



**The State and Future of HIV/AIDS
Webinar/Conference Call Transcript
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Miguel Gomez: Hello everyone. I'm Miguel Gomez and I'm the Director of AIDS.gov and I want to welcome you to today's conference call/webinar, "The State and Future of HIV/AIDS."

The interest in this call has been tremendous. Space was limited but I'm excited to say that we have nearly 2000 registrants from around the United States. And if you are listening to the call, and only listening to the call and want to see slides, please go to the AIDS.gov homepage. And I want you to know, that's not a necessary step to follow along.

Today you're going to hear from a cross-section of Federal HIV/AIDS leadership. And I really want to thank our speakers in advance because of the work they've done to provide you short and concise statements so we can get to as many questions as possible from you all.

And a reminder, if you want to ask a question, you can send a question to contact@AIDS.gov or later in the call if you want, you can ask a live question by hitting "star" and then the "1" on your phone.

Each speaker today will be announced once the previous speaker has finished. And we're going to start the call right now with a colleague from the VA, Dr. Maggie Czarnogorski. Ma'am, could you start us off?

Dr. Maggie Czarnogorski: Thank you Miguel. The nation has marked 30 years since the CDC reported the first cases of AIDS in the U.S. and is heading towards June 27th, observance of National HIV Testing Day.

In July 2010, the Obama Administration showed incredible leadership by developing and releasing the National HIV/AIDS Strategy. Since then, Federal agencies, along with community HIV/AIDS programs have been called to action.

We are all working to meet the Strategy's goals for implementation, including increased Federal collaboration. This Federal coordination is reflected in this webinar with the participation of leadership from some of the key agencies addressing prevention, care, treatment and research.

The Department of Veterans Affairs works to serve over 24,000 veterans living with HIV. On behalf of the VA, it is a pleasure for me to participate in today's dialogue.

I would now like to introduce Mr. David Vos, Director of the Office of HIV/AIDS Housing at the U.S. Department of Housing and Urban Development.

Mr. David Vos: Great. Thank you, Maggie, and on behalf of HUD, let me thank you for joining us today. This is an important conversation because it involves all of us as we work to help our clients.

At HUD, we administer housing programs that help people who have low incomes, people with disabilities and importantly in this call, helping people with HIV/AIDS achieve an important result, stable housing as a way to access care.

My office, the Office of HIV/AIDS Housing, administers the Housing Opportunities for Persons With AIDS Program. And there's more information on that on the AIDS.gov website. It helps address special needs, housing as an introduction to that care.

I'm very pleased then to introduce our partners in this work, Dr. Ron Valdiserri, Deputy Assistant Secretary for Health of Infectious Diseases at the U.S. Department of Health and Human Services. Dr. Valdiserri, I'd be pleased if you could talk something about the National HIV/AIDS Strategy.

Dr. Ronald Valdiserri: Thank you, David, and good afternoon to everyone. As Maggie noted, though, we are marking the 30th anniversary observance of the first case reports of AIDS. And I think it's also a very important opportunity to note that we are approaching the year anniversary of last July 13th when the President released the National HIV/AIDS Strategy.

And I hope that all of you have had an opportunity to read the HIV/AIDS Strategy. If not, you can also find it on AIDS.gov. But a few points. I'd like to just clarify the major goals of the Strategy. But before I do so, it's important to point out that this is not a - merely a Federal strategy, so certainly we're all Federal employees and we're all excited and enthusiastic about our role, but it's very important to remember that all segments of society need to join in and work together in order to achieve the vision of the National HIV/AIDS Strategy.

Now the Strategy has three very specific and important goals. The first one is to reduce the number of new HIV infections, increase the number of people who know their HIV serostatus and reduce the transmission rate of the virus.

And in order to accomplish that goal, the Strategy speaks very eloquently to the need to intensify HIV prevention efforts in communities where the virus is most heavily concentrated and to be able to implement combinations of effective evidence-based approaches.

Now in addition to those highly targeted efforts, the Strategy also reminds us that all Americans need to be educated about the threat of HIV and how they can prevent it.

The second important goal of the Strategy focuses on increasing access to care and improving health outcomes for people living with HIV. And what this particular

goal of the Strategy highlights is the importance of linking people who have been diagnosed with HIV into continuous high quality care in a timely manner.

Furthermore, this particular goal of the Strategy notes that we - all of us have a need to increase the number and diversity of available providers, and I don't just mean doctors and nurses, but I mean pharmacists, dentists, social workers, psychologists, community health workers, all of the vast array of healthcare and social service providers who come together to provide care for people living with HIV.

And as David Vos mentioned a few moments before I got on the line, the Strategy also identifies housing as an extremely important service, a way in fact, to make sure that people with HIV stay healthy by ensuring that they have access to stable housing.

And the third goal of the Strategy is also an extremely important one, especially to those of us in the Office of the Assistant Secretary for Health, and that is to address the disproportionate impact that HIV/AIDS has on certain racial and ethnic and certain behavioral groups, and by reducing HIV related health disparities, by looking at very carefully and intervening to reduce HIV-related mortality in communities that are at high risk for HIV infection, we are reminded also as we read about this particular goal, how important it is to adopt community level approaches to reduce HIV infection.

And certainly the Strategy notes that we have to continue as a society, and again here's where it's very important to realize we're not just talking about the Federal workforce, but all of society, must work to reduce stigma and discrimination against people living with HIV as well as people who are at risk for HIV.

Mr. Gomez: Thank you Ron so much for that and I know there'll be some questions about the Strategy. We're going to turn next to Dr. Carl Dieffenbach, the Director of the Division of AIDS at the National Institute of Allergy and Infectious Diseases at NIH. And he's joining us here on behalf of Dr. Tony Fauci. Thank you, Dr. Dieffenbach.

Dr. Carl Dieffenbach: Thank you, Miguel. I think it's important that we, as a nation, take a step back and look at where we have been with AIDS science over the past 30 years, realizing that on June 5, 1981, the first cases of some very interesting and unexpected infections in young men were reported.

Since that time we've defined the etiology of the disease. We've defined HIV as the causative agent. We've been able to develop successful diagnostic techniques. We've developed an understanding - complex and complete understand of the molecular biology and epidemiology of HIV disease.

Ultimately we have been able to develop successful therapeutics and that is the fundamental crowning glory of the work of the past 30 years where we have taken essentially a defined and definite death sentence for somebody diagnosed with HIV in 1981 to a point today where it is a treatable, manageable chronic disease.

However, moving forward, we are still not done. This past year has seen significant improvements and breakthroughs in the area of HIV prevention with the first positive signal from an HIV vaccine, a validation of pre-exposure prophylaxis as a means of preventing HIV transmission and the first signal of a positive result in a microbicide trial which is used to prevent sexual transmission between men and women.

Going forward, there're three key research goals that we really need to continue to focus on as a nation and as - on a global community.

First is we need to continue to optimize the treatment and care of HIV infected individuals. Even with the life-saving drugs today, there are consequences of long-term treated HIV disease that we need to understand and figure out how to deal with because as more and more treatment is initiated, not just in the United States but globally, this will be an expanding part of dealing with this epidemic.

Secondly, we - as Dr. Valdiserri pointed out, one of the key goals of the National HIV/AIDS Strategy is reducing new HIV infections through the development and implementation of prevention methods that are evidence-based.

That's what the NIH is about, is providing those tools. And as such, we have made progress on pre-exposure prophylaxis, microbicides and working toward an HIV vaccine. Ultimately we will need to combine new modalities with existing behavioral and instructional interventions to really have a profound impact on the epidemic.

And our reach goal - our long term goal as a research question, is can we cure HIV infection? Can we establish a situation where an individual no longer needs to take daily antivirals but essentially is in a disease-free state whether as a functional cure where the body's own immune system keeps the virus in check or we've actually achieved eradication?

In the end, in order to fully control and curtail and ultimately end the HIV epidemic, as a society we're going to need to be able to optimize the detection of newly infected HIV-infected people and maximize their treatment and care. We're going to need to be able to prevent new HIV infections and cure HIV infections. So I think I'll stop there and move on.

Mr. Gomez: And we're going to move on to Dr. Deborah Parham Hopson from HRSA, the lead manager for our Ryan White Program and we're going to talk about care. Ma'am.

Dr. Deborah Parham Hopson: Thank you, Miguel, and good afternoon everyone. The Ryan White HIV/AIDS Program is a Federal program that provides funding for treatment and other services for people living with HIV and AIDS in the United States who do not have sufficient healthcare coverage or financial resources to pay for their care.

This program fills gaps in care not met by other payers and serves about a half a million people each year. Ryan White funded programs are located in each state and in many cities around the country.

There are many healthcare services that the Ryan White Program provides such as outpatient and ambulatory health services, oral healthcare, mental health and substance abuse treatment services, medical case management and medications.

The program also pays for support services such as respite care for persons caring for people living with HIV. The Ryan White Program also supports the AIDS Drug Assistance Program or ADAP.

As the name indicates, ADAP funds provide access to life-saving medications for Ryan White patients. We've recently highlighted an increase in funding of \$50 million for ADAP in fiscal year 2011. This is on top of the \$835 million that is also available, for a total of \$885 million this fiscal year.

This will allow us to improve access to ADAP drugs and help reduce the waiting list down from the current national level. One great thing about the Ryan White Program is that we serve anyone living with HIV or AIDS who is not able to pay for their own care including women, adolescents, men who have sex with men, transgender individuals, people who abuse drugs and others.

The Ryan White HIV/AIDS programs are critical to the success of the National HIV/AIDS Strategy, specifically the Ryan White Program continues to increase access to care and improve health outcomes for people living with HIV.

And in an effort to reduce health disparities, the majority of people served by the Ryan White programs are racial or ethnic minorities which is another goal of the National HIV/AIDS Strategy.

In 2013, the Ryan White HIV/AIDS Program must be reauthorized. The Department of Health and Human Services is committed to reauthorizing the Program so that services will continue uninterrupted for our clients.

We are all looking forward to 2014 when additional provisions of the Affordable Care Act become effective. We anticipate that at that time some people living with HIV and AIDS will become eligible for Medicaid and may no longer need Ryan White funded services.

However, we know that even in 2014, the Affordable Care Act will not solve every problem. Therefore, we expect that the Ryan White Program will continue after health care reform is implemented in 2014.

I'll stop there and turn it back to you, Miguel.

Mr. Gomez: And thank you for referencing the Affordable Care Act because we're going to turn to Mr. Richard Sorian and Richard is the Assistant Secretary for Public Affairs who's stepping in for Mayra Alvarez from the Office of Health Reform who's literally in the air right now. So we want to thank Richard for stepping in.

And Richard, could you please tell us how the Affordable Care Act is helping people living with HIV/AIDS?

Mr. Richard Sorian: Certainly. I'd be pleased to and it's an honor to be on this call with my colleagues and want to thank them for their work. A couple of things are going on. For too long, vulnerable people, particularly people with existing conditions like HIV/AIDS have been either locked out or priced out of the health insurance market.

Now Medicaid, Medicare and the Ryan White CARE Act have helped to create a safety net of coverage for millions of people living with HIV/AIDS. But millions of others have to live without health insurance. Currently only 17% of people living with HIV in the United States have private health insurance and nearly 30% or almost one in three people living with HIV/AIDS have no health insurance of any kind.

And to be blunt, for many people living with HIV/AIDS, not having health insurance can be a matter of life or death. It's a matter of being able to get the care you need, the drugs you need, the physicians and other care that you need or not.

So the Affordable Care Act seeks to make changes in this broken healthcare system in some pretty dramatic ways. And some of the benefits have already begun to take effect. The President signed this bill into law last March. And it's being phased in over several years. But I want to focus quickly on the things that are happening already today.

First of all, beginning last year, children with pre-existing medical conditions, including HIV/AIDS can no longer be denied coverage. Insurance companies can no longer say, "I will not ensure your child because of their health condition."

Adults with these kinds of conditions now have access to a state based program called the Pre-existing Condition Insurance Pool Program or PCIPP. We always have to have an acronym if it's a government program you know. And those programs are providing people with an opportunity to get insurance between now and 2014 when the more comprehensive insurance reforms take place and people have even greater access.

Third, people with Medicare which is a major source of coverage for people with HIV/AIDS are getting help with very high prescription drug costs. The Medicare prescription drug benefit has a gap in the middle that is often referred to as the doughnut hole, during which time people with Medicare have to pay the entire cost of their drugs and for very expensive drugs like many of the drugs for AIDS.

That's a very big cost and often resulted in people skipping medications or trying to make them last longer by cutting pills in half, all those kinds of things that we know aren't good for people.

Last year, anybody in the Medicare program who reached the doughnut hole received a one time tax-free check for \$250. And that's not a lot of help but it's some help that people were able to use to pay for some drugs.

This year the assistance is much greater. Anybody who reaches the doughnut hole are getting 50% discounts on brand name drugs purchased while they're in the doughnut hole, half price on brand name drugs and that includes all of the drugs that are used to treat HIV/AIDS. So that's a significant benefit.

And finally we're working with states to help them expand Medicaid coverage to people living with HIV/AIDS in advance of the 2014 expansions of Medicaid that occur across the country.

So a couple of things that I was able to pull together on these - what kind of impact are these benefits having? You know, are they really getting to the people who need them? So one question is on the PCIPP, the Pre-existing Condition Insurance Pool Program.

Right now there are about 21,000 enrolled in these programs across the country. The number is growing pretty quickly but it still needs to grow a lot more. There are a lot of people without insurance who could benefit from this program.

But already 3% of the 21,000 people are people diagnosed with HIV/AIDS. These are people who have had no health insurance and now have insurance. So one of the things we all need to do is promote this program, and there is one in every state, to people living with HIV/AIDS who don't have health insurance because they can get affordable coverage in these programs for a price that's much less than paying for their care out of pocket which they have to do without insurance.

And then finally on the Medicare benefit that I mentioned, the 50% discounts on drugs while you're in the doughnut hole, already until now, about 32,000 people with Medicare living with HIV/AIDS have received discounts on their drugs when they're in the doughnut hole.

And the savings to them have average \$500 a person, or twice as much as the savings last year. And this year those savings will grow as their medical bills and their - rather their prescription drug bills continue to grow.

So real money back in people's pockets and more importantly, the ability to continue with their treatment. That keeps the healthy, that keeps them well and allows them to live their lives fully.

That doughnut hole will be closed bit by bit each year so the assistance grows every year until the end of this decade. There will no longer be a doughnut hole. So those are the benefits that people are able to access right now.

Mr. Gomez: And Richard, I know we're going to have more questions I'm sure on the Affordable Act Care, asking the questions that are coming in, so I'm actually going to come back to you sir. And I'm going to jump to our colleague, Dr. Mermin from the CDC who's going to actually talk about where we are with the epidemic, where we're going and also highlight the fact that June 27th is National HIV Testing Day. Dr. Mermin.

Dr. Jonathan Mermin: Thank you Miguel and good afternoon. So 1.2 million people are living with HIV in the United States. And this number's risen every year because incidence is relatively stable and survival has increased with the success of anti retroviral therapy.

There're about 56,000 new infections per year and about 17,000 deaths among people with AIDS. We have a net increase of about 40,000 people living with HIV each year.

The stable number of new infections each year also reflects a partial success of prevention as incidences remained about the same even as the number of people with the potential to transmit HIV has grown.

HIV highlights health disparities. About 95% of the people in the U.S. who are living with AIDS are either men who have sex with men, African American, Latino or injection drug users. MSM are more than 40 times more likely to have HIV than other men and women.

African Americans are eight times more likely and Latinos are three times more likely to have HIV than white Americans. And the burden of the epidemic is not evenly distributed across the country. There's a disproportionate geographical impact especially in the south, northeast and west.

Fifty-four percent of the people living with AIDS are in just five states and 90% are living in 23 states. HIV prevalence rates are also inversely related to socioeconomic status with lower household income and education, lack of employment and homelessness associated with higher HIV prevalence.

In some ways, HIV is a quintessential issue of disparity. This is why many of us work in the field and it's why we will never achieve true HIV prevention success without striving for health equity.

So what can we do for HIV prevention? As Dr. Valdiserri already discussed, the National HIV/AIDS Strategy provided us directional guidance including the need to increase awareness about the importance of HIV to the nation.

People's lives are on the line and it makes economic sense. The medical costs for the people with HIV in the country is over \$20 billion per year. At the same time, we need to reduce complacency. The proportion of Americans who rate HIV as the most urgent health problem for the nation has reduced from 44% in 1995 to 6% in 2009.

And we need to encourage action from all of us. We should use science and socioeconomic data and not fear prejudice and opinion to target resources and choose interventions. We should continue to expand HIV testing. More than half of American adults have never been tested for HIV, yet testing is the lynchpin for HIV prevention and treatment.

Without knowing one has HIV, a person can't access HIV-specific care including antiretroviral therapy. And knowing one has HIV greatly reduces risk behavior and the chance that a person will spread the virus to others.

CDC and health departments recently completed the first three years of the expanded testing initiative. As part of the initiative, 2.7 million tests were conducted. Sixty-two percent of participants were African American, 15% Latino and more than 17,500 were newly diagnosed with HIV.

This testing program was successful, linking thousands of people to life prolonging care, averting thousands of infections and saving the health system money for every dollar invested.

Now a critical opportunity for highlighting the importance of HIV testing and care will be on National HIV Testing Day, which as Miguel mentioned, is on June 27th of this year. Thank you.

Mr. Gomez: Thank you so much sir. Really appreciated that. And now we're going to turn to our last presenter, Mr. Jeff Crowley, the Director of the White House Office of National AIDS Policy. And we really appreciate, as Jeff's comments are really going to focus on an important meeting that happened in New York at the UN last week, but also talk about the important partnership between domestic and international programs. Mr. Crowley.

Mr. Jeffrey Crowley: Thank you, Miguel, and it's a pleasure to join all of you. You know, as I begin, I just want to state for you, you know, President Obama is deeply committed to building on the important successes we've had both domestically and around the world in responding to the HIV/AIDS pandemic.

So as Miguel mentioned, last week I had the honor of participating in the United States delegation to the United Nations High-Level Meeting on HIV and AIDS. And that was a very important meeting where world leaders made new commitments regarding the global response to HIV and AIDS and really setting new targets to be met by 2015.

So while I was there, I participated in the launch of a new global plan to work toward the elimination of new HIV infection among children and really working to keep their mothers alive. This was a session that, you know, the UN Secretary General Ban Ki-moon was present, President Clinton, and other high-level leaders were there with Ambassador Goosby, our Global AIDS Coordinator.

I also participated in a session on looking at the integration of HIV and disability, another very important issue. And I joined Ambassador Goosby, Dr. Fauci, who's the Director of the National Institute on Allergy and Infectious Disease and Lois Quam, who's the Director of our Global Health Initiative, for an event on saving lives: America's response to HIV and AIDS.

So a lot of really important work is taking place at the United Nations but I also want to make sure that as this call is mostly focused on domestic issues, people

understand there's really strong and unprecedented leadership that the United States is planning to respond to the global pandemic.

You know, through the PEPFAR, the President's Emergency Plan for AIDS Relief, that was established by President Bush and strongly support and continued by President Obama, the United States is literally saving the lives of millions of people living with HIV around the world.

PEPFAR is supporting more than 3.2 million men, women and children on life-saving treatment and that's up from approximately 1.7 million in just 2008. In 2010, PEPFAR also supported 11 million people in care, including 3.8 million orphans and vulnerable children and again in 2010, the PEPFAR program's reached over 600,000 mothers' services to prevent mother-to-child transmission leading to more than 114,000 infants being born HIV-free in 2010 alone.

Now additionally last month I also participated in the PEPFAR Annual Meeting in Johannesburg, South Africa. And while my work is largely focused on domestic, I went to this meeting because I think it's really important that a number of policymakers are focusing more on the integration of domestic and global responses to HIV and really learning from each other.

And one of the things that was striking is how we're all dealing with the same sets of issues. It's really about following the epidemiology and making sure we're tailoring our responses to the epidemics we have in our own countries, in our own communities, really coming up with the best combinations of prevention and interventions, recognizing that as it's been mentioned on this call, we have a lot of great tools and it's really about putting them together and maximizing their effectiveness.

And as Dr. Dieffenbach mentioned, another key goal is really about optimizing treatment. So we know that we have great treatments but, you know, it's really important that we get to maximum effectiveness of great therapies and that involves a series of steps for making sure everybody learns their HIV status and is tested, you know, has got into care, is put on therapy when it's recommended.

And so all of these conversations are playing out both domestically and globally. And I'll just end by saying that we continue to have very serious challenges but so much is happening and it's a really exciting time to work on HIV and AIDS and I just hope all of you know that your Federal government is just determined and committed to responding as forcefully as possible to the serious pandemic. And I'll turn this over - back over to you, Miguel.

Miguel Gomez: Thank you Jeff. And thanks to all my Federal colleagues who presented. So let's get started with the question and answer portion of today's call. And I want to remind people, if you want to ask a live question, press "star" and then the number "1" on your phone. And I also want folks to know, as Jeff highlighted the importance of our international work, we have Mr. Thomas Walsh, from the Office of the Global AIDS Coordinator, Department of State, on the line with us to help answer questions.

And your questions are coming in fast and furious. As people queue up for a live question, I have a question for Dr. Dieffenbach. We've got lots and lots of questions coming in around a cure and we have Timothy from the University of Buffalo, a Ph.D. student, who asks, after 30 years are we any closer to finding a cure or a vaccine?

And I know you highlighted some of these issues earlier, but I'd like you to reinforce - because we're getting so many questions about a cure - and from - a colleague from Veterans Affairs, we have a question. Is there a person who has been cured? If you could just answer those questions, sir, I'd appreciate it.

Dr. Dieffenbach: Sure. I'd be happy to. So I did mention the fact that we've had an additional signal on the vaccine side. So there is a proof of concept for an HIV vaccine. But I'd also like to point out that there also has been a proof of concept for a cure of an HIV-infected person.

This person received a stem cell transplant and was being treated for leukemia. And while this is not practical for every day use, this does provide at least a sense of a roadmap for how a cure could be achieved.

I'd like to remind everybody that there're still two pathways potentially to a cure. One is eradication and one is establishing control of the HIV infection within an individual.

Those people also exist already. The group at the Ragon Institute at Harvard refers to them as elite controllers. And those individuals have very low viral load, do not progress in their HIV disease and have no viral load.

So we have in many ways a sense of what it would take. It's a matter of now building tools and building agents that can be attempted in trials and make progress toward a cure or a functional cure.

Mr. Gomez: Well, thank you so much. And I'm going to ask the operator if we have any live questions.

Coordinator: Yes we do. Our first question comes from Gloria Steelman.

Mr. Gomez: Gloria, please. Ms. Steelman, are you there?

Ms. Steelman: I'm sorry. I didn't have a question. That was a mistake. I pushed that button.

Mr. Gomez: No problem. It's good hearing your voice. Operator, is there another question?

Coordinator: Josslyn, with the University of Miami.

Mr. Gomez: Hello from the University of Miami.

Josslyn: Hi. That was also a mistake. I apologize.

Coordinator: Samantha Ross Russell. Samantha Ross Russell.

Mr. Gomez: Well, we're getting a lot - while people queue again by hitting the "star" and number "1", we are getting a lot of questions being sent in on email. And a lot of questions about Ryan White Program, many, many questions about the National HIV/AIDS Strategy.

And we have a question from California. Finally there is a National HIV Strategy. How can we meet the goals set forth in the strategy when funding seems to be leveling off or decreasing? And also from Anaheim, how can local communities thus implement the goals of the National AIDS Strategy. Mr. Crowley, would you like to start that?

Mr. Crowley: I think we all weren't decreasing our funding. We've been increasing it. So every budget, you know, the President Obama has proposed - he's proposed increases. But even in the current fiscal year, you know, a couple months ago there was a negotiation over a continuing resolution in a very difficult time where a number of programs took very significant cuts.

We were able to achieve a \$50 million increase in funding for the AIDS Assistance Program, a very strong sign of our commitment to addressing the challenges with waiting lists.

We also, though, at a time when the CDC's budget was cut by roughly \$740 million, we're actually increasing our investment in HIV prevention by \$31 million this year.

So at least at the Federal level we are trying to increase our resources. But, you know, to some extent, it's really more than about money. We will spend about \$21 billion in responding to the domestic HIV epidemic this year.

And any increases we achieve and we receive in that context will be really minimal. So our biggest impact really comes from making sure that this much larger pool of money that ongoing investments we're already making are really focused and having the biggest impact.

So again, to achieve the Strategy's goal, we need to make sure that we're investing in the right interventions, the ones that are designed to - if we're talking about preventing infections, to lower incidence, talk about care, get people into care.

Key recommendations are that we need to recognize we have a series of concentrated epidemics in the United States so we really need to target our resources effectively to the cou- to the communities and populations at greatest risk.

Now there's a question about how local municipalities can help implement the Strategy. And, again, I think there're these key messages in the Strategy. Look at the local epidemic where you are. Who are the groups and populations, the geographic

areas hardest hit and target your resources effectively there, develop the best combinations of interventions.

In some cases this might mean changes and it could produce political challenges or others but we've really got to rely on the best evidence to get the biggest impact.

But for governments thinking about it and especially local municipalities, I think we really want to focus a lot of our efforts on integrating our efforts, integrating both prevention and care resources, public resources with private resources, integrating what's happening at cities and local levels, with state governments.

So there's a lot of work we can do but it's really about taking advantage of the current investments we're making and really trying to integrate them so we can get a bigger impact for what we're currently doing.

Mr. Gomez: Thank you so much sir. I'm going to be brave and try and take another live question. Operator?

Coordinator: Stephanie Curts.

Mr. Gomez: Stephanie, are you there ma'am?

Woman: I'm thinking that was an accident.

Mr. Gomez: Okay, I'm actually going to - there's a - lots of questions, Dr. Parham, about getting more information about what the government specifically is doing for issues around their ADAP and our ADAP waiting list. Also you did highlight the fact that the support the Administration has for the Ryan White Program. But there're enough questions coming in about that, if you would repeat what you said earlier.

Dr. Parham Hopson: Sure. Thank you for those questions. There are 13 states that do have waiting lists for the ADAP Program. What that means is that the programs have identified people who are living with HIV, who qualify for assistance under the AIDS Drug Assistance Program but they do not have funds to support them under ADAP.

But while they're on the waiting list, what we do is we work with them to make sure that these people have access to medications. So while they're waiting for the program, they do have access to medications, oftentimes through pharmacy assistance programs.

So that is one very concrete we do to try to make sure that the people who are living with HIV and are waiting for the ADAP program do have access to medications.

We give out grants to each of the states. We fund each of the ADAP programs and we will be giving out the \$50 million that I'd mentioned earlier that we have to support and give extra money to states that have waiting lists or cost containment strategies in place for their ADAP program. We anticipate giving out those dollars later this summer.

In terms of reauthorization, what I said was that the Ryan White Program must be reauthorized in 2013. It was last reauthorized in 2009 for four years so in 2013 it must be reauthorized. The Department is very committed to reauthorizing that program and so we will work with the Congress to make sure that that happens.

Mr. Gomez: Thank you so much ma'am. I'm going to try one more time to see if we can get a live question. Operator?

Coordinator: Jeff King.

Jeff King: Yes, hello. I believe Dr. Hopson answered my question partly but I was wondering with the increased funding that Mr. Crowley mentioned, if we could begin to see an end to the ADAP waiting list that we see, and for example, over 3000 waiting clients in Florida.

Dr. Parham Hopson: There are over 3000 on the waiting list in Florida. And yes, we do anticipate that the additional \$50 million will help to address that. But as I also said, each state gets money through the Ryan White Program. The State of Florida will get money, including money for their ADAP program that's separate and apart from the \$50 million.

So we do think that with the assistance that we're giving to Florida, they will begin to decrease the number of people who are on their waiting list.

Mr. Gomez: Well thank you, Deborah.

Jeff King: Thank you so much.

Mr. Crowley: This is Jeff. Could I just amplify on that in a couple of respects? So, you know, the way we look at this problem is, you know, ADAP is funded by the Federal and state governments. And so we're currently in a situation where the Federal government's increasing resources while the states are decreasing their resources.

And our view is that we need to - the continued investments at both the Federal and state governments. So we encourage states to continue their investments in these programs. We're also calling on the private sector including the pharmaceutical companies to help us step in and we've been appreciative of the support that's been offered to date.

I would also not that this, thankfully, is a short term problem we believe because the Affordable Care Act, which will greatly expand access to insurance coverage for people living with HIV, really should take a lot of pressure off this in 2014.

So luckily we have a longer term solution and it's really about coming up with a temporary solution until we get to 2014.

Mr. Gomez: And Jeff, I'm glad you bought up 2014 because questions are coming in about the Affordable Care Act. And I'd like to actually ask Richard to share a little bit more

about the Affordable Care Act and what it'll offer for all people but including people with HIV beginning in 2014. Sir?

Mr. Sorian: Sure. Well we talked a little earlier about the broken insurance we have now. In 2014, there'll be a new competitive insurance marketplace in which health insurance companies will actually be required to compete with each other based on two things - one, the price that they charge for their product but two, more importantly the quality of their product.

Are they really providing good benefits and paying for care when it's necessary, helping people stay healthy, helping other people get healthy? So that marketplace begins in 2014 but we're kind of ramping up to that now.

One big thing, I mentioned earlier that today insurance companies can't refuse to sell a policy to a family for their child who has a pre-existing condition. In 2014, that goes across the board. Insurance companies will be prohibited from excluding anyone, a child or an adult, from coverage because of a pre-existing condition. So they can't block people out.

Second, affordability. We can, you know, if you have access to insurance but you can't afford it, that really doesn't help matters. And the average cost of insurance policy right now for a family of four is over \$13,000.

Individuals and small business owners and individual families will be able to buy insurance in these new exchanges which are the web-based and places where you can go to shop for the best price and the best quality. And people will be eligible for tax credits.

Anybody who earns between about 133% of poverty which is about \$14,000 to 400% of poverty which is somewhere over \$85,000.

They'll be eligible for sliding scale tax credits. So bigger tax credits to people who make less and smaller to those who make more, but some assistance for millions of people.

And then small businesses, which often are the hardest pressed to buy insurance for their workers and for themselves, they'll get tax credits of 50% of the cost of coverage. So we really will see a tremendous increase in the number of people with private health insurance.

At the same time, Medicaid eligibility will be expanded to include anyone with income up to or below 133% of poverty, so under \$14,000 a year, Medicaid will cover people and states will be required to open the program to them and that will include women and children and for the first time in many states, childless adults who generally are not eligible for Medicaid in many states.

So we believe that if you take these reforms, together with the Ryan White Program and other programs that have helped to support people with our current system, we will have a real foundation of coverage for people that will be affordable but also

they will own their coverage. They won't be able to have it taken away from them or priced out of the market.

So I think those are the reforms that we're working toward and I think we're making good progress towards getting there.

Mr. Gomez: Sir, thank you so much. And it's a good time to let everyone know who's listening or following the webinar that later this month, at the beginning of next month, we'll actually have a transcript of today's call and also you'll be able to listen to an audio file of this call.

As I know a lot of information is being put forward and I know we have more people on the line wanting to ask questions, so operator.

Coordinator: Thank you. African American Health Program, Silver Spring, Maryland.

Woman: My question is related to the fact that I don't know how the government can support at the community level in terms of getting more of the private providers to offer the same thing to their clients because when they come out to the community centers, some of them do say that they have health insurance but that their provider does not offer it.

So I don't know if there's anything that the government can start to consider in terms of encouraging more of the private providers to offer HIV testing. Thank you.

Mr. Gomez: Well thank you. And I'm going to ask Dr. Mermin to respond to the question.

Dr. Mermin: So thank you for the question. It's a very important issue for the nation and for all of the agencies on the call. In 2006, CDC issued guidelines that recommended the routine offering of HIV testing to people between the ages of 13 and 64 in clinical situations because the vast majority of people, when offered an HIV test as part of a routine service in clinical care will say, "Yes, I'd like to be tested for HIV."

And we've seen very positive results in terms of both uptake and diagnosing people with HIV who did not know that they had been infected. However, you do cite appropriately that not all people in the private sector or even the public sector are actually implementing these new guidelines.

And there are a variety of ways that we would like to expand on testing in the nation. Some of them are through specific initiatives like our expanded testing initiative. Some of it is through the resources that CDC and others provide to state health departments to increase testing in their communities.

And we need to couple the routine offering of HIV tests - testing as well as targeted testing for people at higher risk, like MSM. Of important note, the routine offering of HIV testing is not only a good thing in terms of care because people can access treatment but it's also good in terms of prevention.

People with HIV who find out that they have HIV reduce their risk behavior, thus protecting others from infection. It also highlights the linkage between prevention services and care services. So essentially bringing more people into the Ryan White system and accessing care through other mechanisms also supports prevention.

Mr. Gomez: Thank you, sir. And actually we have another question from a CDC staff person asking if we can highlight some of the ways we can further include people living with HIV/AIDS into our prevention and intervention work. That's from Tracy.

Dr. Mermin: Well, it's an important question. In all aspects of HIV activities, the involvement of people with HIV makes those activities better and I think HIV has set the standard for many other areas of public health and even other aspects of activities throughout the nation.

So you'll find involvement of other people who are affected by certain illnesses, whether it's breast cancer or cardiovascular disease, in some of the decision making process.

So whether it's research and the oversight committees that help decide what are the priority areas to conduct research or whether it's programs, what are the priority populations and interventions that we should be implementing. Having people with HIV involved is a critical aspect of those activities.

And so CDC really does prioritize that. One area that we are able to do that is through community planning and ensuring that the activities that we support do include people with HIV. The other is that the decision-making process that we are involved with at the Federal level also involves people with HIV and continually reminding people that it's the entire nation, including people with HIV, who are in prevention and care for the long haul.

Mr. Gomez: Thank you sir. I know that's true across our other Federal programs.

Dr. Valdiserri: Miguel, this is Ron. I'd like to add a comment.

Mr. Gomez: Oh please sir.

Dr. Valdiserri: I'd like to add a comment to that. Not only is it important in terms of what Dr. Mermin indicated but I think to come back to the issue of stigma and stigmatizing people with HIV/AIDS and discriminating against them. I think that the Strategy very clearly identifies the leadership of people living with HIV and AIDS as a very important component of the equation for confronting ongoing stigma and discrimination.

So I'd like to identify that as another very important way in which those communities and leadership from those communities can help us achieve the goals of the Strategy.

Mr. Gomez: That's so important sir. Thanks for adding that. Operator, do we have another question?

Coordinator: John Berry.

John Berry: Yes, my question is that what sort of funds, what sort of plans are available for outreach for youth and kids in college? Because I know in my experience back in the early '80s it was very important, that whole outreach thing, that information about safe sex and getting tested for the prevention.

Mr. Gomez: Thank you so much for your question especially related to youth. Which of - would any of our panelists like to jump in and answer that question?

Mr. Sorian: Well, this is Richard. It's not a prevention answer but I just did want to mention another important thing that young people can access today. The Affordable Care Act says that insurance companies have to let parents keep their children on their health insurance policy up to age 26.

A lot of times you would see people, young people, they graduate from college or they'd hit 21 and they'd lose insurance because they had to come off their parents' policy and they might not have a job with health insurance.

We're seeing tremendous uptake in that. A lot of young people now are keeping insurance. And I think that's not going to prevent infection but it's going to give them access to healthcare providers who can continue to counsel and provide testing and all the kinds of things that then really help to keep them healthy.

So we're seeing more the 400,000 young people already signed up on their parents' policies and then keep health insurance instead of becoming uninsured.

Mr. Gomez: That's good news and...

Mr. Crowley: This is Jeff. If I could sort of just jump in and sort of respond a little more directly. I can't speak to specifically the resource commitments at different agencies but, you know, one of the key points of the strategy to meet our prevention goals is to recognize that we need to make an ongoing commitment to educating people across the age span about HIV.

So we're always having young people that don't have that basic information. That would even include college-age people. We want to make sure that all people have access to sort of a minimum set of medically accurate information about how they can lower their own risk and prevent themselves from getting HIV.

But, you know, I mentioned also there's a balance to be struck that, you know, our messaging for everybody or all college students with recognizing that even with young people it's - not all young people are at equal risk. So most of the new infections among young people are among gay and bisexual men so we think we need a target there.

Black women tend to be at higher risk than other populations as well. So really looking at some of these key infections - key populations that are becoming infected as young people and making sure that's where we're focusing our efforts.

Mr. Gomez: Thank you both for that. And suddenly we're getting a big influx of questions on the global side of the street from David in Chicago and Cynthia. One of the questions - or sort of a combination of the questions is, on global AIDS, essentially where are we today compared to ten years ago? And what is, then, America's role in that change? And I'm going to ask Tom to help answer that question, and if you'd introduce yourself, sir.

Tom Walsh: Hi, Tom Walsh at the State Department. Thanks very much for the question. It's really been a dramatic turnaround over the last ten years in the global AIDS picture.

In 2001, there were only 50,000 people in all of sub-Saharan Africa getting antiretroviral treatment in order to keep them alive. The number today supported by the U.S. alone is over 3 million.

So it's really gone from being perceived as a death sentence to being perceived as a chronic disease that a growing number of people are living with, millions of them, thanks to the generosity of the American people.

And in addition to treatment we've also seen very encouraging changes on the prevention front in Africa. In Africa, we now have over 20 countries that have had incidence or new infections declined by 25% or more over the last decade.

That's also been true in a number of countries in other regions as well. And again, that has really coincided with this era of tremendous investment, most of it by the United States with the United States providing really the lion's share of investment in global AIDS.

So it's really a dramatically improved situation as we were reminded of during the UN High-Level Meeting last week that Jeff mentioned where we really - the U.S. really went in with a message of building on this incredible success that's happened. How can we move farther? And so we did make the commitment, Jeff mentioned, to virtually eliminate mother-to-child transmission of HIV by the year 2015, a remarkable new commitment.

We also agreed to some global goals for dramatic increases in a number of people on treatment. So it's really a much improved situation and really the American people deserve the credit.

Mr. Gomez: We have time for one more live question. Operator?

Coordinator: David Stuppelbeen.

David Stuppelbeen: Hi there. This is David at Asian & Pacific Islander Wellness Center in San Francisco. So the National AIDS Strategy makes recommendations for local

governments and institutions to improve HIV surveillance in local areas with high concentrations of APIs and native groups.

But like in San Francisco, public health institutions are sort of ignoring this group and following the main groups that are prioritized in the documents. So, for instance, we're losing out on prevention funding for APIs. Will the government be providing stronger recommendations to local governments and health departments on how to improve surveillance in outreach and prevention to groups that aren't prioritized in the Strategy?

Mr. Gomez: Well thank you so much for your question. There's a lot in your question. Who on the panel would like to start a response? Dr. Mermin, Jeff or Dr. Valdiserri?

Dr. Mermin: Yes, this is Jonathan Mermin. I'd be happy to respond. I think the point is really important. You know, from a - so there are many different aspects of the kind of national and state and local surveillance systems for HIV.

It's important that all people who are diagnosed with HIV in all states in the union, that information is provided to both the health departments and ultimately to CDC to - and increasingly as those systems mature, we'll be able to present information reports about all people with HIV.

The question I think that you're raising is the corollary which is if certain populations are disproportionately affected by HIV, and they also get kind of disproportionate resources matching their epidemic for prevention and care, what happens to the populations that are essentially not as affected.

And it's important that we do ask states in our grants to be able to equitable distribute resources to make sure that the epidemic is addressed effectively. And so even for populations that don't make up a large proportion of people with HIV, some resources are meant to address the prevention issues in those populations.

And it is also important that we recognize that sometimes making the maximum difference in the epidemic also includes reducing health disparities. So some populations like transgender individuals, for example, are very disproportionately affected by HIV even though they don't make up a large proportion of all the people with HIV.

And as a nation we are obligated to also address the epidemic in those populations.

Dr. Valdiserri: This is Ron Valdiserri. The other comment I would make about the issue of whether we're talking about Asian Americans or Native American populations or groups that perhaps nationally don't contribute large numbers to the epidemiology, I think that part of what the Strategy directs us to do, and this is very much in line with the discussion of the Affordable Care Act, but part of what the Strategy directs us to do is not only strengthen and better target the categorical programs we have but also push our other systems of care to be responsive to all the populations that they're serving.

So, for instance, when we think about - let's say we think about Asian American populations, I think in terms of HIV/AIDS, it's very important that staff who work in Federally funded community health centers serving large populations of Asian Americans are aware of the particular health issues and health problems, whether those are HIV/AIDS or viral hepatitis.

So I think that - I understand historically we've addressed this epidemic very often with very categorical focused approaches and there was a reason for that. But I think part of the evolution of our national response to HIV/AIDS has to be that we make all of our systems more responsive to the needs of the broad variety of communities who are either living with HIV or at high risk for HIV.

Mr. Gomez: Well, thank you very much. And we're moving towards the 4 o'clock hour. We're running a minute over but I want to turn to two colleagues who started the call to bring us to a close and I want to remind everyone that they'll shortly receive an evaluation that we're going to ask everyone to fill out please.

And there will be a podcast and a transcript available on [AIDS.gov](https://www.aids.gov) later for today's event. And we really encourage anyone who wants to learn more about the issues covered today, the National AIDS Strategy, National HIV Testing Day, to please go to [AIDS.gov](https://www.aids.gov).

And so I'm first going to turn to Mr. Vos. Sir.

Mr. Vos: Great, Miguel, and to my colleagues, thank you. I think the real message is that this involves all of us, that it's not just the government but also every segment of society needs to be part of our response.

And fortunately now we have a plan that helps us organize the parts to get that better result. So I think that's very important. That's a big change. Another is there are benefits already changing for people with HIV/AIDS. So everyone who - living with HIV should be part of a care system, they should pay attention to these changes and use the [AIDS.gov](https://www.aids.gov) site and there are other networks to learn about them and keep up with them.

And I think that's a very important message I heard at the very beginning. So thank you for the opportunity to participate today.

Mr. Gomez: Well, thank you so much. And I'm going to turn to our colleague from the VA to close us out.

Dr. Czarnogorski: Thank you, Miguel. Today we commemorate 30 years of AIDS and we do not forget the pain and suffering of those three decades and many of us still feel the loss of loved ones. But we move forward into the fourth decade of the HIV/AIDS epidemic with hope and optimism.

As you've heard from many colleagues across the government, we are trying to build partnerships between government, local communities, healthcare and service providers, activists and people living with HIV.

None of us can stem the tide of this epidemic alone. Working together is the only way we will find the will and the courage and the resources to stop the HIV in the U.S. and around the world.

I want to close today's call by reading to you the vision statement that's for the National HIV/AIDS Strategy: "The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life- extending care, free from stigma and discrimination."

On behalf of AIDS.gov and my colleagues who have spoken today, I thank you all for joining us.

Mr. Gomez: Thank you and this concludes today's conference call/webinar. This is Miguel Gomez with AIDS.gov. Thank you and good bye.

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