

Political Context in Getting to Zero and Ending the HIV Epidemic: Navigating a Confusing Federal Policy Landscape

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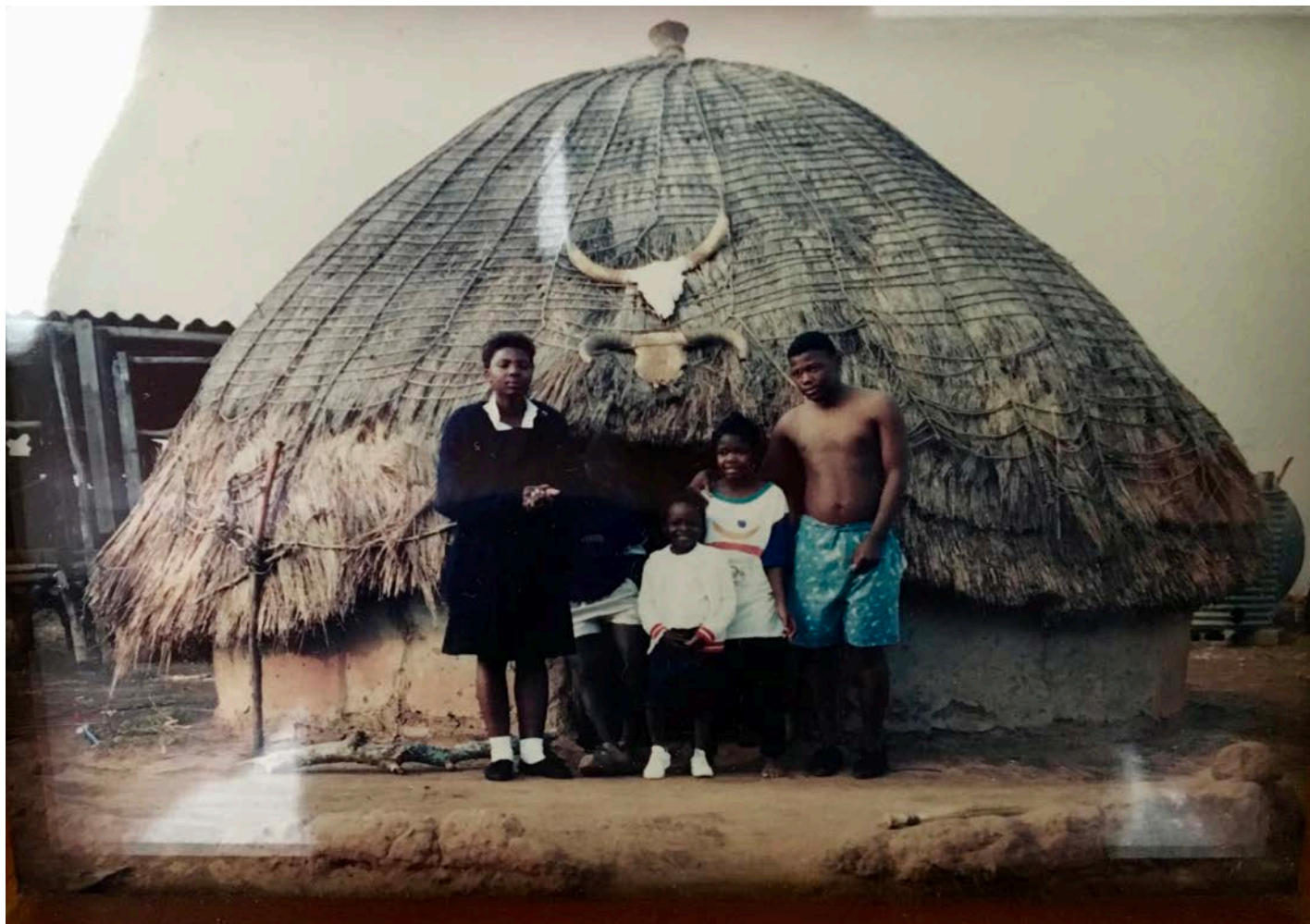
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Vision for the National HIV/AIDS Strategy

The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination”

A BRIEF DIGRESSION



PROPOSED STRUCTURAL CHANGES



Health System Reform

What has happened

- The Congress failed, after several serious attempts, to repeal the Affordable Care Act (ACA). As of September 30, the parliamentary rules allowing a repeal bill to pass the Senate with a majority vote has expired for this year
- The Administration has taken several steps to undermine ACA marketplaces, including 90% cut in grants to support outreach and enrollment, a shortened open enrollment period, and its recent refusal to make cost-sharing reduction (CSR) payments to insurers. CSR payments help low-income enrollees (below 250% of poverty) pay cost sharing and reduces their deductibles. Plans are obligated to credit enrollees for these reductions, but the federal government will not compensate them

What still could happen

- Administrative sabotage will continue that, while not individually catastrophic, will drive continuing premium increases and plan departures, and may increase federal costs; also could lead to more discriminatory plan behavior
- Congress may enact legislation to restore CSR payments

Medicaid Reform

What has happened

- Failed repeal and replace legislation would have eliminated the Medicaid expansion
- Lost in the dust-up over repeal was that the Republican majority also proposed radical changes to the traditional Medicaid program that they have attempted to enact many times before
- Shifting to per capita allotments would not make Medicaid or the health system work better, but would shift more cost to the states and weaken consumer protections

What still could happen

- HHS has broad authority to waive requirements of Medicaid; popular issues among conservatives are work requirements, drug testing, and other punitive measures
- Through state flexibility and non-enforcement of the law, there is huge potential to undermine the broad scope of coverage and longstanding essential consumer protections

Tax Reform

What has happened

- The House and Senate each passed FY 2018 budget resolutions. The Senate resolution included special “reconciliation instructions” to enable them to pass tax reform legislation with a majority vote in the Senate.
- Under the Senate plan, that House leaders have said they will support, the tax cut bill would increase the federal deficit by \$1.5 Trillion
- If 50 Senators were to go along, they could use this vehicle to further cut ACA subsidies or to cut Medicaid
- Moreover, this is also the first step in a renewed drive to cut Medicaid and other human services programs

What still could happen

- Even with reconciliation instructions, this will be difficult to enact, but pressure on Republicans to pass a bill will be intense.
- Struggle to find offsetting savings, witness this week’s blow-up over cuts to retirement deferred-tax programs

Tax Reform

From the Center on Budget and Policy Priorities

The Republican Two-Step Fiscal Agenda

Step 1: Cut taxes for the rich now, driving up deficits

GOP tax framework would give 80% of its tax cuts to top 1% of households, according to Tax Policy Center, and add at least \$1.5 trillion to deficits.

Step 2: Use higher deficits to justify cuts in critical programs for Americans with disabilities, such as:

- Medicaid and Medicare
- Food assistance through SNAP
- Social Security Disability Insurance
- Income assistance for children with disabilities
- Housing assistance

THE FEDERAL HIV FUNDING PICTURE



NIH

	FY 2017 Omnibus	FY 2018 President's Budget	FY 2018 HIV Community	FY 2018 House	FY 2018 Senate Committee
Total	\$34.1 B (+\$2.0 B)	\$26.9 B (-\$7.2 B)	\$36.1 B (+\$2.0 B)	\$35.2 B (+\$1.1 B)	\$36.1 B (+\$2.0 B)
AIDS Research	\$2.99 B (-\$0.01 B)	\$2.44 B (-\$0.44 B)	\$3.225 B (+\$0.235 B)	TBD	TBD

Source: AIDS Budget and Appropriations Coalition (ABAC), as of 09/14/17, full budget document available at <http://bit.ly/2ljAAj5>.

Observations

- Despite major Administration proposed cuts, the Congress has demonstrated strong support for biomedical research
- While AIDS research funding remains unclear, overall NIH increases and recent changes may take off some off the pressure on AIDS research funding

HRSA

	FY 2017 Omnibus	FY 2018 President's Budget	FY 2018 HIV Community	FY 2018 House	FY 2018 Senate Committee
Ryan White HIV/AIDS Program	\$2.319 B (-\$4.0 M)	\$2.260 B (-\$58.8 M)	\$2.465 B (+ \$145.8 M)	\$2.319 B (+ \$0 B)	\$2.319 B (+ \$0 B)

Source: AIDS Budget and Appropriations Coalition (ABAC), as of 09/14/17, full budget document available at <http://bit.ly/2ljAAj5>.

Observations

- Flat funding is a relatively good outcome
- President's budget proposed a large cut to Ryan White despite its earliest budget outline praising the program
- Savings/reduced need in Ryan White produced by insurance coverage gains may take off the pressure, but huge unmet needs, high level of flux in health system mean and absence of any growth in program funding in recent years could limit capacity to experiment and innovate

CDC

	FY 2017 Omnibus	FY 2018 President's Budget	FY 2018 HIV Community	FY 2018 House	FY 2018 Senate Committee
HIV Prevention	\$788.7 M (+\$0.0 M)	\$640.1 M (-\$148.6 M)	\$872.7 M (+\$84.0 M)	\$788.7 M (+\$0.0 M)	\$788.7 M (+\$0.0 M)
Viral Hepatitis	\$34.0 M (+\$0.0 M)	\$33.9 M (-\$0.1 M)	\$70.0 M (+\$36.0 M)	\$34.0 M (+\$0.0 M)	\$34.0 M (+\$0.0 M)
STD Prevention	\$152.3 M (-\$5.0 M)	\$130.0 M (-\$22.3 M)	\$192.3 M (+\$40.0 M)	\$152.3 M (+\$0.0 M)	\$152.3 M (+\$0.0 M)

Source: AIDS Budget and Appropriations Coalition (ABAC), as of 09/14/17, full budget document available at <http://bit.ly/2ljAAj5>.

Observations

- The Trump Administration proposed very significant cuts to HIV and STD prevention. Earlier budget documents stated that they want to reduce low priority programs and redundant research. Precise meaning of their comments is unclear
- Flat funding could be considered a victory in this environment
- Viral hepatitis, in particular, is woefully underfunded, as is STD prevention, especially given the scope of these challenges

SAMHSA

	FY 2017 Omnibus	FY 2018 President's Budget	FY 2018 HIV Community	FY 2018 House	FY 2018 Senate Committee
Total	\$3.76 B (+\$35.0 M)	\$3.89 B (+\$127.0 M)	\$4.32 B (+\$560.0 M)	\$3.46 B (-\$306.0 M)	\$3.77 B (+\$13.0 M)

Source: AIDS Budget and Appropriations Coalition (ABAC), as of 09/14/17, full budget document available at <http://bit.ly/2ljAAj5>.

Observations

- The Administration is expected to declare the Opioid abuse epidemic a national emergency this week. It is unclear how they propose to respond. Lack of action is apparently due, in part, to lack of consensus internally over whether to finance increases at a scale commensurate with the crisis. The President's budget increases are likely intended to be directed to responding to the opioid crisis
- Note the divergent approaches between the House (-\$306 M) and Senate (+13 M)

HOPWA

	FY 2017 Omnibus	FY 2018 President's Budget	FY 2018 HIV Community	FY 2018 House	FY 2018 Senate Committee
Total	\$356.0 M (+\$21.0 M)	\$330.0 M (-\$26.0 M)	\$385.0 M (+\$29.0 M)	\$375.0 M (+\$19.0 M)	\$330.0 M (-\$26.0 M)

Source: AIDS Budget and Appropriations Coalition (ABAC), as of 09/14/17, full budget document available at <http://bit.ly/2ljAAj5>.

Observations

- The National HIV/AIDS Strategy calls for resources to follow the epidemic. HOPWA was the last major HIV program relying on a formula based on cumulative AIDS cases. Legislation was enacted that updated the formula and shifted more resources to the south and away from the largest urban centers. Last year's increase was seen as a critical act of good faith...funding shifts in the absence of this increase would have been highly disruptive, likely leading currently housed people with AIDS to lose housing
- Again, divergent approaches between the House (+19 M) and Senate (-26 M) are troubling. Relative to health, housing resources are much more limited

THE PATH FORWARD



Making Progress at a Time of Uncertainty

The environment in which we operate is unsettled, yet...

- When was that magical time when funding for HIV programs was adequate and guaranteed?
- Was the normal discourse in the country formerly truly respectful of women, immigrants, and people of color?
- Do we have more or fewer allies than in the past that want to share in our success?

Getting to Zero

How will you work to end the HIV epidemic?

- WE need to love each other
 - We need to protect our own resiliency and take care of ourselves
- WE need to fight white supremacy, racism, and support our communities
 - In the face of a hostile environment, we need to demonstrate that we are taking a stand to support all parts of our community and our allies
- WE need to recognize the progress we are making
 - At a time of competing priorities and lots of distractions, we need to tell the compelling story of our success and invite others to help us keep the progress going
- WE need to stay focused on ending the HIV epidemic
 - Nothing in our current environment absolves us of the responsibility to end HIV. With all we have accomplished, there remains a bright future to seize



Supervised consumption services and getting to zero for people who use drugs



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HIV and people who use drugs

- Sharing injection equipment is a major driver of the HIV epidemic in the US
- Other drug use, including alcohol, drives risk behaviors
- Opioid overdose crisis is a leading cause of death
- Criminalization of people who use drugs creates more problems and barriers to care



What are supervised consumption/ injection facilities?

“legally protected places where drug users consume pre-obtained drugs in a safe, non-judgmental environment and may receive health care, counseling, and referrals to other health and social services, including drug treatment.”

(City of Vancouver Four Pillars Drug Strategy)

History of supervised injection facilities

- The first SIFs opened in Switzerland in 1986.
- Now over 100 SIFs in ten countries: Switzerland, Germany, the Netherlands, Spain, Australia, Norway, Luxembourg, Denmark, France, and Canada.
- Insite in Vancouver, British Columbia opened in September 2003 and received permanent authorization in 2011; at least 16 programs have been authorized in Canada so far this year.
- Multiple unauthorized Overdose Prevention Sites have opened in Canada
- There are no authorized programs in the United States, but one underground one has been described in the literature.

Insite



Research findings from Insite

- The SIF has resulted in **reductions in public disorder** related to injection drug use. It has been “associated with reductions in public drug use and publicly discarded syringes and reductions in syringe sharing among local injecting drug users.”
- Use of the SIF has been associated with increased uptake of detoxification services and other addiction treatments. Drug users who use the facility are **more likely to enter detox programs**, especially if they have had contact with the on-site substance use counselor. In Vancouver, use of detox *increased* by over 30% after Insite opened.
- A number of overdoses have and were managed through the administration of oxygen, naloxone, and calls for ambulance support. Importantly, none of the overdose events resulted in a fatality.

Insite



HIV/HCV impact

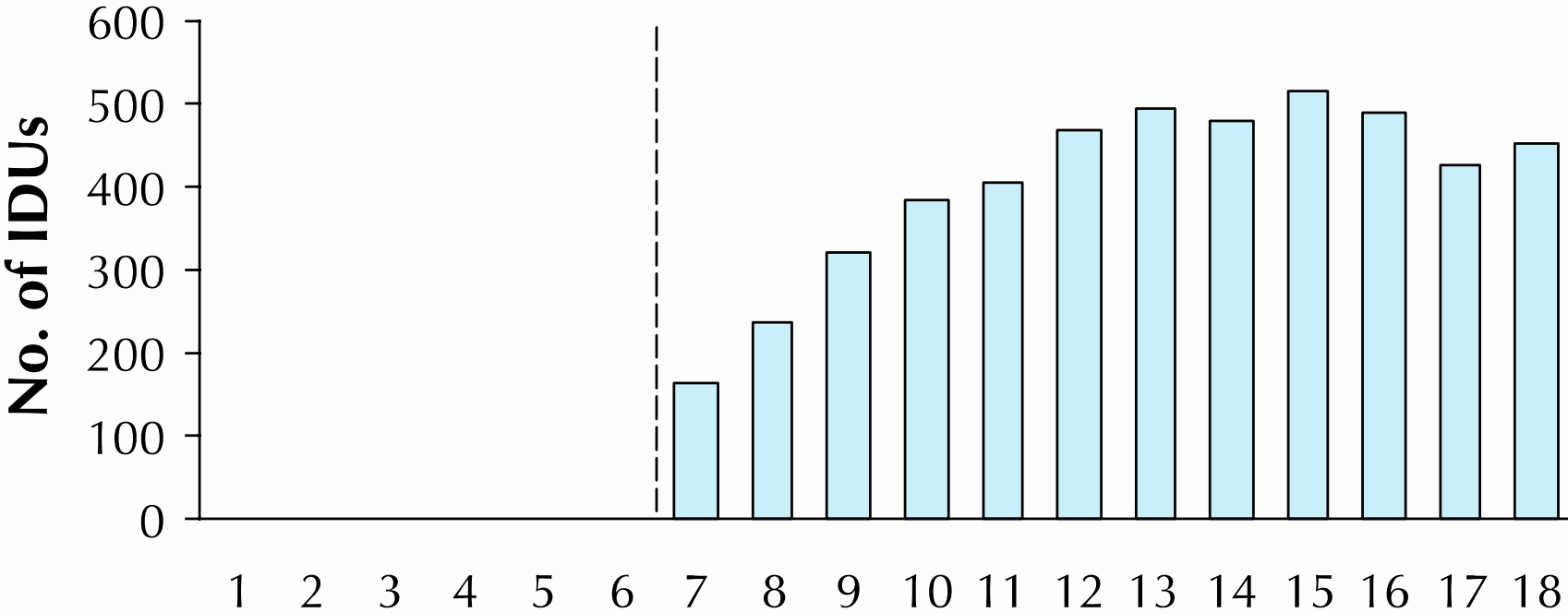
- The SIF has **attracted and retained a high risk population** of IDU who are at heightened risk for HIV and hepatitis C infection and overdose and more likely to be homeless and to frequently inject heroin and cocaine.
- Use of the SIF has been associated with **reductions in HIV and HCV risk behavior** (syringe sharing) and overall injectors used safer injections practices after attending Insite.
- Many individuals at risk for HIV and HCV infection are receiving safer injection education at the SIF, and **increases in safe micro-injecting practices** have been observed

More findings

- The establishment of the SIF has **not prompted adverse changes in community drug use patterns**
- The establishment of the SIF has **not prompted initiation into injection drug use**
- The establishment of the SIF has **not led to increases in drug-related crime**

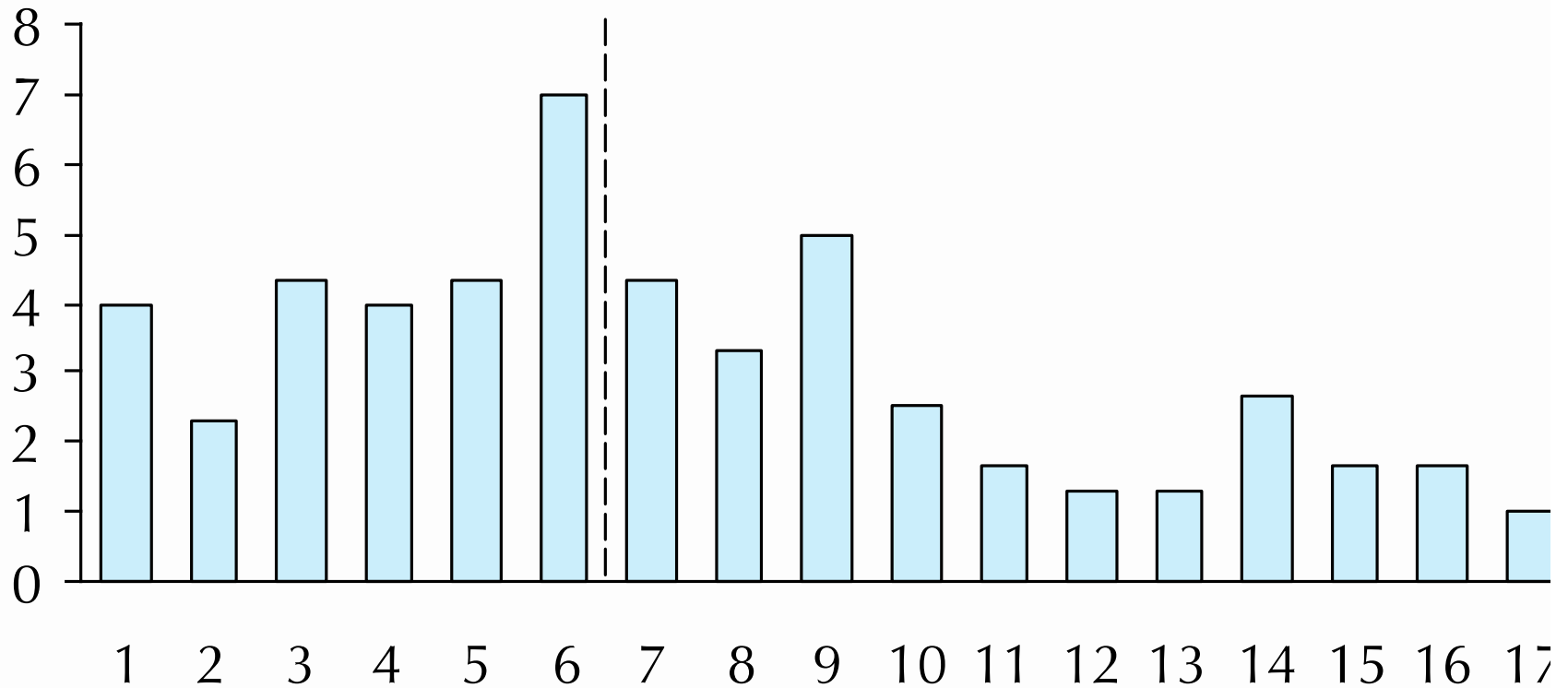
As use of Insite went up...

Daily use of safer injecting facility

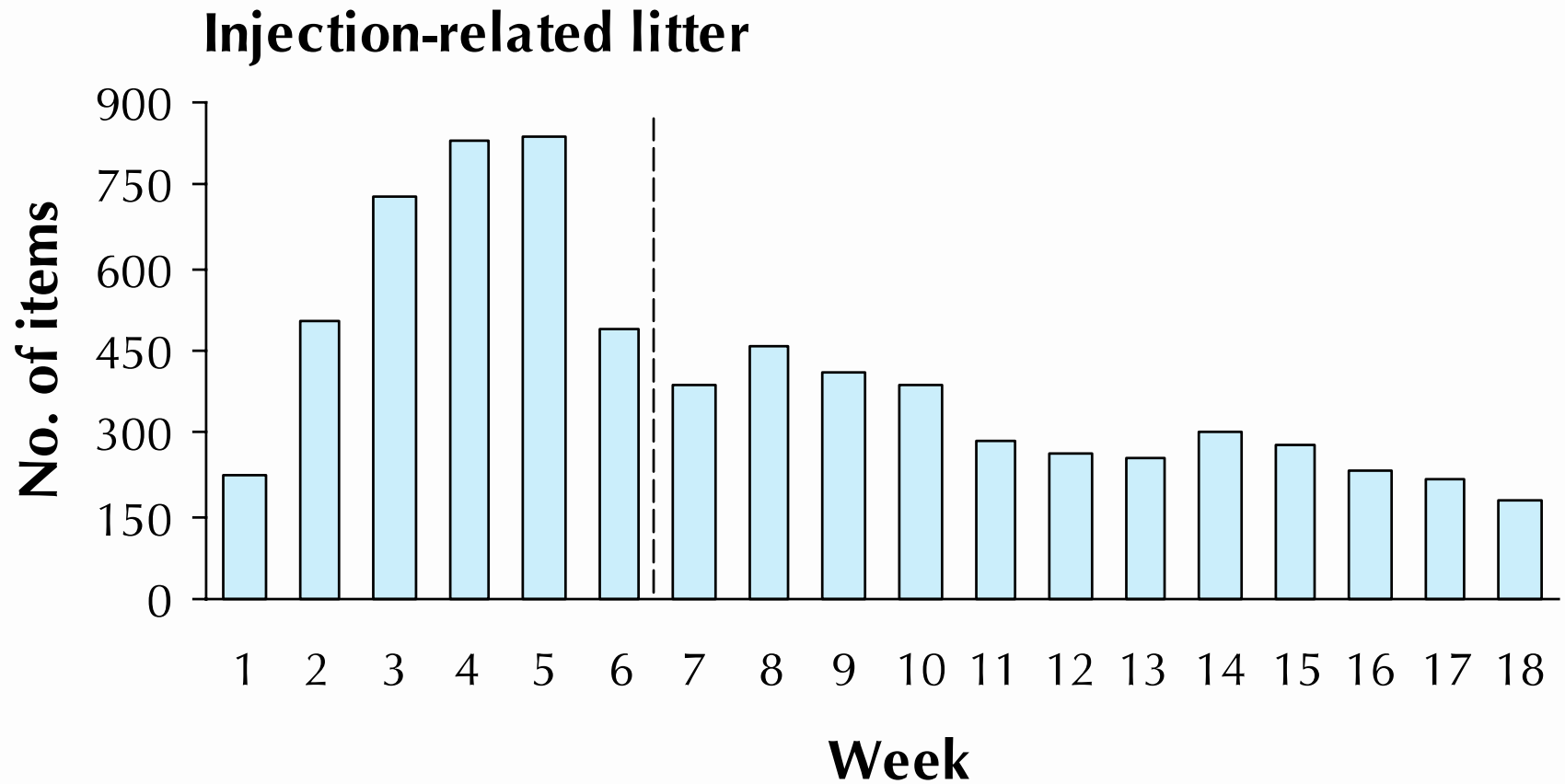


Public injection drug use went down

Public injection drug use



And public disposal of syringes and other injection litter decreased



2005 Lancet article

“This study found that IDUs who use Insite to inject drugs are **70% less likely to share syringes** than IDUs who do not use the facility. An important finding was that IDUs who use Insite were as likely as those who do not use Insite to share syringes before Insite opened. In other words, **the reductions in syringe sharing observed among Insite users only occurred after Insite opened**, suggesting that Insite may have been responsible for this important behavioural change.”

Kerr T, Tyndall M, Li K, Montaner J, Wood E. ***Safer injection facility use and syringe sharing in injection drug users.*** Lancet, 2005; 366(9482): 316-318.

2010 *Addiction* article on cost

“Insite’s safe injection facility and syringe exchange program reduce substantially the incidence of HIV infection within Vancouver’s IDU community. The associated savings in averted HIV related medical care costs are more than sufficient to offset Insite’s operating costs.

Pinkerton S. *Is Vancouver Canada’s supervised injection facility cost-saving?* *Addiction*, **105**, 1429–1436 S



San Francisco



2016 San Francisco epidemiology

- People who inject drugs are 21% of people living with HIV
- Overdose is the **third leading cause of death** for people with HIV, after HIV and non-HIV cancers.
- Worse outcomes for people who inject drugs (PWID), including men who have sex with men and inject drugs (MSM/PWID):
 - Lowest survival rates at three and five years
 - Lowest rates of viral suppression
- While incidence has dropped for MSM, it has not changed much for PWID or MSM/PWID over the last ten years
- How can we get to zero without addressing this?

Cost-benefit analysis in San Francisco (Irwin et al, 2016)

- At least 3.3 averted HIV cases per year. With a lifetime treatment cost of more than \$402,000, this translates to annual savings of \$1.3 million. (Or six percent of the IDU-related HIV cases.)
- At least 19 hepatitis C cases prevented per year. At a lifetime treatment cost of US\$68,000, annual savings of \$1.3 million.
- "Establishing a SIF would create a natural center for locating PWID, providing them with testing, connecting them directly with treatment providers, and monitoring them long-term to retain them in treatment."
- Total savings of \$6.1 million per year. It would be cost-effective: every dollar spent would generate \$2.33 in savings.

SAN FRANCISCO

SAFE INJECTION SERVICES TASK FORCE



2017

FINAL REPORT

California legislation on SCS

- AB 186 (2017): Asm. Susan Eggman, Asm. Friedman, and Sens. Wiener and Lara
- Co-sponsored by DPA, California Society of Addiction Medicine, CAADPE, Project Inform, Tarzana Treatment Center, and Harm Reduction Coalition
- Allows specified counties to open programs
- Creates legal protections for staff, volunteers, participants, and program operators, for programs allowed by the local health jurisdiction.
- Passed Assembly, two Senate committees, on inactive status
- Similar legislation pending in New York, Vermont, Maryland, Nevada



Why isn't syringe access enough?

- Hepatitis C is more easily transmissible and sterile syringe access alone is not enough
- HCV can be transmitted through sharing cookers, cottons, and other injection equipment
- Many harm reduction workers/peers/clinicians already talk about safer injecting practices and distribute sterile supplies
- The “accidental” SIF
- Disposal issues
- Some injectors are more vulnerable to sharing equipment or using risky injection practices
 - Homeless/marginally housed
 - Those who need others to inject them



Criminalization creates risks and barriers to treatment

- Aggressive drug law enforcement is highly associated with higher HIV rates.
- People who use drugs tend to have lower rates of antiretroviral therapy utilization and higher rates of death due to HIV/AIDS.
- Incarceration, often due to drug law offenses, is associated with higher risks of unsafe injecting drug use, unprotected sexual contact and outbreaks of HIV. Up to 25% of people with HIV are incarcerated every year in the U.S.
- Blacks are far more likely to be incarcerated for drug law violations than whites, and these disproportionate incarceration rates are one reason for the far higher rates of HIV infection among blacks.



Portugal model

Components

- Health-based, social inclusion approach
- Decriminalized possession for personal use
- Scaled up treatment capacity, mostly for opiate dependence
- Dissuasion Commissions with health and social workers
- Civil penalties

Results

- Lower HIV rates: *IDU went from 54% of HIV incidence in 2001 to 30 % in 2007*
- Fewer overdose deaths
- Reduced drug use: *prevalence of any drug use among 15-19 year olds dropped from 10.8% to 8.6%*
- Reduced crime
- Increased numbers of people in treatment

Getting to zero

- **Transmissions:** syringe access, SUD treatment including buprenorphine and methadone, SCS
- **Deaths:** naloxone/overdose prevention, SUD treatment, SCS, decriminalization
- **Stigma:** decriminalization



Oct

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