HIV Medicine Association (HIVMA) Policy Statement:
Solutions Needed to Address the HIV Public Health Crisis in the United States

Addendum to *Implications of the HIV Prevention Trial Network (HPTN) Study 052*
Results for the U.S. Response to Domestic and Global AIDS
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On World AIDS Day 2011, President Obama and former presidents Clinton and Bush challenged the world to end AIDS now that our investment in HIV research has produced tools for effectively preventing and treating HIV infection[1]. In the U.S., we can make serious headway against HIV infection by leveraging the National HIV/AIDS Strategy and the Patient Protection and Affordable Care Act's (ACA), particularly the health coverage expansion occurring in 2014.

However, the U.S. cannot afford two more years of the status quo while we await ACA implementation. Immediate, emergency steps are needed to address the domestic HIV crisis. For example, former President Clinton urged us to look for creative solutions to address the domestic HIV crisis, such as facilitating access to the generic antiretroviral drugs available through the PEPFAR program for safety-net medical providers in the U.S. The proposal represents the urgency, spirit and ingenuity with which this public health crisis must be approached. HIVMA urges federal and state policymakers, industry partners, philanthropists, advocates, providers, and HIV professional organizations to collaborate on identifying solutions for ensuring access to HIV care, including expert HIV providers, and treatment for everyone who needs it in the U.S. Specifically, we recommend that the White House Office of National AIDS Policy's Public-Private Partnership Working Group assume this important task.

HIV Treatment Saves Lives and Prevents New Infections

HIV treatment results in near normal life expectancies for those with access to it, and powerful new evidence indicates that people who are on treatment are significantly less likely to transmit the virus[2, 3]. The HIV Prevention Trials Network (HPTN) 052 study – named the scientific breakthrough of the year by *Science* magazine in 2011– found that HIV-infected men and women with relatively healthy immune systems who received immediate antiretroviral therapy were more than 96 percent less likely to sexually transmit the infection to their uninfected partners and were more than 40 percent less likely to experience a clinical event than those whose treatment was delayed[4].

The Domestic HIV Crisis

Poor access to HIV treatment in the U.S. fuels a public health crisis that threatens the lives of low income, uninsured and underinsured people living with HIV infection and those at risk for contracting HIV infection. Of the 1.2 million people living with HIV infection – around 50 percent of people are not in regular care and only 28 percent of persons with HIV in the U.S. have undetectable levels of HIV in their blood – leaving them at risk for disease progression and for transmitting the virus[5]. Around 25 percent of people with HIV infection are uninsured with fewer than 15 percent having private insurance coverage[6]. Nearly 50 percent rely on Medicaid coverage but even then a majority gain coverage after becoming disabled by AIDS[7].

Sadly, these disparities are growing. The domestic HIV crisis is reflected in waiting lists for the Ryan White AIDS Drug Assistance Program that emerged in January 2008 and have grown exponentially despite modest investments of new

federal and state resources and the price concessions made by some pharmaceutical companies[8].[1] The waiting lists are not expected to abate even with the laudable new commitments for 2012 totaling $50 million[9]. Additionally, access to HIV treatment for those eligible for the Medicaid program is increasingly tenuous as all states have implemented policies to contain costs, including increasing cost-sharing requirements and limiting or eliminating coverage for other services critical to effective HIV care[10].

HIV Care and Treatment Costs

Annual costs for HIV antiretroviral therapy are estimated to be $13,000 per patient per year on average in the U.S. and account for a significant percentage of the total annual costs, estimated to be around $20,000 per patient on average[11]. First-line drug regimens used in resource-limited settings are available for less than $200 per patient per year, in some countries second line regimens are available for $450 per patient per year[12].

Mechanisms to lower antiretroviral drug prices that do not compromise access in resource-limited settings or drug development are urgently needed for populations in the U.S. with poor access to care and treatment.

Recommendations

A failure to reduce barriers to HIV care and treatment over the next two years and beyond pending implementation of health care reform will be costly in terms of lives lost to HIV infection, our nation's public health and long-term health care expenditures.

To that end – HIVMA urges:

- Federal and state governments to sustain and grow their investment in HIV care and treatment.
- Philanthropists, industry and other stakeholders to work together to explore all options for lowering the costs of antiretroviral therapies for safety-net medical providers in the U.S. and to identify solutions for ensuring access to HIV treatment for everyone who needs it in the U.S.
- Education for HIV medical providers and programs on health care reforms planned and underway to prepare providers for the new financing and delivery systems. Medical providers also must engage in health care reform implementation planning within their states.
- States and the federal government, when applicable, to facilitate and expedite enrollment in the Pre-existing Condition Insurance Plans (PCIP) for people with HIV/AIDS and ensuring PCIP provider networks include qualified HIV medical providers, including Ryan White Part C providers.
- Federal and states policymakers to maintain Medicaid coverage that does not compromise effective HIV care, including sustaining the federal commitment to the Medicaid program and prescription drug coverage that does not impose limits or cost-sharing that jeopardizes access to antiretroviral therapy according to the federal HIV treatment guidelines[13].
- States to adopt the new Medicaid health home benefit for people with HIV infection to better support comprehensive, well-coordinated HIV care[14].
- Federal and state policymakers to fully fund and implement the Affordable Care Act.

[1] According to data maintained by the National Alliance of State and Territorial AIDS Directors, the current ADAP waiting lists began in January 2008 with one individual and peaked at 9,298 in Sept. 2011. As of Jan. 2012 – 4,774 individuals were on waiting lists in 12 states. It is important to note that not all states maintain waiting lists.

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