THE VOICE OF T·II CANN

Volume 6 Number 1

March/April 2002

ADAP CRISIS

$82 Million Needed in "Emergency Supplemental Appropriation" to Halt ADAP Deterioration

Nationwide, the AIDS Drug Assistance Programs (ADAPs) face a crisis that could threaten access to HIV/AIDS drug treatments for literally thousands of HIV-positive Americans over the next 18-24 months.

The FY '01 appropriation during the closing year of the Clinton administration was $60 million short of the projected program requirements as calculated annually by The ADAP Working Group. Similarly, the FY '02 ADAP appropriation is short by some $74 million. The federal contribution to ADAP is the heart of ADAP funding, and the sole source of funding in some states.

The ADAP shortfall in FY '02 seems to have been a casualty of an agreement between the White House and Congressional leadership to pass a much delayed Budget Appropriation bill in late December 2002. Many programs suffered in the wake of the final appropriations agreement decided on in the wake of September 11th, and ADAP was among them. The FY '02 process was also complicated by a faltering economy, the Republican to Democratic leadership shift in the Senate, lack of access to Congressional offices due to the anthrax scares in Washington, and a disheartening lack of any broad, coordinated, and visible AIDS grassroots activity to keep ADAP on either the Administration's or the Congress' list of priorities.

The $50 million ADAP increase for FY '02 means that when the funds are released on April 1, 2002, ADAP will be starting with a deficit in the FY '01 program of some $82 million.

The ADAP Working Group in Washington is projecting an increase of $202 million needed for FY '03. Historically, this analysis assumes states' responsibility to provide 20 percent (or $40 million) of the need and the Federal Government to provide 80 percent (or $162 million). However, due to existing unmet need created by inadequate appropriations described above, $82 million of the federal share is needed immediately in the form of an "Emergency Supplemental Appropriation" keep ADAPs running through the summer, fall, and winter of 2002. The balance of the federal ($80 million) dollars would then be included during the regular appropriations process and would become available to ADAPs on April 1, 2003, as usual.

Regardless of the political dynamics, however, those in HIV/AIDS work know that amidst the continuing news of improving drug regimens, increasing treatment choices, and lives saved, the AIDS epidemic still continues and indications remain that some 40,000 Americans continue to be infected each year with the number of people in need of treatment growing apace. Presently, only about one-third of the estimated 900,000 Americans living with HIV are receiving care while at least half of those in treatment are un- or under-insured.

Health insurance continues to be a major difficulty for millions of people unable to access, or to afford, health insurance that includes adequate coverage for treatment of any serious illnesses. People with HIV/AIDS have always been disproportionately underinsured and the programs patched together to help them are increasingly strained. Since Medicaid covers only those already suffering social security defined AIDS and Medicare doesn't cover drugs, it is highly likely that a swiftly growing number of the newly infected will have to utilize ADAP for access to drugs. It must

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Late Breaking News...

Dr. Hank McKinnell, CEO, Pfizer, Inc. and a member of the President's Advisory Council on HIV/AIDS, announced at the first PACHA (President's Advisory Council on HIV & AIDS) meeting on March 15 that as a part of their reaction to the current ADAP funding crisis, Pfizer, Inc. would freeze the price of Viracept (the leading selling protease inhibitor) to ADAPs for a period of two years. It appears other drug manufacturers may follow this lead. More details will be included in the next issue of *The Voice*.

Greater Advocacy Efforts Around ETHA Urged

The Early Treatment For HIV Act (ETHA), would allow states to base Medicaid eligibility on an HIV diagnosis, instead of an AIDS diagnosis, thereby solving one of the most vexing access-to-treatment dilemmas now confronting people with HIV disease. In many cases, people with HIV and AIDS cannot access Medicaid until they become sick and disabled even though earlier access to therapies and other Medicaid covered services would significantly slow disease progression for many patients. The legislation, H.R. 2063 and SB 987, has 145 co-sponsors in the House but only 3 of those co-sponsors are Republicans. In the Senate, five co-sponsors are Democrats and one is Republican, Senator Gordon Smith (R-OR). The lack of additional Republican sponsorship underscores the need for greater communication and outreach to Republicans, as many have publicly supported greater access to HIV-related therapies and services yet have not endorsed ETHA.

“The AIDS community needs to take a more active role in generating legislative support among House and Senate Republicans for a bill that would give states the ability to extend Medicaid benefits to the predisabled with HIV disease,” said Robert Greenwald, Project Director of the Treatment Access Expansion Project, a national advocacy group seeking to secure comprehensive health care access for all people living with HIV. “There is no reason Republicans should not support this bill. Republicans need to hear from people in their districts that they support giving states the option to ensure that people living with HIV have early access to care and treatment,” added Greenwald.

Educating people as to why ETHA is so important, what the savings are to the budget, and what it means in terms of quality of life are clearly key to its passage. In particular, it is important to educate House and Senate Republicans about the measure and what it means for their states and for the quality of life for people with HIV and AIDS.

“No good thing of any consequence ever happens in Congress without inside maneuvering and outside mobilization,” said the legislation’s chief sponsor, Representative Nancy Pelosi (D-CA). “We are powerless without you,” added Pelosi, a member of the House Appropriations Subcommittee, which determines all health-related spending in Congress. “Know your own power.”

Despite the lack of Republican sponsorship, the bill has key Democratic sponsorship in both the House and Senate, increasing the chances that the proposal could pass as part of a larger bill addressing Medicaid funding. Representative Richard Gephardt (D-Mo.), the Democratic leader in the House and an original co-sponsor of ETHA, has “taken a tremendous interest in this,” according to Pelosi, who was recently elected Minority Whip of the House, the first woman to hold that position. On the Senate side, Senator Edward Kennedy (D-MA.), Chairman of the Health Education, Labor and Pensions Committee, and Senators Robert Torricelli (D-NJ) and John Kerry (D-MA), both members of the powerful Senate Finance Committee, also support the bill.

Compelling Arguments

ETHA proponents argue that earlier access to Medicaid services would significantly slow disease progression in many patients, preventing expensive illnesses and hospitalizations and thus saving money in the long run. Under the bill, states would have the option of extending Medicaid benefits to the predisabled with HIV who lack insurance. It would not be a mandate. If passed by Congress, advocates will have to work with their state officials to ensure that they endorse the measure and adopt it.

“ETHA also presents a very strong humanitarian case,” said Pelosi, a member of Congress since 1987 and co-chair of the AIDS Task Force of the House Democratic Caucus. “We have always had the idea that as we invested in the

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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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research and made progress, we had a moral responsibility to make the benefits of that research available to every person — whether he or she could afford it or not," said Pelosi, the only California representative on the Appropriations Subcommittee on Labor, Health and Human Services and Education.

Representative Constance Morella (R-MD), one of three Republican co-sponsors of the measure in the House, agrees, saying "the treatment and care of HIV/AIDS patients far surpasses partisan politics." In remarks to *The Voice*, she called ETHA "good health policy." "It makes no sense to deny access to life-saving medications and to make people wait for health care until they develop full-blown AIDS," Morella said. "We need to amend the law to allow states to base Medicaid eligibility on an HIV diagnosis, instead of an AIDS diagnosis."

ADAP Shortfalls Continue

ETHA has profound implications for the nation's AIDS Drug Assistance Programs (ADAPs) as well. ADAPs provide medication assistance to the uninsured and underinsured, essentially filling in the gaps for Medicaid, Medicare, and other forms of private insurance, and thus playing an essential role in the health care paradigm. However, ADAPs are discretionary, not entitlement programs, and as a result, they must balance patient demand with available resources, an increasingly difficult task in the era of highly active antiretroviral therapy (HAART). In recent years, the advent of HAART has sparked dramatic increases in cost and utilization rates, far outpacing ADAP resources and the ability of the programs to meet patient demand.

ETHA may provide a long-term solution for chronic ADAP shortages. If enacted, patients with HIV disease would spend little, if any time on ADAPs, before qualifying for Medicaid, thus turning ADAPs into ancillary programs and eliminating ADAP shortfalls. ■

Surplus Medications Urgently Needed

AIDS Empowerment and Treatment International (AIDSETI) is collecting urgently needed surplus medications. The organization welcomes donations of the following:

- AZT
- Acyclovir
- Epivir (3tc)
- Stavudine (D4T)
- Combivir
- Sustiva
- DDI Videx
- HIVID
- Viramune
- Hydrea
- Gancyclovir
- All Protease Inhibitors — Agenerace, Crixivan, Saquinavir, Viracept, and Rescriptor
- All classes of antibiotics and Diflucan

They are not accepting any narcotics, anti-anxiety, anti-depressants, or sleeping medications.

AIDSETI, through its HIV-positive led and operated NGOs and treatment programs in Africa and the Caribbean, support HAART treatments from donated surplus medicines collected in North America and Europe.

If you have any questions please contact them at (202) 518-0402 or **www.aidseti.org**.

The following is a reliable drop-off location. We will publish additional drop off locations in the next issue of *The Voice.*

Attn: Jesus Aguais
AID for AIDS
515 Greenwich Street · Suite 506
New York, NY 10013
tel: (212) 337-8043
(212) 604 7243 ext 2769
fax: (212) 337-8045
aid4aids@aol.com

If assistance is needed with mailing medications please contact **AID for AIDS** at aid4aids@aol.com. ■

T•II CANN Offers an Alternate Health Coverage Screening Tool

T•II CANN now has a state-specific summary of alternate health coverage, including Medicaid and other programs that are available to HIV-positive patients.

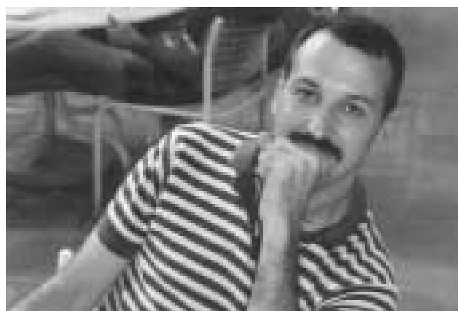
To stretch limited dollars, state ADAPs need to better screen both new applicants and those already covered for the following:

- Medicaid,
- the Children's Health Insurance Program (CHIP),
- VA health coverage,
- state health insurance risk pools,
- state only-medical assistance, and
- a host of other programs.

Materials on alternate forms of health care coverage (and how states can provide even more) is available at www.tiicann.org, www.familiesusa.org, and www.kff.org. In addition, a presentation by Tom McCormack, Public Benefits Policy Consultant for T•II CANN, on the full range of alternate coverages, including how to use T•II CANN's newly-updated alternate health coverage screening instrument, can be arranged through Martin Medical Services. For more information and presentation costs, contact Julia Lam at mmsjel@aol.com or (304) 262-2371. ■

AIDS Advocate and T•II CANN Board Member Mourned

Howard R. Moses, 50, of Topeka, Kansas, who served in the Clinton Administration's Education Department as Deputy Assistant Secretary for Rehabilitation, died Sunday, October 28, 2001, at a Topeka hospital of HIV-related non-PCP pneumonia.



Moses was also an aide to former Kansas Governor John Carlin (D) and former Congressman James Slattery (D); Executive Director of the Kansas Committee on Employment of the Handicapped; Special Assistant to the U. S. Commissioner of Rehabilitation Services; a staffer with the President's Committee on Employment of People with Disabilities; and Deputy Director of the U.S. Equal Employment Opportunity Commission. He played a key role in developing and passing the 1999 "Ticket-to-Work and Work Incentives Improvements Act," which allows states to offer Medicaid to working disabled persons, strengthens their back-to-work benefit protections, and widens their vocational rehabilitation opportunities.

He first became active in disability work after an early diagnosis of cerebral palsy, and remained active professionally even after an AIDS diagnosis. In 1999, *POZ*, a national magazine serving the HIV world, profiled him.

After retiring from federal service in 2000, Moses worked as a consultant on disability, education, and employment; joined the Kansas Department of Social and Rehabilitation Services, where he worked to bring Medicaid to employed disabled persons; served on T•II CANN's board; was active with the Topeka AIDS Project; and worked with the Statewide Independent Living Council of Kansas. Howard "could work inside of the system yet never lose the message of the grassroots advocates, the perfect ADVOCRAT! And he always managed to make everyone feel they came away a winner," says Shannon Jones, Executive Director, Statewide Independent Living Council of Kansas.

The board and volunteers at T•II CANN will miss his energetic spirit.

Survivors include his mother, Mrs. Lorene Moses of Dover, Kansas; his brother, Dennis of Amarillo, Texas; a nephew, Shawn, of Emporia, Kansas; and a niece, Lauren, also of Amarillo.

Memorial contributions may be made to the Emporia State University Alumni Association, Emporia, Kansas; the Whitman-Walker Clinic; or the Topeka Independent Living Resource Center, Topeka, Kansas. ■

Academy of HIV Medicine Offers HIV Accreditation

The American Academy of HIV Medicine (AAHIVM) has started the process of certifying health care providers as HIV specialists, a move that has profound implications for the care and treatment of HIV disease in this country, said R. Scott Hitt, MD, Academy president.

The nonprofit academy, launched in January 2000, has 1,400 members - physicians, nurse practitioners, and physician assistants - who take care of more than 300,000 people with HIV disease, over half of the nation's HIV/AIDS patients. It is offering accreditation to both members and nonmembers of the academy - "all HIV providers we can find who are possible HIV specialists," explained Hitt, chairman of the Presidential Advisory Council on HIV/AIDS from 1995 to 2000. The academy, the only organization in the country to provide HIV specialist credentialing, does not charge a fee for participating in its annual credentialing process.

"Changes in treatment for HIV/AIDS occur more rapidly than any other disease," Hitt explained. "Yearly credential testing is necessary to help HIV medical specialists stay up-to-date with the latest in advancements for the benefit of their patients."

Hitt believes the academy's accreditation process will provide a national standard defining the term HIV specialist, something that has already happened in California. This, in turn, will elevate HIV care to a recognized specialty, enhancing the level of HIV/AIDS care in the country while enabling health care providers to seek higher reimbursement rates based on their status as HIV specialists, according to Hitt. In California, the legislature passed a law requiring managed care companies to provide HIV patients with access to HIV medical specialists. The law, though, did not specify what constitutes an HIV specialist. As a result, Governor Grey Davis proposed a regulation defining an HIV specialist as someone who meets specific criteria or is credentialed by the AAHIVM. The governor's proposal, described as a major victory for people with HIV/AIDS, takes effect on July 1.

"Though it was well intentioned, [the law] hit a brick wall because insurers had no standardized way

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of identifying HIV specialists," said Hitt. "Governor Davis broke through that wall, opening the door to fair medical treatment for all Californians in HMO's living with HIV."

The academy's accreditation process relies on core curriculum topics, educational objectives, self-assessment tools, and self-directed learning guides similar to the ones used by the American Boards of Internal Medicine, Family Practice, and Infectious Diseases. Academy officials mail certification kits to prospective candidates, requiring them to meet the following three objectives to achieve certification:

- they must have a license,
- they must have managed more than 20 patients with HIV disease during the past two years, and
- they must demonstrate continuous professional development on an annual basis.

For further information please call (310) 278-6380 or log on to www.aahivm.org ■

In Brief . . .

Editor's Note: Due to limited space in *The Voice*, the T•II CANN Editorial Committee is often faced with the daunting task of deciding which important information to include in each issue. Since this information is often important to our readers, T•II CANN has created the "In Brief" column to provide this information in a summary format and direct you to the source.

- The new Medicare Medical Nutrition Therapy (MNT) benefit for diabetes and renal disease (pre-dialysis) went into effect on January 1. Although HIV/AIDS is not included as a covered condition at this time, it is expected that Medicare-covered persons living with HIV/AIDS who are diagnosed with diabetes or renal disease (pre-dialysis) will be eligible for the MNT benefit.

  There is a growing body of evidence that nutritional counseling and nutritional support may improve nutritional status in persons with HIV/AIDS. As of FY 2001, the "Grant Application Guidance package for Title I, II, and III of the Ryan White CARE Act" is using a new definition for nutritional counseling. For the first time, nutritional counseling is listed under "Health Care Services" in the "Glossary," and the licensed/registered dietitian is the designated provider of these services. Nutritional Counseling provided by other than a licensed/registered dietitian is under "Counseling Other," and food, meals, and nutritional supplements are part of the sub-category "Food and Home Delivered Meals/Nutritional Supplements" under "Support Services." With this change in definition, HRSA has made it clear that nutritional therapy is part of primary care.

  For more information, contact the HIV/AIDS Dietetic Practice Group, www.hivaidsdpg.org or (202) 333-0945. ■

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be the job of AIDS advocates to ensure that access to care is possible for those who need it. The near-miraculous success of the community-based AIDS response, as funded by the Ryan White CARE Act, must not be betrayed at the point of treatment by saying, "Sorry, we have the medicines, but we can't give them to you right now."

As the problems produced by the American AIDS epidemic continue to grow, AIDS advocacy can not allow two decades of success to be sabotaged by daily events, inattention, today's headlines, or politics as usual. Clearly, national tragedies and urgent global needs must be responsibly addressed. These responses, however, must not be at the cost of shredding the already strained safety net for people living with AIDS that took so many people so long to create.

ADAP offers hope for longer life and improved quality of life for many thousands of Americans living with HIV/AIDS. The statistics speak for themselves. The alternatives to HAART (highly active antiretroviral therapy) are grim and tragically familiar to all of us who were affected by AIDS prior to late 1995 and 1996 when protease inhibitors and combination therapies became available.

Increasing funding of ADAP is a matter of political will and political leadership. We can be successful by making our views clear to the public, the administration, the congress, and the press. We have done it a thousand times before and we will have to do it again in 2002. That means we publicly support local AIDS programs with our time and money and in their local fundraising efforts and we demand action from both our advocates and political leaders in Washington, D.C. and in our state and local governments.

We must all personally and continually contact our state and local political leaders in person, via fax, and by mail. State Legislatures must be informed, educated, and held accountable to their constituents to combat the disease.

We must also speak to our members of Congress - both House and Senate - and must speak to the White House as well. Phone calls. Faxes. E-mails. It's not rocket science. The message must be carried with conviction in 2002.

The power to make the message irresistible must come from grassroots to all levels of political leadership and it must come from a NATIONAL AIDS advocacy effort. This effort will be fueled by Americans currently living with or affected by HIV and AIDS, in the

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AIDS Advocacy — Get Involved Now!

With the current ADAP funding shortfall and the upcoming push to pass ETHA, it is crucial that all *Voice* readers become active advocates for the programs we all rely on. T•II CANN has drafted a letter (to the right) that readers may adapt to include their personal information or opinions and send to their Congressman, Senator, and/or President Bush.

We ask that our readers join us in our plea to the government for emergency supplemental appropriations for the AIDS Drug Assistance Programs (ADAPs), so these programs may continue to provide treatment for low-income, inadequately insured individuals with HIV/AIDS. Also we strongly support ETHA which would give states the option to expand Medicaid coverage to include uninsured, low-income people living with HIV, ultimately allowing them to seek treatment earlier in their disease when it is most effective.

Your representative's name and contact information may be found in the Government Listing section of your local telephone book or by going to the websites: http://www.senate.gov/ for Senate listings and http://www.house.gov/ for the House of Representatives. Letters to the president may be sent to The Honorable George W. Bush, The White House, Washington DC 20500.

Thank-you,
T•II CANN

Dear _______________:

I am writing to ask for your leadership in ensuring access to treatment and healthcare for people living with HIV/AIDS. Specifically, I ask that you support a fiscal year 2002 emergency supplemental appropriation and highest possible funding for FY 2003 for the AIDS Drug Assistance Program (ADAP). In addition, I am asking you to support the Early Treatment For HIV Act (ETHA).

As you know, the AIDS Drug Assistance Program, funded through Title II of the Ryan White CARE Act, provides treatments for low-income people living with HIV/AIDS with no or inadequate health insurance. It is considered a lifeline for many HIV-positive people who otherwise would not have access to therapies. Unfortunately, this program has been underfunded the past two years and is experiencing a fiscal crisis, causing access restrictions in several states. An emergency supplemental appropriation of $82 million for the current fiscal year, and an $80 million increase in the FY 2003 budget is needed to ensure that all state ADAPs can meet the needs of those they serve.

I am also urging your strong support for the Early Treatment for HIV Act (H.R. 2063 /S. 987). This legislation would give states the option to expand Medicaid coverage to include uninsured, low-income people living with HIV. This is a humane and cost-effective bill. It will increase quality of life for people living with HIV, while reducing the cost of emergency care, hospitalization, and treating opportunistic infections. It would also help alleviate the financial burden on HIV/AIDS care and treatment programs (including ADAP) that depend on discretionary spending.

{Insert personal statement here. If you or someone you care about depends on ADAP or would benefit from ETHA, discuss that here}

Finally, as you know, the response to the epidemic must be comprehensive and I urge you to support the highest possible funding for all HIV/AIDS programs. Please do everything in your power to ensure that this health crisis remains a priority.

Sincerely,

xxxxxxxx

Late Breaking News... **The White House Director of the Office of National AIDS Policy, Scott Evertz, has publicly stated that the Bush Administration is now definitely supportive of the principles embodied in the ETHA legislation introduced in both Houses of Congress. *The Voice* will have more details on this development in our next issue.**

Ticket-to-Work Update

Under the 1997 Balanced Budget Act (BBA) and the 1999 Ticket-to-Work and Work Incentives Improvement Act (TWWIIA), states can offer Medicaid with federal support, at small premiums, to working persons with medically disabling conditions (who the Social Security Administration can not consider "disabled" because they are actually working) with incomes up to approximately $44,000 a year (or more, under TWWIIA). TWWIIA also offers states two more options (and even provides extra grants to plan and administer those options over and above the regular matching rate):

- On a demonstration project basis, states can even give Medicaid to "predisabled" workers at risk of full disability, also using similarly generous income rules. However, as of January, 2002 only Mississippi and the District of Columbia (for HIV-positive persons); Rhode Island (for multiple sclerosis patients); and Texas (for schizophrenia and bipolar patients) had successfully applied for such funding, leaving well over $100 million in funds appropriated for this coverage unclaimed and unused by the states.
- States that cover the working, fully disabled can also give Medicaid to those workers who recover from their disabilities while eligible for basic working disabled coverage but still have a potentially serious condition (Arizona, Colorado, Connecticut, Indiana, Kansas, New York, Pennsylvania, and Washington do this, while California, Oklahoma, and Texas are considering doing so.

Any state can take these options. No waiver is needed — and the extra grants can help with state costs.

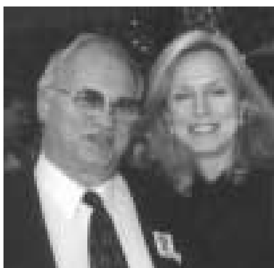
States Offering or Planning Medicaid For Working Disabled With Earnings Income Eligibility Level of $44,000 Yearly or Higher as of January 28, 2002

State Legislation Enacted and/or Approved by CMS (Centers for Medicare and Medicaid Services, formerly HCFA):

Alaska	Washington
Maine[1]	Florida
Missouri	New Jersey
Arizona	Wisconsin
Minnesota	Iowa
Texas	New Mexico
Arkansas	New York
Mississippi	Indiana
Utah	Oklahoma
Colorado	Kansas
Nebraska	Louisiana
Vermont	Pennsylvania
Connecticut	Oregon
New Hampshire	California

[1] Passed law June, 2001 for Medicaid buy-in at up to 300 percent poverty for all self-employed and their families. ■

Community News



This past year, Herbert W. Perry, LPA/EA, founder of T•II CANN, received honorable mention from UNDA – USA for his radio show interview with then National AIDS Policy Director, Sandy Thurman. Herb is the Public Affairs Director for two Infinity Broadcasting, Inc owned FM stations located in Las Vegas, NV. His two radio shows are number one for the targeted listening audience in that time slot.

UNDA – USA, the National Catholic Association for Communicators, sponsors the Gabriel Awards. The association reviews entries they have received for excellence in promoting positive human values in broadcasting at their annual presentation ceremony each year.

Herb has been involved in HIV/AIDS advocacy for over ten years. "I had made a commitment to my son, Steve, that I would do all that I could to help the many individuals who have been either infected or affected by this horrible disease." Herb has done just that by spending many hours of his time and personal finances to help where he can.

According to William "Bill" Arnold, the ADAP Working Group Chair, "Herb has contributed his time and skills to numerous Nevada not-for-profit activities for many years including helping set up several local AIDS service organizations and serving on their Boards of Directors. Since 1996, Herb has participated in numerous Washington, DC AIDS activities ranging from AIDS WATCH (the annual AIDS lobbying day in Washington), supporting numerous ADAP Working Group and T•II CANN work efforts, and has made countless AIDS advocacy visits to members of Congress from his home state of Nevada and many other states. Herb's numerous talk radio programs with an HIV/AIDS focus have been important in raising public AIDS awareness in the Las Vegas and surrounding Clarke County region which is not only the fastest developing area in the United States, but is an area of increasing HIV/AIDS statistics as well.

Herb has more than kept his promise to his son Steve, who was lost early in the epidemic before the development of successful anti-retroviral treatments."

T•II CANN congratulates Herb on receiving this great honor. ■

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Recently, the ADAP Working Group released it's annual pharmacoeconomic model forecasting a need for an increase of $162 million to cover FY 2002 shortfalls and FY 2003 funding under Title II of the Ryan White CARE Act (see main article).

"We knew that uninsured and underinsured, low income, HIV-positive Americans would be in trouble as a result of shortfalls in ADAP funding in the FY '01 and FY '02 budgets. We have been expecting waiting lists and inability to treat patients. We didn't expect to see quite this many stranded patients so quickly. When you forecast carefully, as we do, the numbers indicate that we need these additional funds to provide treatment for 15,135 new patients — for a full 12 months of treatment, if needed - who are unable to access private or public insurance coverage adequate to meet their health care needs. That's beyond the 80,000 patients now being treated each month via ADAP. Recent telephone survey data indicates that several hundred of these untreated patients are lined up already — waiting — and the FY '02 inadequate funding won't even be released until April 1, 2002. This is not acceptable in America. Emergency funds for these people are needed today, not in 2003," said Bill Arnold, long time chairman of the ADAP Working Group, a Washington based advocacy coalition.

memories of the 500,000 Americans already lost to the AIDS epidemic, and on behalf of the millions and millions of their friends, families, loved ones, co-workers, and fellow affected community members.

ADAP requires an increase in federal funding for 2002 and 2003 of a total of $162 million. Eighty-two million dollars of this total must be available as soon as possible in 2002 as an "Emergency Supplemental Appropriation" to help State ADAPs in most severe need. These state ADAPs will need those funds to take actions in the summer and fall of 2002 to prevent closing to new enrollments and other actions which will result in fewer HIV-positive getting access, or getting substandard access to HIV therapies.

We already have many ADAPs closed to new enrollments. We already have many ADAPs with "waiting lists." Do we wait until there are 5,000 HIV-positive people waiting for treatment? 10,000? 15,000? These are our constituents. AIDS advocates must join hands across the entire nation to demand, and insure, that the antiretroviral and HIV disease treatments we finally have are available simply and quickly to EVERYONE who needs them — regardless of personal economic circumstances.

Washington HIV/AIDS organizations will ask for what is needed — but only determined actions at the grassroots can make sure that it really happens. Be prepared to give the help and provide the support when the time comes. ■

CORRECTION

In the Fall 2001 article,"Uses of Viral Resistance Testing Defined," the company name Visible Genetics, the producer of the FDA approved TrueGene resistance test, was incorrectly left uncapitalized.

In addition, while the article which summarized Dr. Bartlett's presentation at the National ADAP Conference stated that the availability of resistance tests would ultimately raise ADAP treatment costs, readers have pointed to a series of studies that suggested that these tests, used correctly, may lower total HIV treatment costs.

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www.tiicann.org.

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