February 3, 2023

Nevada Governor Joe Lombardo
State Capitol Building
101 N. Carson Street
Carson City, NV 89701

Dear Governor Lombardo,

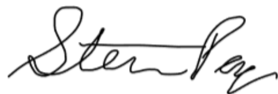
On behalf of the 2021 SB275 Advisory Task Force on HIV Exposure Modernization, I am proud to submit the enclosed report detailing our activities, findings, and recommendations. This report has also been sent to the Director of the Legislative Counsel Bureau for transmittal to the 82nd Session of the Nevada Legislature.

For context, Senate Bill 275 (SB275) of 2021 reestablished this Task Force which was originally established by Senate Bill 284 (SB284) of 2019. According to these bills, the Task Forces were assigned to research the implementation and impact of state statutes, identify any disparities in arrests, prosecutions, or convictions, evaluate current medical and scientific research, and identify any court decisions that relate to the criminalization of human immunodeficiency virus (HIV) exposure. The SB284 Task Force submitted a report in 2020 that led to the writing and passage of SB275. In addition to reestablishing this Task Force, SB275 reformed criminal and public health statutes to ensure that people living with HIV (and all communicable diseases) are treated fairly and appropriately under the law.

The work of this current SB275 Task Force expanded on the findings of the SB284 Task Force and explored the impacts of SB275. Members of the Task Force included people living with HIV, public health experts, community leaders, and advocates. The Task Force met from February 2022 to January 2023 to conduct our research and complete our report.

The report includes our recommendations and describes our efforts to research state law, meet with experts, and discuss current issues relating to the criminalization of people living with HIV. This document reflects the Task Force members' hard work and dedication to modernizing harmful and outdated HIV criminalization laws. Just as the SB284 Task Force helped enact necessary reforms to state law, we hope that our findings will guide policymakers and impact public policy as we enter the 82nd Session of the Nevada Legislature. Please don't hesitate to reach out to me if you have any questions about this report or the work of the Task Force.

Sincerely,



Stephan Page
Co-Chair, 2021 SB275 Advisory Task Force on HIV Exposure Modernization
stephanpage97@gmail.com | (650) 776-0100

REPORT TO THE GOVERNOR and DIR. OF THE LEGISLATIVE COUNSEL BUREAU
for transmittal to the 82ND SESSION OF THE NEVADA LEGISLATURE

Advisory Task Force on HIV Exposure Modernization
January 2023

Authorizing legislation: SB 275 (2021)

Authored by:
Jennifer Howell
Stephan Page
John (Rob) Phoenix
Cheryl Radeloff
André Wade

Quentin Savwoir, Advisory Task Force Chair
Stephan Page, Advisory Task Force Co-Chair

Task Force Members:
Senator Dallas Harris
Jesus (JP) Coleman
Gary Costa
Caesar Espinoza
Jennifer Howell
John (Rob) Phoenix
Cheryl Radeloff
André Wade

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Background

History of Task Force and HIV Modernization in NV

In 2019, Senate Bill 284 was passed and signed by Governor Steve Sisolak to create the Advisory Task Force on Human Immunodeficiency Virus (HIV) Exposure Modernization. The Task Force met throughout 2020 to conduct a comprehensive examination of the statutes and regulations in the State of Nevada related to the criminalization of exposing a person to HIV. After hearing from and consulting with several individuals and organizations, the Task Force submitted a report to the Governor and the Legislative Counsel Bureau in 2020. That report helped influence Senate Bill 275 in 2021.

SB275 (2021), sponsored by Senator Dallas Harris, revises provisions relating to communicable diseases. This bill modernized HIV criminalization laws and other laws relating to public health and criminal justice. Among other changes, the bill achieved the following:

- Repealed Nevada's HIV-specific criminal offense
- Repealed felony punishment for engaging in illegal sex work after a positive HIV test
- Repealed an outdated law that allowed for confinement of people living with AIDS
- Repealed a statute that allowed Nevada inmates to be segregated based on HIV status
- Repealed a statute that authorized STI testing of an alleged perpetrator of a sexual offense
- Amended statutes relating to the authority of health departments to investigate and control the spread of communicable diseases
- Amended a statute that makes it a misdemeanor for a person with a communicable disease to potentially expose others to the disease
- Amended a statute relating to testing someone who may have exposed a public employee (such as law enforcement) to a communicable disease
- Updated statutory language to ensure HIV/AIDS are used correctly and to remove stigmatizing language.
- Adds a statement of intent to use people first language that is respectful when referring to people living with HIV
- Declares that the spread of communicable diseases is best addressed through public health measures rather than criminalization.

The bill also reestablished the Advisory Task Force on HIV Exposure Modernization for the 2021-2022 interim before Nevada's 82nd (2023) Legislative Session.

Task Force Members

Senate Bill 275 (2021) allows the Governor of Nevada to appoint no more than fifteen members to the Advisory Task Force on HIV Exposure Modernization. To the extent practicable, the Governor should reappoint members from the 2019-2020 Task Force. The bill also notes the importance of appointing Task Force members who are members of the LGBTQ+ community, women, persons living with HIV, and sex workers. The following individuals were appointed by Governor Sisolak to be part of the Task Force: Quentin Savwoir, Chair; Stephan Page, Co-Chair; Senator Dallas Harris; Jesus (JP) Coleman; Vince Collins (resigned July 2022); Gary Costa; Caesar Espinoza;

Jennifer Howell; John (Rob) Phoenix; Cheryl Radeloff; André Wade; and Martin Walker (resigned May 2022). The Task Force received support from staff at the Nevada Division of Public and Behavioral Health. Of these ten Task Force members, 6 also served on the 2019-2020 Task Force.

Assignments for the Task Force

SB275 (2021) assigned the following tasks to members of the Task Force:

- Solicit input from persons and nongovernmental agencies with expertise in matters relevant to the Task Force in carrying out its duties, including, without limitation, persons, organizations, and communities that are directly affected by current statutes and regulations of this State that criminalize exposure to HIV or mandate HIV testing or disclosure as part of any civil or criminal law, or are likely to be affected by any law or policy recommended by the Task Force.
- Research the implementation and impact of such statues and regulations of this State that criminalize exposure to HIV, including, without limitation, quantifying their impact through the analysis of records, information and data relevant to this State.
- Identify any disparities in arrests, prosecutions or convictions under such statutes or regulations related to race, color, sex, sexual orientation, gender identity or expression, age or national origin.
- Evaluate current medical and scientific research with respect to the modes of HIV transmission implicated by such statutes and regulations.
- Identify any court decisions enforcing or challenging such statutes and regulations.
- Make recommendations concerning any matter relating to the above duties, including, without limitation, recommendations concerning proposed legislation, proposed regulations and policies

Acknowledgements

The Task Force would like to thank the following State of Nevada staff for their ongoing commitment, assistance, and guidance: Tory Johnson (Section Manager in the Office of HIV, Division of Public and Behavioral Health) and Pierron Tackes (Deputy Attorney General representing the Division of Public and Behavioral Health). We would also like to thank other staff within the Office of HIV who contributed to the Task Force. We express our gratitude to Linda Anderson (former Chief Deputy Attorney General) with the Nevada Public Health Foundation for her support and dedication to the Task Force and our work.

Nevada’s HIV modernization efforts have been fueled by advocates, government officials, public health experts, policy experts, and organizations in Nevada and throughout the country. Thank you to everyone who joined our Task Force meetings to discuss and present on important topics, including the following individuals: Russ Alfano (Nevada Department of Corrections), Nathan Orme (Behavioral Health Bureau of Health Care Quality and Compliance, Division of Public and Behavioral Health), Macy Haverda (Signs of Hope), Serena Evans (Nevada Coalition to End Domestic and Sexual Violence. Lastly, thank you to Nevada Legal Services for collaborating with the Task Force to create informational flyers about SB275, including the following individuals who joined our meetings: Kwame Bell, Briana McNamara, and Kristopher Pre.

Summary of Task Force Work

This current (2021-2022 interim) Advisory Task Force on HIV Exposure Modernization held its first meeting on February 3, 2022. Andre' Wade, the Chair of the 2019-2020 Task Force, provided an overview of Senate Bill 284 (which created the original 2019-2020 Task Force) and Senate Bill 275 (Nevada's HIV modernization bill that reestablished the Task Force). The first order of business was the nomination and election of Quentin Savwoir as Chair of the Task Force and Stephan Page as Co-Chair. Task Force members also agreed to meet biweekly (every other Thursday) at 5pm. The Task Force adopted the same bylaws from the 2019-2020 Task Force (with a few changes to reflect current dates and language in SB275) on March 3, 2022.

Senate Bill 275 of 2021 already modernized many of the laws that the 2019-2020 Task Force identified and recommended for amendment or repeal. Therefore, there was consensus among the Task Force members that our focus would include identifying concerns or issues with SB275 from interested/affected parties, identifying other statutory issues that were not addressed by SB275, and discussing other ways to modernize HIV laws and improve outcomes for people living with HIV. Several initial topics were presented regarding SB275 and concerned parties.

A primary concern was the impact of SB275's repeal of NRS 441A.320. A few different organizations were concerned with the repeal of this statute, including health departments and law enforcement. On top of that, the original version of SB275 received some pushback from representatives of firefighters and other first responders. Many discussions with these representatives occurred in 2021 and language in the bill was amended to accommodate their concerns. Nonetheless, the Task Force felt that it was important to hear from these representatives to confirm their position on the bill. Nevada health departments also had some concerns regarding some of the recommendations that the 2019-2020 Task Force submitted. Consequently, the Task Force also wanted to include the views of these health districts. Lastly, the Task Force wanted to hear from the Nevada Department of Corrections (NDOC) regarding the repeal of NRS 209.385. Despite our support for the statute's repeal, the Task Force wanted to ensure that NDOC was complying with its repeal while still offering testing and education around HIV and STIs.

The Task Force also realized that there was a big need to engage communities around the impact of SB275 and to educate people about its passage. Members of the Task Force reached out to organizations that represent specific communities that we felt were most impacted by SB275 and the Task Force's work. We also invited them to participate in the Task Force by tuning in to our open meetings or by applying for an appointment to join the Task Force. Members of the Task Force also discussed ways in which we can spread the word about SB275. Members decided that an informational flyer should be created so that it can be posted and disseminated.

The Task Force considered the possibility of making SB275 apply retroactively in order to clear the records of individuals who were criminalized under statutes that SB275 repealed. Members also discussed other topics including HIV modernization reforms in other states, HIV/STI testing and treatment for minors, and support for victims of sexual assault. When Rob Phoenix was appointed to the Task Force in August 2022, he introduced several new ideas for issues that the Task Force should address. Some of these issues included prohibiting co-pay accumulation, requiring all insurances in NV to cover all HIV/STI treatments and prevention medications, encouraging

HIV/Hepatitis C (Hep C) testing for Nevada inmates, ensuring standards of care for Nevada inmates regarding HIV and Hep C, and removing other barriers to healthcare access.

Rob Phoenix also informed Task Force members that the 2023 HIV Fast Track Cities Conference was looking for a host city. He presented the benefits of having the conference be held in Las Vegas considering the important work that has been accomplished in Nevada regarding HIV care and policy. Although a host city was chosen for the 2023 conference before we could approve our letter, The Task Force submitted a letter in support of the conference being held in Las Vegas at some point in the future.

Throughout 2022, there were public hearings regarding LCB File No. R002-22. The Task Force was interested in this proposed regulation because it related to HIV; more specifically, it related to Senate Bill 211 of 2021 which relates to HIV/STI testing. There was some opposition among Task Force members to the definition of "medically indicated" that was being used. The Task Force drafted a letter in support of the regulation but stating our opposition to the definition of "medically indicated" in the errata. In August 2022, the upcoming public hearing was canceled and a working group was created to refine the regulations. Consequently, our letter has not been submitted to the State Board of Health as of the writing of this report.

In December of 2022, the Task Force learned of a Nevada inmate being charged with a crime relating to the possible transmission of a communicable disease. The law in question, NRS 212.189, is similar to another law that the 2019-2020 Task Force recommended for amendment in order to further protections for people with communicable diseases. Task Force members felt that it was important for us to review this statute and make a possible recommendation.

The consensus among Task Force members is that additional research, collaboration, and action is needed to address issues that this Task Force aimed to address. For example, in January of 2023, Task Force members learned of an alleged story regarding a Nevadan who was denied employment as a firefighter due to their positive HIV status. We hope that issues regarding the discrimination, mistreatment, or criminalization of people living with HIV in Nevada are properly addressed as they arise.

More information about all of the work described in this summary can be found in the proceeding sections of this report.

Community engagement and the need to share info related to SB275

In the first meetings of this Advisory Task Force in 2022, members identified community engagement as a top priority. We felt that the Task Force needed to 1) inform the community about the major changes that SB275 enacted, and 2) reach out to communities that were impacted by SB275 and/or address any concerns that communities had with the bill.

Members of the Task Force realized that many Nevadans were not aware of the important changes that SB275 made to our state's criminal and public health laws, especially the communities that are most affected. We wanted to ensure that, first, people living with HIV knew how the changes in the bill protect them from unfair criminalization based on their HIV status. We also identified several other communities that need to be informed of these changes to state law, including but not limited to, law enforcement, first responders and other public employees, lawyers and criminal justice experts, sex workers, Department of Corrections staff, and sexual assault advocacy groups.

Considering the structure of the Task Force, we found that it may be difficult for the Task Force to host or partner on educational events to help spread the word. One approach we decided we could take instead was to develop a fact sheet that could be disseminated to the public. Although other community groups have already begun to share information, such as the Nevada HIV Modernization Coalition and Silver State Equality, we felt that the community would greatly benefit from additional information sharing. We contacted Nevada Legal Services knowing that they've created helpful fact sheets for other legislation and state laws in the past. Luckily, Nevada Legal Services had the capacity to develop a fact sheet for SB275 thanks to a grant they had received. A representative from Nevada Legal Services attended our meeting in June to learn about the information that we want to share. Nevada Legal Services then produced flyers targeting the general public, law enforcement, and medical providers. The Task Force and Nevada Legal Services worked together for several months to review drafts and recommend revisions. Final versions of the flyers are being completed and will soon be ready to share with the public.

The Task Force also thought of a few other strategies to reach certain communities. We felt that many police officers, prosecutors, and defense lawyers may not be aware of how SB275 impacts their work, especially in terms of arrests and prosecutions of people living with HIV and sex workers. To reach people in these professions, we realized that we could publish informational pieces in specific publications, such as statewide law journals, the Vegas Beat Magazine, or even national publications for law enforcement and lawyers.

In addition to informing the community about the bill, there are certain communities we wanted to engage with to ensure that they were content with certain provisions of the bill that affected their specific community. Outreach to the sex work community was a huge priority considering the repeal of NRS 201.356 and NRS 201.358. To reach this community, we contacted organizations such as the Nevada Brothel Association, the Cupcake Girls, and the Sex Workers

Alliance of Nevada. Task Force members informed representatives from these organizations about SB275, asked for their opinions about these legal changes, and invited members of their organizations to attend a meeting to speak during public comment. We also extended an invitation for members of these organizations to join the Task Force if they were interested. We did not hear any opposition to the bill from any of these groups.

Members of the Task Force also learned that one of SB275's changes may have had an unintended, negative consequence. With the repeal of NRS 441A.320, health departments no longer had the authority to test an alleged perpetrator of a sex related crime. This change was concerning to health departments, law enforcement, and advocates of sexual assault victims. Consequently, the Task Force prioritized this issue and contacted the concerned parties in hopes of hearing their point of view and possibly learning of solutions. We reached out to contacts at the Washoe County and Southern Nevada Health Districts, the Attorney General's Advisory Committee on the Rights of Survivors of Sexual Assault, the Center Advocacy Center at The Center in Las Vegas, the Washoe County Sherriff's Office, the Nevada Coalition to End Domestic and Sexual Violence, and Signs of Hope (a sexual assault resource organization in Las Vegas). More information about this issue and our outreach can be found in the "NRS 441A.320" and "Public Health Authority" sections of this report.

SB275 made many changes to public health law, including changes to health departments' authority to investigate and control the spread of disease. Both the Southern Nevada Health District and the Washoe County Health Department were very involved in discussions regarding these statutes leading up to the passage of the bill. Consequently, members of this current Task Force felt that it was important to include the health districts' perspectives in this report, which can be found in the section titled "Public Health Authority."

We also prioritized outreach to representatives of first responders, including the union that represents Nevada firefighters. The Task Force felt it was important to connect with them because of their opposition to the 2019 Task Force's recommendations regarding NRS 441A.195. More information about this is in the "First Responders" section of the report.

Ultimately, the Task Force believes that additional outreach and education is extremely necessary to ensure that Nevadans are well aware of the changes made by SB275. Community advocates and organizations will play a major role in this education once the Task Force adjourns, and many members of the Task Force are committed to working with these individuals and groups to continue informing the public. We have also tried our best to engage all interested parties and solicit their opinions to ensure that any inadequacies of SB275 can be addressed during the 2023 Nevada Legislative Session. Going forward, the Task Force hopes to see continued collaboration around all of these issues.

NRS 441A.195 – First Responders

Nevada Revised Statute 441A.195 allows for testing of person or decedent who may have exposed lawenforcement officer, correctional officer, emergency medical attendant, firefighter, county coroner ormedical examiner, person employed by or volunteering for agency of criminal justice or certain other public employees or volunteers to communicable disease. The 2019 Task Force, through recommendations from the Center for HIV Law and Policy and community advocates, recommended changes to this statute in an effort to protect the rights of a person required to be tested and aligning the current science of HIV transmission and acquisition risk with legislation.

Language in the statute, prior to changes passed in the 2021 legislative session, noted that if there was "possible" exposure to a communicable disease through the transfer of blood or bodily fluids from a person or decedent to the person in a position stated above, that the person potentially exposed could petition the court to order a test for exposure to a communicable disease. Prior to petitioning the court,the person exposed should submit information about the exposure to a designated health care officer for the employer or public agency or the person designated by the employer to document and verify the exposure and the likelihood of disease transmission from a person or decedent to the potentially exposed person, based on current scientific information.

Concerns from community members were brought forward to the 2019 Task Force that the use of "possible" in relation to exposure was too subjective. The scientific information on what constitutes substantial exposure to a communicable disease is specific to the communicable disease. People have been ordered to test based on perceived exposure to a communicable disease that is not grounded in scientific information of what exposure facilitates disease transmission. Examples of this situation are people that have been ordered to provide a sample for testing of HIV because they exposed a protectedperson, i.e. law enforcement, first responders and other named above, to urine, feces, or saliva. Scientific information demonstrated that these body fluids do not facilitate HIV transmission. In some circumstances, criminal charges have been imposed based on the alleged exposure. These charges andorders for testing were often based on stigma, fear, and discrimination related to HIV.

Feedback from first responder representatives and advocates voiced concern that a change in the statute would limit the potentially exposed person from the timely testing to ascertain the communicable disease status of the person or decedent that transferred blood or bodily fluids. Further concern was voiced that a delay in testing may also delay appropriate post exposure prophylaxis to helpprevent acquisition from the exposure. First responder representatives and advocates acknowledged that they did not support language that furthers HIV stigma. Their concern was the protection of the first responders and the protection of their ability to receive medical information to direct additional medical intervention in case of exposure. Representatives and advocates were from Clark County Fire Fighters Association and Professional Fire Fighters of Nevada.

Ongoing meetings between advocates, first responder representatives, public health representatives, and the sponsoring legislator discussed the implication of the word "possible"

in relation to exposure. After much deliberation, the group gained consensus on a change from "possible" to "likely" with regard to exposure. The group agreed that "likely" was a stronger word.

A Task Force member who was involved in the meetings where the verbiage change was discussed followed up with first responder representatives and advocates a year after the legislation was passed, to inquire about any consequences, positive or negative, from the change. The representatives appreciated the follow up and stated that no consequences had been reported from the language changes.

Public Health Authority

Portions of NRS 441A, dealing with public health authority were identified to be addressed through the SB 275 legislation in the 2021 Nevada legislative session. Engagement between state and local health authorities, community members, community advocates, and the sponsoring legislator took place in ongoing meetings. Many meetings included representation from first responders including Clark County government liaison, Clark County Emergency Medical Services, and Professional Fire Fighters of Nevada. The Williams Institute on Sexual Orientation and Gender Identity at UCLA Law and the Center for HIV Law and Policy also provided input. In addition, the topics were discussed exhaustively during meetings of the 2019 Task Force.

NRS 441A.160 and NRS 441A.180 were identified in the 2020 Report to the Governor and the Director of the Legislative Counsel Bureau as recommended to be amended. The existing statute allowed a health authority to investigate suspected and confirmed cases of communicable disease to immediately investigate and take measures for the prevention, suppression, and control of the disease as required by regulation of the state board of health or a district board of health. This statute also allows the health authority to enter private property at reasonable hours to investigate cases or suspected cases of a communicable disease. Within this statute, the health authority has the ability to require a suspected case of a communicable disease for testing and to take action to prevent the spread of the communicable disease through treatment, isolation, and/or quarantine.

Concern was raised on the ability of a health authority to order such actions and an overstep into individual privacy rights and interference with the Americans with Disabilities Act. Language in the statute that could allow for overreach included allowance for the health authority to act under suspicion or belief of the presence of a communicable disease.

Public health representatives offered education to the group on disease reporting and investigation processes, noting that common practice was to make contact and provide testing and treatment direction in the least restrictive manner possible, while protecting a person's confidentiality. Examples of intervention and investigation of other communicable disease, beyond sexually transmitted diseases and HIV, also covered by NRS 441A, were provided to highlight the need for the authority to exist.

After much deliberation, the following points were agreed to, an amendment was accepted by the bill sponsor, and the changes were passed into new legislation. These generalized points were:

- Changing softer and more subjective language of "suspect" and "believe" to having a "reasonable factual and medical basis to suspect" as more objective and directive language that supports the need for proof of public health action and authority.
- Language that directs public health to intervene at the least restrictive level possible, based on medical knowledge and to not risk the life of an individual because of a public health order.
- Establish the requirement of public health to state the reasons of actions. In addition, any person being ordered to engage in the public health action must be provided

information ontheir rights, including the right to appeal the order.
- Updating language and the related action to follow common epidemiological definitions ofisolation and quarantine.
- Providing that there needs to be evidence of a person's communicable disease infectious state or the probability, based on medical evidence, that the disease can progress to an infectious state.
- Allowing public health to conduct business and exercise authority to determine if a suspect case or report is in an infectious state or the risk of developing into a progressed state that endangers the health of the person with the communicable disease.

Through the ongoing commitment to protecting individual rights and the need for public health to have the authority to investigate communicable disease, the group was able to bring forth meaningful changes that met the objectives of all parties.

HIV and Nevada State Prisons

NRS 209.385 was repealed with the passage of Senate Bill 275 of 2021. This statute related to testing offenders for HIV and consequent treatment of inmates with HIV. In the report submitted in 2020, the Advisory Task Force on HIV Exposure Modernization recommended that this statute be repealed for several reasons. Primarily, Task Force members were concerned that inmates who tested positive for HIV "must be segregated from every other offender whose test results are negative" according to the statute. Task Force members believed that this requirement was not medically necessary due to the ways in which HIV can be transmitted. Additionally, members worried that inmates living with HIV could have been subjected to inferior treatment after being segregated from inmates without HIV. In fact, the US Justice Department shared similar concerns regarding this statute. The Justice Department found that this practice by the Nevada Department of Corrections was in violation of the Americans with Disabilities Act, and the two parties reached an agreement in 2021 to stop this illegal segregation.[1]

Although this current Task Force is happy to see this provision be repealed, there were certain parts of NRS 209.385 that we believe are important to keep in practice, such as testing inmates for HIV and establishing an education program for inmates and employees regarding HIV. To find out more about HIV in Nevada prisons, the Task Force reached out to the Nevada Department of Corrections and requested for a representative to attend one of our meetings.

On August 18, 2022, Russ Alfano, Medical Administrator for the Nevada Department of Corrections, attended our Task Force meeting and answered our questions. First, he told us that, to his knowledge, the Department of Corrections is no longer segregating inmates based on HIV status. Mr. Alfano also confirmed that HIV testing is still available in Nevada prisons along with other medical tests. He stated that inmates are offered testing when entering the Department of Corrections and may also be tested if deemed medically warranted. Mr. Alfano told us that inmates still receive counseling regarding HIV if they test positive while in prison, and information about HIV is still provided to staff and inmates along with other medical information.

Overall, it seems as though the repeal of NRS 209.385 has not had a detrimental effect on the Nevada Department of Corrections' ability or mandates to offer HIV and other communicable disease testing in prisons. They seem to have no issue with its repeal and have changed their practices to avoid illegal segregation and support inmates and staff in knowing their HIV status.

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[1] Office of Public Affairs, US Dept of Justice. "Justice Department Reaches Agreement with Nevada to End Discriminatory Policies Against Inmates with HIV and Inmates with Disabilities." The US Department of Justice. February 11, 2021. https://www.justice.gov/opa/pr/justice-department-reaches-agreement-nevada-end-discriminatory-policies-against-inmates-hiv

Nonetheless, more work needs to be done within the Nevada Department of Corrections to improve the treatment of inmates living with HIV and other infections, especially hepatitis C. An article from 2019 detailed how prison officials in Nevada "have denied or limited access to the drugs" that treat hepatitis C.[2] That same article also alludes to the need for increased testing for hepatitis C in Nevada prisons. In 2021, the Nevada HIV Modernization Coalition heard from an incarcerated person at the Washoe County Detention Center who claimed he was not receiving his HIV medication consistently. Ultimately, the standard of care for inmates with HIV or hepatitis C is not always equal to the care that people receive outside of the prison system. In general, lack of access to medication and quality healthcare has been an ongoing issue in the Nevada Department of Corrections as evidenced by lawsuits in 2008[3] and reports in 2017[4].

At the end of 2022, the Task Force learned of a story that highlights another statutory issue relating to Nevada prisons. A Nevada inmate, who has an unspecified communicable disease, was recently arrested on a felony charge after allegedly spitting on a deputy.[5] NRS 212.189 states that a prisoner cannot store, use, propel, or discharge (among other actions) any human excrement or bodily fluid with the intent to have the excrement or fluid come into physical contact with another person or under circumstances in which it is reasonably likely for it to come into contact with another person. The punishment for violating this statute ranges from a gross misdemeanor to a category A felony. Since this person is aware that he has a communicable disease that is "likely to cause substantial bodily harm" if transmitted, he is being charged with a category A felony.

This statute is somewhat related to NRS 441A.195, which Senate Bill 275 amended in 2021. That law allows for testing of a person who may have exposed a public employee, like a police officer, to a communicable disease if the public employee came into contact with that person's bodily fluids (see more information about this statute in the "First Responders and NRS 441a.195" section of this report). The 2019-2020 Advisory Task Force on HIV Exposure

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[2] Hassan, Anita. "Nevada prisoners denied hepatitis C treatment sue the state." NBC News. December 27, 2019. https://www.nbcnews.com/news/us-news/nevada-prisoners-denied-hepatitis-c-treatment-sue-state-n1107381

[3] ACLU. "ACLU Lawsuit Charges Grossly Inadequate Medical Care At State Prison In Nevada." American Civil Liberties Union. March 6, 2008. https://www.aclu.org/press-releases/aclu-lawsuit-charges-grossly-inadequate-medical-care-state-prison-nevada

[4] Botkin, Ben. "Nevada gets low marks for inmate health spending." Las Vegas Review-Journal. November 6, 2017. https://www.reviewjournal.com/news/politics-and-government/nevada/nevada-gets-low-marks-for-inmate-health-spending/

[5] Penrose, Kelsey. "30-year-old Carson City prisoner arrested for felony spitting; could face up to life in prison for the offense." Carson Now. December 17, 2022. https://carsonnow.org/story/12/17/2022/30-year-old-carson-city-prisoner-arrested-felony-spitting-could-face-life-prison-of

Modernization recommended that NRS 441A.195 be amended to require actual exposure in order for a court to order testing. The Task Force made that recommendation to protect the rights of a person required to be tested, align the law with the current science of HIV transmission, and prevent unnecessary testing that could have led to wrongful criminalization.

The 2021-2022 Task Force recommends changes to NRS 212.189 to prevent unnecessarily harsh punishment. It seems extremely harsh that someone already in prison for their crime(s) could face an additional category A felony sentence for behavior that might not actually cause physical harm to another person. A prime element of HIV modernization is the idea that any penalty must be proportionate to the harm that it caused, and we believe that this idea should apply to this statute too. Additionally, while the law requires intent to have the bodily fluid come into contact with another person (or situations in which it is reasonably likely for contact to occur), the law does not require intent to transmit a communicable disease or for actual transmission to occur. Another prime element of HIV modernization states that laws should only apply to acts with specific intent to transmit and in instances that carry a substantial risk of transmission. The law should be amended to align with this principle.

As stated before, the statute imposes harsher punishment (a category A felony) if the person knows that they have a communicable disease that is likely to cause harm if transmitted. The Task Force is curious to know how the Nevada Department of Corrections educates their inmates on communicable disease transmission and how the Department documents that education. It is important that inmates are being taught medically accurate information about the transmission of diseases, including which fluids can and cannot transmit certain diseases. Since this statute imposes harsher punishment for those who know their communicable disease status and how it can be transmitted through bodily fluids, the Task Force wants to ensure that inmates are truly being educated on these issues and that documentation of that education exists.

Ultimately, the Task Force is pleased to know that the potentially harmful practice of isolating inmates due to their HIV status is no longer happening while HIV testing and information is still available for inmates and staff. At the same time, we hope to see additional actions taken to ensure equal quality of care for all Nevada inmates and to prevent unnecessarily harsh punishment for inmates with communicable diseases.

NRS 441A.320

This statute has been a key focus of this Task Force. NRS 441A.320 allowed for a perpetrator of a sex related crime to be tested for sexually transmitted diseases. Senate Bill 275 of 2021 repealed this statute and instead requires information concerning HIV and STD testing to be provided to sexual assault victims (in addition to the information that the Sexual Assault Survivors' Bill of Rights already requires be given to victims).

When the 2019 Task Force on HIV Exposure Modernization originally reviewed this statute, we recommended that the law be amended so that testing is offered to the victim instead of testing the perpetrator first. Since then, we have realized the problematic nature of this recommendation because it goes against principles of victims' rights. Additionally, the repeal of this statute has already caused issues in cases of sexual assault here in Nevada. While law enforcement originally thought this issue did not concern them, their position changed when dealing with a case that involved a person living with HIV and multiple victims who are minors.

To learn more about issues stemming from this statute's repeal, members of the Task Force reached out to the Washoe County and Southern Nevada Health Districts, the Attorney General's Advisory Committee on the Rights of Survivors of Sexual Assault, the Center Advocacy Network at the Center in Las Vegas, the Washoe County Sheriff's Office, the Nevada Coalition to End Domestic and Sexual Violence, and Signs of Hope (formerly known as Rape Crisis Center).

The Task Force also wanted to learn more about the Sexual Assault Survivors' Bill of Rights to find out what kind of information is already being offered to victims. Nathan Orme, the Education and Information Officer at the Nevada Department of Health and Human Services, attended our meeting on September 29, 2022 to answer our questions. One of our concerns was whether or not health providers were providing the information that is required to be provided to victims by the Bill of Rights. In a follow-up email, Nathan told us that his office has not received any citations of non-compliance regarding health providers providing this information.

A representative from Signs of Hope attended our meeting on September 15, 2022. The representative acknowledged that the organization was not very aware of this legislative change due to staffing within the organization. Nonetheless, the representative presented concerns regarding testing for sexual assault victims, and there was a discussion in regards to providing urgent testing and resources for sexual assault victims.

Serena Evans, the Policy Coordinator at the Nevada Coalition to End Domestic and Sexual Violence, attended our meeting on October 27, 2022 to discuss this statute. By putting the onus of testing on the victim, Serena said that it places an even bigger burden on victims when they already have a big burden to carry. She also mentioned that more accountability and responsibility should be placed on the perpetrator. Although the Coalition does not have an official stance on this statute's repeal and whether or not it should be reinstated, Serena said she would let us know if they do release an official statement. Serena also expressed concerns about health providers not providing the information that is required by the Sexual Assault Survivors' Bill of Rights. Although Nathan Orme's office has not received any citations of non-compliance,

we know that there may be instances where the information is not provided and it never gets reported or cited. Serena expressed the importance of working with health providers to ensure that this information is always provided to victims.

Despite our outreach efforts, we did not hear from some of the groups that we wanted to hear from. It seems as though many people may still be unaware of this statute's repeal and its impact. Nonetheless, it might be best to reinstate NRS 441A.320 or a variation of this statute to help protect victims of sexual assault. Additional collaboration and research should be done on the impact of this bill on survivors of sexual assault. More specifically, the Task Force believes that additional discussions between advocates, public health, and law enforcement are necessary to determine next steps regarding this statute.

Comprehensive Sexual Education

The Northern and Southern Nevada HIV Prevention Planning Groups have identified youth and young adults as a priority population.[1] Moreover, the State of Nevada Ending the HIV Epidemic (EHE) Plan states that comprehensive sexual education is a necessity for HIV prevention.[2] According to the Center for Disease Control (CDC), medically accurate sex education can help prevent HIV and other sexually transmitted infections (STIs) among youth.[3] The US Department of Health and Human Services also notes that youth made up 21% of new HIV diagnoses in 2018 and youth are the least likely to know about their HIV status, remain in care, or achieve viral suppression.[3]

Evidence shows that Nevada's sex education curriculum is failing students. Data from the 2019 Nevada High School Youth Risk Behavior Survey (YRBS) Report shows that "31% of Nevada high school students reported having sexual intercourse at least once" and that "44% did not use a condom."[3] Nevada is one of many states that does not require sex education to be medically accurate and is only one of five schools where parents or guardians must provide written consent before students can receive sex education (also known as an "opt-in" system).[3] Data from the CDC's School Health Profiles also shows that Nevada schools failed to teach all students about important sexual health topics.[4]

The Nevada Department of Education (NDOE) recommends instruction about HIV and STIs in the 2020 Nevada Academic Content Standards for Health.[5] While the NDOE has these education standards, this curriculum might not be adhered to by all school districts. A commitment to comprehensive sex education aligns with the goals of ending the HIV epidemic as well as the recommendations of this Task Force.

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[1] Lensch, Taylor, Dermid, Gerold Etiller, Nilay, and Scavacini, Veronika. *2022-2026 Nevada HIV Integrated Prevention and Care Plan*. Reno: Larson Institute for Health Impact and Equity, School of Public Health, University of Nevada, Reno. October 2022. https://endhivnevada.org/wp-content/uploads/2022/12/NV-22-26-HIV-Integrated-Plan.pdf

[2] Bennett, Jennifer, Cristiansen, Elizabeth, Karls, Mary, Morning, Kelly, and Young, Victoria. *State of Nevada Ending the HIV Epidemic (EHE) Plan*. Carson City: Nevada State Division of Public and Behavioral Health. 2021. https://endhivnevada.org/wp-content/uploads/2021/01/Nevada-EHE-Plan-Final.pdf

[3] Todd, Camalot. "CCSD, lawmaker eye shift to opt-out sex education, more medically accurate info." Nevada Current. December 9, 2022. https://www.nevadacurrent.com/2022/12/09/ccsd-lawmaker-eye-shift-to-opt-out-for-sex-education-more-medically-accurate-info/

[4] SIECUS. "Nevada State Profile." SIECUS. March 29, 2021. https://siecus.org/state_profile/nevada-fy21-state-profile/

[5] Breen, Erin et al. *2020 Nevada Academic Content Standards (NVACS) for Health*. Carson City: Nevada Department of Education, Office of Standards and Instructional Support. November 2021. https://doe.nv.gov/uploadedFiles/nde.doe.nv.gov/content/Nevada_Academic_Standards/Health_and_PE/2020NVACSHealth.pdf

Table 11. Sexual behaviors among high school students in Nevada, Nevada Youth Risk Behavior Survey, 2017 and 2019.

Indicator	2017	2019	Change
Percentage of high school students who ever had sexual intercourse	36.8%	31.8%	**Significant decrease**
Percentage of high school students who had sexual intercourse for the first time before age 13 years	4.1%	2.4%	**Significant decrease**
Percentage of high school students who had sexual intercourse with four or more persons during their life	9.5%	8.1%	**No significant change**
Percentage of high school students who had sexual intercourse with at least one person during the 3 months before the survey	25.8%	22.4%	**No significant change**
Percentage of high school students who drank alcohol or used drugs before last sexual intercourse (among students who were sexually active in the past 3 months)	17.7%	17.9%	**No significant change**
Percentage of high school students who used a condom during last sexual intercourse (among students who were sexually active in the past 3 months)	55.7%	56.8%	**No significant change**

Source: State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. Nevada High School Youth Risk Behavior Survey (YRBS) Comparison Report, 2017- 2019.

Table from the NV Integrated HIV Prevention and Care Plan 2022-2026.[6]

Evidence also proves the need for sex education curriculum to be inclusive of all pupils, especially LGBTQ+ students and other minorities. LGBTQ+ students in Nevada "were significantly more likely to report having sexual intercourse for the first time before age 13 years, having sexual intercourse with four or more persons during their life, and were less likely to report using a condom at last sexual intercourse."[6] Asian, Black, and Hispanic students were also less likely to report using a condom, and STIs are consistently higher among the Black community.[6] Considering these disproportionate outcomes for minorities, Nevada needs to ensure that sex education curriculum is being well received by these communities.

Several pieces of legislation have been introduced within the last decade that attempted to reform Nevada's sex education curriculum. In 2017 and 2019, Assembly Bill 295 would have required sex education to be evidence-based, made the curriculum "opt-out" rather than "opt-in," and more. Assembly Bill 348 from 2017 would have required school districts to report on sex education curriculum to ensure that it is current, age-appropriate, medically accurate, culturally responsive, and appropriate for different language and ability levels. Similar legislation was also introduced in prior years, but none of these bills became law.

Current Nevada state law only requires that school districts establish a sex education curriculum that includes factual information on HIV, the reproductive system, related communicable diseases, and sexual responsibility. In addition to these vague requirements, state law also states that parents or guardians must submit written consent for their children to participate in sex

[6] ibid (Lensch, 2022)

education. It's important to note that both the Clark County and Washoe County School Districtshave adopted improved sex education curriculum requirements.[7] Nonetheless, legislation is still required to enact statewide requirements to ensure that all Nevada students have access to the sexhealth education that they need and deserve.

The Task Force recommends legislation that would create inclusive, comprehensive sexual health education requirements across the entire state. Legislation could resemble bills that have already been presented, such as Assembly Bill 295 from 2017 and 2019. Curriculum for all Nevada school districts should also adhere to the standards within the Nevada Department of Education Nevada Academic Content Standards for Health. Among other things, changes to Nevada's sex education curriculum should include the following:

1. Require curriculum to be comprehensive, evidence-based, and medically accurate
2. Provide information regarding contraceptives and methods to prevent STIs
3. Provide information about consent, sexual assault, and domestic violence
4. Provide resources for reproductive health services
5. Require that curriculum be updated periodically so that it is current and accurate
6. Be inclusive of all pupils regardless of race, gender, gender identity or expression, religion, sexual orientation, ethnic or cultural background, or disability
7. Make sex education an "opt-out" system rather than "opt-in" (enroll all students in sexeducation unless parents or guardians refuse for their children to participate)

This is not an exhaustive list of necessary changes but implementing these provisions would greatly improve sex education curriculum for all Nevada students. As of the writing of this report, a bill draft request (BDR) regarding sex education has not been introduced for the 2023 session. Nonetheless, it is still a topic being discussed. It their list BDR ideas for the 2023 legislative session, the Clark County School District included "change sex education statutes for instruction to be opt-out rather than opt-in" as something they are considering for the BDRs they can submit as an authorized entity.[8]

The Task Force hopes to see legislation in 2023 that addresses our sex education curriculum in order to provide better outcomes for our youth and contribute to efforts to end the HIV epidemic.

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[7] ibid (SIECUS, 2021)
[8] ibid (Todd, 2022)

Age of Consent Regarding STI Testing and Treatment

The rates of new HIV diagnosis (and STI's more broadly, including HPV) amongst youth is of concern in the state of Nevada. Also of concern is the historical rate of unplanned teenage pregnancies. To address this health issue, a law was passed in 1971 and amended in 1989 to allow minor children to receive HIV and STI treatment and testing without the consent of a parent or guardian.[1] A minor is defined as someone who is under the age of 18. Informed consent is the active information-sharing and decision-making process for health care, through which a provider engages the patient—and often, in the case of minors, a surrogate decision maker—to discuss the nature of care, its associated benefits, risks and alternatives, while concurrently assessing patient/surrogate decisional capacity and values.[2]

To better fight against the high rates of STI diagnosis and unplanned pregnancies, including the high rates of new HIV diagnosis in Nevada, it is important to allow adolescents under the age of 18 to also receive preventative medication and services to prevent them from getting an STI, of any type, or find themselves in a situation of having an unplanned pregnancy. Although, ideally, the adolescent and the parent/surrogate decision-maker would agree that an adolescent getting preventative care and treatment is in the patient's best interest, in circumstances where the parent/surrogate refuses to grant consent, or is unavailable, clinicians may not feel comfortable delivering care to the minor absent clear legal as well as ethical approval.[3][4] Changes in the law will support a clearer approval.

According to the Centers for Disease Control (CDC), the number of adolescents ages 13-14 diagnosed with HIV in 2018, across the U.S., was 87. Youth ages 15-19 diagnosed with HIV was 20. Although the Nevada Department of Health and Human Services Division of Public Health does not specifically report on the discrete rate of young people ages 13-17 who are newly diagnosed or living with HIV, the data does illustrate that minor youth are living with and impacted by HIV.[5] Even with the data that exists, Nevada law does not allow a minor to consent to receive preventative services like HIV prevention medication without their parents' consent.

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[1] Nevada Revised Statute. Judicial Emancipation of Minors. https://www.leg.state.nv.us/NRS/NRS-129.html#NRS129Sec060

[2] Zimet, G. D., Silverman, R. D., Bednarczyk, R. A., & English, A. (2021). Adolescent Consent for HumanPapillomavirus Vaccine: Ethical, Legal, and Practical Considerations. *The Journal of pediatrics*, *231*, 24–30. https://doi.org/10.1016/j.jpeds.2021.01.026

[3] American Academy of Pediatrics Committee on Bioethics. Informed consent in decision-making inpediatric practice. Pediatrics. 2016;138:e2 0161484. [PubMed] [Google Scholar]

[4] Michaud PA, Blum RW, Benaroyo L, Zermatten J, Baltag V. Assessing an adolescent's capacity forautonomous decision-making in clinical care. J Adolesc Health. 2015;57:361–6. [PubMed] [Google Scholar]

[5] Nevada Department of Health and Human Services Division of Public and Behavioral Health Office of HIV - HIV Prevention and Surveillance Program, Office of Analytics. Nevada 2020 HIV Fast Facts. https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Nevada%202020%2 0HIV%20Fast%20Facts.pdf

Most youth who acquire HIV during adolescence do so through sexual transmission.[6] And many are unaware that they are living with HIV[7]. Although condoms can be purchased by minors and free condoms can be obtained at sexual health clinics and at some community-based organizations, it is reported that there is a low rate of condom use amongst youth.[8] This data suggests that young people should continuously be encouraged to use condoms and be educated on how to access condoms. The data also suggests that other interventions are necessary to help prevent the transmission of HIV for minor youth who are engaging in sex. HIV preventative medication like PEP and PrEP are viable tools in the fight to end the HIV epidemic.Studies show that PEP is 99 percent effective in stopping the transmission of HIV[9] and PEP canalso greatly reduce exposure.[10] Therefore, minor youth who are engaging in sex should have the option to receive PEP and PrEP, without their parents' consent, to protect their sexual and overall health, which, in turn, helps to protect public health. To address the sexual health of young people, it is encouraged to allow young people to consent to access HIV prevention medication like PEP and PrEP to mitigate new rates of HIV infections amongst this vulnerable population.

The ability of minors to access PrEP and PEP without parental consent is interpreted by some to fall under NRS 129.030(3), which allows minors seeking physical, behavioral, dental, or mental health services without the consent of a parent. In this scenario, the minor would understand the nature and purpose, probable outcome, and voluntarily request the proposed services. As a result, there may be a question as to whether or not new legislation is needed orif current legislation needs to be clarified to be specific on this matter.

"While adolescent and young adult perspectives on using PrEP are diverse—as expected given variations in values, knowledge, cultural norms, and concerns about stigma—youth are generally open to and interested in PrEP. A systematic review described strong interest and support for PrEP use among many younger populations at risk of HIV infection including adolescent girls and young women, youth who identify as transgender, and, to a lesser extent, youth who inject drugs [26]."[11]

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[6] HIVinfo.org NIH.gov. (2021, August 19). HIV and Specific Populations. Retrieved August 11, 2022 fromhttps://hivinfo.nih.gov/understanding-hiv/fact-sheets/hiv-and-children-and-adolescents

[7] ibid

[8] ibid

[9] U.S. Centers for Disease Control & Prevention, Pre Exposure Prophylaxis (PrEP), CDC.gov (Aug 13,2022), https://www.cdc.gov/hiv/risk/prep/index.html;

[10] U.S. Centers for Disease Control & Prevention, PEP, CDC.gov (Aug13, 2022), https://www.cdc.gov/hiv/basics/pep.html.

[11] Allen, E., Gordon, A., Krakower, D., & Hsu, K. (2017). HIV preexposure prophylaxis for adolescents andyoung adults. *Current opinion in pediatrics*, *29*(4), 399–406. https://doi.org/10.1097/MOP.0000000000000512

In addition to HIV preventative services, minors are in need of access to broader STI preventative services, including those that protect against HPV. HPV is the most common STI,[12] which can lead to cancer.[13] Immunize Nevada, a statewide nonprofit dedicated to immunization advocacy and education, recommends that minors between the ages of 11 and 12 should receive the HPV vaccine in addition to older minors who did not receive their initial dose during the previously stated age range. However, if minors who are sexually active do not get the vaccine under their parent's guidance, they are unable to do so for themselves, without their parents' consent, to protect against HPV.

In the 1990s and early 2000s, Nevada consistently ranked in the top 5 states in the U.S. for teen pregnancy and birth rates. Between 1991 and 2020, the teen birth rates decline by 75% in the U.S.[14] During the same period in Nevada, the teen birth rates has decreased 77%. However, 1,506 teen births were recorded in Nevada in 2020[15]. The teen pregnancy rate in Nevada has dropped 66% between 1988 and 2013, with 4,190 pregnancies among teens age 15-19. Preventing teen births has saved Nevada $29 million due to declines in the teen birth rate.

Teens are engaging in behaviors that may lead to STIs, including HIV, and unplanned pregnancies. Nevada's 2019 Youth Risk Behavior Survey (YRBS) results report that 33% of high school student respondents reported having sexual intercourse and 23.1% were currently sexually active. Of those that have had sexual intercourse 44.1% reported no condom use during their last sexual intercourse, and 54.9 of females reported condoms were not used the last time they had sexual intercourse. Of male and female respondents who reported being sexually active, 89.75 reported no condom or birth control use during the last sexual intercourse[16]

The recommendation for adolescent minors to have access to HIV and STI preventative services and medication does not come without the recognition of ethical and legal considerations, messaging and unintended consequences.[17] Laws should be enacted to support adolescent access to preventative services and be in consideration of insurance provider policies, and patient confidentiality. Furthermore, Teens need the resources to make healthier reproductive and sexual health choices including greater access to contraception, testing, treatment and prevention services. Current Nevada Revised Statute 129.060 does notallow minors to obtain contraception without parental consent.

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[12] Center for Disease Control and Prevention. Genital HPV Infection - Basic Fact Sheet. Retrieved August11, 2022 from https://www.cdc.gov/std/hpv/stdfact-hpv.htm

[13] Immunize Nevada. Human Papillomavirus (HPV). Retrieved August 11, 2022 from https://www.immunizenevada.org/hpv

[14] (https://powertodecide.org/what-we-do/information/national-state-data/teen-pregnancy-rate).

[15] (https://powertodecide.org/what-we-do/information/national-state-data/nevada

[16] (CDC, YRBS Nevada 2019 Results, https://nccd.cdc.gov/youthonline/App/Results.aspx?LID=NV).

[17] Zimet, G. D., Silverman, R. D., Bednarczyk, R. A., & English, A. (2021). Adolescent Consent for HumanPapillomavirus Vaccine: Ethical, Legal, and Practical Considerations. *The Journal of pediatrics*, *231*, 24– 30. https://doi.org/10.1016/j.jpeds.2021.01.026

Client/Patient Access to Medications

Removing barriers to care related to cost; Copay Accumulator

Health care costs continue to be a significant source of barriers to care for all patients. Individuals livingwith HIV are not exempt from this barrier, and in fact may have significant more challenges than an HIV negative person.

Strategies such as Treatment As Prevention (TaSP) and Undetectable equals untransmittable (U=U) are scientifically validated approaches to ending the HIV epidemic. When People living with HIV (PLWH) face barriers to medications such as costs, these strategies are jeopardized as is the overall health of thePLWH. Accelerated aging in the PLWH is a medical concern of growing significance, and access to medications is an important strategy to minimize long term effects of HIV. According to the CDC over 50% of the PLWH are now over the age of 50, making the HIV and aging a growing medical condition, asmore PLWH are living healthier longer lives.

The Kaiser Family Foundation reported that annual deductibles have increased over 25% during the past five years (American Society of Clinical Oncology, 2021). The American Society of Clinical Oncology in their position statement on copay accumulators highlight the rising costs of deductibles from 4% to 12%in the past 15 years (American Society of Clinical Oncology, 2021). These rising costs, along with other costs of living increases are a barrier to care for PLWH.

To help offset the costs of medications, manufactures have copay assistance programs and medicationassistance programs. The goal of these programs is to help reduce the barriers of cost. All manufactures for HIV medications have programs to this affect.

Limitations on care or denial of care is a common practice among insurance companies and is hidden behind the mask of utilization management. The utilization policies do not positively impact the PLWH,they only benefit the insurance company. Copay accumulators are an example of a utilization management policy that only benefits the insurance company by allowing them to legally double dip oncopay amounts that PLWH are subject to. Copay accumulator adjustment programs prevent funds provided by manufacture coupons from being applied to toward a patient's annual out-of-pocket maximum or deductible. Utilization management policies prevent the amount of the manufacture support from being applied to the patient's out-of-pocket responsibility.

These copay accumulator policies undo the intended goal of manufacture assistance programs and remove an important safety net feature in our medical system. According to their position statement, the American Society of Clinical Oncology found that "these programs have the potential to harm patients by discouraging the appropriate utilization of specialty therapies and reducing adherence to recommended treatments" (American Society of Clinical Oncology, 2021). They go on to say that theseprograms contribute to lower monthly prescription fills, higher risk and rates of discontinuation, and lower proportion of days of coverage for medications (American Society of Clinical Oncology, 2021). Allof these things have negative consequences on the work towards Ending the HIV Epidemic in the US.

AIMED ALLIANCE penned a letter to the Department of Health and Human Services related to the protections the section 1557 of the Patient Protection and Affordable Care with respect to

possible "discrimination on the basis of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation, gender identity, and sex characteristics) in covered programs and activities. Our letter to HHS supported recognizing that Section 1557 includes discrimination in benefit design and excessive benefit utilization policies; and reiterated our long-standing position against the use of discriminatory quality adjusted lifeyear (QALY) value assessments."

The AIDS Institute (www.aidsinstitute.org) also highlights the broken system that allows insurance companies and pharmacy benefit managers to essentially double charge patients for copayments, deductibles and medication expenses through these copay accumulator type programs. As a result of advocacy within the state of Florida by agencies such as the AIDS Institute, SB1480 and HB1063 have been introduced as possible legislation to protect Floridians from this predatory and over utilization process that is specifically prohibited in Section 1557 of the ACA legislation.

Fifteen states have either implemented legislation, or have pending legislation, around copay accumulator programs.

1. Arizona HB 166 HB166
2. Alabama HB 569 HB569
3. Connecticut SB003 SB003
4. Georgia HB946
5. Illinois HB0465 HB0465
6. Kentucky SB45 SB45
7. Louisiana SB94 SB94
8. Maine SB1783
9. North Carolina SB257
10. Oklahoma HB2678 HB2678
11. Tennessee HB2515 HB2515
12. Virginia HB2515 HB2515
13. West Virginia HB2770 HB2770
14. Delaware SB267 SB267 (introduced 4/14/2022)
15. Washington SB5610 SB5610 (effective 1/1/2023)

AIDS Institute has published the following examples of how copay accumulator negatively impact patients and positively impact insurance companies and pharmacy benefit managers.

How Copay Assistance Works with Copay Accumulator Adjustment Policies

When a patient who uses copay assistance has a health insurance plan with a copay accumulator adjustment policy, they may be confused when they have to pay the full cost of their medicines or their full deductible at the pharmacy counter several months into the plan year. At that point, they have spent their copay assistance and may have to pay their entire deductible (again) before they can get their prescription. Their pharmacy bill could run as high as several thousand dollars. Many patients cannot afford that and walk away empty-handed.

Copay accumulator adjustment policies put patients with chronic conditions in a tough position – forcing them to choose between their health and other financial obligations.

Example 1 is a simplified overview of how copay accumulator adjustment policies work for patients who use copay assistance.

Example 1

- Patient has a $1,000 deductible and $500 in copay assistance.

Without a Copay Accumulator Adjustment Policy

The $500 copay assistance *will* count toward the patient's deductible.

$1,000 - $500 = $500. The patient has to pay only the remaining $500 to reach their deductible.

With a Copay Accumulator Adjustment Policy

The $500 copay assistance *will not* count toward the patient's deductible.

$1,000 - $0 = $1,000. The patient has to pay the full $1,000 to reach their deductible.

Example 2 below provides more detail on how, several months into the plan year, a patient's deductible has not been reduced by the amount covered by their copay assistance. In Example 2, when the patient goes to the pharmacy in May, their copay assistance would be maxed out, and they would have to pay for the remainder of the drug's cost. The patient would continue

(The AIDS Institute, 2020)

Example 2

- Plan deductible: $4,600
- Annual out-of-pocket maximum: $8,550
- Cost-sharing for specialty tier prescription: 50% after deductible is met
- Monthly medication cost: $1,680
- Copay assistance total: $7,200

Scenario 1: Plan ***Without*** a Copay Accumulator Program

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Insurer collects
Copay Assistance	$1,680	$1,680	$1,240	$840	$840	$840	$80	$0	$0	$0	$0	$0	$7,200	
Remaining Deductible	$2,920	$1,240	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0		$8,550
Consumer Pays	$0	$0	$0	$0	$0	$0	$760	$590	$0	$0	$0	$0	$1,350	

Deductible is met Copay assistance limit is met Out-of-Pocket maximum is met

Scenario 2: Plan ***With*** a Copay Accumulator Program

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Insurer collects
Copay Assistance	$1,680	$1,680	$1,680	$1,680	$480	$0	$0	$0	$0	$0	$0	$0	$7,200	
Remaining Deductible	$4,600	$4,600	$4,600	$4,600	$3,400	$1,720	$40	$0	$0	$0	$0	$0		$15,160
Consumer Pays	$0	$0	$0	$0	$1,200	$1,680	$1,680	$40	$840	$840	$840	$840	$7,960	

Deductible is met Copay assistance limit is met Out-of-Pocket maximum is met

The insurer makes more money when a copay accumulator adjustment policy is part of the health plan.

An Updated Report on Copay Accumulators | 7

(The AIDS Institute, 2020)

The examples can be viewed in their entirety at AIDS Institute Copay accumulator examples

Example 2 is a clear representation of the overcharging for services that patients experience by this discriminatory practice, that only serves to disenfranchise people from accessing needed medications.

This committee is recommending that legislation be drafted to be implemented into the 2023 legislativesession to address and remove this barrier to care. This barrier negatively impacts PLWH, but on a broader scale, impacts every Nevadan that could benefit from manufacture assistance in reducing costs of medication.

Our recommendation is that this legislation be simple. Arizona drafted HB 2166 that makes clear theintent of the law and the problem it is designed to address.

AMENDING TITLE 20, CHAPTER 5, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1126; RELATING TO INSURANCE COST SHARING.

Be it enacted by the Legislature of the State of Arizona:

Section 1. Title 20, chapter 5, article 1, Arizona Revised Statutes, is amended by adding section 20-1126, to read:

20-1126. Health care insurers; pharmacy benefits managers; cost sharing; calculation; definitions

A. WHEN CALCULATING AN ENROLLEE'S CONTRIBUTION TO ANY OUT-OF-POCKET MAXIMUM, DEDUCTIBLE, COPAYMENT, COINSURANCE OR OTHER APPLICABLE COST SHARING REQUIREMENT, THE HEALTH CARE INSURER THAT PROVIDES PHARMACY BENEFITS OR A PHARMACY BENEFITS MANAGER THAT ADMINISTERS PHARMACY BENEFITS FOR A HEALTH CARE INSURER SHALL INCLUDE ANY COST SHARING AMOUNT PAID BY EITHERTHE ENROLLEE OR ANOTHER PERSON {OR ENTITY} ON BEHALF OF THE ENROLLEE FOR A PRESCRIPTION DRUG THAT IS EITHER:

1. WITHOUT A GENERIC EQUIVALENT.

2. WITH A GENERIC EQUIVALENT WHERE THE ENROLLEE HAS OBTAINED ACCESS TO THE PRESCRIPTION DRUG THROUGH ANY OF THE FOLLOWING:

(a) PRIOR AUTHORIZATION.

(b) A STEP THERAPY PROTOCOL.

(c) THE HEALTH CARE INSURER'S EXCEPTIONS AND APPEALS PROCESS.

B. FOR THE PURPOSES OF THIS SECTION:

1. "GENERIC EQUIVALENT":

(a) MEANS A DRUG THAT HAS AN IDENTICAL AMOUNT OF THE SAME

ACTIVE CHEMICAL INGREDIENTS IN THE SAME DOSAGE FORM, THAT MEETS APPLICABLE STANDARDS OF STRENGTH, QUALITY AND PURITY ACCORDING TO THE UNITED STATES PHARMACOPEIA OR OTHER NATIONALLY RECOGNIZED COMPENDIUM AND THAT, IF ADMINISTERED IN THE SAME AMOUNTS, WILL PROVIDE COMPARABLE THERAPEUTIC EFFECTS.

(b) DOES NOT INCLUDE A DRUG THAT IS LISTED BY THE UNITED STATES FOOD AND DRUG ADMINISTRATION AS HAVING UNRESOLVED BIOEQUIVALENCE CONCERNS ACCORDING TO THE ADMINISTRATION'S MOST RECENT PUBLICATION OF APPROVED DRUG PRODUCTS WITH THERAPEUTIC EQUIVALENCE EVALUATIONS.

2. **"HEALTH CARE INSURER" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-1379.**

Sec. 2. Effective date

Section 20-1126, Arizona Revised Statutes, as added by this act, is effective from and after December 31, 2019.

Thank you for the opportunity to participate in this valuable committee that together we can modernize HIVin Nevada, and move Nevada toward a resolution of the HIV epidemic in our State.

Provider Parity

Provider parity is defined as health plans covering services for medical, behavioral, and substance use atthe same rate of reimbursement based on the services provided, not the provider's credentials. Nurse Practitioners (NPs) are advanced practice registered nurses prepared at the master's or doctoral level toprovide primary, acute, chronic, and specialty care to patients of all ages and walks of life. Physician Assistants (Pas) are licensed medical professionals who hold advanced degrees and can provide direct patient care. This document refers PA education and practice emphasize patient education, preventive care, and chronic care management. PAs generalist medical training enables them to provide a broad spectrum of patient care and treat the "whole patient" as Advanced Practice Providers (APP). Daily practice includes assessment; ordering, performing, supervising, and interpreting diagnostic and laboratory tests; making diagnoses; initiating and managingtreatment, including prescribing medication and non-pharmacologic treatments; coordinating care; counseling; and educating patients, their families, and communities. APP are also integral to the treatment continuum for HIV care and HIV prevention services. APP practice in nearly every healthcare setting, including clinics, hospitals, Veterans Affairs, and Indian Health Care facilities, emergency rooms,urgent care sites, private physician or NP practices (both managed and owned by NPs), nursing homes, schools, colleges, retail clinics, public health departments, nurse-managed clinics, homeless clinics, and home health. APP holds prescriptive authority in all 50 states and the District of Columbia. Notably, 86.6% of NPs are certified in primary care, the majority of whom see Medicare and Medicaid patients. NPs complete more than one billion patient visits annually.

A study of 26 capitated primary care practices with approximately two million visits by 206 providers determined that the practitioner labor costs and total labor costs per visit were lower in methods whereNPs and physician assistants (PAs) were used to a greater extent. Based on a systematic review of 37 studies, Newhouse et al. (2011) found consistent evidence that cost-related outcomes such as length of stay, emergency visits, and hospitalizations for NP care are equivalent to those of physicians. In 2012, modeling techniques were used to predict the potential for increased NP cost-effectiveness in the futurebased on prior research and data. Using Texas as the model state, Perryman (2012) analyzed the potential economic impact associated with greater use of NPs and other advanced practice nurses, projecting over $16 billion in immediate savings that would increase over time. Established in 1967, the PA profession currently has around 159,000 practitioners in the US, engaging in more than 500 million patient interactions yearly. According to the Health Care Cost Institute 2016 report, primary care visits provided by APP increased by 129% compared to an 18% decrease in visits provided by physicians (Wooldridge, 2018).

NP's cost-effectiveness is not dependent on actual practice settings and is demonstrated in primary, acute, and long-term care settings. For instance, NPs practicing in Tennessee's state-managed managedcare organization (MCO) delivered health care at 23 percent below the average cost associated with other primary care providers, which achieved a 21 percent reduction in hospital inpatient rates and 24 percent lower lab utilization rates compared to physicians (Spitzer, 1997). In addition, nurse-managed centers (NMCs) with NP-provided care have demonstrated significant savings, less costly interventions, and fewer emergency visits and

hospitalizations (Hunter, Ventura, and Keams, 1999; Coddington & Sands, 2009). A 2014 Harris Poll found that 92 percent of Americans who have seen a PA or have a family member who has seen a PA said that having a PA makes it easier to get a medical appointment (American Academy of Physician Associates, 2022).

Chenowith, Martin, Pankowski, and Raymond (2005) analyzed the healthcare costs associated with aninnovative on-site NP practice for more than 4,000 employees and its dependents, finding savings of $0.8 to $1.5 million, with a benefit-to-cost ratio of up to 15-1. Later, they tested two additional benefit-to-cost models using 2004–2006 data for patients receiving occupational health care from an NP, demonstrating a benefit-to-cost ratio ranging from 2-1 to 8.7-1, depending on the method (Chenowith,Martin, Pankowski and Raymond, 2008). In addition, time lost from work was lower for workers managed by NPs compared to physicians, as another aspect of cost savings (Sears, Wickizer, Franklin, Cheadle, and Berkowitz, 2007).

Several studies have documented the cost-effectiveness of NPs in managing the health of older adults. Hummel and Prizada (1994) found that, compared to the cost of physician-only teams, a physician-NP team at a long-term care facility was 42 percent lower for intermediate and skilled care residents and 26percent lower for those with long-term stays. The physician-NP teams also had significantly lower rates of emergency department transfers, shorter hospital lengths of stay, and fewer specialty visits. A one- year retrospective study of 1,077 HMO enrollees residing in 45 long-term care settings demonstrated a $72 monthly gain per resident, compared to a $197 monthly loss for residents seen by physicians alone (Burl, Bonner, Rao, and Kan, 1998). Intrator (2004) found that residents in nursing homes with NPs were less likely to develop ambulatory care-sensitive diagnoses requiring hospitalizations. Bakerjian (2008) summarized a review of 17 studies comparing nursing home residents who are patients of NPs to others,finding lower rates of hospitalization and lower overall costs for NP patients. The potential for NPs to control costs associated with the health care of older adults was recognized by United Health (2009), which recommended that providing NPS to manage nursing home patients could result in $166 billion in healthcare savings.

NP-managed care within acute-care settings is also associated with lower costs. For example, Chen, McNeese-Smith, Cowan, Upenieks, and Afifi (2009) found that NP-led care was associated with lower overall drug costs for inpatients. In addition, when Paez and Allen (2006) compared NP. and physician management of hypercholesterolemia following revascularization, they found that patients in the NP- managed group had lower drug costs while being more likely to achieve their goals and comply with theprescribed regimen.

Collaborative NP-physician management was associated with decreased length of stay and costs and higher hospital profit, with similar readmission and mortality rates (Cowan et al., 2006; Ettner et al., 2006). For example, the introduction of an NP model in a health system's neuroscience area resulted inmore than $2.4 million in savings in the first year and a return on investment of 1,600 percent; similar savings and outcomes were demonstrated as the NP model was expanded in the system (Larkin, 2003).Boling (2009) cites an intensive short-term transitional care NP program documented by Smigleski et al.through which health care costs were decreased by 65 percent or more after enrollment, as well as theintroduction of an NP model in a system's cardiovascular area associated with a decrease in mortality from 3.7 percent

to 0.6 percent. More than 9 percent decreased cost per case (from $27,037 to $24,511).

In addition to the total cost, other factors are essential to healthcare cost-effectiveness. These include illness prevention, health promotion, and outcomes (American Association of Nurse Practitioners, 2013).

APP are increasingly vital as front-line healthcare providers. Although there are some significant differences in training and maintenance of certification requirements, the similarities between PAs andNPs far outweigh the differences. What is essential for patients to know is that, regardless of whether they see a PA or an NP, they are being treated by a highly educated, well-trained healthcare provider who places the patient at the center of their care (American Academy of Physician Associates, 2021).

According to a new Commonwealth Fund report, the United States ranks last among 11 industrialized countries on health system quality, efficiency, access to care, equity, and healthy lives despite having the most expensive healthcare system. The other countries included in the study were Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom. While there is room for improvement in every country, the US stands out for having the highest costs and lowest performance—the US spent $8,508 per person on health care in 2011, compared with $3,406 in theUnited Kingdom, which ranked first overall (The Commonwealth Fund, 2014).

For example, for a moderate complexity follow-up visit (code 99214), an APRN or PA is reimbursed $69.95 compared to $105.45 for the same service, or 66% of the physician's reimbursement (NevadaAdvanced Practice Nurses Association, 2021).

Impacts of failure to provide equity:

- Without provider parity, Nevada is discouraging APP from practicing in our state, creating less and slower access to primary and specialized care providers. The costs associated with operating a primary care practice are the same regardless of your professional designation. For example, Medicare/Medicaidreimburses APP at 80% of the rate of physicians. Still, the costs of employing staff in a APP office are the same as those in a physician's office. In some instances, more due to restrictions on the types of employees the NP can supervise, such as a medical assistant ($15.73/hr) versus a Licensed Practical Nurse ($25.72) (Ebel, Bair, Lasater, Belcher, & Bratianu, 2022).
- Fewer Nevadans have access to a primary or specialty care provider who shares the same race,ethnicity, background, and life experience they do.

Solutions:

- Establish reimbursement parity in the State Medicaid budget for the next biennium.
- Meet NRS requirements for parity within all insurance plans regulated by the Nevada Division ofInsurance. (Nevada Advanced Practice Nurses Association, 2021)
- Provider parity will increase the pool of providers needed to deliver the necessary care to a populationthat continues to age and experience improving comorbid medical conditions

such as diabetes, hypertension, high cholesterol, and obesity.
- APP are valuable resources for providing primary and specialty care. However, entities need to havesufficient reimbursement for providing the same level of care and services.

In the context of HIV modernization, implementing provider parity will help to alleviate the providershortage that creates a barrier to care for the person living with HIV.
Parity is equity:

American Academy of Physicain Associates. (2022). *What is a PA?* Retrieved from AAPA: https://www.aapa.org/about/what-is-a-pa/

American Academy of Physician Associates. (2021). *PA & NP similarities and differences.* Retrieved fromAAPA: https://www.aapa.org/about/what-is-a-pa/https://www.aapa.org/download/60509/

American Association of Nurse Practitioners. (2013). *Nurse Practitioner Cost Effectiveness.* Retrieved from American Association of Nurse Practitioners: https://www.aanp.org/advocacy/advocacy-resource/position-statements/nurse-practitioner-cost-effectiveness

Ebel, A., Bair, D., Lasater, L. M., Belcher, E., & Bratianu, P. (2022). *Licensed Practical Nurse (LPV) vsMedical Assistant.* Retrieved from Practicalnursing.org: https://www.practicalnursing.org/medical-assistant-vs-lpn

Nevada Advanced Practice Nurses Association. (2021). *Health Equity in Nevada. APRNs provide it, APRNsdeserve it.*

The Commonwealth Fund. (2014, June 16). *US Health system ranks last among eleven countries on measures for access, equity, quality, efficience and healthy lives.* Retrieved from The Commonwealth Fund Press release: https://www.commonwealthfund.org/press-release/2014/us-health-system-ranks-last-among-eleven-countries-measures-access-equity

Wooldridge, S. (2018, November 20). *More patients seeing NPs and PAs for primary care needs.* Retrieved from beneftispro.com: https://www.benefitspro.com/2018/11/20/more-patients-seeing-nps-and-pas-for-primary-care/

Removing Barriers to Care:
Improve HIV-related health outcomes of people living with HIV

The Department of Health and Human Services published a National Strategic plan, a roadmap to End the Epidemic for the United States that outlines three goals of the program (US Department of Health & Human Services, 2021).

As part of the HIV modernization task force, we recommend that the State of Nevada legislature support the work that has been outlined in the 2022-2026 Nevada HIV integrated prevention and care plan as updated in June 2021 (Nevada office of HIV/AIDS, 2022) and posted online at https://endhivnevada.org/integrated-plan-2022-2026/#:~:text=The%202022%20%E2%80%93%202026%20Nevada%20HIV,(HRSA)%20in%20June%202021.

Nearly two-thirds of the U.S. population live in counties with no or inadequate ID physician coverage, disproportionately affecting already medically underserved populations (Infectious Diseases Society of America, 2022)

Multiple publications document the success of primary care management of HIV as part of primary care, reduction in access barriers, and increased retention in care versus specialty or Infectious disease requirements.

Weber et al. 2003:

- Switzerland: 1-year prospective cohort study recruiting 60 patients at general practices and 60 patients at a specialized university outpatient clinic, interviewed at baseline, months 6 and 12
    - GP 42% of the study population, had 72% viral load suppression
    - infectious disease 31%, and 74% viral load suppression
    - shared care 8%, and 88% viral load suppression

Landon et al. 2005:

- N = 5247 patients linked to 177 physicians (58% general medicine vs. 42% Infectious disease)
    - 63% of generalists (37% of overall physicians) considered themselves an expert
    - ID and expected generalists had similar performance
    - 20 pt experience

Page et al. 2019:

- N = 1960 practices, 4930 providers, 60496 Medicaid enrollees in 14 US States with the highest HIV prevalence (review of Medicaid claims from 2008-2012)
    - Each year pt saw the same provider: 6% increase in adherence (95% CI: 5.7-6.3)
    - GP had a 1.6% increase in adherence than seen by ID specialists along (95% CI 0.6-2.5, P<0.001)

Multiple publications have demonstrated the barriers to care based on prescription restrictions.

Zamini-Hank 2016, reviewed a state's Medicaid coverage of HIV meds and found:

- The average monthly out-of-pocket cost per person ranged from $12 to $667 per medication.
- Three insurance carriers placed all 31 HIV medications on the highest cost-sharing tier, charging 50% coinsurance. (Phoenix & Huynh, 2022)
- High out-of-pocket costs and medication utilization restrictions discouraged PLWHA from enrolling in health plans and threatened interrupted medication adherence, drug resistance, and increased risk of viral transmission

Kates et al. 2021, reviewed payer sources for PLWH & patient costs for Medicare:

- Premiums and cost-sharing might be substantial for both services and prescription drugs
- no cap on out-of-pocket spending under Part A and Part B
- some subsidies and supplemental coverage are offered for low-income beneficiaries;
- when covered under Part D, it is subject to cost-sharing; manufacturer co-pay assistance programs cannot be applied to Part D cost-sharing;
- cost-sharing support is available from ADAPs, foundations, and other sources based on financial eligibility criteria

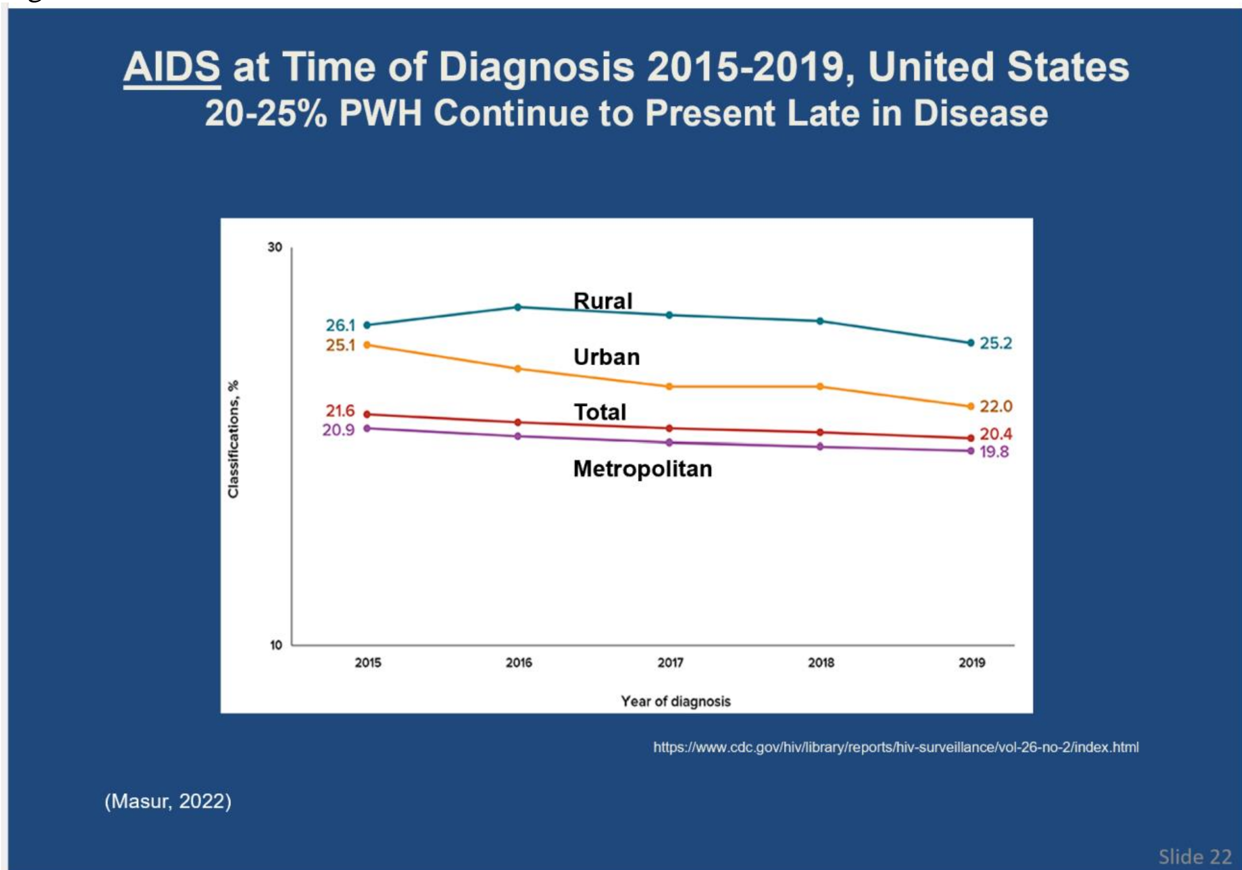
Wohl et al. 2017,

- medication cost or coverage led to a lapse in ARVs by 10%
- median duration of missed ARVs was two weeks
- 21% enrolled in ADAP reported lapse due to problems with ADAP or med cost

Data published by the CDC document that Black/African American and Hispanic/Latinos account for most new HIV infections. Black/African Americans represent 13% of the US population but account for 41% of new HIV infections. Hispanic/Latinos represent 18% of the US population but account for 28% of all new HIV infections (Phoenix & Huynh, 2022).

Figure 1, identifies that people residing in rural areas are more likely to present late in the diagnosis of HIV/AIDS. When clients present later in care the costs associated of care are higher, as are the complication rates and loss of life. According to the 2022 Nevada Statewide HIV needs assessment, 4.6% of respondents live outside Clark and Washoe Counties (Collaborative Research, 2022), yet there are no permanent providers of HIV care located outside of Clark, Washoe and or Carson City, requiring people living with HIV to travel long distances to care.

Figure 1



(Phoenix & Huynh, 2022)

Goal number 1 is to prevent new HIV infections.

To reach that goal, we need to increase access to HIV prevention strategies such as Treatment as Prevention (TaSP), Undetectable equals Untransmittable (U=U), and biomedical HIV prevention medications. In addition, increasing HIV testing in the community will help raise awareness of HIV status. According to a 2021 report by the University of Nevada Ending the HIV Epidemic statewide assessment plan, one in four Nevadans are HIV unaware, compared to the national average of one in seven. Forty percent of people living in Nevada have never had an HIV test.

Recommendations:

1. Support implementation and adherence to Nevada SB211, testing for sexually transmitted diseases in primary care and non-life threatening situations within hospitals and emergency department settings passed in the 2021 legislative session
2. Support implementation and adherence to Nevada SB325, pharmacist-based HIV Pre-Exposure Prophylaxis, and HIV Post Exposure Prophylaxis, passed in 2021 legislative
3. Support improved access to HIV testing, including insurance coverage for HIV testing in settings required under SB211

4. Require all Nevada insurance carriers to cover all FDA-approved HIV prevention medications supported by local, state, or federal government agencies (CDC) and professional organizations such as the American Academy of HIV Medicine and Infectious Diseases Society of America.
5. Require all insurance carriers to cover all FDA-approved HIV medications used for the treatment of HIV as recommended by Department of Health and Human Services Guidelines, IDSA guidelines, or other nationally recognized professional organization without step edits, prior authorizations, specialty referral requirements, eliminate pharmacy benefit management program restrictions, stop copay accumulator policies by PBMs that create financial hardships for persons living with HIV
6. Require all insurance carriers to cover all FDA-approved HIV biomedical prevention medications used for the treatment of HIV as recommended by Department of Health and Human Services Guidelines, IDSA guidelines, or other nationally recognized professional organization without step edits, prior authorizations, specialty referral requirements, eliminate pharmacy benefit management program restrictions, stop copay accumulator policies by PBMs that create financial hardships for persons at risk of HIV acquisition.
7. Require all insurance providers to cover all FDA approved Hepatitis C medications used for the treatment of Hepatitis C as recommended by Department of Health and Human Services Guidelines, IDSA guidelines, American Association for the study of liver disease, or other nationally recognized professional organizations without step edits, prior authorizations, specialty referral requirements, eliminate pharmacy benefit management program restrictions, eliminate copay accumulator policies by PBMs that create financial hardships for persons living with Hepatitis C
8. Require insurance carriers to provide unrestricted coverage of condoms for adolescents and adults
9. Require the State of Nevada to develop a program for the free distribution of condoms to adolescents and adults at local retail pharmacies, health provider offices, and other appropriate venues.
10. Require the State of Nevada to develop a program to support full access to all harm reduction services and support the harm reduction services currently being offered in our communities. This should include services supported by the CDC syringe services programs, which the CDC recognizes as an evidence-based intervention for HIV prevention and other communicable diseases of concern.
11. Expand and improve implementation of effective prevention interventions, including treatment as prevention, PrEP, PEP, and Syringe Service Programs (SSPs), and develop new options. For example, they require retail pharmacies to provide access to clean needles and syringes without a prescription for any injectable medication.
12. Increase the capacity of healthcare delivery systems, public health, and the health workforce to prevent and diagnose HIV
13. Insurance is required to cover testing, treatment, and prevention for all sexually transmitted infections such as chlamydia, gonorrhea, syphilis, HIV, and hepatitis as preventative health services for adolescents and adults.
14. Adoption of a status-neutral approach to HIV services—in which HIV testing serves as an entry point to services regardless of the positive or negative result—can improve testing as well as prevention and care outcomes. In this approach, people diagnosed with HIV are

linked to care and treatment services as quickly as possible to achieve and maintain viral suppression, which both protects their health and prevents transmission

15. Develop and provide a funding mechanism for a statewide HIV advisory board consisting of people living with HIV, whose mission is to advise the State of Nevada Legislature on strategies to help End the HIV epidemic in Nevada. Members of the HIV advisory board would be provided a stipend for participating in meetings.
16. The Nevada Department of Corrections and all City and County Correctional agencies provide access to HIV prevention strategies, such as condoms and HIV biomedical prevention medications, upon request from those in custody.
17. Recommend comprehensive, medically accurate, and inclusive sex education programs for school-age children alining with other sections of this report
18. Prohibit insurance companies from developing policies that restrict same-day access to HIV care, and medication
19. Prohibit insurance companies from developing policies that require Infectious Disease Specialists to manage the care of people living with HIV or to prescribe HIV specialty medications.

Does Early ART Initiation Work?

- **2011[1,2]**
  - Prevention of HIV-1 Infection With Early ART
    - Final results in 2016
    - Early ART → 93% lower risk of transmission
    - No linked infections with VS index patient
- **2015[3]**
  - Initiation of ART in Early Asymptomatic HIV Infection
    - The INSIGHT START Study Group
    - Early ART led to HR of 0.43 for death, AIDS- related events, or serious non–AIDS-related events
- **2015[4]**
  - A Trial of Early Antiretrovirals and Isoniazid Preventive Therapy in Africa[4]
    - Earlier ART resulted in HR of 0.56 for death or severe HIV-related illness
- **Meta-analysis of rapid ART[5]**
  - Likely results in greater viral suppression and better ART uptake at 12 months
  - May improve retention in care
  - Lower mortality estimate

(Rana, 2022)

HR, hazard ratio; VS, virologically suppressed.
1. Cohen MS, et al. *N Engl J Med*. 2011;365(6):493-505; 2. Cohen MS, et al. *N Engl J Med*. 2016;375(9):830-839; 3. INSIGHT START Study Group. *N Engl J Med*. 2015;373(9):795-807;
4. TEMPRANO ANRS 12136 Study Group. *N Engl J Med*. 2015;373(9):808-822; 5. Mateo-Urdiales A, et al. *Cochrane Database Syst Rev*. 2019;6(6):CD012962.

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(Phoenix & Huynh, 2022)

Goal 2. Improve HIV-related Health Outcomes of People with HIV

Recommendations:

1. Link people to care immediately after diagnosis and provide low-barrier access to HIV treatment.
    a. Programs focusing on the immediate (ideally same day or within seven days after diagnosis) initiation of ART have demonstrated success, are expanding in communities across the nation, and are a central tenet of ending the HIV epidemic in Nevada. All insurance providers should have policies and processes in place to remove barriers to same-day access to HIV care as well as the same-day start of medications.
    b. The Nevada Department of Corrections and all City and County Correctional agencies only contract with agencies or providers that have a proven track record of rapid start programs, with at least 95% of the newly diagnosed patients being offered treatment at the time of diagnosis and starting treatment the same day but no more than seven days of diagnosis.
    c. The Nevada Department of Corrections and all City and County Correctional agencies must provide access to medication for the treatment of HIV in the manner recommended by the prescribing healthcare provider, for example, single tablet formulations and injectable medications.
    d. Prohibit insurance companies from developing policies that restrict same-day access to HIV care, and medication
    e. Prohibit insurance companies from developing policies that require Infectious Disease Specialists to manage the care of people living with HIV or to prescribe HIV specialty medications.
2. Identify, engage, or reengage people with HIV who are not in care or not virally suppressed
    a. Remove insurance restrictions around HIV and Hepatitis C medications
    b. Remove insurance restrictions around HIV specialist treatment requirements, allowing primary care providers to treat HIV and Hepatitis C
3. Increase retention in care and adherence to HIV treatment to achieve and maintain long-term viral suppression
    a. Remove insurance restrictions around HIV and Hepatitis C medications
    b. Remove insurance restrictions around HIV specialist treatment requirements, allowing primary care providers to treat HIV and Hepatitis C
    c. Remove restrictions around 90-day supplies and mail order pharmacies of HIV and Hepatitis C medications
4. Remove step edits, prior authorization requirements, formulary restrictions, and copay accumulator programs for all FDA-approved HIV, Hepatitis C, medication-assisted therapies such as Suboxone, Methadone, Naltrexone, and FDA-approved medications used to support safe withdrawal such as lofexidine.
5. Increase the capacity of healthcare delivery systems, public health, and the health workforce to serve people with HIV.
    a. Develop policies to include more diverse community input in program development—engagement of people living with HIV, Hepatitis C, and Substance Use Disorder.

   b. Prevent insurance carriers from implementing restrictions on primary care treating HIV, Hepatitis C, and Substance use patients, for example, removing requirements for specialist referral or maintenance such as Infectious Disease providers, Gastroenterologists, or Addiction Specialists. Instead, primary care providers should be free to treat patients within their scope of practice and training and utilize specialists as needed for consultation.

Goal 3: Reduce HIV-Related disparities and health inequities

1. Reduce HIV-related stigma and discrimination.
   a. Remove HIV-specific criminal laws as they perpetuate HIV-related discrimination and stigma
   b. Strengthen enforcement of civil rights laws (including language access services and disability rights), reform state HIV criminalization laws, and assist states in protecting people with HIV from violence, retaliation, and discrimination associated with HIV status, homophobia, transphobia, xenophobia, racism, and sexism
2. Reduce disparities in new HIV infections, in knowledge status, and along the HIV care continuum
   a. Develop grassroots-based interventions to address the social determinants of health, such as substance use, homelessness, race and ethnicity stigma/discrimination, gender and sexual orientation stigma/discrimination, and socioeconomic barriers
   b. Ensure that healthcare professionals and front-line staff complete education and training on stigma, discrimination, and unrecognized bias toward populations with or at risk for HIV by requiring 2 hours of the educational content needed for license renewal by all professional boards to include content around HIV each license renewal period.
   c. Recommend comprehensive, medically accurate, and inclusive sex education programs for school-age children aligning with other sections of this report.
3. Engage, employ, and provide public leadership opportunities at all levels for people with or at risk of HIV
   a. Support communities in efforts to address misconceptions and reduce HIV-related stigma and other stigmas that negatively affect HIV outcomes
   b. Work with communities to reframe HIV services and HIV-related messaging so they do not stigmatize people or behaviors
   c. Develop and support programs for the training of HIV peer advocates, including adolescents and young adults
4. Address social determinants of health and co-occurring conditions that exacerbate HIV-related disparities.
   a. Develop whole-person systems of care that address co-occurring conditions for people with or at risk for HIV
   b. Adopt policies that reduce cost, payment, and coverage barriers to improve the delivery and receipt of services for people with or at risk for HIV.
   c. Improve screening and linkage to services for people with or at risk for HIV who are diagnosed with and are receiving benefits for co-occurring conditions
   d. Develop and implement effective, evidence-based, or evidence-informed interventions that address social and structural determinants of health among people with or at risk

for HIV, including lack of continuous health care coverage, HIV-related stigma and discrimination in public health and health care systems, medical mistrust, inadequate housing and transportation, food insecurity, unemployment, low health literacy, and involvement with the justice system.

   e. Develop new and scale up effective, evidence-based or evidence-informed interventions to improve health outcomes and quality of life for people across the lifespan, including youth and people over age 50 with or at risk for HIV, and long-term survivors
   f. Develop new and scale-up effective, evidence-based or evidence-informed interventions that address intersecting factors of HIV, trauma, violence, and gender, especially among cis- and transgender women and gay and bisexual men
   g. Require agencies providing services to individuals living with HIV or at risk for HIV to develop policies that provide uninterrupted care in a public health emergency, such as the online provision of services, smartphone/device-based applications, and telephone numbers not having restricted/blocked caller IDs.

Goal 4: Achieve integrated, coordinated efforts that address the HIV epidemic among all partners and stakeholders

1. Integrate programs to address the syndemic of HIV, sexually transmitted infections (STIs), viral hepatitis, substance use, and mental health disorders
   a. Expand outreach and education efforts addressing issues that intersect HIV, such as intimate partner violence, STIs, viral hepatitis, substance use, and mental health disorders
   b. Implement a no-wrong-door approach to screening and linkage to services for HIV, STIs, viral hepatitis, substance use, and mental health disorders across programs
2. Increase coordination of HIV programs across all levels of government (federal, state, tribal, local, and territorial) and with faith-based and community-based organizations, the private sector, academic partners, and the community
   a. Foster the development of community-based organizational efforts to create and implement street-level interventions designed to address these barriers, such as street-based HIV testing, mobile HIV medical care, street-based medicine programs, street-based syringe exchange programs, street-based medication-assisted therapy (MAT)
   b. Focus resources, including evidence-based and evidence-informed interventions in the geographic areas and priority populations disproportionately affected by HIV
   c. Support collaborations between community-based organizations, public health organizations, education agencies and schools, and health care delivery systems to provide linkage to and delivery of HIV testing, prevention, care, and treatment services as well as supportive services
3. Enhance the quality, accessibility, sharing, and use of data, including HIV prevention and care continuum and social determinants of health data
4. Identify, evaluate, and scale up best practices, including through translational, implementation, and communication science research
   a. Develop program support for integrating HIV, mental health services, and primary care in single settings. Provide a mechanism for enhanced reimbursement for

coordinated service provision, including provider parity among physician and advanced practice providers (APRNs, PAs)

   b. Promote and support collaborative research efforts among academic centers, health departments, community-based organizations, patients and their advocates, and other partners that aim to discover, adapt, and scale up effective interventions to improve HIV outcomes

5. Improve mechanisms to measure, monitor, evaluate, report, and disseminate progress toward achieving organizational, local, and national goals
   a. Strengthen monitoring and accountability for adherence to requirements, targets, and goals by funded partners
   b. Identify and address barriers and challenges that hinder the achievement of goals by funded partners and other stakeholders.

Collaborative Research. (2022). *Nevada Statewide HIV needs assessment.* Retrieved from ENDHIVNEVADA: https://endhivnevada.org/wp-content/uploads/2022/11/2022-Nevada-HIV-Care-Statewide-Needs-Assessment.pdf

Infectious Diseases Society of America. (2022, December). *Are you passionate about growing the field of ID.* Retrieved from IDSA foundation: https://mailchi.mp/056fa5ea43b5/foundation-id-insights-august-621041?e=9ae4d69b1a

Nevada office of HIV/AIDS. (2022, Dec). *Integrated Plan 2022-2026.* Retrieved from ENDHIVNEVADA: https://endhivnevada.org/integrated-plan-2022-2026/#:~:text=The%202022%20%E2%80%93%202026%20Nevada%20HIV,(HRSA)%20in%20June%202021.

Phoenix, J., & Huynh, J. (2022). Reducing barriers to access to care. *Autumn Update 2022.* Incline Village.

US Department of Health & Human Services. (2021). *National Strategic Plan. A roadmap to End the Epidemic for the United States 2021-2025.* Washington DC.