



February 25, 2019

Tammy R. Beckham, Director
Office of HIV/AIDS and Infectious Disease Policy
U.S. Department of Health and Human Services
Room L001
330 C Street SW
Washington, DC 20024
Attention HIV/Viral Hepatitis RFI
HepHIVStrategies@hhs.gov

Dear Dr. Beckham:

On behalf of Trust for America's Health (TFAH), thank you for the opportunity to provide comments on the National HIV/AIDS Strategy (NHAS) and the National Viral Hepatitis Action Plan (NVHAP). TFAH is a non-partisan public health policy, research and advocacy organization that envisions a nation that values the health and well-being of all and where prevention and health equity are foundational to policymaking at all levels of society. We are writing to express our strong support of robust plans to address both epidemics. We appreciate the dedicated and ambitious vision to prevent and control these epidemics. It offers the nation the possibility of saving lives and preventing the suffering of untold numbers of residents in the U.S. It is with this spirit in mind that we offer proposals that we believe will be instrumental in achieving their goals.

Health Department Capacity and Preparedness

As the national HIV/AIDS strategy and the hepatitis plan reflect, state and local health departments play key roles in surveillance, prevention, planning, and community outreach. However, overall, state and local health departments are facing ongoing financial threats. According to an analysis undertaken by TFAH, 31 states cut their public health budgets between FY2015-16 and FY 2016-17.¹ At the local level, over 55,000 public health positions have been lost due to layoffs and attrition since 2008. These existential challenges pose a threat to state and local ability to address and prepare for all types of public health challenges. Health department capacity is necessary for primary prevention, disease surveillance, and collaboration with healthcare, justice and other sectors to stem these two epidemics.

We encourage the revised HIV and Hepatitis strategies to note the overall needs of the public health infrastructure and encourage investments that strengthen health departments and lead to sustainable and robust systems and workforces.

¹ Trust for America's Health, "A Funding Crisis for Public Health and Safety (March 2018)."
<https://www.tfah.org/report-details/a-funding-crisis-for-public-health-and-safety-state-by-state-and-federal-public-health-funding-facts-and-recommendations/>

Public Health Surveillance

Within the context of public health infrastructure, we encourage a continued focus on strengthening surveillance systems and interoperability. As noted by Centers for Disease Control and Prevention (CDC) leadership in 2017, “many current systems rely on disease-specific approaches that inhibit efficiency and interoperability (eg, manual data entry and data recoding that place a substantial burden on data partners) and use slow, inefficient, out-of-date technologies that no longer meet user needs for data management, analysis, visualization, and dissemination.”² These challenges mean that understanding the nature of the epidemics – and targeting interventions to contain them – will be limited without further investment.

Both strategies include goals related to improving data coordination and interoperability; these should be maintained, with additional attention to building federal, state and local data capacity and data sharing across federal agencies, between federal and state systems, and among states.

Addressing Stigma

As noted in both existing documents, stigma is a major barrier to addressing HIV and Hepatitis. In the most recent version of the HIV strategy, the goal of reducing HIV-related disparities and health inequities includes a step to “Reduce stigma and eliminate discrimination associated with HIV status.” Similarly, the hepatitis plan notes that stigma and discrimination can cause people to avoid testing and treatment for hepatitis. We urge HHS to retain a focus on addressing stigma in the next iterations of both reports. As experts noted in a TFAH convening on MSM health, stigma related to LGBT status, as well as to HIV itself and to race, continue to intersect and drive health risks, including HIV, hepatitis, and substance use.³ Solutions are needed to increase individual resiliency, foster supportive communities, improve access to quality healthcare, and transform the social environments in which people live.⁴

In addition to generally combating stigma, we share the concern of many in the community that ongoing and recent state and federal policy actions perpetuating stigma will hinder the effectiveness of both the HIV and Hepatitis strategies.

One such trend is HIV criminalization. The existing HIV strategy notes that states should reconsider whether existing laws further the public health. Unfortunately both HIV-specific laws, and prosecutions for “HIV exposure” under general criminal laws, persist.⁵ Similar cases

² Richards, C. L., Iademarco, M. F., Atkinson, D., Pinner, R. W., Yoon, P., Mac Kenzie, W. R., ... Frieden, T. R. (2017). Advances in Public Health Surveillance and Information Dissemination at the Centers for Disease Control and Prevention. *Public Health Reports*, 132(4), 403–410. <https://doi.org/10.1177/0033354917709542>

³ Addressing the Social Determinants of Health Inequities Among Gay Men & Men Who Have Sex With Men. *Trust for America's Health*. 2014. <https://www.tfah.org/report-details/addressing-the-social-determinants-of-health-inequities-among-gay-men-men-who-have-sex-with-men/>

⁴ *Id.*

⁵ The Center for HIV Law and Policy, “HIV Criminalization in the United States: A Sourcebook on State and Federal HIV Criminal Law and Practice” (2017). www.hivlawandpolicy.org/sourcebook

have arisen with regard to hepatitis exposure.⁶ Both the HIV and Hepatitis strategies must continue to encourage states to reconsider their treatment of HIV and Hepatitis exposure as crimes, particularly in states with laws that allow prosecutions related to behaviors that cannot, in fact, transmit the viruses. In addition, the community needs reassurance that ongoing and new forms of disease surveillance – such as molecular surveillance – should not exacerbate concerns about privacy or prosecution.

In addition to criminalization, TFAH is concerned that an ongoing set of federal policies has been perpetuating stigma against people living with HIV, LGBT people, and other affected communities. For example, HHS has highlighted “provider conscience” protections, which providers may use to deny care if they morally object to a given patient or the patient’s behavior.⁷ The Department has worked to pull back protections for transgender people in the military, and under a range of federal civil rights statutes.⁸ We urge HHS to use the new versions of the strategies as an opportunity to reject policies that exacerbate stigma and hinder efforts to address the HIV and Hepatitis epidemics.

Harm Reduction

Injection drug use remains a significant driver of both HIV and hepatitis infection. We have known for decades that harm reduction services, including syringe exchange programs, are effective at lowering transmission risk without increasing drug use and offer a linkage to substance use treatment and other services.⁹ However, many people who inject drugs lack access to such services.

A lack of funding and state and local policy resistance create overlapping barriers to harm needle exchange services. Current federal law permits the use of federal funds only for certain portions of syringe service programs, but excludes funding for the syringes themselves.¹⁰ Meanwhile, multiple state laws continue to pose barriers to effective program implementation.¹¹

The new HIV and hepatitis strategies should unequivocally encourage both federal and state policymakers to remove financial and legal barriers to syringe exchange programs and other harm reduction approaches to addressing the epidemics.

Primary Prevention Among Youth

⁶ See, e.g., Sonia Salzman, “Hepatitis C Exposure Is a Crime in Some States; Is This the New HIV Criminalization?” (Feb. 26, 2018). www.thebody.com/content/80840/hepatitis-c-exposure-is-a-crime-in-some-states-is-.html

⁷ Diamond and Haberkorn, “Trump to overhaul HHS office, shield health workers with moral objections.” *Politico* (Jan. 17, 2018). www.politico.com/story/2018/01/16/conscience-abortion-transgender-patients-health-care-289542

⁸ Meckler, Schmidt and Sun, “Trump administration considering ‘different concepts’ regarding transgender rights, with some pushing back internally.” *Washington Post* (Oct. 24, 2018). www.washingtonpost.com/national/trump-administration-considering-different-concepts-regarding-transgender-rights-with-some-pushing-back-internally/2018/10/22/0668f4da-d624-11e8-83a2-d1c3da28d6b6_story.html?utm_term=.290e3cb53e4a

⁹ CDC, “Syringe Services Programs” (Updated Dec. 2018). <https://www.cdc.gov/hiv/risk/ssps.html>

¹⁰ Consolidated Appropriations Act, 2016. <https://www.congress.gov/114/bills/hr2029/BILLS-114hr2029enr.pdf>

¹¹ Bramson et al., “State laws, syringe exchange, and HIV among persons who inject drugs in the United States: History and effectiveness.”

The current HIV strategy calls comprehensive sex education “an important structural intervention” but notes that it has not been brought to scale across the county. In TFAH’s research, we have found that strategies to promote individual resilience, foster supportive communities,¹² and promote comprehensive sex education can reduce the risks of HIV, sexually-transmitted infections and other adverse health outcomes.¹³

Currently, CDC’s Division of Adolescent and School Health (DASH) supports evidence-based HIV, STD, and pregnancy prevention programs in schools by promoting protective factors and reducing risk behaviors. These programs have a demonstrated impact on reducing high-risk substance use and improving mental health. We encourage the new plan to include specific proposals to bolster DASH’s funding and ensure scale-up of evidence-based primary prevention across the country.

Access to Care

TFAH urges the Department to address in both plans the potential impact of reduced health care coverage from modifications to the Affordable Care Act (ACA). Administrative and legal changes to the ACA and Medicaid will have significant ramifications for people with HIV and hepatitis. Changes to essential health benefits could result in sub-optimal care for people with HIV and hepatitis. Prior to the ACA, people with HIV were often considered to have “pre-existing conditions,” meaning they did not have reasonable access to comprehensive healthcare coverage under private insurance. In addition, prior to the ACA, low-income adults with HIV often could not qualify for Medicaid until they were already quite sick and disabled, despite the availability of treatments.¹⁴

Together, the loss of coverage by private and public payers would result in an inability to contain the epidemics, additional burden to the Ryan White program, community health centers and other safety net programs. We urge the Department to explicitly address the way that any changes to ACA implementation may create barriers to access to care and coverage.

Analysis of Public Charge Impact

TFAH urges the Department to address in both plans the potential impact of the Administration’s public charge rule on access to HIV and hepatitis screening and treatment services and for the plans to include recommendations regarding the overall impact of the rule on public health.

¹² Addressing the Social Determinants of Health Inequities Among Gay Men & Men Who Have Sex With Men. *Trust for America’s Health*. 2014. <https://www.tfah.org/report-details/addressing-the-social-determinants-of-health-inequities-among-gay-men-men-who-have-sex-with-men/>

¹³ Furthering the Adaptation and Implementation of LGBTQ-inclusive Sexuality Education. *Trust for America’s Health*. 2016. <https://www.tfah.org/report-details/furthering-the-adaptation-and-implementation-of-lgbtq-inclusive-sexuality-education/>

¹⁴ Dawson L and J Kates, Kaiser Family Foundation, “What is at Stake in ACA Repeal and Replace for People with HIV?” May 5, 2017. <https://www.kff.org/hiv/issue-brief/what-is-at-stake-in-aca-repeal-and-replace-for-people-with-hiv/#footnote-212249-1>

The Administration's proposed public charge rule would vastly broaden the set of benefits that would count as a negative factor in certain immigration status assessments¹⁵ and potentially penalize *documented* immigrants who access such benefits. As noted in a letter to the Department, TFAH is deeply concerned about individuals and families who, worried about potentially being classified as public charges, could proactively disenroll or forego benefits for which they are eligible.¹⁶

In the context of HIV and HCV this could be a significant obstacle to achieving the goals of the Strategy and Plan. While the proposed public charge rule would continue to exempt “[p]ublic health assistance... for testing and treatment of symptoms of communicable diseases,” we are concerned that this exemption is unlikely to provide sufficient reassurance and the fear and confusion would create would result in a decline in uptake of testing and other services.

Conclusion

As an organization committed to promoting public health, we strongly support coordinated, national plans to address the HIV and hepatitis epidemics, and are eager to work with HHS and other stakeholders as the plans are implemented.

If you have any questions, please contact Dara Lieberman, TFAH's Director of Government Relations, at dliberman@tfah.org.

Sincerely,



John Auerbach
President & CEO
Trust for America's Health

¹⁵ Department of Homeland Security, “Inadmissibility on Public Charge Grounds” (Oct. 10, 2018). Available at <https://www.federalregister.gov/documents/2018/10/10/2018-21106/inadmissibility-on-public-charge-grounds#citation-335-p51169>.

¹⁶ Passel J. Trends in noncitizens' and citizens' use of public benefits following welfare reform. *Urban Institute*. 1999. <https://www.urban.org/research/publication/trends-noncitizens-and-citizens-use-public-benefits-following-welfare-reform>