voting and Political Participation in the Aftermath of the HIV/AIDS Epidemic." National Bureau of Economic Research Working Paper 27504.

Marcus, Julia L, Wendy A Leyden, Stacey E Alexeeff, Alexandra N Anderson, Rulin C Hechter, Haihong Hu, Jennifer O Lam, William J Towner, Qing Yuan, Michael A Horberg, et al. 2020. "Comparison of Overall and Comorbidity-Free Life Expectancy Between Insured Adults With and Without HIV Infection, 2000-2016." *JAMA Network Open*, 3(6): e207954–e207954.

Miller, Sarah, Sean Altekruse, Norman Johnson, and Laura R Wherry. 2019. "Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data." National Bureau of Economic Research.

Roser, Max and Hannah Ritchie. 2018. "HIV / AIDS." *Our World in Data*. https://ourworldindata.org/hiv-aids.

Rubin, Marcie S, Cynthia G Colen, and Bruce G Link. 2010. "Examination of Inequalities in HIV/AIDS Mortality in the United States From a Fundamental Cause Perspective." *American Journal of Public Health*, 100(6): 1053–1059.

Ruhm, Christopher J. 2000. "Are Recessions Good for Your Health?" *The Quarterly Journal of Economics*, 115(2): 617–650.

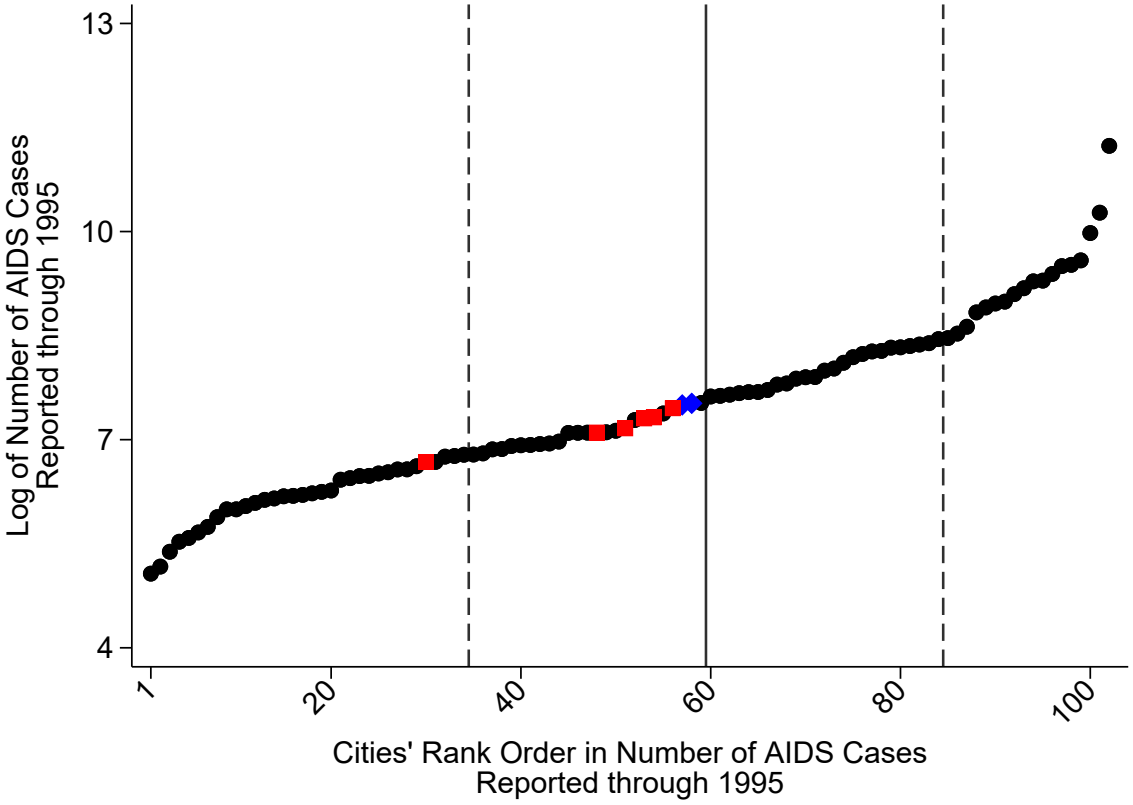
SEER. 2019. "Surveillance, Epidemiology, and End Results (SEER) Program Populations (1969-2018)." *National Cancer Institute, DCCPS, Surveillance Research Program*.

Shambaugh, Jay C and Ryan Nunn. 2018. *Place-Based Policies for Shared Economic Growth.* Hamilton Project, Brookings.

Sood, Neeraj, Timothy Juday, Jacqueline Vanderpuye-Orgle, Lisa Rosenblatt, John A Romley, Desi Peneva, and Dana P Goldman. 2014. "HIV Care Providers Emphasize The Importance Of The Ryan White Program For Access To And Quality Of Care." *Health Affairs*, 33(3): 394–400.

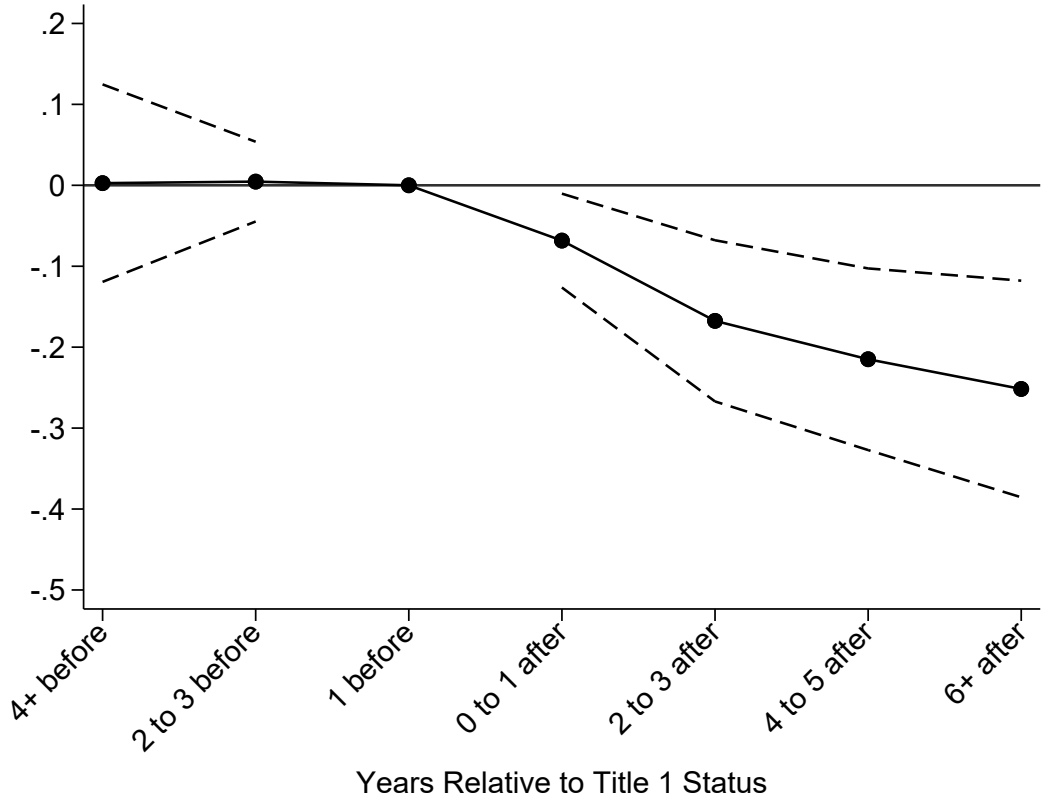
U.S. Congress Senate Committee on Health, Education, Labor, and Pensions. 2006. "Examining Reauthorization of the Ryan White CARE Act Relating to Fighting the AIDS Epidemic of Today." 109th Congress, 2nd Session.

Figure 1: Cities' AIDS Cases by March 31, 1995



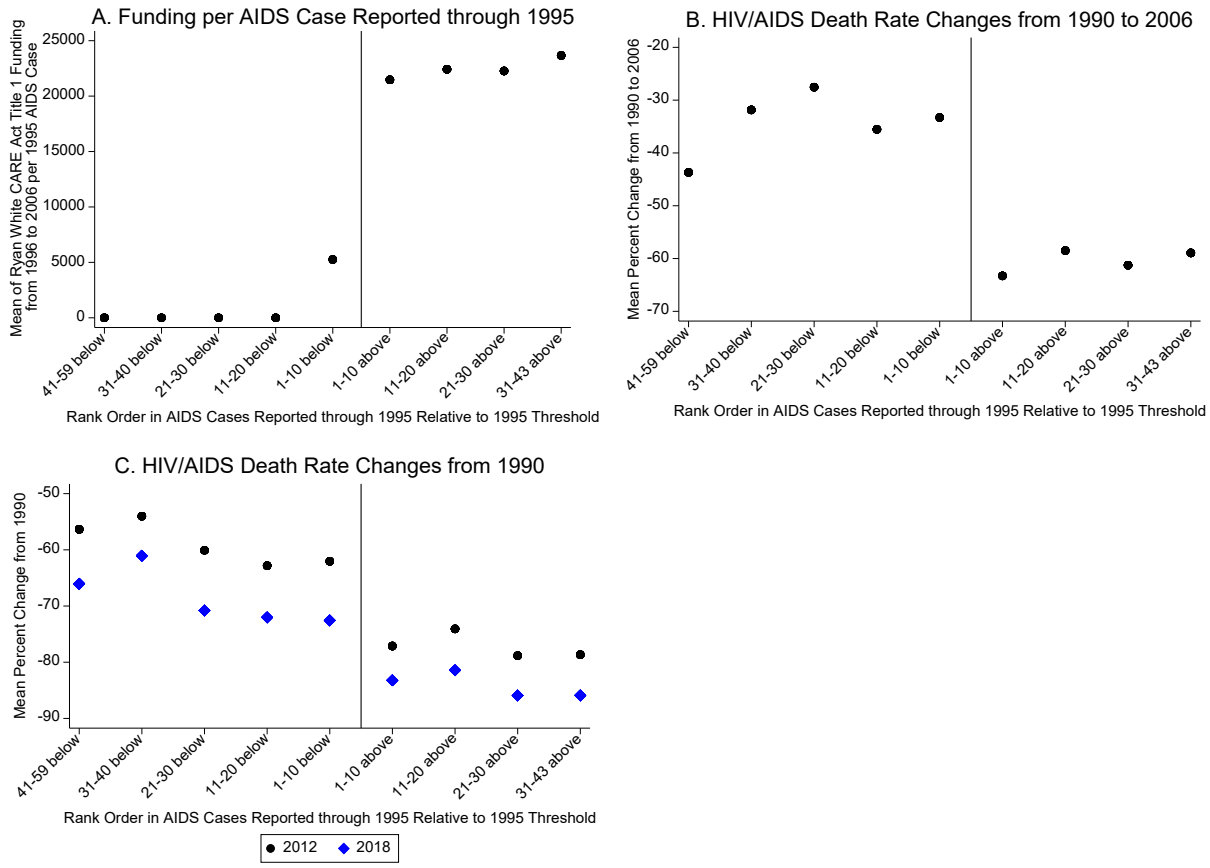
Notes: Each marker represents a separate city. The x-axis indicates cities' rank order in AIDS cases reported by March 31, 1995. The y-axis indicates the log of cities' AIDS cases reported by March 31, 1995. Cities to the right of the solid vertical line qualified for Title 1 status under the original rules for Title 1 eligibility. Cities to the left of the line did not. The blue diamonds represent cities that became eligible for Title 1 status under the rules put in place in 1996. The red squares represent cities that became eligible for Title 1 status under the rules put in place in 2007. Cities between the dashed line are included in the main sample. Data on AIDS cases reported come from the AIDS Public Information Data Set.

Figure 2: Relationship between Title 1 Status and HIV/AIDS Death Rates



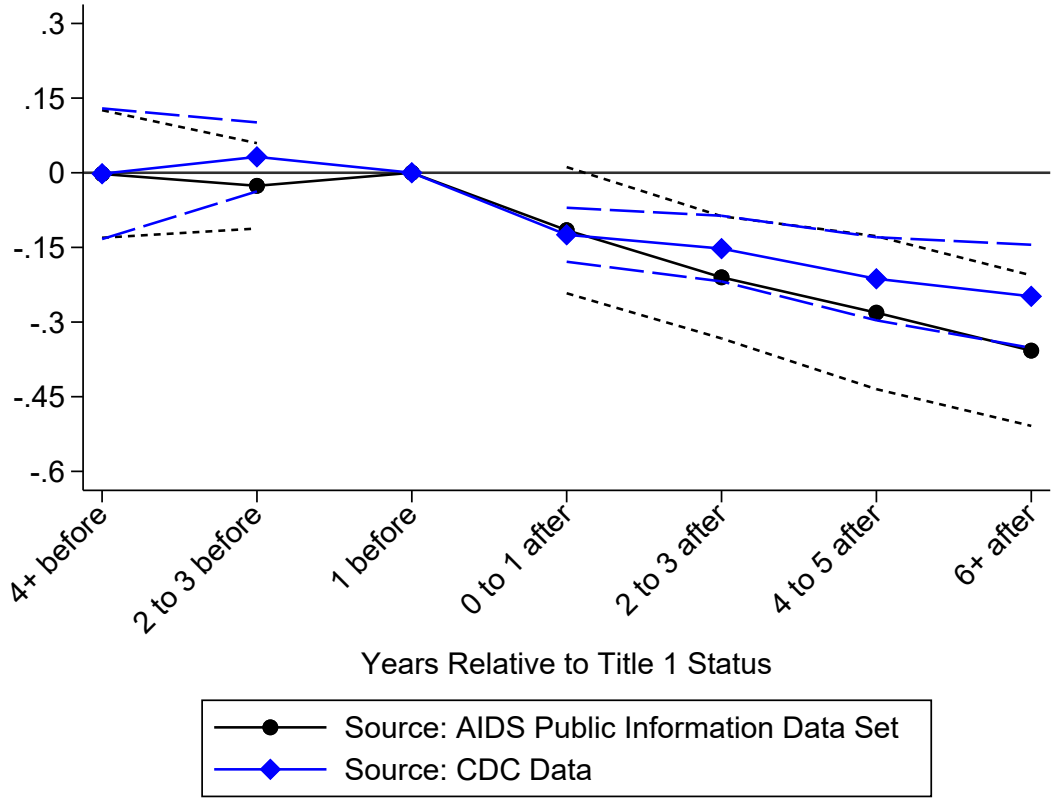
Notes: Each marker is a coefficient on Title 1 status interacted with number of years from initial Title 1 status eligibility from a single regression with the log of HIV/AIDS death rates as the dependent variable. The x-axis indicates the number of years from Title 1 status. The y-axis indicates the coefficient estimate. The sample contains 850 observations from 50 cities from 1990 to 2006. The regression includes city fixed effects, year fixed effects, and the demographic controls described in the text. The dashed lines indicate 95-percent confidence intervals calculated using standard errors clustered by city.

Figure 3: Title 1 Funding and Changes in HIV/AIDS Death Rates since 1990 by Cities' Rank Order in AIDS Cases Reported by March 31, 1995



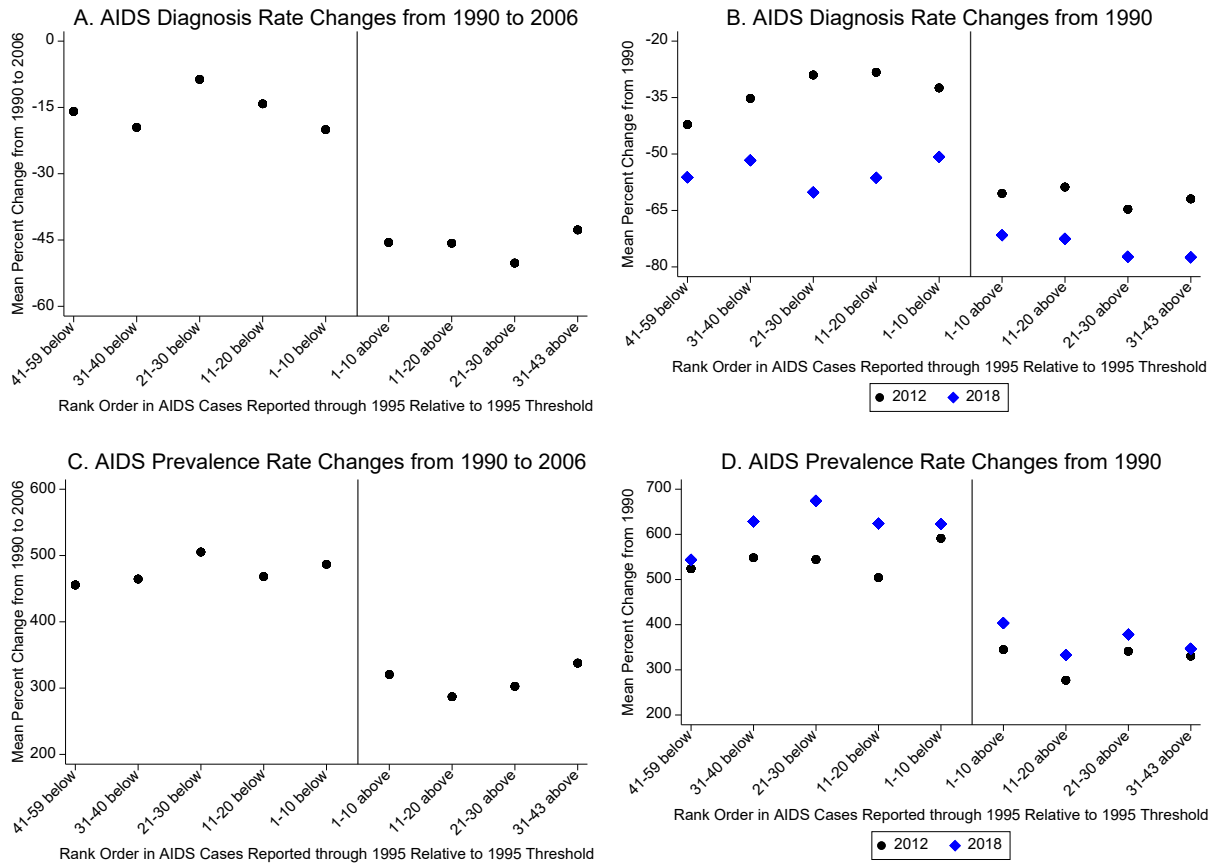
Notes: Each marker represents a set of cities grouped based on their rank order in AIDS cases reported by March 31, 1995. The x-axes for all graphs indicate cities' rank order in AIDS cases reported by March 31, 1995, relative to the original threshold for Title 1 eligibility. The y-axis in graph A indicates mean Title 1 funding from 1996 to 2006 per AIDS case reported by March 31, 1995. The y-axes in graphs B and C indicate the mean percent change in HIV/AIDS death rates in the indicated year since 1990.

Figure 4: Relationship between Title 1 Status and Rates of New AIDS Cases



Notes: Each marker is a coefficient on Title 1 status interacted with number of years from initial Title 1 status eligibility. The x-axis indicates the number of years from Title 1 status. The y-axis indicates the coefficient estimate. The black circles are from a single regression with the log of annual AIDS diagnosis rates from the CDC as the dependent variable. The sample contains 782 observations from 46 cities from 1990 to 2006. The blue diamonds are from a single regression with the log of rates of new AIDS cases reported from the AIDS Public Information Data Set as the dependent variable. The sample contains 650 observations from 50 cities from 1990 to 2002. Each regression includes city fixed effects, year fixed effects, and the demographic controls described in the text. The dashed lines indicate 95-percent confidence intervals calculated using standard errors clustered by city.

Figure 5: Changes in AIDS Diagnosis and Prevalence Rates since 1990 by Cities' Rank Order in AIDS Cases Reported by March 31, 1995



Notes: Each marker represents a set of cities grouped based on their rank order in AIDS cases reported by March 31, 1995. The x-axes for all graphs indicate cities' rank order in AIDS cases reported by March 31, 1995, relative to the original threshold for Title 1 eligibility. The y-axes indicate mean percent changes in the indicated measure and year since 1990.

Table 1: Characteristics of Control and Treatment Cities

	Fewer than 2,000 AIDS Cases Reported through March 31, 1995 (Control Cities)		More than 2,000 AIDS Cases Reported through March 31, 1995 (Treatment Cities)	
	Mean	St. Dev.	Mean	St. Dev.
Panel A. City-by-Year Level Data (n=1,450)				
Population Size	1,033,971	410,823	1,584,696	633,287
Fraction of Population Male	0.48	0.01	0.49	0.01
Fraction of Population Younger than 18	0.25	0.03	0.25	0.02
Fraction of Population 65 or Older	0.12	0.02	0.12	0.03
Fraction of Population White	0.82	0.10	0.85	0.06
Fraction of Population Black	0.16	0.11	0.10	0.07
Fraction of Population Hispanic	0.03	0.05	0.12	0.11
Panel B. City Level Observations (n=50)				
HIV/AIDS Deaths per 100,000 People in 1990	7.3	2.6	12.0	7.8
Change in HIV/AIDS Deaths per 100,000 People from 1990 to 1991	0.17	0.29	0.17	0.11
Total Title 1 Funding from 1991 to 1996	0	0	7,284,073	6,876,145
Total Title 1 Funding from 1997 to 2006	3,852,918	13,346,971	68,864,959	22,426,453
Total Title 1 Funding from 2006 to 2018	17,804,023	30,787,974	71,477,627	23,817,116
Total Title 1 Funding through 2018	21,656,941	39,689,725	147,626,659	48,692,930

Notes: The control and treatment groups include 25 cities each. The descriptive statistics in panel A are for years 1990 to 2018.

Table 2: The Effect of Title 1 Status on HIV/AIDS Death Rates

	(1)	(2)	(3)	(4)	(5)
Title 1	-0.170	-0.168		-0.164	-0.183
	(0.055)	(0.063)		(0.052)	(0.052)
	[0.003]	[0.010]		[0.003]	[0.001]
Title 1 * 1(Before 1996)			-0.014		
			(0.047)		
			[0.768]		
Title 1 * 1(1996 to 2018)			-0.224		
			(0.076)		
			[0.005]		
Years	1990-2006	1990-2018	1990-2018	1990-2018	1990-2018
Number of Cities	50	50	50	50	102
n	850	1,450	1,450	1,450	2,958
Mean of Dependent Variable in Levels	8.9	6.3	6.3	5.2	6.6
Population Weights				x	

Notes: Each column displays the effect of Title 1 status from Equation (1). The unit of observation is a city and year combination. The dependent variable is the log of HIV/AIDS deaths per 100,000 people. Numbers of HIV/AIDS deaths each year come from the Vital Statistics Mortality data. All regressions include city fixed effects, year fixed effects, and the demographic controls described in the text. Standard errors are clustered by city and are shown in parentheses. P-values are shown in brackets.

Table 3: Alternative Specifications for Estimates of the Effect of Title 1 Status

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Panel A. Dependent Variable: Log(HIV/AIDS Deaths per 100,000 People)								
	-0.170	-0.168	-0.164	-0.163	-0.170	-0.168	-0.160	-0.163
	(0.055)	(0.063)	(0.054)	(0.063)	(0.055)	(0.063)	(0.055)	(0.067)
	[0.003]	[0.010]	[0.004]	[0.013]	[0.003]	[0.011]	[0.006]	[0.019]
Additional Controls	Baseline		Unemployment Rate		Same-Sex Marriage		Region-by-Year Fixed Effects	
Years	1990-2006	1990-2018	1990-2006	1990-2018	1990-2006	1990-2018	1990-2006	1990-2018
Number of Cities	50	50	50	50	50	50	50	50
n	850	1,450	850	1,450	850	1,450	850	1,450
Panel B. Alternative Dependent Variables								
Dependent Variable	Log(Age-Adjusted HIV/AIDS Death Rate per 100,000 People)		Log(HIV/AIDS Deaths)		Log(Non-HIV/AIDS Deaths per 100,000 People)			
	-0.167	-0.166	-0.180	-0.185	0.000	-0.006		
	(0.054)	(0.062)	(0.061)	(0.074)	(0.008)	(0.011)		
	[0.003]	[0.010]	[0.005]	[0.016]	[0.972]	[0.602]		
Years	1990-2006	1990-2018	1990-2006	1990-2018	1990-2006	1990-2018		
Number of Cities	50	50	50	50	50	50		
n	850	1,450	850	1,450	850	1,450		

Notes: Each column displays the effect of Title 1 status from Equation (1). The unit of observation is a city and year combination. The dependent variable in Panel A is the log of HIV/AIDS deaths per 100,000 people. The dependent variables for the regressions in Panel B are indicated in the table. Numbers of deaths each year come from the Vital Statistics Mortality data. All regressions include city fixed effects, year fixed effects, and the demographic controls described in the text. Additional controls are indicated in the table for the regressions in Panel A. Standard errors are clustered by city and are shown in parentheses. P-values are shown in brackets.

Table 4: The Effect of Title 1 Status on HIV/AIDS Death Rates for Different Demographic Groups

	Mean HIV/AIDS Deaths per 100,000 People	(1)	(2)	Implied Share of Deaths Avoided out of All Deaths Avoided
Panel A. Sex				
Male	10.4	-0.155	-0.155	87%
		(0.054)	(0.061)	
		[0.006]	[0.014]	
Female	2.4	-0.082	-0.081	13%
		(0.068)	(0.086)	
		[0.230]	[0.353]	
Panel B. Age				
Younger than 18	0.2	-0.067	-0.090	2%
		(0.083)	(0.102)	
		[0.421]	[0.378]	
Ages 18 to 64	9.6	-0.153	-0.140	94%
		(0.055)	(0.066)	
		[0.007]	[0.039]	
65 or Older	1.8	-0.184	-0.136	4%
		(0.110)	(0.108)	
		[0.101]	[0.215]	
Panel C. Race				
Black	18.6	-0.218	-0.188	54%
		(0.066)	(0.070)	
		[0.002]	[0.010]	
White	4.2	-0.120	-0.146	45%
		(0.056)	(0.065)	
		[0.038]	[0.030]	
Other	1.0	-0.164	-0.182	2%
		(0.184)	(0.180)	
		[0.377]	[0.317]	
Years	1990-2018	1990-2006	1990-2018	1990-2018

Notes: Each column displays the effect of Title 1 status from Equation (1). The unit of observation is a city and year combination. The dependent variable is the inverse hyperbolic sine of HIV/AIDS deaths per 100,000 people for each group. Numbers of HIV/AIDS deaths each year come from the Vital Statistics Mortality data. All regressions include city fixed effects, year fixed effects, and the demographic controls described in the text. Standard errors are clustered by city and are shown in parentheses. P-values are shown in brackets. The sample for each regression contains 850 observations from 1990 to 2006 and 1,450 observations from 1990 to 2018.

Table 5: The Effect of Title 1 Status on Rates of New AIDS Cases

	(1)	(2)	(3)	(4)	(5)
Title 1	-0.192	-0.206	-0.200	-0.213	
	(0.056)	(0.037)	(0.037)	(0.044)	
	[0.001]	[0.000]	[0.000]	[0.000]	
Title 1 * 1(Before 1996)					-0.122
					(0.040)
					[0.004]
Title 1 * 1(1996 to 2018)					-0.255
					(0.058)
					[0.000]
Source	AIDS Public Information Data Set	CDC	CDC	CDC	CDC
Years	1990-2002	1990-2002	1990-2006	1990-2018	1990-2018
Number of Cities	50	46	46	46	46
Mean of Dependent Variable in Levels	21.0	19.0	17.3	13.4	13.4
n	650	598	782	1,334	1,334

Notes: Each column displays the effect of Title 1 status from Equation (1). The unit of observation is a city and year combination. The dependent variable is the log of AIDS cases reported or diagnosed per 100,000 people. Numbers of AIDS cases reported each year come from the AIDS Public Information Data Set. Numbers of AIDS cases diagnosed each year come from the CDC. All regressions include city fixed effects, year fixed effects, and the demographic controls described in the text. Standard errors are clustered by city and are shown in parentheses. P-values are shown in brackets.

Table 6: Comparing the Costs of Title 1 to Benefits from Lives Saved

Panel A. Title 1 Funding Information

Total Title 1 Funding Received by Treated Cities through 2018: $3.69 billion
Total Title 1 Funding Received by Comparison Cities through 2018: $0.54 billion
Additional Title 1 Funding Received by Treated Cities through 2018: $3.15 billion
Total Title 1 Funding through 2018: $18.96 billion

Panel B. Cost Benefit Calculation

	(1) Single Title 1 Estimate	(2) Duration-Specific Title 1 Estimates
Estimated Lives Saved for Treated Cities in Sample	10,024	10,118
Title 1 Funding per Life Saved	$314,180	$311,252
Implied Total Lives Saved by All Title 1 Funding through 2018	60,359	60,927
Benefits from Title 1 for a Value of Statistical Life of $10 million	$604 billion	$609 billion
Benefit-Cost Ratio	32	32

Notes: Column 1 of Panel B assesses the implications of the estimated impact of Title 1 from the baseline specification for years 1990 to 2018, while column 2 of Panel B assess the implications of estimates from a specification that allows the effect of Title 1 status to vary with the number of years that a city has had Title 1 status for years 1990 to 2018.

Appendices

A Appendix Tables and Figures

Figure A.1: Cities in the AIDS Public Information Data Set

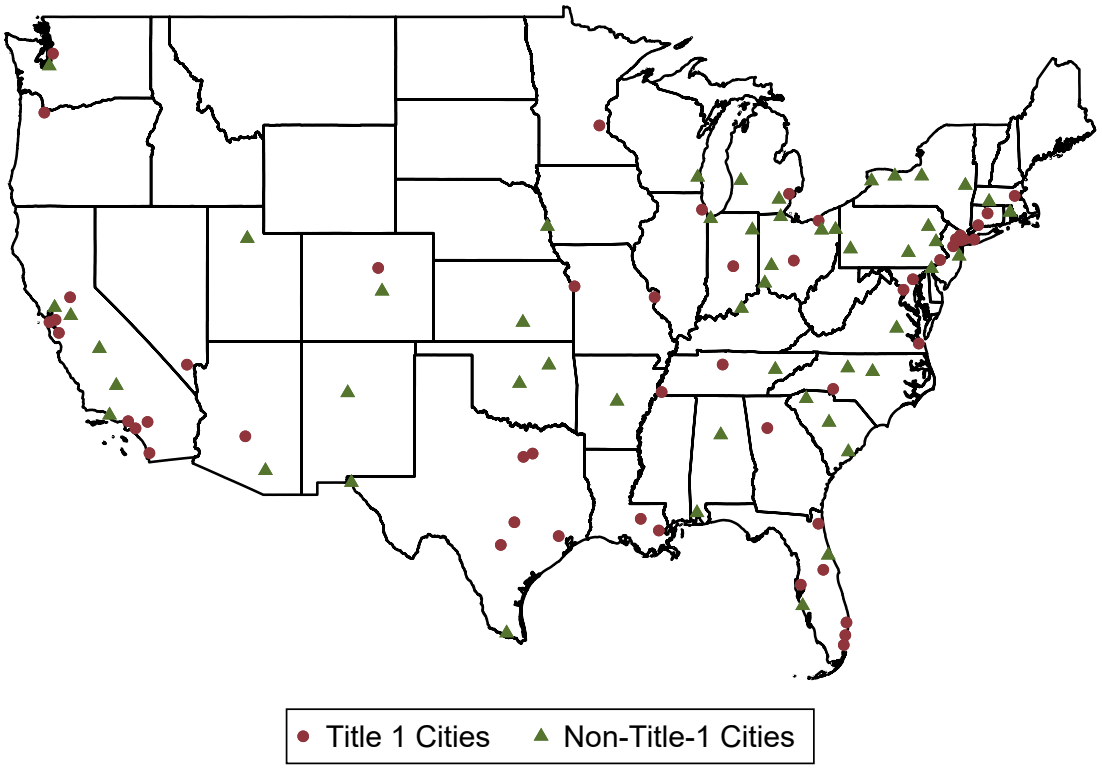


Table A.1: Cities in the AIDS Public Information Data Set

City	AIDS Cases by Original Cutoff	Ranking	Main Sample	Year Title 1 Status Achieved
Akron, OH	312	7	no	
Albany-Schenectady, NY	1,001	39	yes	
Albuquerque, NM	651	24	no	
Allentown, PA	461	13	no	
Ann Arbor, MI	252	4	no	
Atlanta, GA	9,729	93	no	1991
Austin, TX	2,466	68	yes	1995
Bakersfield, CA	527	20	no	
Baltimore, MD	7,811	90	no	1992
Baton Rouge, LA	794	30	no	2007
Bergen-Passaic, NJ	3,602	75	yes	1994
Birmingham, AL	1,038	43	yes	
Boston, MA	8,938	92	no	1991
Buffalo, NY	883	34	no	
Charleston, SC	885	35	yes	
Charlotte, NC	1,216	48	yes	2007
Chicago, IL	13,385	97	no	1991
Cincinnati, OH	1,211	46	yes	
Cleveland, OH	2,044	60	yes	1996
Colorado Springs, CO	288	6	no	
Columbia, SC	1,012	40	yes	
Columbus, OH	1,512	54	yes	2013
Dallas, TX	8,020	91	no	1991
Dayton, OH	616	21	no	
Daytona Beach, FL	649	23	no	
Denver, CO	3,945	78	yes	1994
Detroit, MI	4,742	85	no	1993
El Paso, TX	488	16	no	
Fort Lauderdale, FL	7,380	89	no	1991
Fort Wayne, IN	159	1	no	
Fort Worth, TX	2,063	61	yes	1996
Fresno, CA	715	28	no	
Gary, IN	402	10	no	
Grand Rapids, MI	485	15	no	
Greensboro, NC	1,016	41	yes	
Greenville, SC	796	31	no	
Harrisburg, PA	517	19	no	
Hartford, CT	2,244	66	yes	1996
Houston, TX	11,965	96	no	1991
Indianapolis, IN	1,725	56	yes	2007
Jacksonville, FL	2,697	70	yes	1995
Jersey City, NJ	4,406	83	yes	1991
Kansas City, MO	2,705	71	yes	1994
Knoxville, TN	402	9	no	
Las Vegas, NV	1,810	57	yes	1999
Little Rock, AR	630	22	no	
Los Angeles, CA	28,912	101	no	1991
Louisville, KY	748	29	no	
McAllen-Edinburg-Mission, TX	176	2	no	
Memphis, TN	1,490	53	yes	2007
Miami, FL	14,545	99	no	1991
Middlesex, NJ	2,098	62	yes	1996
Milwaukee, WI	1,214	47	yes	
Minneapolis-St Paul, MN	2,180	65	yes	1996
Mobile, Al	674	25	no	
Monmouth-Ocean City, NJ	1,862	59	yes	
Nashville, TN	1,291	51	yes	2007
Nassau-Suffolk, NY	4,230	81	yes	1993
New Haven, CT	3,913	77	yes	1994
New Orleans, LA	4,132	79	yes	1993
New York, NY	75,781	102	no	1991
Newark, NJ	10,861	95	no	1991
Norfolk, VA	1,852	58	yes	1999

Continued on next page

Table A.1 – continued

City	AIDS Cases by March 31, 1995	Ranking	Baseline Sample	Year Title 1 Status Achieved
Oakland, CA	5,588	87	no	1992
Oklahoma City, OK	1,067	44	yes	
Omaha, NE	441	12	no	
Orange County, CA	3,773	76	yes	1993
Orlando, FL	3,324	74	yes	1994
Philadelphia, PA	10,750	94	no	1991
Phoenix, AZ	3,057	73	yes	1994
Pittsburgh, PA	1,600	55	yes	
Portland, OR	2,644	69	yes	1995
Providence, RI	1,220	49	yes	
Raleigh-Durham, NC	1,209	45	yes	
Richmond, VA	1,456	52	yes	
Riverside-S Berndino, CA	4,322	82	yes	1994
Rochester, NY	1,247	50	yes	
Sacramento, CA	2,177	64	yes	1996
Saint Louis, MO	2,968	72	yes	1994
Salt Lake City, UT	954	37	yes	
San Antonio, TX	2,427	67	yes	1995
San Diego, CA	6,868	88	no	1991
San Francisco, CA	21,560	100	no	1991
San Jose, CA	2,145	63	yes	1996
Sarasota, FL	867	33	no	
Scranton, PA	266	5	no	
Seattle, WA	4,672	84	yes	1993
Springfield, MA	958	38	yes	
Stockton, CA	470	14	no	
Syracuse, NY	714	27	no	
Tacoma, WA	506	18	no	
Tampa-Saint Petersburg, FL	5,060	86	no	1993
Toledo, OH	359	8	no	
Tucson, AZ	900	36	yes	
Tulsa, OK	686	26	no	
Vallejo-Fairfield-Napa, CA	859	32	no	
Ventura, CA	495	17	no	
Washington, DC	13,635	98	no	1991
West Palm Beach, FL	4,151	80	yes	1994
Wichita, KS	421	11	no	
Wilmington, DE	1,030	42	yes	
Youngstown, OH	218	3	no	

Table A.2: Characteristics of HIV/AIDS and Non-HIV/AIDS Deaths from 1990 to 2018

	HIV/AIDS Deaths	Non-HIV/AIDS Deaths
Fraction Male	0.80	0.50
Fraction Female	0.20	0.50
Fraction Younger than 18	0.01	0.02
Fraction Ages 18 to 64	0.95	0.24
Fraction 65 or Older	0.04	0.73
Mean Age	42.4	72.3
Fraction Black	0.45	0.12
Fraction White	0.54	0.86
Fraction in City in AIDS Public Information Data Set	0.83	0.61
Total	478,194	70,373,631

Notes: The data come from the Vital Statistics Mortality data from 1990 to 2018.

Table A.3: The Effect of Title 1 Status on HIV/AIDS Death Rates from Alternative Samples

	Number of Cities	(1)	(2)
Baseline	50	-0.170	-0.168
		(0.055)	(0.063)
		[0.003]	[0.010]
n		850	1,450
30 Cities Closest to Original Threshold on Both Sides of Threshold	60	-0.151	-0.146
		(0.054)	(0.061)
		[0.007]	[0.020]
n		1,020	1,740
20 Cities Closest to Original Threshold on Both Sides of Threshold	40	-0.164	-0.182
		(0.067)	(0.075)
		[0.019]	[0.020]
n		680	1,160
10 Cities Closest to Original Threshold on Both Sides of Threshold	20	-0.147	-0.151
		(0.095)	(0.097)
		[0.136]	[0.135]
n		340	580
Excluding 5 Cities Closest to Original Threshold on Both Sides of Threshold	40	-0.193	-0.173
		(0.072)	(0.080)
		[0.011]	[0.036]
n		680	1,160
Excluding Cities Obtaining Title 1 Status before 1994	47	-0.162	-0.156
		(0.058)	(0.066)
		[0.007]	[0.024]
n		799	1,363
Years		1990-2006	1990-2018

Notes: Each column displays the effect of Title 1 status from Equation (1). The unit of observation is a city and year combination. The dependent variable is the log of HIV/AIDS deaths per 100,000 people. Numbers of HIV/AIDS deaths each year come from the Vital Statistics Mortality data. All regressions include city fixed effects, year fixed effects, and the demographic controls described in the text. Standard errors are clustered by city and are shown in parentheses. P-values are shown in brackets.

B Estimating the Effect of Title 1 Status Using Variation in Title 1 Status from the 2006 Ryan White CARE Act Reauthorization

As described in the main text, the primary analysis defines the Title 1 status treatment variable as an indicator variable equal to one for cities obtaining Title 1 status under the original rules for Title 1 eligibility. The 2006 Ryan White CARE Act reauthorization changed the eligibility rules to allow some cities on the worst HIV/AIDS trajectories to obtain Title 1 status. In this Appendix, I first show that estimating a naive difference-in-differences model that uses variation in Title 1 status from the 2006 reauthorization to identify the impact of Title 1 status without accounting for pre-existing trends would wrongly attribute the worsening HIV/AIDS outcomes associated with these cities qualifying for Title 1 status in 2007 as being part of the effect of Title 1 status. I then show that estimating a specification that includes a control for linear city-specific time trends accounts for the pre-existing trends and provides further evidence that Title 1 status reduces HIV/AIDS deaths.

For this analysis, I focus on the five cities obtaining Title 1 status in 2007 after the eligibility rules were changed. These cities are Baton Rouge, Charlotte, Indianapolis, Memphis, and Nashville. I include as the control cities the 25 cities with the most AIDS cases reported by 1995 that did not achieve Title 1 status before the 2006 Ryan White reauthorization and focus on years 1998 to 2018.[25]

The black series in Figure B.1 shows estimates of duration-specific effects of Title 1 status from Equation (1). The estimates indicate HIV/AIDS death rates for the cities that obtained Title 1 status in 2007 were increasing in the early 2000s relative to other cities. Within a few years of these cities obtaining Title 1 status in 2007, HIV/AIDS death rates begin to fall relative to non-Title-1 cities. This profile of estimates is consistent with the evidence in the main text that Title 1 status reduces HIV/AIDS deaths. However, the pre-existing trend towards more HIV/

[25] I exclude Columbus, which obtained Title 1 status in 2013, though a similar analysis could also be done to estimate the impact of Title 1 status on Columbus.

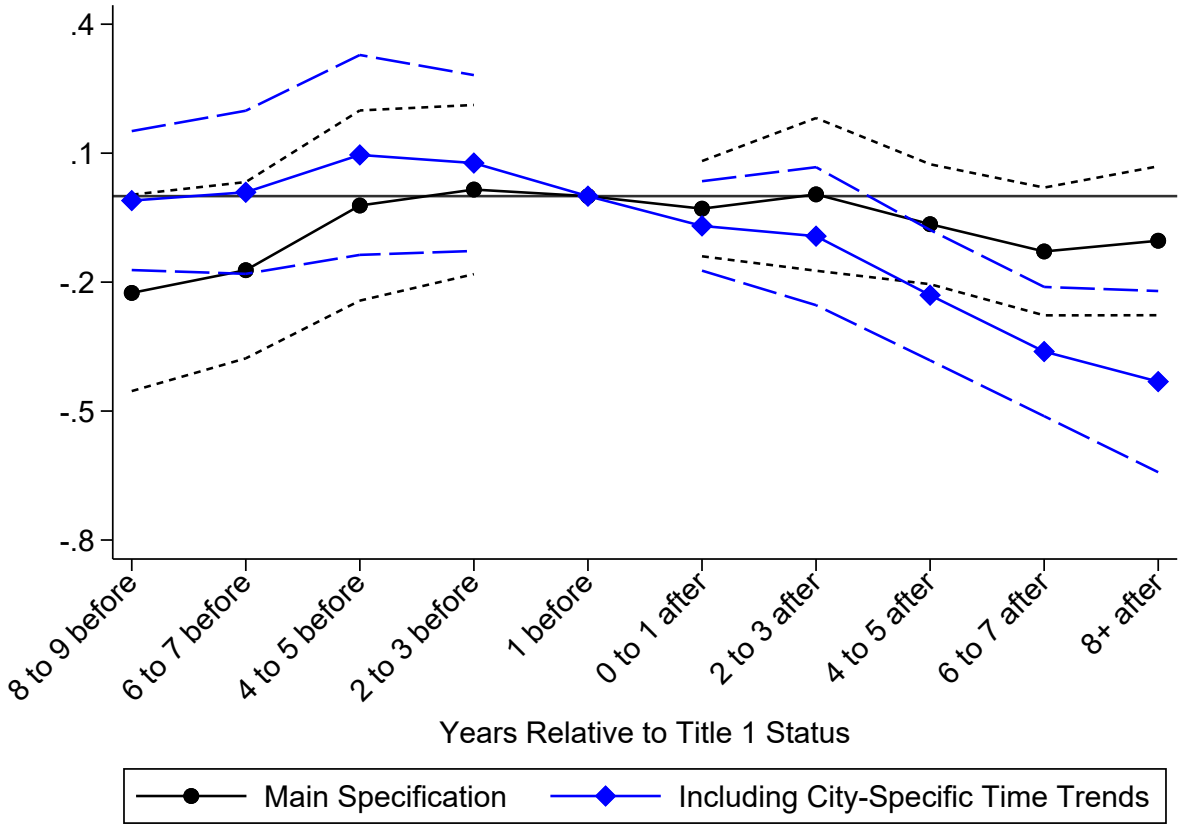
AIDS deaths for the 2007 Title 1 cities means that the parallel trends assumption required for difference-in-differences models is violated and that the baseline estimating equation will not yield valid estimates of the impact of Title 1 status. Table B.1 displays the estimated effect of Title 1 status from Equation (1). The point estimate is positive and statistically insignificant.

One approach to accounting for the differential pre-trends is to supplement Equation (1) with city-specific linear time trends. Under the assumption that the differential trends would have continued linearly absent Title 1 status, the estimated impact of Title 1 status from Equation (1) is valid once city-specific trends are included. To implement this approach, I first estimate 30 city-specific linear time trends using years 1998 to 2006 by estimating models with city fixed effects, year fixed effects, and the interaction of year and city. I then include the product of each city's coefficient on its year-city interaction and the year as a control in Equation (1) with data from 1998 to 2018.[26]

The blue series in Figure B.1 displays the coefficients on years relative to Title 1 status from including the control for city-specific time trends. Column 2 of Table B.1 displays the estimate of the average impact once the control for city-specific time trends is included. Once the differential trends that led to certain cities obtaining Title 1 status are accounted for, the estimates follow a similar pattern as the estimates of Title 1 status presented in the main text. The estimate in Table B.1 indicates that Title 1 status leads to a reduction in HIV/AIDS death rates of 21.7 percent.

[26] As Goodman-Bacon (2018b) explains, this two-step procedure is preferred over including city-specific time trends directly in Equation (1) because, unlike using only pre-treatment data to estimate the city-specific trend coefficients, directly including city-specific time trends risks attributing duration-specific treatment effects to being part of the city-specific time trend.

Figure B.1: Relationship between Title 1 Status and HIV/AIDS Death Rates for Cities Obtaining Title 1 Status in 2007



Notes: Each marker is a coefficient on Title 1 status interacted with number of years from initial Title 1 status eligibility with the log of HIV/AIDS death rates as the dependent variable. The x-axis indicates the number of years from Title 1 status. The y-axis indicates the coefficient estimate. The black circles are from a single regression with city fixed effects, year fixed effects, and the demographic controls described in the text. The blue diamonds are from a single regression that includes a city-specific linear time trend in addition to the baseline controls. The sample contains 630 observations from 30 cities from 1998 to 2018. Each regression includes city fixed effects, year fixed effects, and the demographic controls described in the text. The dashed lines indicate 95-percent confidence intervals calculated using standard errors clustered by city.

Table B.1: Estimated Effect of Title 1 Status Using Variation in Title 1 Status from 2006 Ryan White CARE Act Reauthorization

	(1)	(2)
	0.019	-0.217
	(0.093)	(0.093)
	[0.841]	[0.027]
Years	1998-2018	1998-2018
City-Specific Linear Trend		x
Number of Cities	30	30
n	630	630
Mean of Dependent Variable in Levels	4.0	4.0

Notes: Each column displays the effect of Title 1 status from Equation (1). The unit of observation is a city and year combination. The dependent variable is the log of HIV/AIDS deaths per 100,000 people. Numbers of HIV/AIDS deaths each year come from the Vital Statistics Mortality data. All regressions include city fixed effects, year fixed effects, and the demographic controls described in the text. Standard errors are clustered by city and are shown in parentheses. P-values are shown in brackets.