



The Our American States podcast—produced by the National Conference of State Legislatures—is where you hear compelling conversations that tell the story of America’s state legislatures, the people in them, and the policies, process and politics that shape them.

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### **Ending HIV/AIDS in the U.S. | Feb. 8, 2021 | OAS Episode 121**

Ed: Hello and welcome to “Our American States,” a podcast from the National Conference of State Legislatures. This podcast is all about legislatures: the people in them, the policies, process and politics that shape them. I’m your host, Ed Smith.

*“About half of new HIV infections in the nation are now occurring in only 50 local jurisdictions: 48 of the more than 3,000 counties in the nation, and Washington, D.C, and San Juan, Puerto Rico. So, HIV is geographically concentrated.”*

That was Dr. Jonathan Mermin, Director of the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention at the Centers for Disease Control and Prevention. He’s a guest on the podcast to talk about efforts to end HIV/AIDS.

HIV/AIDS has killed about 700,000 people in the U.S. since it first emerged more than 40 years ago. Deaths have dropped dramatically since the mid-90s. The U.S. Department of Health and Human Services in 2019 launched the Ending the HIV Epidemic initiative. It aims to eliminate the disease in this country.

Dr. Mermin discusses the range of treatments available to fight HIV/AIDS, strategies to prevent the spread of the disease, and the role of state policymakers in helping eradicate HIV/AIDS.

My other guest is Charlie Severance-Medaris, a policy expert at NCSL. Charlie explains the steps states are taking to help people get access to critical medications, changes in laws that have criminalized some behaviors for people with HIV/AIDS, and other efforts at the state level to end the epidemic.

Let’s start with Dr. Mermin. Welcome to the podcast.

Dr. M: Thank you for inviting me.

*Time Marker (TM): 02:00*

Ed: So, let's start out. Could you tell us a little more about HIV in the United States and why the time is now to try to end the HIV epidemic?

Dr. M: HIV matters to America. There are about 1.2 million people in the country living with HIV, an infection that is fatal unless treated. However, there have been major scientific advancements over the past 25 years that, coupled with well-directed funding and services by state and local governments and community organizations, have helped bring the annual number of HIV infections to an all-time low from a peak of 130,000 infections annually in the mid-1980s to about 38,000 new infections per year recently.

And a number of states and jurisdictions have been able to substantially reduce HIV incidents over the past few years. For example, there was an over 60% decline in incidents in Washington, D.C., over 30% in Connecticut and over 10% in Florida. So, we know HIV prevention works.

But at a national level, progress has stalled, and annual infections have been relatively stable for the past few years because many people still aren't getting the prevention and treatment they need. And there are major disparities in HIV. For example, Black and LatinX communities, gay, bisexual and transgender persons and people living in the southern U.S. continue to be disproportionately affected.

And about half of new HIV infections in the nation are now occurring in only 50 local jurisdictions: 48 of the more than 3,000 counties in the nation, and Washington, D.C. and San Juan, Puerto Rico. So, HIV is geographically concentrated.

And for state governments, there are not only profound human costs, but financial ones as well. Lifetime medical care costs for HIV are about \$500,000. So, good HIV prevention saves lives and saves money.

For example, we used a mathematical model at CDC to estimate the impact of reducing the number of new HIV infections in the nation by 90%. Even though it will cost money to do this, in the end it will save the healthcare system and taxpayers billions of dollars. And state governments will rapidly feel that benefit, sooner than with many other public health interventions.

COVID-19 has shown all of us how epidemics can move in the wrong direction overall and in terms of health inequity without concerted effort by leadership and communities.

*TM: 04:42*

Ed: Now, I understand in 2019 the Ending the HIV Epidemic Initiative was announced. Can you talk a little bit about that?

Dr. M: The Ending the HIV Epidemic Initiative, or EHE, is a cross-federal agency, multi-year effort that aims to reduce new infections by 90%. Initial federal funding for planning for the initiative started in fiscal year 2020 and we started the implementation phase this fiscal year. EHE is first

focusing on those 50 local jurisdictions that account for more than half of new HIV infections and seven states with a substantial rural burden of HIV.

If additional resources become available, the initiative will eventually expand to other areas in the nation. The initiative works by scaling up four key strategies in the hardest-hit communities: diagnose as many people as we can – currently an estimated 14% of people with HIV in the nation don't know they have it; treat everyone effectively; prevent new infections with proven interventions like pre-exposure prophylaxis, syringe service programs and behavioral change education; and respond rapidly and effectively to new outbreaks of HIV.

EHE is built on local innovation and community-driven plans to tailor the four key strategies to each state and community's needs.

*TM: 06:09*

Ed: Well now, we know that treatment options for people with HIV have improved dramatically. What does that mean for prevention and what can states do? What is the role of the states to get more people with HIV onto effective treatment regimens?

Dr. M: People who take HIV treatment as prescribed have life expectancies that approximate people who don't have HIV. The drugs work that well. In addition, people are virally suppressed; that is the level of HIV in their blood is undetectable. They have effectively no risk in transmitting HIV to sexual partners. This is something that is possible for almost everyone with HIV because of the new treatments.

This means doing more HIV testing and providing the support for people to take their medication saves lives and prevents new infections. And there are a number of opportunities for states to help us achieve these goals.

We need to make HIV testing as routine and normal as screening for cholesterol or high blood pressure. For example, Ed, how many times a year do you get your blood pressure taken?

Ed: Well, I have mild hypertension, so I check it myself. But also, every time I go to the doctor I'm checked and, interestingly, along these lines, I was diagnosed with high blood pressure in 1990 just on a routine appointment and I was a marathon runner at the time. I thought I was the healthiest person around and it turned out I had a real problem that needed to be addressed.

Dr. M: Exactly what preventive care should do for us. If we are able to screen people for HIV that frequently or even once a year, we will help many people like you know about something they might not know about their health, in this case that they have HIV, and then they can immediately start taking life-saving medications.

States have access to a lot of health data that can help direct efforts, whether identifying a cluster of new infections and responding rapidly with the public health system, helping people get the prevention and treatment they need, or using laboratory or pharmacy prescription to see where and when people living with HIV have fallen out of care and need that extra social or economic or medical support. All states have people called disease intervention specialists or DIS. They're essentially community health workers that can help people get back into care.

And finally, Ed, as we respond to the COVID pandemic, we have an opportunity to build stronger systems of reaching those who need care for HIV and other infectious diseases at the same time.

I would encourage states to think about where and how to build testing and vaccination and outreach strategies for COVID that can also be used to help deliver vital services for other infectious diseases like HIV, sexually transmitted diseases, and viral hepatitis. And some places have already done that.

For example, New York City has established rapid COVID testing sites at the sexually transmitted disease clinics that they have throughout the city. And once we've recovered from the COVID pandemic, these same sites and rapid testing capabilities can be used to get people quickly diagnosed and into care for a variety of illnesses and conditions.

*TM: 09:18*

Ed: The other side of this coin as I understand is that there are medications people can take to prevent getting HIV in the first place. Can you talk a little bit about these and why are they important to this conversation?

Dr. M: Post-exposure prophylaxis involves a person who does not have HIV taking HIV medicine after a potential exposure to the virus to prevent infection. We call this PEP. And PEP can be an option for a possible sexual exposure, for example, when a condom breaks, or for medical professionals or law enforcement who get a needle stick injury. PEP is most effective when taken within 72 hours after the potential exposure and it's taken for about 28 days.

The newest intervention we have is kind of a modified form of PEP. We call it PREP or pre-exposure prophylaxis, and PREP is a daily medicine people at risk for HIV take to prevent getting HIV from sex or injection drug use. In addition, recent studies have shown that a shot once every two months with a PREP medication was highly effective at preventing acquisition of HIV.

When taken as prescribed, PREP reduces the risk of getting HIV from sex by over 99%, and PREP also has minimal or no side effects for most people. But, Ed, we also have challenges: just 18% of the estimated more than one million Americans who would benefit from PREP are using the medication, and some of the largest gaps are among the populations who need PREP the most, including gay and bisexual men of color.

Everyone who is at risk for acquiring HIV infection should be screened and offered PREP if appropriate, and states can help those at risk get access to PREP by looking closely at their scope of practice laws. For example, allowing pharmacists and nurse practitioners to begin PREP could both prevent infections and reduce some of the disparities that are so prominent in the HIV epidemic.

*TM: 11:18*

Ed: Well, I have to imagine many people don't know those medications are available, so it really is an opportunity for states to message to those who might benefit.

Dr. M: Exactly. States can play a great role through their healthcare systems as well as their public health systems, and there is also a space for communication campaigns and community leaders to really champion the effectiveness and safety of PREP.

*TM: 11:42*

Ed: Another topic is the criminalization of HIV. There are laws that may criminalize certain behavior when HIV even is not transmitted. Where do these laws come from and can you tell us why some states in the last decade have made the decision to review their statutes and update or change their laws?

Dr. M: So, Ed, you were covering a lot of HIV when you were in California. During that time, many states passed these laws in an attempt to discourage behavior that might lead to transmission, and as a requirement for receiving federal funds to support HIV treatment at that time. Then, very little was known about HIV including how HIV was transmitted and how best to treat the virus. And many of these laws criminalized behaviors, however, that cannot transmit HIV such as biting or spitting. And the laws apply regardless of actual transmission.

What's resulted is a confusing situation where people with HIV can be prosecuted for behaviors that pose little to no risk of HIV transmission and for consensual sexual behaviors, even when the highly effective prevention measures that we've discussed earlier are used. So, because the majority of new HIV infections occur among men who have sex with men, and people of color, these laws often disproportionately affect these populations.

Our research at CDC has shown that the laws do not reduce HIV transmission and they have not had any detectable prevention benefit. Since 2014, at least five states have modernized their HIV criminal laws and changes that they've implemented include removing HIV prevention issues from the criminal code and including them under disease control regulations, requiring an intent to transmit for prosecution, or requiring actual HIV transmission, or providing defenses for taking some of the measures we talked about to prevent transmission, such as being virally suppressed, using condoms or taking PREP.

My hope is that state leaders will examine their laws, align them with current science, and consider rescinding, reforming and revising the application of the laws for the sake of people with HIV and for the public's health.

*TM: 13:59*

Ed: Now, for the most part, we've talked about the transmission of HIV and sexual activity, but we haven't talked too much about injection drug use and the risk of HIV infection for people who inject drugs. What can states consider to prevent transmission of HIV in this population? Do these same strategies or other strategies apply?

Dr. M: Absolutely. The prescription opioid and heroine crisis has led to increased numbers of people who inject drugs, placing new populations at risk for a variety of infectious diseases including HIV, and being at risk for overdose. People who inject drugs are at high risk for getting HIV if they use needles, syringes or other equipment that someone with HIV has already used.

The drug crisis has affected many of the areas where HIV prevalence rates have historically been low, including rural parts of America. Often these areas have limited services for HIV prevention and treatment and substance disorder treatment because they haven't had decades of effort put into place to try to address the issues.

About one in ten HIV diagnoses is among people who inject drugs, and many of these people face the social and economic factors that limit access to services. However, we can prevent these infections and prevent overdoses through something we call syringe service programs or SSPs.

These are community-based services that can provide a range of helpful activities including linkage to substance use disorder treatment, access and disposal of sterile syringes and injection equipment, distribution of Naloxone, which prevents death with people who have overdosed, vaccination testing, and linkage to care and treatment for infectious diseases like HIV and viral hepatitis that can be transmitted through drug use.

These syringe service programs also have substantial benefits for the community. They help protect the public and first responders by safely disposing of used needles and syringes, so they prevent the accumulation of used needles in the environment, and they can help prevent disease outbreaks.

Many of our state and local communities have embraced these SSPs as a standard part of public health services just the way they would a TB clinic or an STD clinic. To do this though requires partnership between elected officials, communities, clients and the public health system, and it really does involve regular communication and support because these are new to some communities and people can start off being skeptical until they see their benefits.

State decisionmakers have a unique role to play in identifying statutes and regulations within their states that may enable SSPs and allow them to reach the people who need them, including changing blanket restrictions on needle distribution or carriage of drug paraphernalia, and sometimes even retail sales of needles and syringes over the counter at pharmacies.

CDC can provide more information and tools and we actually just issued a technical assistance package, kind of a toolkit that states can use to take a look at their policies and practices and epidemiological situations that they can use to make some sound decisions about syringe service programs.

*TM: 17:21*

Ed: Well, Dr. Mermin, thanks so much for taking the time to discuss this really critical issue. And I wonder before we wrap up, if there is anything else you'd like to share.

Dr. M: As I like to remind myself, the science to treat and prevent HIV has come leaps and bounds in the last decade, and we have a once-in-a-lifetime opportunity to end new HIV infections. We at CDC and the federal government can't do it alone. We really need state and local governments, the nonprofits and state legislators to partner with.

In many cases, the state health departments will need support from their legislative bodies. And I hope that after listening today, there's a new-found inspiration to save lives, save money and end the HIV epidemic.

Ed: Well, Doctor, thanks again, and you stay safe. I'll be right back after this with Charlie Severance-Medaris.

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Ed: And I'm back with Charlie Severance-Medaris from NCSL's health program. Charlie, welcome back to the podcast.

CSM: Thanks for having me back, Ed.

*TM: 18:53*

Ed: So, Charlie, I just spoke with Dr. Mermin about a lot of the different strategies to prevent HIV transmission. Let's start by talking about PREP and PEP, the pre-exposure and post-exposure prophylaxis. What are states doing to increase access to this preventative medicine?

CSM: Several states have taken different steps to increase access to these medications for people at risk of HIV infection. In 2020, Colorado enacted House Bill 1061 and California enacted Senate Bill 159. These authorized pharmacists to dispense prep or PREP and pep or PEP without a prescription from a doctor after first testing and counseling people at risk of HIV infection.

The Colorado bill also requires insurance carriers to reimburse a pharmacist employed at an in-network pharmacy for prescribing HIV infection prevention drugs.

In 2020 as well, Georgia enacted House Bill 793. This creates a three-year pilot program for the purpose of providing PREP drug assistance to individuals who have tested negative for HIV, but who have risk factors that expose them to HIV. The program is open in specific counties identified by the CDC for being at risk of outbreaks of HIV as a result of opioid use, and in other counties identified as being at risk by the state health department.

In 2019, Washington enacted Senate Bill 5602. This required the Department of Health to develop recommendations for increasing awareness about financial support that is already available for individuals who could benefit from a PREP prescription.

And finally, Alabama in 2018 enacted House Joint Resolution 183. This joint resolution recognized March 7<sup>th</sup> as Alabama HIV Awareness Day and encouraged Alabamians to increase their awareness and understanding of HIV and participate in prevention efforts including building awareness of and expanding access to PREP.

*TM: 20:52*

Ed: In the previous segment, we also spoke about laws that criminalized certain behaviors for people living with HIV/AIDS. What states have reviewed their statutes on this topic?

CSM: Since 2014, there have been at least five states, California, Colorado, Iowa, Michigan, and North Carolina, which have changed their HIV criminalization laws either through regulatory action or through legislation.

To focus on the legislative approach, in 2017 California enacted Senate Bill 239. This reduced and repealed some of the punishments for violations of California's HIV exposure laws, namely reducing the penalty for exposing someone to HIV without disclosing your status from a felony punishable by three to eight years in prison to a misdemeanor punishable by up to six months in prison.

This also required that prosecutors prove that an individual charged under the law acted with specific intent to transmit HIV and that their action posed a substantial risk of transmission. The bill also permits as a defense if a person took or attempted to take measures to prevent transmission.

In 2014, Iowa enacted House File 2297. Prior to the enactment of House File 2297, a person living with HIV who engaged in any intimate contact without disclosing their HIV status could be charged with a felony, punishable by up to 25 years in prison.

House File 2297 created different levels of intention and punishment for transmission and, similar to the California statute, allowed evidence that an individual took measures to prevent transmission to be used in their defense.

And finally, in 2019, Michigan actually enacted two pieces of legislation, House Bill 6020 and 6021. These bills altered Michigan's statute so that the state's HIV laws only target sexual activity that is highly likely to transmit HIV and created different levels of offenses based on an individual's state of mind and whether HIV transmission actually occurred.

For instance, it is a felony punishable by up to four years of prison for a person to not disclose their HIV status, engage in high-risk behavior and do so with a specific intent of transmitting HIV. It's now only a misdemeanor if a person did not first disclose their HIV status but did not act with a specific intent of transmitting HIV.

*TM: 23:16*

Ed: Now, what about injection drug use? NCSL does some legislative tracking related to syringe service programs and how states are increasing access to treatment for opioid use disorder. I know that. Can you talk a little bit about those programs?

CSM: Yeah. We do track legislation related both to syringe service programs and substance use disorder treatment programs. Some bills I'd like to highlight. Kentucky, in 2015, enacted Senate Bill 192. This bill allowed counties to establish syringe service programs. In Kentucky, these SSPs

or syringe service programs can now refer participants to substance use disorder treatment, provide overdose prevention education, and test for infectious diseases. They can also provide Hepatitis A and B vaccinations.

In Florida, in 2019, the legislature enacted Senate Bill 366. Similarly, this bill allowed county commissions to authorize sterile needles and syringe exchange programs. These programs can refer individuals to substance use disorder treatment and treatment for screening and treatment of infectious diseases like HIV.

And in Minnesota in 2019, the last bill I'll highlight, House File 19-4601, provided a grant of \$367,000 to the Rural Aids Action Network to support syringe exchange services in rural parts of the state. This included support for distribution of Naloxone kits, which is the opioid overdose reversal medication, and to provide other relevant training opportunities.

*TM: 24:50*

Ed: So, are there any other legislative efforts NCSL has tracked related to people with HIV or the national initiative to end the HIV epidemic?

CSM: Yes. So, part of this conversation is around obviously raising general awareness among the general public of the benefits of medications like PREP and PEP, but another part of this conversation is raising awareness among doctors and other healthcare providers about the benefits of these medications and who can benefit from them.

On that note, in 2019, New Mexico enacted Senate Bill 536. This bill appropriated \$364,000 to the University of New Mexico to support the extension for community healthcare outcomes, or project ECHO, and provided that \$107,000 of that appropriation be for the HIV PREP program to improve awareness of PREP and its benefits among healthcare professionals.

States are also innovating and looking for different opportunities in the realm of testing and screening for HIV. For instance, in Indiana in 2019, the legislature enacted Senate Bill 141. This required that the state's medical licensing board develop rules and protocols to allow HIV screening to take place in opioid treatment programs.

And I'd also like to quickly note the role that state health departments are going to play in the national initiative to end the HIV epidemic. Many state health departments have already developed and submitted plans for how they will work with the CDC on this initiative and you can find those plans by reaching out to your health department's legislative liaison, but we will also link to a compilation of those plans in the resources section of this podcast.

*TM: 26:25*

Ed: Well great, Charlie. Thank you for giving us this state-level perspective on what's being done to try to end the HIV epidemic. I wonder before we wrap up, if there is anything else you'd like to share.

CSM: Actually, I think to wrap up, I'd just like to mention a few NCSL resources that we have available for legislators on our website. I mentioned we track legislation related to syringe service

programs, and we do that in our injury prevention database. This database also tracks all introduced legislation related to substance misuse prevention.

We do also have our substance use disorder treatment database, which as the name suggests, tracks all enacted legislation related to the treatment of opioid use disorders.

Finally, I'd like to highlight that we did a webinar on infectious diseases earlier this year and also have a legis brief on infectious diseases for those folks who would like to dive a little more into different legislative examples in this realm. Those are available on our website. You can find them by googling them, but we'll also make sure that they are available in the resources section of this podcast.

Ed: Well, thanks Charlie, I will be sure to link to those items and let people learn more about this topic. I thank you again for your time and your expertise and stay safe.

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Ed: And that concludes this edition of our podcast. We encourage you to review and rate our episodes on iTunes, Google Play or Spotify. You may also go to Google Play, iTunes or Spotify to have these episodes downloaded directly to your mobile device when a new episode is ready. For the National Conference of State Legislatures, this is Ed Smith. Thanks for listening and being part of "Our American States."