

VOICE OF T.I.CANN

ADAPS In Growing Crisis

Five months into the current funding year, at least 12 state AIDS Drug Assistance Programs (ADAPs) have been forced to take steps to limit access to life-saving HIV medications for uninsured and underinsured Americans due to inadequate federal funding.

"And this is only the tip of the iceberg," said William Arnold, Chair of the ADAP Working Group. "If 12 states are imposing emergency cost-containment measures right now, we must expect that the vast majority of state ADAPs – most of which are now planning drastic service reductions in case no federal relief is forthcoming – will follow suit by early 2003 when big states with heavy AIDS impacts like Florida, New York, and Texas already expect huge financial constraints."

Some states in fiscal crisis have made the difficult decision to impose waiting lists, trim formularies, and lower income eligibility levels. The most dramatic illustrations of the depth of the crisis come from two southern states, North Carolina and Texas. North Carolina ADAP has maintained a waiting list since early this year. That waiting list presently includes over 800 patients. North Carolina may be saved by a one-time infusion of state funding but that will not solve their underlying structural problem. Texas recently announced that to close its deficit, it will retroactively lower its income limits from 200 percent of the federal poverty level (300 percent with spend downs) to 140 percent. That action will require **the removal of 2,500 presently enrolled ADAP clients from the program by June 1, 2003.** Finally, New York, according to a

member of the state's ADAP advisory board, must address a \$10 million structural deficit if either state and/or federal funding is not increased by that amount. According to the most recent National Alliance of State and Territorial AIDS Directors' (NAS-TAD) Report, the following states have also initiated waiting lists as of October 5, 2002: Alabama (250), Indiana (34), Kentucky (62), Montana (2), Oregon (18), and South Dakota (43). "It's a dire situation. A lot of people are waiting to get life-sustaining medications," said Arthur Okrent, head of North Carolina's beleaguered ADAP.

The reasons for the crisis are clear. "Insufficient federal funding levels in FY 2001 and 2002 are the major drivers of the present shortfall," stated Lei Chou, Co-chair of the Data Committee of the ADAP Working Group and Access Project Director at the AIDS Treatment Data Network. "Additional stress is being caused by severely strained health care budgets at the state level so that this year state ADAP contributions are flat and/or reduced from last year's levels."

While ADAP drug spending has increased an average of 17 percent per year since 1998, according to the report, more and more patients need help. According to NASTAD this increase is attributable to two major factors – increases in enrollment and increases in drug utilization. "A major factor in enrollment growth," said Arnold, "lies in the success of the new drugs in decreasing deaths and slowing progression to AIDS. People are staying alive longer and so they need ADAP longer. In addition, intensified testing and counseling efforts have made

more people aware of their status and they want to be treated. These seem like things to be celebrated but in fact, dollars flowing to the programs are not being increased to take care of the swelling numbers of people we are keeping alive."

Some relief for beleaguered ADAPs is being provided by the pharmaceutical companies producing the majority of HIV/AIDS therapies. Five companies, Pfizer/Agouron, Hoffmann-La Roche, GlaxoSmith-Kline, Abbott, and Merck, have frozen the prices of their presently marketed HIV/AIDS drugs to the entire American market for two years. Other companies are also offering price concessions to ADAPs including Bristol Myers Squibb with a two-year price freeze.

Peter Hare, Vice President for HIV at GlaxoSmithKline in announcing his company's freeze stated "as leaders in HIV/AIDS treatments, we share a responsibility to step into the breach and help patients access adequate HIV/AIDS therapy in the U.S., just as we are doing in the developing world. However, a sustainable system must be set in place to adequately fund state ADAPs."

"There are presently no efforts by either the Congress or the Administration to deal with the FY 2002 crisis," said Arnold. "No sponsor could be found to attach an \$82 million ADAP emergency appropriation to the Emergency Supplemental bill. We are concentrating, therefore on meeting the FY 2003 need which requires a minimum of \$162 million in new federal funding. The Senate Appropriations Committee recently reported a bill including \$100 million

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Update on TAEP and ETHA

Treatment Access Expansion Project (TAEP)

The Treatment Access Expansion Project (TAEP) was established in 1998 to secure support for the development of Medicaid expansion programs to improve access to early and comprehensive health care for non-disabled persons living with HIV. Currently, individuals living with HIV who have not received an AIDS diagnosis are generally ineligible for Medicaid because they do not meet the programs disability standards. These standards reinforce a system where access to care and treatment lags far behind the Public Health Service's published standards of care for treating HIV.

Relatively new treatments have greatly improved both the health and quality of life for many people living with HIV permitting them to live as long as their HIV negative peers. However, without access to early intervention health care and treatment, these advances remain out of reach for thousands who are non-disabled and low-income. TAEP

seeks to eliminate disparities in access to care suffered by many traditionally underserved populations.

TAEP is currently a collaborative project of consumer, health care provider, and pharmaceutical industry groups, including the National Association of People with AIDS, the National Association of State and Territorial AIDS Directors (NASTAD), the Title II Community AIDS National Network (TII•CANN), the HIV Medicine Association, Project Inform, Bristol-Myers Squibb, Hoffmann-La Roche, Abbott Laboratories, and GlaxoSmith-Kline.

Proposed Goals and Objectives for 2002-03

TAEP will continue to work to secure passage of the Early Treatment for HIV Act (ETHA), to implement state-based early intervention health care and treatment programs, and to ensure that state Medicaid programs provide comprehensive care, including unre-

stricted access to HIV medications. Ongoing TAEP activities will include the following:

- **To lead a nationwide effort to secure passage of the Early Treatment for HIV Act (ETHA).** Our nationwide advocacy network, including national, state, and local community-based organizations, is poised to mobilize in support of this bill. For many, ETHA is a top legislative priority. TAEP will coordinate the further development of a nationwide advocacy campaign and of bi-partisan congressional support for passage of ETHA.
- **To work with states developing Medicaid expansion proposals.** Currently, TAEP is working with individuals in Illinois on designing an HIV Waiver expansion proposal. Individuals in North Carolina and Washington have expressed an interest in working with TAEP to develop waiver proposals.

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If you have anything of interest to share with the Title II community, please fax it to (202) 588-8868. Visit T•II CANN's website at www.tiicann.org.

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ATAC Needs You!

The AIDS Treatment Activists Coalition (ATAC) was founded in 2001 at a meeting of national HIV/AIDS activists. The group spent several days discussing the treatment challenges of people with HIV/AIDS and the need for effective advocacy in areas such as novel therapies, vaccines, and microbicides (used during sexual intercourse to prevent transmission of HIV). One theme was especially clear: the need for new people to become involved in the fight to cure HIV/AIDS. ATAC was formed to create a national organization of treatment activists that could deal with issues as a united front, to train and mentor new treatment activists, and to provide a forum for discussion and debate of emerging issues.

ATAC is open to anyone interested in HIV/AIDS treatment activism (except for people employed by

pharmaceutical companies). Training and educational sessions are scheduled several times a year in locations across the country. The next session will be in December at the North American AIDS Treatment Action Forum (NATAF) in New Orleans.

To find out more about ATAC, go to www.atac-usa.org. You can join the ATAC e-mail list, by sending a message to info@atac-usa.org that lists your real name, your e-mail address, and the reason why you are interested in HIV/AIDS treatment education or advocacy.

Activists are also needed in ATAC's "SAVE ADAP" Committee, an adhoc group addressing the current crisis in many state AIDS Drug Assistance Programs.

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Barcelona: A Personal View

By: Gary Rose, Public Policy Director, T•II CANN

The International AIDS Conferences have become bizarre and ritualized dances; you move two steps forward, then one step back, or one to the side, then one step forward again. I am embarrassed to admit that I can't dance this dance. I can't figure out what the steps are and I am constantly stepping on my own feet. I found



the XIV International AIDS Conference held in Barcelona this past July, to be a particularly frustrating exercise. I was usually exhausted and numb, wondering what I was hearing, what it was supposed to mean, and, at times, why I was there at all.

Barcelona was particularly bewildering after the relative clarity of Durban in 2001, where the world seemed to discover with an astonishing degree of simultaneity the international AIDS crisis. That conference also possessed a particularly riveting point of reference since at the same time as the international media was trumpeting numbers of HIV-positive people approaching 40 million, the President of South Africa was grappling with whether he believed in HIV at all. The combination of the macro and micro views provided a perspective that contextualized everything we heard and did. I left Durban energized and expectant that great deeds would soon be done.

Barcelona had no such easy frames of reference. In fact, the new numbers from UNAIDS were even more intimidating than they had been two years earlier. Now

the world had nearly 50 million HIV-positive people, over 20 million people had died of AIDS, and another 8,000 were dying every day. It was also estimated that at least 100 million people would be HIV-infected by 2010 with corresponding growths in cumulative and daily death tolls. Huge numbers of people and institutions were responding, often brilliantly, to these horrifying numbers with thousands of proposals for treatment, prevention, and research programs and dozens of carefully conducted pharmacoeconomic, labor, productivity, and epidemiologic analyses. It seemed like the world had taken a collective deep breath – programs were ready, patients were ready, governments were ready – but nothing could move forward because western governments seemed collectively unwilling to meet the price tag of about \$9 billion a year. What made all this so disconcerting was that the unwillingness to pay the tab by the West reduced the programs themselves to interesting theoretical exercises instead of palpable responses to the most deadly public health epidemic in recorded history. To make matters worse, the West's unwillingness to pay as an absolute bar to moving forward was seldom addressed in the same room at the same time as the programs and the analyses. It made people want to holler.

Fortunately, an opportunity to holler was soon made available. On July 9th, American advocates arrived for morning conference sessions to be greeted with a flood of rumors from the United States. It appeared that Scott Evertz, the gay AIDS Czar, and Pat Ware, the conservatively doctrinaire Executive Director of the Presidential Advisory Council on HIV/AIDS, had been fired. Later, we learned that Evertz was merely being reassigned to handle international AIDS in Secretary of Health and Human Services Tommy Thompson's office and was to be replaced by another gay man, Dr. Joseph O'Neill, longtime HRSA AIDS ser-

vices coordinator. It also seemed that Ware's dismissal was retracted, supposedly due to massive and immediate "don't you dare" responses from the Christian right. Since it was already pretty clear that the United States had no real AIDS agenda, either international or domestic, one wondered why such a shakeup would occur during an international AIDS conference. In retrospect, it seems fairly clear. Not only didn't the Bush Administration have an AIDS agenda, the supposed struggle between Ware and Evertz was making it seem that there was disarray in the Bush Administration's positions on its non-agenda and attention, even negative attention, could force the Administration to clearly articulate an agenda, something they have been resolutely loath to do.

The anger over inadequate responses by the American government to the international AIDS crisis and the personnel changes came to a head during Secretary Tommy Thompson's speech at the conference that afternoon. Well over a hundred attendees whistled, shouted, and marched throughout Thompson's speech (which accord-



ing to the printed version available in the press room didn't say much of anything, anyway). It actually felt good to stand there shouting with many of the same people who had formed the consciousness of the epidemic since the beginning. Not surprisingly, after we'd returned home, bitter unnamed sources in the Administration and

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- **To ensure that state Medicaid programs offer comprehensive benefits packages, including unrestricted access to HIV medications.** Given the important role that prescription drugs play in the lives of those living with HIV, ensuring open access to this benefit will become an increasingly visible and essential component of TAEP's work. TAEP will work to build coalitions to address Medicaid-based prescription drug access issues for people living with HIV and to ensure the inclusion of our concerns in the agenda of national organizations working to address Medicaid-based prescription drug issues. TAEP will develop written materials, including a proposed advocacy agenda for the National Organizations Responding to AIDS, highlighting the important role that prescription drugs play in the lives of Medicaid beneficiaries living with HIV. TAEP activities will include presentations at national and state conferences, trainings, and community organizing, to highlight how measures such as prior authorization, restricted formularies, cost-sharing/co-payments, and limits on the number of prescriptions compromise the health of beneficiaries and undermine the effectiveness of HIV care and treatment programs. TAEP will provide state-based support/technical assistance to jurisdictions facing Medicaid prescription drug benefit reductions and those working to expand drug coverage.
- **To update and provide new tools for the use of our pharmoeconomic model, demonstrating the cost-effectiveness of earlier intervention HIV therapy.** The TAEP model will be updated to address the savings and benefits of Medicaid expansion beyond the Medicaid program. These benefits include, among others, the improved treatment of co-infections, decreased rates of new HIV and hepatitis cases, savings to SSI and other public benefits programs, and increased tax revenues. The TAEP model will be used to work with the

Congressional Budget Office in determining the costs/savings of ETHA and to provide the fiscal basis for state-based 1115 Waivers before the Centers for Medicare and Medicaid Services.

- **To work with states that are implementing approved Medicaid expansion programs to ensure the successful implementation of the programs.** TAEP will work to ensure that states' outreach and marketing efforts maximize the participation of people living with HIV. In particular, we will support efforts that encourage testing and bringing individuals, who are not presently diagnosed or integrated in any care or service system, into Medicaid. TAEP will develop marketing/outreach materials and serve as a clearinghouse for the dissemination of state-designed materials. The primary outreach message will be "Get Tested. Get Care. If you are HIV-positive you can now get free health care coverage through Medicaid."

The Early Treatment for HIV Act (ETHA)

The Early Treatment for HIV Act (ETHA) would allow states to extend Medicaid coverage to uninsured, non-disabled people living with HIV. ETHA represents a breakthrough in assuring early access to care for thousands of low-income, non-disabled people living with HIV. Currently, individuals with HIV must become disabled by AIDS and meet strict income and asset criteria in order to receive Medicaid coverage.

Medicaid is government health insurance, funded jointly by the federal and state governments and administered by state government. States have many options regard-

ing who is covered by the program and what services are provided. Medicaid rules vary greatly from state to state but for most people living with HIV, the path to Medicaid eligibility has been closely tied to strict Supplemental Security Income (SSI) disability rules. These rules reinforce a system where access to care and treatment lag far behind established medical standards of care for treating HIV.

Relatively new HIV/AIDS treatments, such as highly active antiretroviral therapy, are successfully delaying the progression from HIV infection to full-blown AIDS. These advancements have improved both the health and quality of life for many people living with this disease. However, without access to early intervention health care and treatment, these advances remain out of reach for thousands of non-disabled, low-income people living with HIV.

The Early Treatment for HIV Act (H.R. 2063, S. 987)

ETHA is the most comprehensive effort to date to address the early intervention health care needs of people living with HIV. The proposed legislation allows states to readily amend their Medicaid eligibility requirements to include non-disabled persons living with HIV.

The Traditional Medicaid Approach and ETHA's Changes

Income/Asset Limits

Traditional Medicaid eligibility standards have two components – income/asset limits and categorical requirements. In general, Medicaid's income and asset limits

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CORRECTION . . .

In the July/August issue of *The Voice*, Maine was incorrectly identified as a state that has an ADAP waiting list of 85. At one point, Maine's ADAP restricted access and instituted a waiting list for protease inhibitors (PIs) due to a budgetary crisis. However, the waiting list never reached anywhere near 85. Several months ago, Maine lifted their restrictions on PIs due to the approval of their 1115 Medicaid waiver. At that time, Maine was removed from the NASTAD ADAP Funding Watch list. We apologize for this error and any inconvenience it may have caused our readers.

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track SSI limits. Under current Medicaid rules an individual cannot have more than \$2000 in assets, excluding a home (if the individual resides there) and a few other exceptions. There are no specific income limitations for Medicaid eligibility. In many states, however, if an individual's countable income (i.e., income minus any applicable deductions) exceeds the SSI level (approximately \$500-\$700 per month), this will be considered surplus income and result in ineligibility for an equivalent value of medical expenses. So, for example, if a person had countable income of \$1,000 per month, he or she would be presumed to have \$300-\$500 available for medical expenses.

While ETHA retains traditional asset limitations, it allows states to adopt significantly higher income limits. ETHA establishes minimum income guidelines for eligibility, yet allows states to set maximum income limits. In short, ETHA allows states to readily expand eligibility to uninsured, low-income, non-disabled people living with HIV and allows them to both earn income and receive Medicaid benefits.

Categorical Eligibility

In addition to strict income rules, the traditional Medicaid program also requires that people fit into a particular category to be eligible for coverage. People living with HIV/AIDS usually meet this requirement only when they are found to be "disabled" under the strict SSI definition of disability.¹ The SSI definition of disability is "unable to engage in any substantial gainful activity by reason of a medically determined physical or mental impairment expected to result in death, or that has lasted or can be expected to last for a continuous period of at least 12 months." Generally, this means that people with HIV are not eligible until their health has significantly worsened — often, until their disease has progressed to AIDS.

ETHA eliminates the need for people with HIV to meet this dis-

ability requirement by creating a new category of eligibility based solely on HIV status. Under ETHA, from the moment a person tests HIV-positive, he or she meets Medicaid's categorical eligibility requirements.

Scope of Covered Services

As with the traditional Medicaid program, ETHA gives states tremendous flexibility to determine the scope of care and treatment services to be provided. All states must provide the following federally-mandated Medicaid services: inpatient hospital services; outpatient hospital services; laboratory and x-ray services; skilled nursing facility services; physician's services; early and periodic screening, diagnosis, and testing services; and family planning services and supplies.

Federally-optional Medicaid services include the following: prescribed drugs; home health care services; nursing home services and intermediate care facility services; durable medical equipment; private day nursing services; clinical services; podiatry; dental services; physical, occupational and speech therapy; optometrists; and hearing aids.

¹ Non-disabled, low-income parents and children who meet the standards that were in place for the former welfare program Aid to Families with Dependent Children (AFDC) as of July 1996, and certain other pregnant women and children, automatically meet Medicaid's categorical requirements.

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Spotlight on Tennessee

TennCare, Tennessee's current expanded Medicaid program is changing on January 1, 2003.

Under the old TennCare, all those with income under 400 percent of poverty (\$2,952 monthly for one person) were eligible for TennCare if they were under 19; on SSI or welfare; or were medically "uninsurable" (not sold health insurance or Medicare supplement insurance at all, or only sold to at high prices or with harsh preexisting condition exclusions). Even uninsured, "pre-disabled" HIV-positive persons were eligible.

Budget problems have forced the state to cut back eligibility. Those currently eligible for TennCare under the old, liberal eligibility rules will be "grandfathered-in" under those rules for future coverage — IF they apply on time for eligibility re-certification beginning in January. NEW applicants, however, will face much more restrictive eligibility rules.

Those on TANF (welfare), on SSI (which has an income level of \$545 monthly), children in families with incomes under 200 percent of poverty, and those fully disabled patients with incomes below — or whose medical bills reduce their

incomes well below the SSI level — will get "TennCare Medicaid."

A "TennCare Standard" program will be offered to all those "pre-disabled" adults grandfathered in (IF they were eligible under the old liberal rules AND IF they continue to reapply on time) and to newly-applying "medically eligible" (i.e., uninsurable) persons — including both fully disabled and "pre-disabled" HIV-positive persons — under 100 percent of poverty (\$738 monthly).

These two new programs will have two different benefit packages. "TennCare Medicaid" will continue to offer TennCare's old benefits, except that home health visits will be limited to 125 per year and some patients may get higher copays for prescriptions than now. "TennCare Standard" will offer a slimmed-down benefit package resembling private health insurance or HMO coverage — with higher copays and more limited benefits than under present TennCare or an ordinary Medicaid program. As detailed rules are made and become available, the Tennessee Health Care Campaign (615) 227-7500 or www.thcc2.org will make them available to patients and advocates. ■

ADAP Funding Watch

Provided by: The National Alliance of State and Territorial AIDS Directors (NASTAD)

ADAPs provide life saving HIV treatments to low income, uninsured individuals living with HIV/AIDS in all 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, the Marshall Islands, the Northern Mariana Islands, and Guam. Federal funding for ADAPs in FY2001 and FY2002 did not meet the needs specified by state and territorial AIDS programs and is expected to lead to wide spread ADAP access restrictions in FY2002. The Administration's FY2003 proposed budget includes no increase in federal funding for ADAPs—even to address annual inflationary costs.

Due to insufficient resources in FY2001 and FY2002, 12 ADAPs have already closed enrollment to new clients or limited access to antiretroviral treatments (ARVs). In addition, 6 states report the potential need to implement ADAP restrictions in early 2003 based on current funding levels and projected trends in program utilization. ■

ADAPs with waiting lists, client expenditure caps, and/or drug access restrictions¹

Alabama (175)	North Carolina (776)
Guam (4)	Oregon (18)
Idaho	South Dakota (43)
Indiana (34)	Texas (ARV restrictions)
Kentucky (62)	Wyoming
Montana (2)	Washington

ADAPs anticipating waiting lists and access restrictions in early 2003

Colorado	Nebraska
Florida	New York
Georgia	

¹ Numbers in parenthesis indicate the number of individuals on waiting list as of 10/03/02.

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for ADAPs but that falls \$62 million short of the actual need and the House is not likely to act on a bill at all. We are back into a dangerous process of potential long term continuing resolutions that would, in effect, maintain the President's proposal to flat fund ADAPs."

"Our biggest question is where is the Administration?" asked Gary Rose, Public Policy Director of TII•CANN and a member of the ADAP Working Group Coordinating Committee. "We have the support of the Congressional Black Caucus, the Congressional Latino Hispanic Caucus, the American Pacific American Caucus, the Presidential Advisory Council on HIV/AIDS (PACHA), and a number of state congressional delegations and state governors. Will the President acknowledge the acute need for new ADAP funding? I can only hope so. The lives of tens of thousands of people living with HIV may depend on his response."

"Ironically, the Administration, in attempting to save money in the short-term, may cost tax payers more money in the long-term," said Dr. Gene Copello, member of the ADAP Working Group and

Director of Florida AIDS Action Council. "Recent data presented by the University of Alabama at Birmingham at the International AIDS Conference in Barcelona clearly demonstrates that early treatment for HIV/AIDS prolongs life, enhances quality of life, and actually reduces long-term costs of care. The average cost of care for a person with early HIV disease is approximately \$14,000 a year while waiting to treat that person until they are disabled costs about \$34,000 a year. It seems clear that providing appropriate care at an earlier disease stage not only saves lives, families, and communities but actually saves money."

Fears of particularly serious problems for FY 2003 are exacerbated by the expected arrival of new drugs that few programs in crisis are likely to be able to afford. Fuzeon (T-20), the first fusion inhibitor to reach the market, could provide urgently needed support for patients whose anti-retroviral options have run out when it is approved in early 2003. The drug is expected to have a very high price tag, however, due to complexities in the manufacturing process. That price tag could force ADAPs to ignore the need for the drug in their search for means of balancing their

budgets. The second class of drugs that are likely to meet budget walls in ADAPs are the pegylated interferons to treat HCV. While HCV has become the number one cause of death among people with HIV, it is extremely unlikely that even the 11 states now covering pegylated interferon will be able to maintain that coverage while other states will struggle to maintain present formularies and will likely be highly resistant to adding new categories of medications.

State level funding issues are also likely to make matters worse. Most states are facing large and unmanageable deficits in health care budgets for FY 2003 and few are likely to find new funding for ADAPs. In addition, over a dozen states from across the country from New Jersey to South Dakota presently contribute no state dollars to their ADAPs which are forced to rely entirely on federal funding.

The only real hope for ADAPs lies in a renewed commitment by the advocacy community to join together and fight for a solution. In the short-term, that means taking whatever actions are necessary to

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assure that ADAPs are funded at a level appropriate to meet the need.

In the longer term, advocates will have to work harder to agree on and support a permanent solution to yearly ADAP crises, a solution such as the Early Treatment for HIV Act which would provide Medicaid coverage to non-disabled but otherwise eligible people living with HIV/AIDS. "Only by creating an entitlement to medical care for uninsured and underinsured people living with HIV will we ever find a way out of this endless cycle of funding crises," said Robert Greenwald, Director of the Treatment Access Expansion Project.

There are a number of ways individuals and groups can engage in this effort:

- If your organization is not already a member, consider joining the **ADAP Working Group**. The Working Group needs new community organizations to help carry the burden of ADAP advocacy at the state and local level.

For more information on membership, contact Bill Arnold at weaids@ix.netcom.net or see <http://www.tiicann.org>.

- The **AIDS Treatment Advocacy Coalition** (ATAC) works on a wide variety of AIDS treatment issues and has formed an ADAP advocacy network. For more information, see <http://www.atac-usa.org> or contact Ryan Clary at rclary@projectinform.org or (415) 558-8669 x224.
- **AIDSWatch 2003** will be an important effort to build federal support for AIDS programs. This national lobbying effort is held in Washington, D.C. in the spring. For more information, see www.napwa.org/aidswatch.htm or call (866) 243-7282
- For information on advocacy surrounding the Early Treatment for HIV Act, contact Robert Greenwald of the **Treatment Access Expansion Project** at rgreenwa@law.harvard.edu. ■

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While ETHA does not change the scope of Medicaid covered services, any successful early intervention plan must include coverage for medications, including highly active antiretroviral therapy. These drugs help preserve health, and thus reduce other health care costs, such as hospitalizations associated with opportunistic infections.

Legislative History

ETHA is modeled after the successful "Breast and Cervical Cancer Prevention and Treatment Act of 2000," which allows states to provide early intervention access to Medicaid to women with breast and cervical cancer.²

ETHA was originally filed in the House of Representatives of the 106th Congress with sixty-one co-sponsors. Representative Nancy Pelosi (D-CA) and House Minority

² Forty-five states have amended their categorical eligibility requirements to implement this initiative.

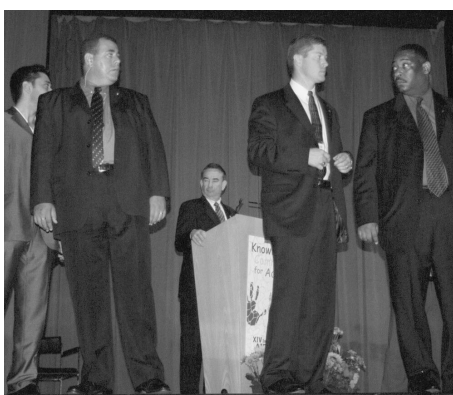
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certain rabid Congressfolk (Representative Mark Souder, chief amongst them) were calling for federal audits of all organizations that participated in the Thompson action. What they don't understand (besides the first amendment) is that the shouting wasn't about Thompson. Most people, in fact, have a pretty good opinion of Thompson and feel that if he were given any latitude whatsoever, the United States might possibly create a coherent and effective national and international AIDS policy instead of its present dependence on right wing platitudes about "abstinence only" and opposition to needle exchange; Luddite, anti-science positions that are more likely to promote the spread of HIV than the reverse. Predictably, in the age of terror, the demonstration was read as an act of disloyalty to the United States (for United States, read the Bush Administration) by pointing out that the emperor had no clothes. In response to the Reagan Admin-

istration's "Just Say No," we now have the Bush Administration's "Just Shut Up."

It seems absurd that this Administration can find hundreds of



billions for tax cuts, hundreds of billions for the military, hundreds of billions for wars on terrorists, and another couple of hundred billion to fight a suspected terrorist, but they can't find a loose \$10 or \$12 billion to fight the most

vicious public health enemy we have ever faced. To then expect people not to take umbrage seems the height of hubris. The fact is that everyone is waiting to make their move until the U.S. makes their move and the U.S. must make a substantial move now. It is simply unacceptable for us to permit 8,000 people a day to die when that could be prevented. It is equally unacceptable that the richest country in the world can't seem to afford adequate health care for its own citizens living with HIV/AIDS (see cover story). We know these opinions won't make us any friends in this Administration but we have the sneaky feeling they don't like us already. At minimum, they would like us to shut up. We respectfully refuse.

For data and reports on the XIV International AIDS Conference, you can look at www.natap.org, kaiser-network.org/aids2002/info.cfm, or for links to many websites go to www.aidsnews.org. ■

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Leader Richard Gephardt (D-MO) were the lead co-sponsors of the bill. Immediately after its introduction, the Presidential Advisory Council on HIV/AIDS and most major national AIDS organizations came out in support of the bill. Time constraints, reauthorization of the Ryan White CARE Act, and election-related activities all worked against securing passage of the bill.

ETHA was reintroduced in the 107th Congress. It was reintroduced in the House by the original lead co-sponsors and with 110 other co-sponsors. The bill now has 152 co-sponsors in the House, and is currently before the House Energy and Commerce Committee's subcommittee on Health. Identical ETHA legislation was filed in the Senate, with Senators Robert Torricelli (D-NJ), John Kerry (D-MA), and Gordon Smith (R-OR) as lead co-sponsors. The Senate bill currently has 11 co-sponsors and is before the Senate Finance Committee.

Conclusion

The Early Treatment for HIV Act addresses a cruel irony in the current Medicaid system—that is, that people must become disabled by AIDS before they can receive the health care that could have prevented them from becoming so ill in the first place. ETHA would bring Medicaid coverage into line with medical standards of care for HIV disease, by providing access to early intervention and treatment. ETHA would also help eliminate the disparities in access to care suffered by many traditionally underserved populations.

By preserving the health of people living with HIV, preventing opportunistic infections, and slowing the progression to AIDS, ETHA could ultimately save taxpayer dollars. If ETHA can garner the bipartisan support needed to become law, the United States will take an important step towards ensuring that all people living with HIV can get the medical care they need to stay healthy for as long as possible.

We need your help. We will be distributing ETHA strategies through TAEP, ATAC, and other coalitions. We will need a tremendous outpouring of constituent support, particularly in Republican House and Senate districts. Please stay in touch with our efforts and be prepared to respond. ■

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This committee has developed a comprehensive grassroots campaign aimed at encouraging Congress to provide a significant increase for ADAP, including letter writing campaigns, district visits, and a lobby day in Washington, D.C.

Membership is open to anyone who meets ATAC membership requirements. You should first join ATAC, then e-mail rclary@projectinform.org for more information about joining SAVE ADAP. ■

Visit T•II CANN's website at
www.tiicann.org.



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