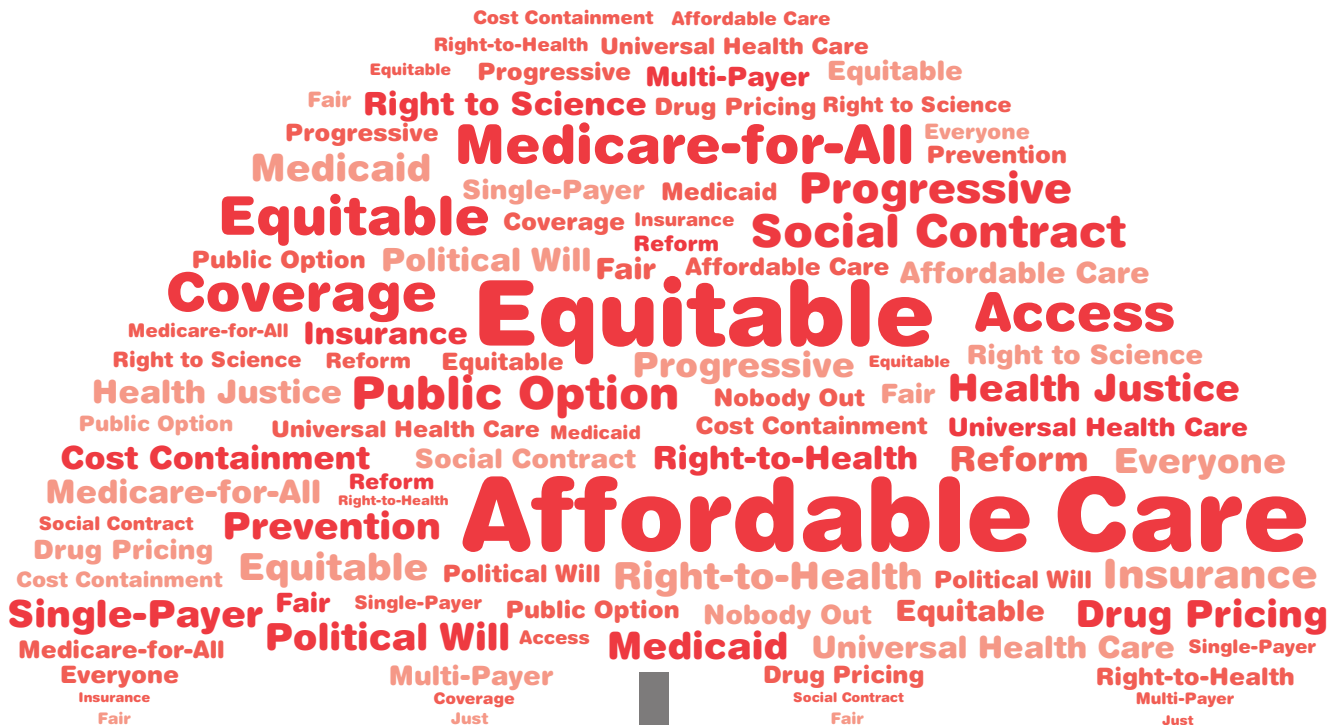


tagline

NEWS ON THE FIGHT TO END HIV/AIDS, VIRAL HEPATITIS, AND TUBERCULOSIS



EVERYBODY In, NOBODY Out

By Tim Horn

Arguments favoring universal health care (UHC) are easy. Achieving political consensus as to the best strategy to achieve this is considerably more vexing. This is particularly true in the U.S., where the Affordable Care Act (ACA) patchwork of legislation and regulations has faced a barrage of executive and legislative attacks since the beginning of the year. And although the ACA and expansion of Medicaid in 32 states represents the closest the U.S. has come to ensuring UHC for its citizenry, it continues to fall short for millions of Americans, meaning that it must be either repaired or replaced with an entirely new system that ensures equitable access to care.

But what would politically feasible and sustainable UHC look like in the U.S.? As Annette Gaudino elegantly argues in “Coverage Isn’t Care” (page 3), it is crucial that health care be seen as a human right and that we avoid the perils of risk-based financing, which continues to stigmatize people living with HIV, tuberculosis, and hepatitis C and further undermines the social contracts necessary for investments necessary to eliminate these three—among many other—global killers.

Although the ACA and expansion of Medicaid in 32 states represents the closest the U.S. has come to ensuring UHC for its citizenry, it continues to fall short for millions of Americans.

In “The Long Game for Health Justice” (page 5), Suraj Madoori and AIDS Foundation of Chicago’s Maximillian Boykin describe a number of legislative pathways to UHC in the U.S., notably the potential for single-payer health care. A number of Democrats have embraced the idea, either in concept or in support of specific legislation (e.g., the Medicare for All Act of 2017). But single payer is anything but simple. There will be a lot of moving parts requiring input and a tremendous need

for robust advocacy to galvanize bipartisan support, all of which will require fierce HIV community mobilization and engagement.

For UHC strategies to be affordable and successful, reining in the high cost of health care—particularly in the U.S., which far surpasses all other countries in health expenditures—is imperative. This very much includes prescription drug costs (see page 10). Here, too, the U.S. tops all per-capita spending indices.

The potential merits of UHC in efforts to end HIV as an epidemic are also clear. As Richard Jefferys reports, extant research confirms that UHC could contribute to reducing HIV incidence by improving access to proven evidence-based interventions and ancillary services for reducing transmission (page 11).

And dovetailing with TAG’s campaign to support community leaders in the Deep South toward HIV/AIDS-epidemic-ending strategies, Jeremiah Johnson and Kenyon Farrow explore the opportunities for maximizing access to care and services in jurisdictions that are heavily affected by the structural drivers of infection and increased mortality, including significant gaps in health care coverage (page 13). Importantly, community-led End the Epidemic campaigns in Southern states, counties, and cities aren’t simply about making do with what is available, but mobilizing stakeholders and social justice allies to push for policies that benefit the health care needs of all, not just those living with and vulnerable to HIV.

COVERAGE isn't CARE

Globalizing the insurance model will harm global public health

By Annette Gaudino

In the New York City of the 1850s, firefighting was a private enterprise. Homeowners and landlords purchased insurance plans that included protection from a dedicated fire brigade. When a fire broke out, brigades would arrive on the scene and look for an insurance company seal on the building. No hoses would be turned on until insurance coverage was verified. Often the building would have no seal, as fire insurance was not required. In that case, the rival brigades would fight—at times, rioting—over who would get paid by the insurance company. And while they brawled, the home would keep burning.

Eventually, both the public and the insurance companies realized that everyone would benefit from universal fire protection. If your neighbor's house is on fire, then you're also in danger, and every house is vulnerable to destruction. Out-of-control fires also meant heavy financial losses for the insurance industry. In 1865, the New York Fire Department was born, funded by tax dollars and free at the point of delivery. Fire insurance would continue to provide compensation for property loss, but the delivery of life-saving care would be treated as a public good.

The Gangs of New York-era fire brigades are a comically apt metaphor for the current U.S. health care system. Although broadly acknowledged as a defense of a flawed status quo, recent mass mobilizations to stop the repeal of the Affordable Care Act both reflected and contributed to the increasing acceptance in the U.S. political consciousness that health care is a public good and a human right. At the same time, global institutions such as the United Nations (UN) and World Health Organization (WHO) have shifted global health away from the broadly accepted human rights- and care-based framework towards a framework that is based on access to insurance coverage. Although national governments can be held accountable for failing to guarantee the right to health care, the insurance coverage framework recasts health care as a commodity with no legal guarantee of access. This shifts responsibility to individual patients, leaving them to navigate systems armed only with their

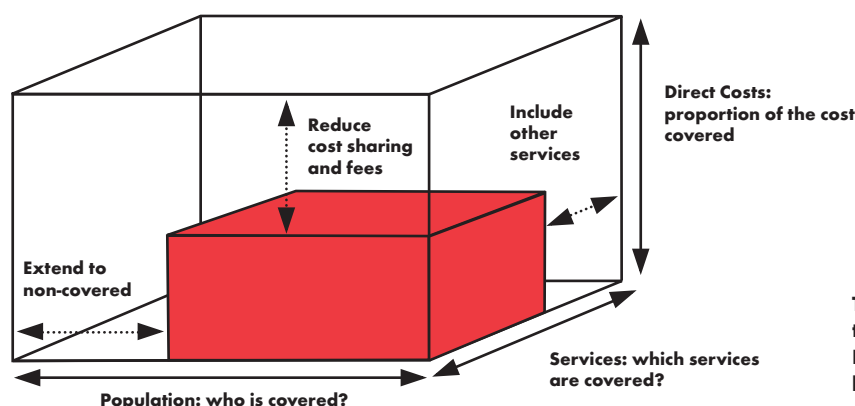
purchasing power, and presents a significant barrier to care for the approximately 80 percent of people living with chronic hepatitis C virus (HCV) infection who live in low- and middle-income countries.

This can be seen most clearly in WHO's interpretation of the UN's Sustainable Development Goal (SDG) #3, which ensures healthy lives and promotes well-being for all. This SDG explicitly aims to: "Achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality, and affordable essential medicines and vaccines for all." In other words, national governments and international donors are called on to protect citizens from the financial destitution that can result from illness, but not from lack of care itself. Universality is stated as a goal, not as the first requirement of any system, enforceable by law. This subtle shift in language has profound implications for the global response to the public challenges posed by infectious diseases, particularly viral hepatitis, HIV, and tuberculosis.

The emphasis on coverage and financial risk protection brings the SDGs up to date—with 19th century concepts of health care rights. The insurance model finances protection by pooling risk—everyone pays into a shared fund and withdraws as needed. The first health benefits offered to workers were social insurance funds, implemented by German Chancellor Otto von Bismarck in the 1880s, that replaced lost wages due to illness. These locally administered funds were run by boards elected by fund members and tended to reflect the higher contributions from workers to these funds: two-thirds from workers versus one-third from employers. These sickness funds established the principle of coverage as something that is owed to workers and a risk that is best shared communally.

But what happens when workers' rights and the social contract are weakened? The rise of neo-liberal ideology in the late 1970s and early 1980s may be best summed up by Margaret Thatcher's infamous declaration, "There

THE THREE DIMENSIONS OF UNIVERSAL CHANGE



Three dimensions to consider when moving towards universal coverage. 2017. World Health Organization. http://www.who.int/health_financing/strategy/dimensions/en/

is no such thing as society. There are individual men and women, and there are families." She continued: "...there is no such thing as an entitlement unless someone has first met an obligation." Thus, the employer's obligation to their workers is erased and replaced with individual responsibility operating in an idealized marketplace, where all things are already equal and the only barriers are deficiencies of character. If there is no such thing as society, then there can be no social contract, and financing for the public good is outside of the acceptable space of public debate. Stigma and discrimination, the twin forces driving infectious diseases, are the natural result of the moral failings of individuals.

The risk-based financing model now takes on another dimension. Instead of offering a shared safety net to catch us when the inevitable facts of life, illness, old age, birth, and death, leave us vulnerable, we must prove our worthiness by avoiding 'risky' behaviors. For example, to prove they are worthy of employment and inclusion in an insurance pool, individuals are required to prove, again and again, that they don't use illicit drugs. Those deemed costly are blamed for rising health costs and individuals are encouraged to believe that each is immune to human frailty. Your house will never burn if you're careful; illness is only for those who don't take care of themselves. In a deft reversal of the very concept of insurance, you should never have to pay for someone else's care. When private profit is added to this system, the pressure to cut costs intensifies, further driving exclusion of the neediest from mechanisms originally designed to share costs and reduce individual burdens.

Indeed, this ideological shift has proven to be deadly in high-income countries, providing intellectual cover for mass government inaction in response to public health

crises affecting groups that are considered by nature to be risky and unhealthy: gay and bisexual men, people who use drugs, women, people of color, immigrants, and sex workers. The sick are moral failures and burdens on a so-called general public, conceived precisely to exclude those very groups deemed outside the norm, something for government officials to pray over rather than communities with needs to be met.

In the U.S., rights not explicitly enumerated under the Constitution are not recognized by large segments of the public, including the right to health care. As long as certain social groups are reduced to sets of risky behaviors and the human right to health care remains unrecognized, insurance-based coverage will always incentivize the exclusion of those most in need of care.

Exportation of the insurance model to developing countries, especially at a time of global austerity, institutionalizes the retreat from the social contract at just the moment when investment in infectious diseases could result in the elimination of these global killers. What will be the cost in lives of replacing solidarity and the public good with the logic of the liberal marketplace?

Financing health care on the basis of risk leads to blaming individuals rather than protecting communities. Elimination targets for infectious diseases, including HIV, HCV, and TB, require a public health approach that goes beyond individual risk. By definition, communicable diseases happen between people within communities, and simply cannot be successfully addressed on the level of individual behavior alone. We must continue to advance health care as a human right and public good to achieve global elimination goals.

The LONG GAME for HEALTH JUSTICE

Claiming and strategizing the HIV community's role in universal health care advocacy

By Suraj Madoori and Maximillian Boykin

Perhaps the most impressive narrative in the lead-up to the dramatic defeats of the disastrous Affordable Care Act (ACA) repeal-and-replace bills in the House and Senate involved the thousands of activists who were activated, organized, and mobilized in an effort save U.S. health care. For months, hundreds of email alerts were sent, a deluge of phone calls made to Congressional offices, and busloads of HIV, disability, and health justice advocates bravely sacrificed their bodies on Capitol Hill in civil disobedience and direct actions, demanding that their elected officials protect their care before the ultimately doomed votes.

The community mobilization and advocacy to stop the legislation is a clear example of how vital the ACA has been to transforming the health and lives of people living with, and vulnerable to, HIV. However, in celebrating the defeat of these bills, we have failed as a community to further galvanize this energy to clearly project and envision the health care system that we truly need. Now is the time for us to engage in ongoing national conversations on a single-payer system that can potentially shift our current health care paradigm to one that is radically transformative, universal, cost-saving, and just for all people living with HIV (PLWHIV) and vulnerable communities.

The gains ushered in with the ACA cannot go understated, especially for PLWHIV. According to the Kaiser Family Foundation, several provisions, including removal of pre-existing conditions, elimination of benefit limits, and providing subsidies for the purchase of marketplace plans, have had direct benefits for PLWHIV and vulnerable communities in the U.S. Furthermore, the ACA works remarkably well in tandem with the Ryan White CARE Act, which acts as a critical safety net for those who fall within the ACA's coverage gap or lose insurance.

But even with these and other important gains, there are stark challenges and uncertainties that call into question whether the ACA is the health care panacea for our communities. More than 20 million U.S. residents remain uninsured, including a disproportionate number of Black and Brown people. Undocumented immigrants are walled off. Since 2015, we have seen a reduction in the number of in ACA marketplace plans being offered through insurers, often in response to undermining and destabilizing forces. These include relentless conservative rhetoric and legislative efforts to toss the ACA, including the vital individual mandate. Then there are the executive orders ending cost-sharing reduction subsidies and the endorsement of weak subprime insurance policies.

On the very heels of the American Health Care Act and the Better Care Reconciliation Act in the House, Blue Cross Blue Shield of Georgia announced on August 7 that it had withdrawn from Metro-Atlanta's Obamacare exchange, along with 72 other counties. The move is significant, as it is yet another insurer exiting a highly vulnerable jurisdiction that is affected by HIV. These trends are being seen across HIV-affected areas in the South, with larger insurers continuing to pull back in key areas (see Figure, page 7).

The situation is made worse by many southern states not expanding Medicaid. With scarce options, many people vulnerable to HIV and other health disparities, especially young people of color, will choose to go without insurance they cannot afford—essentially negating the reason for the ACA. The retraction of marketplace plans puts the HIV community in a lurch. What good are the key ACA provisions of protecting those with pre-existing conditions, essential health benefits, out-of-pocket cost caps, and premium tax subsidies if insurance options are being depleted in highly affected areas?

The Obamacare 'death spiral' has certainly provided fuel for efforts to supplant the ACA, but it also provides ideal cover to shift public attention from where the ACA and health care system is most stable: Medicaid. While the insurance markets continue to bend and collapse under destabilizing forces, government-funded Medicaid stands pat.

The Center for Budget and Policy Priorities (CBPP) strengthened the defense of Medicaid against GOP proposals to restructure, cap, and block-grant the program. Research published by CBPP in June 2017 illustrates Medicaid as "efficient and effective," particularly with improved health outcomes and increased access to health care across expansion states

Despite the powerful mobilizing efforts of HIV activists and leaders in stopping the destruction of the ACA, we have missed the boat on paralleling our organizing alongside a projection of our vision on what a truly just and equitable health care system can and should be.

such as Arkansas and Kentucky. Medicaid continues to buck the trend where market-driven solutions fail, providing robust coverage and critical access to health care for numerous low-income and vulnerable populations.

Medicaid's backbone of success, especially across expansion states, is strong federal government involvement and funding. Contrary to conservative arguments, government intervention in health care provides remarkable stability to the overall health care system while expanding access to critical health and preventive care to vulnerable communities. Supporting this notion is not only the tremendous public outcry to GOP efforts to cull Medicaid, but public polling showing that support for any government-funded health care, such as single-payer or Medicaid, is peaking. According to a June 2017 Pew Research survey of U.S. adults,

60% of respondents said the federal government is responsible for ensuring health care coverage for all Americans. A growing 33% support government-funded single-payer insurance or a mix of private and government programs. Nearly 57% of Republicans in that same poll say the government "should continue Medicaid and Medicare for the elderly or very poor," even if they do not support increased government responsibility for ensuring health care.

Riding the wave for increased public support of government-funded health care is a slew of state and federal legislation for a public option or single-payer insurance. Much of the momentum is owed to Senator Bernie Sanders (VT), who pitched Medicare-for-All as a key plank in his 2016 Presidential campaign and recently introduced a bill in Congress, which received significant attention in this latest health care battle waged on the Medicaid and the ACA.

California is being watched closely as a state pushing single payer. Although legislation (SB-562) introduced in the State Assembly in June 2017 was ultimately put on hold, it has maintained critical support and organization coming from multiple community stakeholders. A state the size of California gaining a single-payer system may yield tremendous power to consolidate prescription drug purchasing and negotiate prices with pharmaceutical companies, a driver of rising health care costs that continues to go unaddressed by current health care schemes (see "Universal Health Care and Prescription Drug Pricing," page 10). There's a saying: "As California goes, so goes the nation."

But where is the HIV community? Despite the powerful voice and mobilizing efforts of our activists and leaders in stopping the destruction of the ACA, we have missed the boat on paralleling our organizing alongside a projection of our vision on what a truly just and equitable health care system can and should be. Even more concerning is the mixed messaging we send to communities on what we are fighting for in terms of a health care system. In a recent email call-to-action issued by NMAC on August 15, a hyperlink leads to a Google form titled, "Universal Healthcare! (NOT Tax Cuts)." In the context of the attempted raids on the ACA, this raises several critical questions. What are we as an HIV community defining as universal health care (UHC)? Do we really believe that the ACA is UHC? Have we even come together as a community to agree on what UHC truly looks like for all of us? What are our responsibilities of allyship—as a movement that has earned tremendous

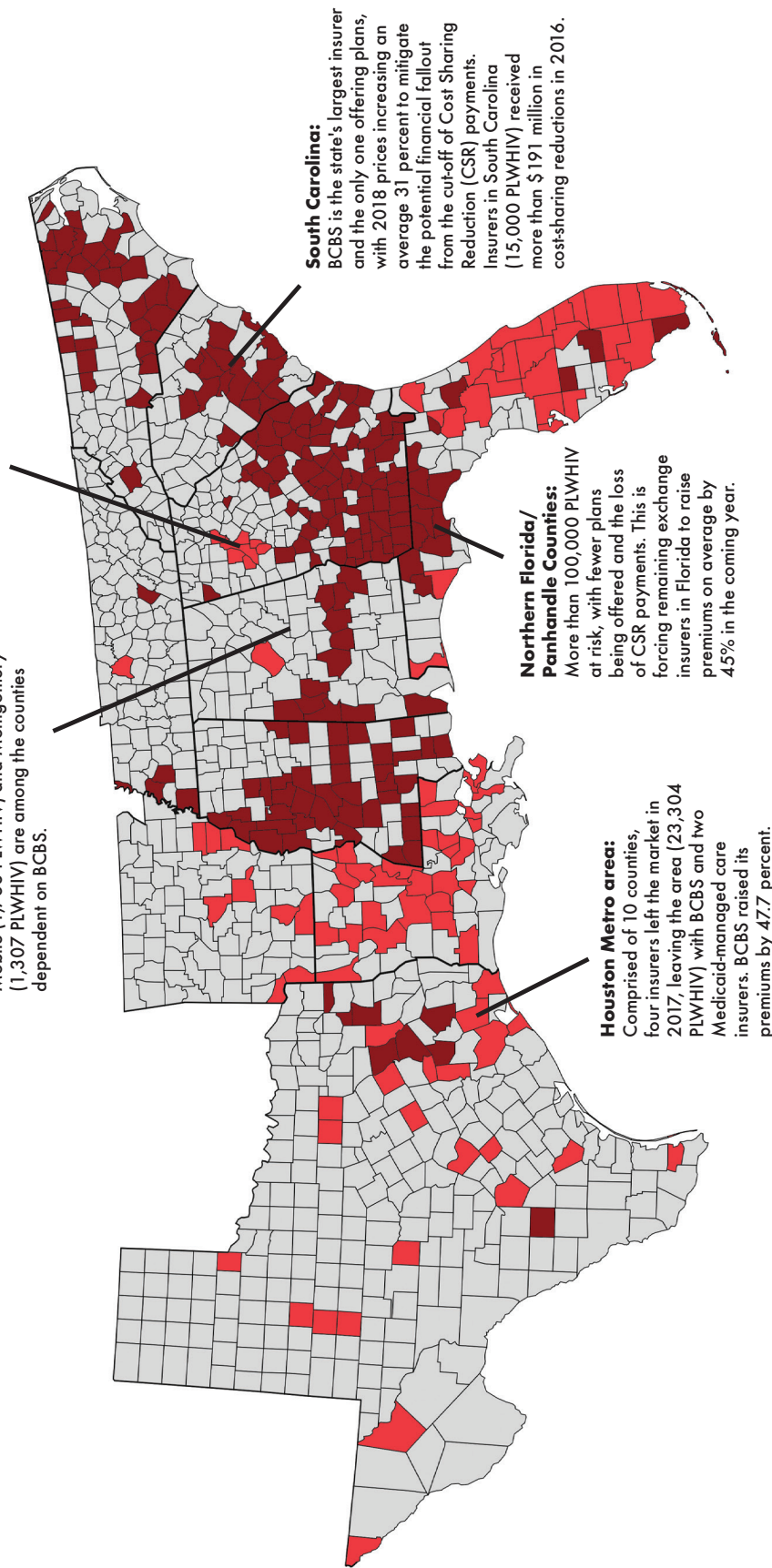
HIV AND THE FLIGHT OF ACA INSURANCE PLANS IN THE DEEP SOUTH

Alabama:

The state has only one insurer participating in 2017, Blue Cross Blue Shield (BCBS), with Bright Health joining in 2018, but it will be restricted to just three counties. Birmingham's Jefferson County (3,351 PLWHIV in 2014) is one of the three; Mobile (1,738 PLWHIV) and Montgomery (1,307 PLWHIV) are among the counties dependent on BCBS.

Atlanta, GA, Metro:

BCBS of Georgia announces withdrawing from the metro Atlanta exchange in August 2017, leaving two marketplace insurers. Approximately 33,000 Atlanta residents are living with HIV.



All red highlighted areas are high HIV prevalence counties (>251 PLWHIV per 100,000 population)

Only one ACA marketplace plan available

Two ACA marketplace plans available

Data sources:

Centers for Medicare and Medicaid Services. County by county Analysis of plan year 2018 insurer participation in health insurance exchanges. October 2017. <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2017-10-20-Issuer-County-Map.pdf>
AIDSvu. Rates of persons living with diagnosed HIV, 2014. <https://aidsvu.org/map>
created with mapchart.net ©

victories for our survival through activism and advocacy—for marginalized communities that currently lack health equity and access?

These questions remain unanswered as momentum grows for a radically different health care system in the U.S. that catches up with the rest of the industrialized world, where UHC is already recognized and guaranteed. Several developments, however, have provided a glimpse of what's possible. Without a doubt, government-funded Medicaid expansion has been critical to expand health care to PLWHIV and vulnerable communities. A board resolution from the AIDS Foundation of Chicago, for example, details that more than 13,000 PLWHIV in Illinois are covered by Medicaid. It has become the largest single payer of HIV care in the state.

Medicaid expansion, notably cross-movement organizing for continued expansion across the South, must continue as a chief strategy. The HIV community's reliance on Medicaid positions us as a leader to support a move towards a robust, government-funded system that ensures consistent, universal access to health care, treatment, and prevention that can help drive viral-suppression and lower HIV rates. The HIV community also has the ability to show how UHC, backed by robust government support, can benefit PLWHIV and provide cost-effective strategies against conservative-minded replacement bills that only emphasize health inequity by potentially driving HIV health disparities and are not cost-effective.

As this issue of *TAGline* goes to press, Democrats are aligning themselves behind the single-payer and UHC momentum generated by the attacks on health care (see Table).

In late August, Senator Brian Schatz (D-HI) previewed a proposal (now called the State Public Option Act) that allows middle- and high-income earners to buy into Medicaid through Obamacare exchanges—building on the narrative of the program as a stable source of health care. Senators Elizabeth Warren (D-MA) and Kirsten Gillibrand (D-NY) have recently come out in strong support of a single-payer or public option as well.

Members of the Congressional Black Caucus (CBC), including Senator Kamala Harris (D-CA) and Representative Robin Kelly (D-IL), stand behind a single-payer option.

In October, Senators Michael Bennet (D-CO) and Tim Kaine (D-VA) proposed Medicare X, which would allow Americans to buy a public health insurance plan.

One of the chief architects of the ACA, retired Senator and former chair of the powerful Senate Finance Committee Max Baucus (D-MT), has come out in strong favor of single payer.

Given that HIV/AIDS is a strong bipartisan issue, we are well positioned to support our allies in Congress to reach across the aisle to build even more support for realizing a vision of UHC, especially for PLWHIV. Capitalizing on data illustrating how Ryan White fills critical gaps in the ACA and the effect of Medicaid expansion on the care continuum for PLWHIV can give us evidence towards how effective a UHC system can be for PLWHIV.

Without involvement and inclusion in these current debates, we risk being left behind and without the opportunity to define and inform how any system, including single payer, can meet the critical needs of PLWHIV. As the authors of this article, we do not write to convince the larger community that single payer is the one-stop solution to our health care system. Rather, we note that these national conversations towards single-payer and other UHC models are now happening and that we are failing to make our voices heard in ensuring that any proposed health system, scheme, or concept is informed by the meaningful involvement of PLWHIV and vulnerable communities.

While the fight to defend the ACA continues, so does our fight for truly UHC. Take it from the two authors, who have lost our own health insurance at one time, lost family members to not having health insurance, case-managed HIV-positive young people struggling with homelessness and no health care, led demonstrations against large insurers as students, and organized in communities that still struggle to gain the critical access to health care. UHC in each of these instances could have positively changed the trajectories of many members of these communities and our own lives. We have fought to keep the ACA because we believed it would save lives, which it has. But let's not rest on our laurels until we have achieved true UHC for all.

Maximillian Boykin is at the HIV Prevention Justice Alliance and the AIDS Foundation of Chicago.

Activist's Guide to Universal Health Care

Universal Health Care/Coverage (UHC): all people and communities can use the promotive, preventive, curative, rehabilitative, and palliative health services that they need (equity), of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship (protection). (World Health Organization)

Terms and definitions	U.S. proposals
<p>Single Payer: a system in which a single public agency organizes and finances health care, with all medically necessary services covered. Health care services are often provided by the private sector. Also known as a National Health Insurance model, it has been successfully implemented in industrialized countries such as Canada, Taiwan, and South Korea. The United Kingdom's National Health Service (NHS) has also been cited as a single-payer model, but with many health providers employed directly by the government.</p>	<p>Federal:</p> <ul style="list-style-type: none"> ■ Medicare (for ages > 65 years)* ■ Medicare at 55 Act (S. 1742) ■ Medicaid (for low-income individuals/families)* and Children's Health Insurance Plan (CHIP)* ■ Medicare for All Act of 2017 (S.1804) ■ Expanded & Improved Medicare For All Act (H.R. 676) <p>State:</p> <ul style="list-style-type: none"> ■ Healthy California Act ■ Illinois Universal Health Care Act ■ Colorado Universal Health Plan ■ Maryland Health Security Act ■ An Act for Improved Medicare for All in Massachusetts: Providing Guaranteed, Affordable Health Care ■ Minnesota Health Act ■ Missouri Universal Health Assurance Program ■ Health Security Act (New Mexico) ■ New York Health Act ■ Nevada Care Plan ■ An Act To Establish a Unified-Payor, Universal Health Care System (Maine) ■ Affordable Health Care For All Oregon Plan ■ Ohio Health Plan ■ The Palmetto Comprehensive Health Care Act (South Carolina) ■ Health Care for All Washington
<p>Public Health Insurance Option: creation of a public health insurance plan (i.e. public option) that would compete against private, market-based insurance. ACA debates in 2009 once hinged on the withdrawing of a proposal to offer a public option through the legislation.</p>	<ul style="list-style-type: none"> ■ Keeping Health Insurance Affordable Act (S. 1511) ■ Public Option Deficit Reduction Act (H.R. 1307) ■ Medicare Buy-In and Health Care Stabilization Act of 2017 (H.R. 3748) ■ Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act (H.R. 635 and S. 194) ■ State Public Option Act (S. 2001 and H.R. 4129) ■ Medicare X Choice Act of 2017 (H.R. 4094 and S. 1970)
<p>All-Payer Model: a price-setting mechanism in which all payers ranging from government, private insurers, businesses, and individuals, pay the same price regionally for a health care service. Many of these innovative models are being advanced by states through the Centers for Medicare and Medicaid Services (CMS) 1115 waiver program, and Maryland has pioneered and implemented all-payer price-setting successfully. France, Japan, and the Netherlands also use all-payer price-setting in their health care systems.</p>	<ul style="list-style-type: none"> ■ Maryland* (Maryland All-Payer Model) ■ Vermont* (All-Payer Accountable Care Organization Model) ■ Pennsylvania* (Pennsylvania Rural Health Model)
<p>Mixed/Multi-Payer: Similar to single payer, but health care is financed by multiple sources, including public/government and private insurers. EU countries have implemented a range of mixed payer systems ranging from near single payer (France) to others in which other coverage entities play larger financing roles (Germany and Belgium).</p>	<ul style="list-style-type: none"> ■ Patient Protection and Affordable Care Act (ACA)/Obamacare ■ Medicare Part C/Advantage* ■ Medicare Part D (prescription drug coverage)
<p>Subsidized Private: Individuals are required to purchase health care insurance (individual mandate), but support in the form of government subsidies helps to keep private insurance affordable. Switzerland and Singapore also utilize this model.</p>	<ul style="list-style-type: none"> ■ Patient Protection and Affordable Care Act (ACA)/Obamacare

UNIVERSAL Health Care and PRESCRIPTION Drug Pricing

Reining in prescription drug prices isn't so much a potential benefit of universal health care, but rather a factor in its affordability and success

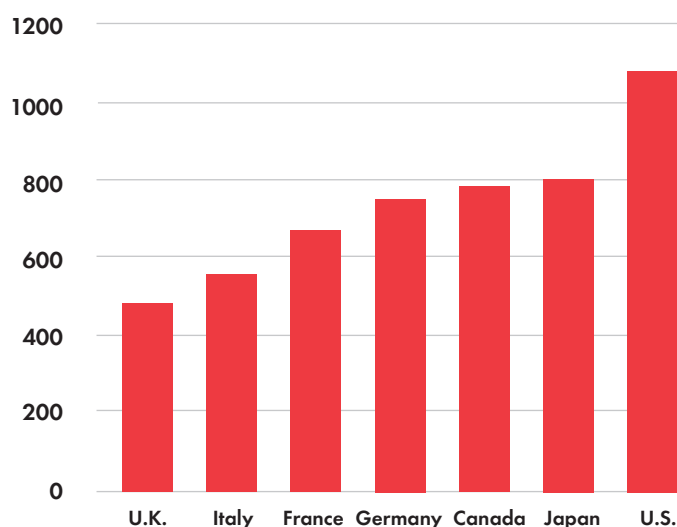
By Tim Horn

If there is one thing the majority of Americans agree on, it's that health care costs—prescription drugs, in particular—are out of control and are significantly contributing to our broken health care system. Despite some campaign trail rhetoric that put the pharmaceutical industry on notice, the White House has yet to announce a bold agenda for curtailing egregious drug pricing. Likewise, Republicans in Congress completely ignored these costs in their cruel and misguided war on the Affordable Care Act and Medicaid, and those on both sides of the aisle in both houses have consistently failed to pass any meaningful price-control legislation.

Actual spending on prescription drugs in the U.S. is controlled by largely secretive and complex systems of negotiations, discounts, rebates, cost-sharing schemes, and assistance programs. They differ considerably from one payer system to another, are based on regulations and statutes that have not kept pace with industry tactics to circumvent these measures, and often yield prices that are still beyond what health care systems and patients can reasonably afford. Can universal health care (UHC) coverage in the U.S. streamline these processes and rein in prescription drug costs, similar to what has been seen in other high-income countries? Possibly, but it will depend on steadfast efforts to dethrone the U.S. as the country with the highest health expenditures in the world (currently \$10,000 per capita).

Prescription drug costs in the U.S., relative to overall health spending, are actually the lowest among all G7 countries (Canada, France, Germany, Italy, Japan, the United Kingdom, and the U.S.). According to the Organization of Economic Cooperation and Development (OECD) data, pharmaceutical spending accounts for 12% of health spending in the U.S., as compared with 17.5% in Canada (second to Japan at 18.8%). However, the U.S. ranks highest in

PHARMACEUTICAL SPENDING: TOTAL, US DOLLARS PER CAPITA, 2014



Source: Organization of Economic Cooperation and Development

pharmaceutical spending per capita (US\$1,081), surpassing second-highest Japan (US\$803) and the lowest-ranking United Kingdom (US\$481) (see Figure).

Five of the G7 countries ensure UHC, with Japan and the U.S. relying on a patchwork of public and private insurers and an individual mandate. And there are nuances to consider with respect to prescription drug coverage. In Canada—the most frequently cited example of single-payer health coverage—provincial public funds only cover outpatient drugs for the elderly, the very poor, and the very sick. Supplementary private insurance plans and out-of-pocket spending are otherwise required. Canadian health care activists frequently point out that a nationalized scheme to negotiate and cover outpatient

prescription drugs is what's necessary to reduce their costs relative to all health care costs in the country and, ultimately, spending per capita (third highest of G7 countries in 2014 at \$786).

A recent study by University of British Columbia and Harvard researchers, published in June 2017 by the *Canadian Medical Association Journal*, concluded that, among ten high-income UHC countries, per capita spending on six categories of primary care medicines was lowest in countries that were largely dependent on single-payer systems for prescription drug coverage (New Zealand, Australia, Sweden) and highest in countries with mixed (Canada) or multi-payer systems (France, Germany, and the Netherlands). The U.S. wasn't included in the analysis because it doesn't ensure UHC and because it "has such exceptionally high pharmaceutical expenditures that its inclusion in the analysis would skew comparisons among the ten more comparable countries studied here."

The factors that contributed most to reduced expenditures in all of the UHC countries included in the analysis, particularly single-payer countries, were the average mix of low-cost drugs selected in therapeutic categories (choice effects) and differences in the actual prices paid for medicines prescribed (price effects). In essence, countries with centralized—and empowered—systems that can apply a mix of statutory regulations, cost-effectiveness considerations, formula supply contract negotiations, internal and external reference pricing, administrative efficiencies, and voluntary price discounts and patient access schemes are the most likely to control drug costs.

The same will ultimately hold true in the U.S. Guaranteeing health care for all is only half the battle; its affordability will depend on federal and state governments bearing the teeth necessary to rein in high health care costs and prescription drug prices. As TAG fixes its eyes on the former in the wake of the failed ACA repeal and replace efforts, it remains firmly committed to the known successes of the latter.

UNIVERSAL Health Care and Reducing HIV INCIDENCE

What does the **research** tell us?

By **Richard Jefferys**

After a long period during which HIV incidence rates seemed distressingly immutable, the last few years have seen a rapid accumulation of evidence that pre-exposure prophylaxis (PrEP) and HIV viral load suppression by antiretroviral therapy (ART) can dramatically reduce transmission risk. The effects of these interventions are now beginning to manifest at the population level, with reports emerging of declining HIV incidence in a number of different settings. But these interventions can only work if people are able to access them, and, although there can be many barriers to access, health coverage is clearly among the most significant.

The first robust evidence for an effect of ART on HIV transmission came from the HPTN 052 study in serodiscordant heterosexual couples by Cohen *et al.*, which ultimately reported a 93% reduction in acquisition risk associated with earlier initiation of treatment in the *New England Journal of Medicine (NEJM)* in 2016. Since that time, there has been an avalanche of confirmatory data, including results from studies involving gay couples such as those published by Rodger *et al.* in the *Journal of the American Medical Association* in 2016 and presented by Andrew Grulich at the International AIDS Society 2017 conference. The key lesson from this research is

that suppression of HIV viral load to undetectable levels is associated with zero risk of transmission, prompting the 'Undetectable = Untransmittable' advocacy campaign.

Similarly, initial evidence that daily PrEP with Truvada significantly reduces HIV acquisition risk came from the iPrEx trial reported by Grant *et al.* in *NEJM* in 2010, and has subsequently been bolstered by results from additional studies. Initial concerns regarding efficacy in women have been ameliorated by a meta-analysis of the outcomes in multiple trials, published by Fonner *et al.* in the journal *AIDS* in 2016, which found that PrEP was effective if daily dosing was maintained.

With the efficacy of these interventions being convincingly established, a number of research groups have investigated how health insurance coverage may affect access to them. An analysis involving 17,140 HIV-positive participants at 11 U.S. clinics—described by Yehia and colleagues in *PLoS One* in 2015—found that individuals with neither private insurance nor Medicaid were significantly less likely to be retained in care and virologically suppressed than their cohort counterparts. In the U.S. Women's Interagency HIV Study, privately insured participants were reported to have the highest rates of viral load suppression in a 2016 paper published in the *Journal of Acquired Immune Deficiency Syndromes (JAIDS)* by Ludema *et al.*

A lack of continuous health insurance has also been independently associated with discontinuation of ART among participants in the U.S.-based Medical Monitoring Project, as reported by Hughes *et al.* in *JAIDS* in 2014. A U.S. study looking at HIV-positive young black men who have sex with men (MSM), the population most affected by HIV infection, unsurprisingly found that having insurance was associated with a far greater likelihood of being in care. Hightow-Weidman *et al.* published these results earlier this year in *PLoS One*.

Research into barriers to accessing Truvada PrEP paints a similar picture, with most, but not all, of the investigations finding that insurance coverage is a factor in uptake of the intervention. A recent paper in *PLoS One* from Patel *et al.* reviewed data from three PrEP clinics in Jackson, Mississippi, St. Louis, Missouri, and Providence, Rhode Island during the period of 2014–2015. The researchers found that insured individuals were four times more likely to use Truvada PrEP services compared with their uninsured counterparts. Broadly consonant findings have emerged from studies covering cohorts in Los Angeles, San Francisco and Miami, Florida; these results were published this year by Okafor *et al.* in the *Journal of Urban Health* and Doblecki-Lewis *et al.* in *JAIDS*.

ART and PrEP can only work if people are able to access them, and, although there can be many barriers to access, health coverage is clearly among the most significant.

In conclusion, although it may seem to be a confirmation of the obvious, extant research results indicate that robust universal health coverage (UHC) could contribute to reducing HIV incidence by improving access to proven tools for reducing transmission. In addition to ART and PrEP for sexual transmission, there would also be the potential to enhance prevention of mother-to-child transmission (as has occurred in Thailand as a result of UHC). Furthermore, UHC that facilitates the uptake of important ancillary services, such as HIV and STI testing and syringe exchange, would carry the promise of diminishing HIV incidence by a multiplicity of means.

ENDING the Epidemic without MEDICAID?

How U.S. southern states are **moving ahead** without full health care coverage

By Jeremiah Johnson & Kenyon Farrow

Activists and health departments around the country continue to advance strategies to 'End the Epidemic' (EtE) in their jurisdictions, yet a central question remains. Are these ambitious plans appropriate in all U.S. jurisdictions, particularly given uneven access to health care systems? In places such as New York State, Washington State, and Washington, DC, Medicaid expansion through the Affordable Care Act (ACA) has made it possible to provide nearly all uninsured people with comprehensive health care, including free HIV testing and pre-exposure prophylaxis (PrEP) access. In these settings, a call to end HIV/AIDS as an epidemic through increased testing, linkage to care and treatment, and comprehensive prevention services seems more feasible. But with Louisiana being the only state in the Deep South that has expanded Medicaid to date, are EtE strategies realistic in the southern U.S.?

TAG is currently working in partnership with the Southern AIDS Coalition to provide capacity and technical support in three southern jurisdictions interested in launching EtE strategies: Louisiana, Alabama, and Nashville, Tennessee (Fulton County, GA, and Houston, TX, have been implementing their own EtE strategies). Not only are there clear reasons for the advancement of EtE strategies in these jurisdictions, there is also tremendous determination among community activists and health departments to take full advantage of existing opportunities despite the failure of Republican governors to accept federal assistance to expand health care coverage for the poor and marginalized residents in their state.

Increased advocacy and key stakeholder involvement in southern jurisdictions in which EtE initiatives are moving forward can lead to better utilization of existing HIV/AIDS funds available through the Ryan White program.

"Southerners are known for their creativity and ability to stretch a dollar," says Carolyn McAllaster, Director of the Duke HIV/AIDS Policy Clinic and the Southern HIV/AIDS Strategy Initiative (SASI). "Most southern states are using their AIDS Drug Assistance Program (ADAP) to help pay for medical insurance including premiums, co-payments, and co-insurance costs."

Are ambitious End-the-Epidemic plans appropriate in all U.S. jurisdictions, particularly given uneven access to health care systems?

Melanie Thompson, chair of the prevention and care committee on the HIV/AIDS task force in Fulton County, GA, echoed the possibilities of leveraging Ryan White funds to gain access to broader health care coverage. "We're expanding the use of Ryan White funds to pay for the Health Insurance Continuation Program (HICP), which has been happening for quite a while," she said, referring to the use of federal and state dollars to cover private health insurance premium costs for people living with HIV. "The Strategy to End AIDS in Fulton County recommends forming a working group to troubleshoot issues with HICP/ADAP, and that suggestion has now been approved by the Georgia Department of Public Health."

Ryan White, particularly at current funding levels, is not enough to address the needs of the ever-growing HIV-positive patient population it is meant to serve. With increased advocacy, however, Ryan White may increase insurance access for more people living with HIV with little to no income, improving outcomes on health issues that require specialty care not covered by Ryan White. Community mobilization under EtE initiatives may also ensure that Ryan White programs are running efficiently with no lag time between diagnosis, linkage to care, and access to medications.

In the last few years, the Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA) have strongly encouraged—and in most cases required—that jurisdictions develop

To end epidemics, marginalized communities also need plans that provide solutions to the social and structural determinants of health that drive HIV epidemics and are frequently left out of jurisdictional plans.

integrated plans for the care, treatment, and prevention of HIV. The hard work to develop these integrated plans has created new opportunities for better coordinated efforts within state governments and potentially lessened the administrative burden of submitting separate care and prevention plans, which was required in the past. With this restructuring only recently completed, some southern jurisdictions may wonder what added benefit an EtE plan would provide.

To end epidemics, marginalized communities also need plans that provide solutions to the social and structural determinants of health that drive HIV epidemics and are frequently left out of jurisdictional plans. Arizona recognized this need in developing their integrated plan and decided to mobilize community early in that planning process, addressing structural barriers and stigma more

specifically in the recommendations and effectively turning their integrated plan into an EtE document.

States with conservative governors who have refused to expand Medicaid are perhaps the most in need of this enhanced collaboration between key stakeholders and increased advocacy. McAllaster agreed, “EtE initiatives can push policy makers who are not typically focused on HIV to become engaged. I’m thinking of city mayors who, for the most part, stay silent on the issue of the HIV epidemic.”

Even if expansion remains unlikely, plans can push state and city governments and health departments to more intently focus on barriers to care and treatment, better coordinate resources, and advocate for Medicaid waivers that are friendly for HIV and vulnerable populations.

Even without Medicaid expansion, southern states have the opportunity to improve linkage to care and PrEP access. Many jurisdictions are already having some success with this. With increased attention and advocacy through EtE planning, successes in the region may be translated and replicated.

According to Thompson, “six clinics have implemented pilot Rapid Entry programs in keeping with a recommendation from the Strategy to End AIDS in Fulton County, with initial medical visits on the same day or within three days of initial presentation or presentation for reengagement. Of these, four received specially targeted Ryan White funds to begin their clinics.”

Even without EtE initiatives, other southern states have found creative ways to improve linkage to care. In much of the South, large percentages of people living with HIV reside in rural areas, differing from the character of the epidemic in the rest of the country. Thanks to the efforts of community advocates, North Carolina and Alabama have implemented telemedicine to treat individuals living outside of large urban areas. In addition, several states, including Louisiana, North Carolina, and Virginia, have launched data-to-care strategies: using surveillance information to notify health care workers when a patient they’re seeing may have fallen out of care.

Finding those windows of opportunity to link people living with HIV to support and health care services is key. According to McAllaster, “The Corrections Navigation Program that was implemented in 2014 in Tennessee

is an important initiative to provide persons living with HIV who are being released from prison with enhanced transitional case management and incentives to promote linkage to medical care.”

McAllaster also notes that, where PrEP access is concerned, southern jurisdictions are on the move. “There are an increasing number of community health centers that provide access to PrEP as well as HIV treatment,” McAllaster explained. “An example would be the Open Arms Clinic in Jackson, MS. In Jacksonville, FL, the non-profit JASMYN is focused on LGBTQ youth ages 13 to 23, providing them with services and advocacy, including an STI clinic, HIV care linkage services, case management, transportation, social activities, and support groups.” State AIDS Education and Training Centers are improving provider knowledge about PrEP, and several clinics have gotten foundation or other funding for PrEP clinics.

A key component of EtE strategies is the ownership and leadership of affected communities in every step of drafting, finalizing, implementing, and evaluating the final plan. Stronger community organizing among people living with or vulnerable to HIV in the South is perhaps one of the most important opportunities that emerges out of this process. With very dire circumstances in southern states involving limited resources, high levels of HIV and LGBT stigma, and hostile political environments, building a critical mass of people living with or vulnerable to HIV who are willing to directly challenge elected officials and the political establishment can be a daunting task. Ending HIV, as a campaign framework, creates new possibilities to mobilize people living with HIV in what have historically been more difficult political climates.

EtE campaigns give key stakeholders a broad platform to advance new, ambitious policy changes. With the advent of PrEP and proof that people with HIV who are successfully on treatment and virally suppressed cannot pass on the virus to others even with condomless sex, a whole range of new arguments are available for advancing policy and program changes at the city, county, or state level that increase access to effective prevention and treatment while decreasing the stigmatization and criminalization of affected communities.

In addition to using an EtE framework to unite a number of prevention, treatment, and structural policy issues under one umbrella, EtE campaigns can be a great way to highlight the cost of not expanding Medicaid in Southern states. In June 2017, the Mississippi Department of Health announced that it was closing one of its STD clinics in Jackson. Even worse, it would also begin charging \$25 for an HIV test in the poorest state in the country.

An EtE campaign in a place such as Jackson, MS—where TAG is looking to begin work with community leaders in this jurisdiction in early 2018—could effectively scale up public pressure on the state to show the cost of divestment in public resources for comprehensive health coverage through Medicaid. According to estimates,

Ending HIV, as a campaign framework, creates new possibilities to mobilize people living with HIV in what have historically been more difficult political climates.

nearly 300,000 people in Mississippi would qualify for Medicaid under the expansion, and the state would receive \$427 million in new funding from the federal government. So although Southern jurisdictions that haven’t expanded Medicaid can still do a lot under an EtE plan, it should dovetail with advocacy for Medicaid expansion under the ACA.

Despite the ongoing struggles to expand Medicaid in Republican-controlled states and relentless federal attacks on the ACA, we believe the time to continue pushing for the resources to end the HIV epidemic in the U.S. is now. Several opportunities are still available in the South, all of which are dependent on community leadership as part of an EtE process.

Continued from page 4

This goes for domestic elimination goals as well. In the aftermath of the recent all-out Senate and House attacks on the Affordable Care Act and Medicaid, compounded by cruel undermining tactics by the White House administration, it has become abundantly clear that risk-based financing can be profitable or sustainable, but it cannot be both. Although the ACA has lived to see another day and the insurance and health industries are no poorer for it, the U.S. model for universal health care remains a house of cards that continues to fail, especially for the longstanding victims of broken social contracts: the working poor and middle class. As Suraj Madoori lays out in “The Long Game for Health Justice,” beginning on page 5, the time is ripe to look beyond fragile patchworks of access and coverage and focus instead on publicly funded schemes, particularly single payer.

As wildfires rage across the American West and Europe, we are reminded of our shared vulnerability in the face of nature and our own failure to meet systemic challenges. No house is safe, and entire communities can be devastated unless we act in a concerted fashion to quickly stop and prevent deadly outbreaks. Now is not the time for prayers, ideological experiments, or protecting private industry profits. Only recognition of the universal human right to care can achieve what the moment demands: global investment to heal communities and end infectious disease as a public health threat.

SUPPORT TAG

As TAG works to advance its campaigns to end the HIV, TB, and HCV epidemics while defending against new and unprecedented political challenges, your support is needed now more than ever before. Donate online: www.treatmentactiongroup.org/donate.

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ABOUT TAG

Treatment Action Group (TAG) is an independent, activist and community-based research and policy think tank fighting for better treatment, prevention, a vaccine, and a cure for HIV, tuberculosis, and hepatitis C virus.

TAG works to ensure that all people with HIV, TB, or HCV receive lifesaving treatment, care, and information.

We are science-based treatment activists working to expand and accelerate vital research and effective community engagement with research and policy institutions.

TAG catalyzes open collective action by all affected communities, scientists, and policy makers to end HIV, TB, and HCV.

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