

Lifelong AIDS Alliance 2012 Federal Policy Agenda

Overview

At the 30 year anniversary of HIV/AIDS much has changed in our thinking and actions towards the disease, and the people living with HIV today. Lifelong AIDS Alliance is has renewed our Policy and Advocacy focus, on the state and federal levels.

Lifelong has formed and supports the **Washington HIV AIDS Community Advocacy Network, (WHACAN)**, a group of people living with HIV/AIDS, members of local government and community based organizations to help us identify and pursue effective state and local policy decisions.

Our primary focus remains full funding of the programs that provide care, medication, support, housing and prevention for those living with, and at risk for, HIV/AIDS. As we move towards implementation of federal health reforms in accordance with the **Personal Protection and Affordable Care Act (PPACA)**, we recognize the need to be at the table and representing the needs of the people we serve.

A great concern for many in the HIV/AIDS service community is what service delivery will look like in a post **Ryan White CARE Act** world. It is our desire to represent the needs of people we serve by educating and engaging stakeholders in the design of federal and state health care implementation.

Our agenda is closely aligned with the **Office of National AIDS Policy's (ONAP) National HIV/AIDS Strategy (NAHS^[1])**, and the goals outlined within. These include:

- By 2015, lower the annual number of new infections by 25% (from 56,300 to 42,225)
- Reduce the HIV transmission rate, which is a measure of annual transmissions in relation to the number of people living with HIV, by 30% (from 5 persons infected per 100 people with HIV to 3.5 persons infected per 100 people with HIV)
- By 2015, increase from 79% to 90% the percentage of people living with HIV who know their serostatus (from 948,000 to 1,080,000 people)
- By 2015, increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis from 65% to 85% (from 26,824 to 35,078 people)
- By 2015, increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care (at least 2 visits for routine HIV medical care in 12 months at least 3 months apart) from 73% to 80% (or 237,924 people in continuous care to 260,739 people in continuous care)
- By 2015, increase the number of Ryan White clients with permanent housing from 82% to 86% (from 434,000 to 455,800 people). (This serves as a measurable proxy of our efforts to expand access to HUD and other housing supports to all needy people living with HIV)

Budget & Appropriations

Recognizing that there is a need to control spending, we will advocate for a responsible approach to cuts and implementation of the **Budget Control Act**. \$1.2 trillion in cuts would decimate programs for people living with HIV/AIDS (PLWHA).

Funding in FY 2012 cut \$700 million from the Department of Health and Human Services (HHS) budget. Programs that maintained FY 2011 funding levels include: **Centers for Disease Control and Prevention's HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases and Tuberculosis Prevention** programs; the **Minority AIDS Initiative**; and the **Ryan White HIV/AIDS Program**. The need for programs increases each day, and funding must keep up with demand, we will advocate for realistic funding increases in programs to meet the needs of people living with HIV/AIDS.

We support the continued reauthorization of the Ryan White Programs. It is necessary that the Ryan White Programs funded and in place for a seamless transition to health care reform. People with HIV/AIDS depend on these programs for critical services, and the delivery cannot be in jeopardy.

Treatment and Prevention

Suppression of viral load (the amount of virus in the blood stream) is key to maintaining the health of people living with HIV/AIDS, and to stopping transmission to others. As demonstrated by recent clinical trial data (HPTN 052^[ii]) people who are adherent to their medication lower their risk of transmission to sexual partners by 96%.

One part of this solution is unencumbered access to medications and care. But access to medications is not enough; safe and affordable housing, nutrition and support services are necessary components for maintaining health and lowering health care costs. We will continue our work with HUD, state and local partners to increase the affordable housing options for people living with HIV/AIDS.

The other part is prevention and testing. Prevention funds have been cut at the state level and this hinders our ability to educate, test and prevent new HIV infections.

The goals of the **NAHS** to reduce new infections by 25% and viral load by 20% by 2015 are attainable only with the cooperation and assistance of our federal and state partners.

We support a reversal of the ban on federal funding for syringe exchange programs (SEP's). The science is clear that these programs are a cost effective form of harm reduction. SEP's prevent new infections and do not increase drug use. Injection drug users account for 25% of all new HIV infections each year^[iii]. If we are to reach the goals of the NAHS, we must fully fund SEP's.

We support increasing AIDS drug assistance program (ADAP) funding as required to meet demand. As of January 12, 2012, there are 4,717 individuals on ADAP waiting lists in twelve (12)

states. President Obama announced \$35 million in additional funding on World AIDS Day (December 1, 2011). The distribution of these funds has not yet been determined. The Administration has a stated goal of removing 3,000 clients from the wait list as a direct result of receipt of the \$35 million, which would still leave 1,717 people waiting for life sustaining medications.

Increased funding of the Housing Opportunities for People with AIDS (HOPWA) program.

Housing of PLWHA is prevention. Research demonstrates a direct relationship between improved housing status and reduction in HIV risk behaviors. Homeless or unstably housed persons are up to six times more likely to use hard drugs, share needles, or exchange sex than stably housed person with the same personal and service characteristics. Housing assistance improves access and adherence to antiretroviral medications, which lowers both individual and community viral loads. If we are to succeed with the goals outlined in the NAHS we must prioritize housing for PLWHA.

In FY2012, \$298.8 million in HOPWA formula funds were awarded to 125 grantees within 135 eligible areas. There are 1.1 million PLWHA in the United States, 140,000 need housing assistance, with an estimated per voucher cost of \$7,700 per year. To fund the need fully would require \$1.08 billion. In Seattle, we have 2 applicants for every available housing slot.

We support the request of \$59.8 million to the Centers for Disease Control Division of Viral Hepatitis. Decisive measures, similar to that taken in HIV/AIDS care, must be taken to stem the 56,000 new infections of Hepatitis A, B, and C in the United States^[iv].

We support the funding and work of community based organizations the testing and treatment sexual transmitted infection (STI's) programs. Community partners play a vital role in the education, testing and treatment of STI's for many uninsured people, as well as those uncomfortable with being treated in traditional medical settings.

We oppose ineffective and non scientific abstinence-only-till-marriage based sexual education programs. Such programs are politically motivated and fail to address the needs of educating young people to take personal responsibility for their sexual health. We will work towards the return of \$10 million to the CDC's HIV Division of Adolescent and School Health (DASH) programs.

Health Care Reform

PLWHA, and other individuals living with chronic communicable disease, have unique needs in health care. As we move toward full implementation of the **PPACA** and our own state health exchange board we will be working closely with HHS in the design of an essential health benefit package which is inclusive of these needs.

Policies addressing the lives of PLWHA

The rescission of the travel ban on PLWHA last year was a victory and will be celebrated this year as the **International AIDS Conference** returns to Washington, DC this summer.

We support any and all measures to address and reduce the stigma associated with HIV/AIDS.

HIV related stigma is unfortunately still very real here in the US. It hinders our work in prevention and treatment. Nearly 1 in 6 American surveyed admitted to feelings of “disgust” related to PLWHA, and 1 in 5 agreed with the statement “People who got AIDS through sex or drug use have gotten what they deserve.”^[v]

We support Rep. Barbara Lee’s REPEAL HIV Discrimination Act (HR 3053). The act would provide states with incentives and support to reform outdated criminal laws that target people living with HIV, and will work with the **White House ONAP** and **Justice Departments** to achieve these goals in the courts and in Congress. Thirty-four states have laws that criminalize the transmission of HIV^[vi], including forcing people convicted to register as sexual offenders, impacting their personal and professional lives. These laws are outdated in a time of accessible treatment, and disproportionately impact gay men and people of color.

For more information, please contact:

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^[i] <http://www.whitehouse.gov/administration/eop/onap/nhas>

^[ii] http://www.hptn.org/research_studies/hptn052.asp

^[iii] http://nastad.org/Docs/Public/Publication/2006213_NASTAD_IDUStandAlone.pdf

^[iv] http://www.cdc.gov/hepatitis/pdfs/disease_burden.pdf

^[v] <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447072/pdf/0920341.pdf>

^[vi] [http://thomas.loc.gov/cgi-bin/query/z?c112:H.R.3053:](http://thomas.loc.gov/cgi-bin/query/z?c112:H.R.3053)