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Addressing the HIV/AIDS Epidemic
at Home and Abroad:
Short Term Policy Options
Under Consideration by the
New Administration and Congress

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This past summer, the United States government's global HIV/AIDS program was reauthorized¹ and the U.S. Centers for Disease Control and Prevention (CDC) released new data indicating that the epidemic at home was worse than previously thought.² These events called significant attention to HIV/AIDS and together present the new Administration and Congress with a unique opportunity to address the epidemic at home and abroad. Several short-term HIV-specific policy options have already been proposed for consideration, or are under consideration, by the new Administration and Congress. This brief provides an overview of some of these options, as put forward by non-governmental organizations (NGOs),* and by President Obama. It is not, however, meant to be inclusive of all proposed options nor does it address any broader, non HIV-specific policy changes that are also underway – namely, national health care reform and foreign aid reform – although such efforts will undoubtedly have significant implications for the government's response to HIV.

The sources reviewed for this document are listed below. They are followed by a table which arrays each of the main options identified for short-term policy attention and indicates whether the option would necessitate an administrative and/or legislative action. A more detailed discussion of options is also provided.

MAIN SOURCES REVIEWED FOR THIS SUMMARY INCLUDE:

1. Obama Campaign & Transition Documents:
 - a. *Barack Obama and Joe Biden's Plan To Combat Global HIV/AIDS* : www.barackobama.com/pdf/issues/FactSheetAIDS.pdf ;
 - b. *The Obama-Biden Plan to Combat Global HIV/AIDS*: http://change.gov/pages/the_obama_biden_plan_to_combat_global_hiv_aids/
2. *AIDS in America*: www.theaidsinstitute.org/downloads/AIDSinAmericaFinal.pdf
Put forth by a coalition of approximately 100 organizations
3. *National AIDS Strategy*: www.nationalaidsstrategy.org/
Put forth by a coalition of approximately 350 organizations and 1,200 individuals
4. Global Health Council's Global AIDS Roundtable Recommendations (GHC/GAR): www.globalhealth.org/images/pdf/2009_transition/gar_document.pdf
Put forth by a coalition or more than 100 U.S.-based and international organizations

* For purposes of developing this document, in addition to official documents released by the Obama Campaign and Transition, only proposals provided by the main, large coalitions of NGOs were reviewed. It is important to note, however, that many of the organizations that signed onto these proposals as well as other organizations have also developed their own, individual organizational proposals and options papers.

TABLE OF SHORT-TERM OPTIONS & ADMINISTRATIVE AND LEGISLATIVE MECHANISMS: DOMESTIC

Domestic	PROPOSED BY			MECHANISM FOR ADDRESSING	
	Obama	AIDS in America	National AIDS Strategy	ADMINISTRATIVE	LEGISLATIVE
1. National HIV/AIDS Strategy, Coordinator, and Office					
a. Develop National HIV/AIDS Strategy	✓	✓	✓	✓	✓
2. Increase Investment in HIV Prevention, Particularly at State and Local Level					
a. Increase funding for HIV prevention	✓	✓		✓	✓
b. Promote coverage of routine HIV screening by State Medicaid Programs		✓		✓	
c. Make routine HIV screening a covered service under Medicare		✓			✓
d. Permit federal funding of needle/syringe exchange in U.S.	✓	✓			✓
3. Increase Access to Care and Treatment for People with HIV/AIDS					
a. Extend current Ryan White authorization beyond "sunset" of September 2009; Increase funding for Ryan White Program	✓	✓		✓	✓
b. Make ARVs a protected drug class under Medicare Part D		✓		✓	
c. Permit ADAP spending to count toward TrOOP under Medicare Part D		✓		✓	
d. Expand Medicaid eligibility to cover low-income individuals with HIV prior to disability	✓	✓			✓

TABLE OF SHORT-TERM OPTIONS & ADMINISTRATIVE AND LEGISLATIVE MECHANISMS: GLOBAL

Global	PROPOSED BY			MECHANISM FOR ADDRESSING	
	Obama	AIDS in America	National AIDS Strategy	ADMINISTRATIVE	LEGISLATIVE
1. Address Outstanding Barriers to Implementation of Comprehensive Response to the Global Epidemic					
a. Eliminate Mexico City Policy <i>UPDATE: Presidential Memorandum Rescinding Policy Issued on January 23, 2009³</i>	✓			✓	
b. Address Anti-prostitution pledge				✓	✓
c. Broaden uses of funding for HIV prevention	✓			✓	
d. Clarify "Right of Refusal" Language				✓	
e. Permit federal funding of syringe/needle exchange in global AIDS programs	✓			✓	
2. Continue U.S. Commitment to People with HIV on Antiretroviral Treatment and to Scale-up Prevention Efforts					
a. Increase funding for treatment and prevention as authorized under current law				✓	✓
3. Finalize Policy Change to End The HIV Travel and Immigration Ban					
a. Remove HIV from Government's List of Excludable Health Conditions				✓	

PART I: ADDRESSING THE DOMESTIC EPIDEMIC

Below are the short-term options that have been identified by President Obama and/or the major coalitions of NGOs. They are designed to strengthen the response to the domestic epidemic with an emphasis on strategy and coordination, increased investment, and a focus on some of the main challenges that remain, particularly the difficulty of bringing HIV incidence down, the need to increase the number of people who know their HIV status and are receiving services, and the disproportionate impact of HIV on some populations.

1. Establish National HIV/AIDS Strategy, Leadership, and Centralized Coordination of Domestic HIV/AIDS Response.

Issue: New data released by the CDC signal that the domestic HIV/AIDS epidemic is far from over, and is worse than previously thought. It is now believed that more than 56,000 people are newly infected with HIV each year in the U.S., 40% higher than the previous estimate, and a level that has remained unchanged for more than a decade.² In addition, of the more than one million people living with HIV in the U.S., many do not have access to care and services,⁴ including one in five who do not know they are infected.⁵ Finally, certain populations bear the brunt of the epidemic's impact, particularly Black Americans and gay and bisexual men of all races/ethnicities. The federal government's response, which began in the 1980s, includes ten federal agencies and numerous programs and funding streams. However, there is no federal mechanism or strategy for coordinating across all these programs and funding. As a result, and given the new data, two large coalitions of national AIDS organizations have called for the development of a national HIV/AIDS strategy with funding and coordinating authority,⁶ the 110th Congress passed a concurrent resolution calling for a strategy⁷ and a similar resolution has just been introduced in the House in the new Congress,⁸ and President Obama stated his intention to develop a national strategy. The NGO coalitions have noted that such a plan is recommended by the United Nations *Declaration of Commitment*⁹ and *Three Ones Principles*¹⁰, both of which have been signed onto by the United States. It is also central to the U.S. government's global AIDS response, which revolves around one centralized office, coordinator, global and country plans, and authority over all federal funding and programs across agencies, an approach which has been credited with success.

Option: Create First National HIV/AIDS Strategy. The new Administration is expected to take steps to begin development of a national HIV/AIDS strategy. While such a strategy will take time to develop, the Administration could announce a timeline, broad goals, funding plan, and process for short and long-term strategy development and planning could begin immediately. In doing so, there are questions that will need to be addressed including: whether a new national office and new position of national HIV/AIDS coordinator, with authority to oversee the strategy and coordinate across all domestic HIV programs and funding streams, will be created [as distinct from the existing Office of National AIDS Policy (ONAP) and its Director, created in the late 1990s to coordinate domestic HIV activities but only given authority to develop policy guidance; rather, it has been recommended that they be modeled after the U.S. global AIDS response, which includes a Global AIDS Coordinator and Office, its own funding, and authority over the entire funding and program portfolio]. If such an office and position are created, the Administration will have to decide on where they should be located (e.g., in the White House or at a department, such as the Department of Health and Human Services); who the coordinator will be; the nature of the funding authorities that would be desirable for the coordinator to have and funding levels for the new office itself; the roles and responsibilities of each federal agency vis a vis a new centralized office, taking into account their current HIV/AIDS portfolios; and the roles and responsibilities of non-federal partners, particularly state and local jurisdictions, which receive the bulk of federal funding for HIV/AIDS and are largely responsible for designing and implementing programs and services. It is likely that new Congressionally-mandated authorities are needed to take some of these steps, and the Administration could begin working with Congress to identify and include them in legislative language.

2. Increase Investment in HIV Prevention, Particularly at State and Local Level

Issue: As reported by CDC, the new HIV incidence estimates, and confirmation of the epidemic's disproportionate impact on certain populations, provide a "wake-up call" to the U.S. on HIV prevention, and have led to a renewed focus on the need to augment domestic HIV prevention efforts. Yet numerous barriers to doing so remain. For example, despite national recommendations issued by the CDC in 2006 calling for routine HIV screening in health care settings for all adults and adolescents, significant shares of people with HIV do not

know they are infected and many are diagnosed late in their illness. In addition, national HIV prevention goals have not been met in part because HIV prevention has not been funded or implemented at the level needed to make a further impact^{11,12,13} – since FY 2002, for example, federal funding for HIV prevention at CDC has decreased by 4 percent.¹⁴ It was \$753.6 million in FY 2008 (only 4% of the federal AIDS budget), and no increase was requested for FY 2009. Furthermore, many state and local jurisdictions, which rely heavily on federal prevention funding, already face economic hardship and in a recent survey cited funding shortages as the top challenge confronting their HIV prevention response.¹⁵ These trends prompted the House Committee on Oversight and Government Reform to convene a hearing on domestic HIV prevention and to request that CDC provide an estimate of the funding that would be needed (a professional judgment budget) to fully implement effective HIV prevention in the United States.¹⁶ According to CDC, in order to prevent thousands of new HIV infections and reduce HIV-related disparities, an additional \$877 million would be needed in FY 2009, and \$4,784 million over 5 years.¹³ Some of the options identified that the new Administration and Congress could undertake to signal a high-level national commitment to HIV prevention and/or provide immediate fiscal relief include:

Option: Increase Funding for HIV Prevention. As part of its first budget request, for FY 2010, which is expected to be released in the spring of 2009, the Administration could include the additional funding requested for HIV prevention in the CDC’s professional judgment budget. It could also announce the importance of elevating the HIV prevention response early on, calling attention to the continued epidemic in the United States and noting that HIV prevention will be a prominent part of the national HIV/AIDS strategy. The Congress could also take short-term steps by appropriating the additional funds requested in the CDC’s professional judgment budget for FY 2009.

Option: Promote Routine HIV Screening Through Medicaid and Medicare

Despite public health service recommendations calling for routine (population-based) HIV screening, there continue to be barriers to funding and implementing them, including by other federal programs, particularly Medicaid and Medicare. While routine screening is technically a reimbursable service under Medicaid, the nation’s federal-state health insurance program for low-income individuals which reaches significant shares of those living with and at risk for HIV, it is considered an optional benefit, meaning that states have to choose to cover it if they want to receive federal matching funds. To date, no guidance has been provided by the federal government to the states on the new public health service recommendations, the importance of routine screening for the Medicaid population, and the ability of states to cover routine screening as an optional benefit and receive federal matching funds for its provision. The Centers for Medicare and Medicaid Services (CMS), the federal agency which administers Medicaid, could inform all states about routine screening and encourage them to cover it in their state Medicaid plans. A further avenue that can be used to promote routine screening is Medicare, the federal health insurance program for the elderly and disabled. Medicare also reaches people at risk for HIV (particularly the under-65 disabled) but, while HIV testing of individuals in the context of a medical care visit is a covered service under Medicare (if recommended by a provider), routine HIV screening is not. Congressional legislation would be needed to make such a change in Medicare.

Option: Remove Ban on Use of Federal Funds for Needle/Syringe Exchange (NSEPs)

Injection drug use (IDU) continues to contribute to HIV transmission in the United States, although prevention efforts have been successful at driving down its impact over time.^{2,17} Still, injection drug use directly accounts for more than a quarter of HIV transmissions which have occurred since the beginning of the epidemic, and a greater share indirectly, through transmission to the sexual partners and children of IDUs.¹⁸ To help reduce IDU-related HIV transmission, a comprehensive prevention approach is recommended, including the use of sterile needles and syringes. As CDC states: “for injection drug users who cannot or will not stop injecting drugs, using sterile needles and syringes only once remains the safest, most effective approach for limiting HIV transmission.”¹⁹ Needle and syringe exchange programs (NSEPs), however, have been controversial in the United States and U.S. law has prohibited the use of federal funding for this purpose since 1988. To date, therefore, NSEPs have had to rely on funding from state and local governments and private organizations only. At the same time, there have been numerous scientific studies, including by the CDC, the U.S. Government Accountability Office (GAO), Institute of Medicine (IOM), and others, showing that NSEPs, offered as part of a comprehensive prevention strategy, are associated with a decrease in drug-related HIV risk behavior and do not lead to increased drug use, crime, or discarded needles/syringes.²⁰ As a result, many groups have issued recommendations to remove the federal funding ban on NSEPs and President

Obama indicated his intention to do so during his campaign. Because the ban is codified in U.S. law, however, any change would need to be made legislatively by Congress. A bill to eliminate the ban, *The Community AIDS and Hepatitis Prevention Act* (H. R. 179), was recently introduced in the 111th Congress.²¹

3. Increase Access to Care and Treatment for People with HIV/AIDS

Issue: Despite great strides in HIV care and treatment, including the introduction of highly active antiretroviral therapy in 1996 which has led to a dramatic reduction in HIV-related deaths and extended the lives of thousands of people with HIV^{22,23}, many still face barriers to accessing programs and services. For example, a recent analysis found that only 55 percent of those who met the clinical criteria for antiretroviral therapy were receiving it.⁴ Among the many challenges they face are program eligibility restrictions, capacity limitations, and variation in the availability of services across the country. For example, eligibility rules for Medicaid, the major source of coverage for people with HIV in the U.S., present a “Catch-22” relative to the current standard of HIV care in that many low-income people with HIV are not eligible for Medicaid until they become disabled, despite available therapies through Medicaid that may prevent disability. The Ryan White Program, the nation’s single largest federal program designed specifically for people with HIV/AIDS who have no or limited insurance coverage, and which includes the AIDS Drug Assistance Program (ADAP), has faced funding shortages for several years, resulting in ADAP waiting lists and other program limitations.²⁴ There are several short-term administrative and legislative options that have been identified to lessen or even eliminate some of these barriers and enhance access including:

Option: Include Antiretrovirals as Protected Drug Class under Medicare Part D. The basic formulary standard in Medicare Part D, the prescription drug program of Medicare, requires plans to cover at least two drugs per drug class. Since the Part D program started, annual guidance has been issued by CMS requiring plans to cover “all or substantially all” drugs in six key classes, including antiretrovirals. Congress recently sought to codify this policy (under P.L. 110-275) by establishing a process for the Secretary to designate drug classes for special protection. Just this month, CMS announced an interim final rule that would extend such protection through 2010, but the rule has not yet gone into effect.²⁵ This rule could be finalized and protection ensured for beneficiaries with HIV and other groups, who benefit from such protections.

Option: Permit ADAP Spending to Count Toward TrOOP under Medicare Part D. When Congress established the Medicare Part D program, drug spending by other government programs was prohibited from counting toward true out-of-pocket costs (TrOOP), costs that accrue during the coverage gap or “doughnut hole” of Part D, during which coverage is not available until a catastrophic ceiling has been reached. Congress exempted State Pharmacy Assistance Programs (SPAPs) from this requirement but the Administration interpreted the law such that ADAPs are not considered SPAPs. Therefore, any ADAP funding used for Medicare eligible people with HIV is not counted toward TrOOP, potentially leading to a situation where an individual can never reach the catastrophic coverage level and will continue to need to rely on limited ADAP funds. The Administration could reinterpret its rules and determine that ADAPs qualify as SPAPs, which would loosen up pressure on ADAP funds.

Option: Enact the Early Treatment for HIV Act (ETHA) to Enhance Access to Medicaid. To change Medicaid eligibility to cover low income individuals with HIV who are not disabled or otherwise categorically eligible, would require Congressional legislation. Congress has introduced such legislation, allowing for a state Medicaid option to provide Medicaid coverage to low income people with HIV prior to disability and receive an enhanced federal Medicaid match, for the past several years. The legislation has not passed Congress. Congress could enact legislation thereby expanding eligibility in those states that choose to use the option.

Option: Extend Reauthorization of the Ryan White HIV/AIDS Treatment Modernization Act and Increase its Funding

The Ryan White Program, first created in 1990, was reauthorized for the third time in 2006. Unlike prior authorizations of the program, which each spanned a five-year period, the most recent reauthorization was for a three-year period and includes a sunset provision ending the authorization on September 30, 2009.²⁶ This shorter time frame was chosen by Congress to allow for the bill to be reauthorized in 2006

despite the existence of several outstanding and complicated issues. However, many believe not enough time has gone by to fully implement the last reauthorization, which would prevent some critical decisions from being reached. As such, Congress could extend the current Act through a later period, and ensure continuity in the program, while some of the other issues are being addressed. In addition, funding for the program, other than ADAP, has remained relatively flat for several years; while ADAP has received some increases, it continues to struggle with waiting lists and other limitations. The current economic downturn is likely to further pressure on programs like Ryan White. Congress could appropriate additional funding for FY 2009 for Ryan White, and the President could request funding over this amount for FY 2010.

PART II: THE GLOBAL EPIDEMIC

The last several years have seen the creation of a major new U.S. global AIDS initiative, including a significant increase in funding, which has been cited as a bipartisan success with U.S. leadership helping to lead to a stepped-up response throughout the world. Looking forward, it will be important for the U.S. to continue its existing effort, build upon its successes, and improve its response where needed and given changes in the epidemic and country needs over time. Possible short-term options that have been identified include:

1. Address Outstanding Barriers to Implementation of a Comprehensive Response to the Global Epidemic

Issue. The creation of the President's Emergency Plan for AIDS Relief (PEPFAR) in 2003, with strong support by the President and Congress, marked a historic move forward in the global response to the epidemic, and has been cited as a prime example of bipartisan cooperation. Over the first five years of the program, PEPFAR supported antiretroviral treatment for more than 2 million people, prevention of more than 7 million infections, and care for more than 10 million.²⁷ In addition to successes, the first five-years of PEPFAR provided many lessons learned and the recent reauthorization of the program, now called The Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, addressed several of these issues, including for example, increasing annual authorization levels, relaxing some earmarks on HIV funding generally and for prevention specifically, and ending a statutory prohibition against HIV-positive visitors and immigrants. Still, President Obama and NGO coalitions have identified several outstanding issues that could benefit from additional policy guidance and clarification, or through new legislative language.

Already, one of the issues that had been identified – that of rescinding the Mexico City Policy, or so-called Global Gag Rule – was acted upon by the President during his first week in office. The Mexico City Policy had prohibited the provision of federal funding to any NGO that performed or promoted abortion, even if such activities were funded through separate sources. First initiated by President Reagan in 1984, the policy was rescinded by President Clinton in 1993, and re-instated by President Bush in 2001. In 2003, President Bush issued a memorandum exempting PEPFAR funding from this restriction. The Mexico City Policy has been controversial throughout its history, with many organizations that provide services to women at risk for and living with HIV indicating that the rule, even with the PEPFAR exemption, was at best ambiguous and at worst had discouraged or even prevented some organizations from being able to reach populations in need. On Friday, January 23, 2009, President Obama issued a memorandum rescinding the policy.³

Additional issues that have been identified include the following:

Option: Clarify “Anti-Prostitution Pledge” Requirement. The first authorization of PEPFAR included language forbidding the receipt of funding organizations unless they had an explicit policy in place opposing prostitution and sex trafficking; the reauthorization maintained the language. The 2003 language was initially interpreted by the Administration to apply only to foreign NGOs, but extended to U.S.-based NGOs in 2005. The policy as applied to U.S.-based NGOs was challenged in court, including a challenge to federal guidance that sought to clarify that private funds could be used freely without a pledge requirement if an organization set up a separate entity for this purpose. A recent federal court ruling found the requirement to be a violation of the First Amendment, a decision which has since been appealed by the government. This court decision, coupled with an ongoing concern that the provision has prevented some organizations from reaching all those in need of services, has led to

some calling for the Administration and Congress to address the issue in the short run. This could be done by the Administration through a reinterpretation of policy to exempt U.S.-based NGOs from the requirement (although the provision would still apply to foreign NGOs). Congress could pass legislation removing all or part of the requirement.

Option: Clarify Reauthorization Language on the Need for “Balanced Funding” for HIV Prevention. One of the challenging issues that arose during the first five-years of PEPFAR was the earmark on HIV prevention funding, requiring that 33 percent of PEPFAR funds appropriated for prevention be spent on abstinence-until-marriage programs. The General Accounting Office, the Institute of Medicine and other organizations recommended the removal of this requirement after finding that it limited program reach on the ground.^{28,29} The recent reauthorization removed the earmark and relaxed the condition, substituting instead a requirement for “balanced funding” for prevention, including a report to Congress if less than half of prevention funds in any host country were provided to “abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction”. Existing policy guidance does not yet reflect this new language and there continues to be confusion about the interpretation of the new language. The Administration could issue guidance updating the language and indicating that the earmark has been removed, as well as providing parameters on what kind of report would be required if needed.

Option: Change Policy to Permit Use of Federal Funds for Syringe/Needle Exchange in Global AIDS Programs

Globally, there are an estimated 13.2 million injecting drug users, most of whom (78 percent) live in developing and transitional countries. According to UNAIDS, injecting drug use accounts for at least 10 percent of all new HIV infections globally, rising to nearly one-third of new infections outside of sub-Saharan Africa. In some regions and countries, injecting drug use is the main driver of the HIV epidemic.³⁰ The current legislative ban on the use of federal funding for NSEPs, first instituted in 1988, only applies to funding provided through the Department of Health and Human Services and no similar legislative ban exists for other funding streams. However, since 2002, the U.S. Agency for International Development (USAID) has promulgated policy prohibiting the use its funds for NSEPs^{31,32} and the Office of the U.S. Global AIDS Coordinator at the State Department has issued such guidance as applied specifically to global AIDS funding.³³ While U.S. funding for global HIV/AIDS activities provided by the State Department and USAID can be coordinated with NSEP activities supported by other donors, U.S. funds must be segregated, coded separately, and thoroughly monitored to ensure that they are not being used for needles and syringes. As noted above, numerous scientific studies have determined that NSEPs, offered as part of a comprehensive prevention strategy, are associated with a decrease in drug-related HIV risk behavior and do not lead to increased drug use, crime, or discarded needles/syringes.²⁰ Therefore many organizations, including the Institute of Medicine in a recent report, have issued recommendations to change this policy as it applies to U.S. global AIDS funding and President Obama has indicated his intention to remove restrictions on such funding during his campaign. Such a change could be made through new policy guidance issued by the State Department and USAID and would not require legislative action.

Option: Clarify the Need to Ensure the Continuity and Timeliness of Services if Conscience Clause/Right of Refusal is Invoked

The initial global AIDS authorization in 2003 included language permitting organizations eligible to receive global AIDS funding to opt out of providing a prevention or treatment service on religious or moral grounds, often referred to as the “refusal” or “conscience” clause. The 2008 reauthorization reaffirmed and extended the conscience clause language beyond prevention and treatment to apply to “care”. Concerns have been raised that this could result in individuals not getting services they need or facing lapses in service delivery. The IOM, in its Congressionally-mandated report on PEPFAR, raised this concern and underscored the importance of ensuring routine and consistent referrals where needed.²⁸ While changing or removing this language would require Congressional legislation, the Administration could issue guidance to the field about the necessity of ensuring the continuity and timeliness of the provision of high quality prevention, treatment, and care services to all clients whether or not an organization refused to provide a particular service directly.

2. Continue U.S. Commitment to People with HIV on Antiretroviral Treatment and Scale-up Prevention

Issue. One of the reasons the Congress and Administration moved to reauthorize the global AIDS program this past summer was to help send a message to recipient nations that the U.S. commitment would continue, and to authorize increased funding levels for the program in recognition of the growing costs of keeping people on antiretrovirals, reaching more people with treatment, and need to greatly scale up HIV prevention services. The reauthorization raised funding levels from \$15 billion over the first five-year period to \$48 billion for the next five-year period. However, since that time, the global financial crisis has called all large-scale programs into question and new concern about the continuation of the U.S. commitment has been raised. While all recognize that the economic crisis has changed the stakes, there is also a need to keep people on antiretroviral treatment and further address the epidemic.

Option: Continue Global AIDS Funding. The Congress is still finalizing FY 2009 appropriations and could include a minimal increase over FY 2008 funding levels of almost \$6 billion, as already requested by President Bush. The new Administration could include an additional increase in its request for FY 2010 funding. Both of these steps would ensure continuation of existing programs, including meeting growing program costs, while leaving additional scale up to later years.

3. Finalize Policy Change Ending HIV Travel and Immigration Ban

Issue: The recent reauthorization of PEPFAR removed a statutory ban that had been in place since 1993 and which prohibited people with HIV from traveling or immigrating to the United States.³⁴ The removal of the legislative ban returned the decision about which such health conditions were grounds for exclusion to the Department of Health and Human Services, which maintains the list of inadmissible conditions of public health significance. To date, the Department has not removed HIV from the list although it has indicated that it is working to do so.

Option: Expedite Removal of HIV from the Government's List of Excludable Health Conditions. The Administration could expedite the removal of the ban by immediately having the Department of Health and Human Services remove HIV from the list of inadmissible conditions of public health significance. Once HIV has been removed from the list, the Administration could issue new guidance to all immigration and naturalization officers and offices to ensure as smooth a transition as possible.

CONCLUSION

While the new Administration and Congress will face daunting challenges and economic pressures, the U.S. government's response to HIV/AIDS remains critical. On the global front, the U.S. program has been cited as a bipartisan success, with U.S. leadership helping to result in a larger global response – continuing that effort and allowing it appropriate flexibility could be pursued in the short-term and send important signals, particularly to those countries and people who depend on U.S. government support. Domestically, a variety of options have been proposed that could be pursued in the short-term by the new Administration and Congress and which could help to provide an immediate impact and/or signal an ongoing commitment. In both cases, short-term responses can also help to lay the groundwork for how HIV/AIDS fits into broader national health reform and foreign aid reform efforts.

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- ³ White House. Presidential Memorandum, "Mexico City Policy and Assistance for Voluntary Population Planning"; January 23, 2009. Available at: www.whitehouse.gov/the_press_office/MexicoCityPolicy-VoluntaryPopulationPlanning/.
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- ⁷ S. CON. RES. 98, Sept 25 2008; H. CON. RES. 413, Sept 15 2008.
- ⁸ H.CON.RES.24, January 21, 2009.
- ⁹ The Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS (convened 25-27 June 2001), paragraph 37 "by 2003, ensure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS....". Available at: www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html.
- ¹⁰ First developed by AIDS officials from African nations and other organizations in 2003, and agreed to by the United States and other donors in 2004, the Three Ones principles are: (1) one action framework/plan (2) one national coordinating authority (3) one monitoring and evaluation framework. Available at: www.unaids.org/en/CountryResponses/MakingTheMoneyWork/ThreeOnes.
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- ¹² Holtgrave DR. "Testimony on HIV/AIDS Incidence and Prevention before the House Committee on Oversight and Government Reform", September 16, 2008. Available at: <http://oversight.house.gov/story.asp?ID=2171>.
- ¹³ Centers for Disease Control and Prevention, *Professional Judgment Budget*, Requested by Henry A. Waxman, Chairman, U.S. House of Representatives Committee on Oversight and Government Reform, September 16, 2008. Available at: <http://oversight.house.gov/story.asp?ID=2171>.
- ¹⁴ Kaiser Family Foundation analysis of data from OMB and HHS, January 2009.
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