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House Bill 2943 Policy Brief

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What does this bill do?

This bill would require hospitals to conduct testing for HIV and Syphilis on all emergency department patients who are already receiving other blood work (unless the patient declines). There are a few other key provisions, however:

- Requires health insurance coverage of HIV and Syphilis screening conducted in hospital emergency departments.
- Provides protections for healthcare personnel from actions for civil damages relating to the screening.
- Appropriate funds from the General Fund to the Oregon Health Authority to cover costs incurred by counties in carrying out investigation and outreach related to the increase in HIV and Syphilis screening.

What is the problem we are addressing?

There is an ongoing HIV and Syphilis syndemic (the aggregation of two or more concurrent epidemics) in Oregon that is impacting public health outcomes in our communities.

- Since 2012, we have seen a **418% increase in the incidence rate of Syphilis**[1] in spite of the fact that patients have access to Doxycycline (an antibiotic), which can be taken as STI Post-Exposure Prophylaxis (PEP) and is 70% effective at preventing the transmission of Syphilis.[2]
- Between 2014 and 2022, there was a **1,750% increase in the rate of Congenital Syphilis**[3] which can cause miscarriage, premature birth, or anomalies.[4]
    - 10.5% of Congenital Syphilis cases end in stillbirth or neonatal death.[5]

[1] Oregon Health Authority - Syphilis Dashboard
[2] U.S. Centers for Disease Control and Prevention - Clinical Guidelines on the Use of Doxycycline Postexposure Prophylaxis for Bacterial Sexually Transmitted Infection
[3] Oregon Health Authority - Congenital Syphilis
[4] U.S. Centers for Disease Control and Prevention - About Congenital Syphilis
[5] Oregon Health Authority - Increasing Congenital Syphilis in Oregon

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- Though incidence of HIV decreased from 2012-2020, we have seen an uptick in cases since the pandemic and are now seeing **the highest incidence rate for HIV since 2013**.[6] This is in spite of the fact that:
    - HIV-positive individuals can take medication to suppress their viral load (the amount of HIV in their blood) and become "undetectable" which means they can no longer transmit HIV.[7]
    - HIV-negative individuals can access PrEP, which is 99% effective at preventing HIV transmission[8] -- even when their partner's viral load is not suppressed.

Who is most impacted by HIV?[9]

There are many communities who are being disproportionately impacted.

- HIghest prevalence is among individuals aged 55-64, but recent trends show that a disproportionate number of new diagnoses are among **individuals aged 25-34** (2022).
- **Black people and Latinos** are the only two racial/ethnic groups whose prevalence *and* recent diagnosis rates are larger than their share of the overall population (2022).
- **Men** have significantly higher prevalence rates and are seeing the most new diagnoses -- especially if they have sex with other men (2022).
- **Rural communities** are disproportionately impacted. The number of new diagnoses (per 100k residents) was highest in **Malheur County** -- almost double the number of new diagnoses in **Multnomah County**, which came in second. **Umatilla County** had the third highest rate, with just 1 less diagnosis than Multnomah County (2022).

Who is most impacted by Syphilis?[10]

There are many communities who are being disproportionately impacted.

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[6] Oregon Health Authority - End HIV Oregon
[7] HIV.gov - Viral Suppression and an Undetectable Viral Load
[8] HIV.gov - Pre-Exposure Prophylaxis
[9] AIDSVu - Understanding the Current HIV Epidemic in Oregon
[10] Oregon Health Authority - Syphilis Dashboard

- Over the past 10 years, **individuals aged 30-39** experienced the highest rates. Individuals aged 20-29 and 40-49 experienced significant prevalence, too.
- In 2023, **Native Americans and Black people** experienced the highest rates. Latinos and Pacific Islanders experience rates above the statewide average.
- **Rural communities** are disproportionately impacted. In 2023, the number of new diagnoses (per 100k residents) were highest in **Jefferson County**. Second highest rates were in **Coos County**, followed by **Multnomah County** in third.
- **Men** have significantly higher prevalence rates.

If we have highly effective preventative options available to patients, why are HIV and Syphilis continuing to spread at concerning rates?

Because of the prevalence of individuals who are living with at *least* one of these conditions but who are unaware of their status. There are many reason why this could be the case:

1. **They lack access to comprehensive, affordable, and culturally competent health care.** Many Oregonians face barriers to accessing consistent primary care -- a critical element of preventative health. They are starved of the opportunity to discuss their health concerns with a provider who can provide critical information and help guide their patients toward taking preventative measures. Even when they *do* have this opportunity, many patients cannot afford to pay for recommended actions such as routine screening or preventative prescription drugs. Changing this status quo is going to take years of uninterrupted, incremental policy making.

2. **They don't even realize they are at risk for HIV or Syphilis to begin with.** A 2023 study conducted as part of an opt-out screening pilot program in Chicago reported that an overwhelming majority of patients who met the CDC's criteria for PrEP did not consider themselves to be at risk for HIV or Syphilis, even though clinical assessments indicated them to be at moderate or even high risk for transmission.[11] That same study shared that 80% of patients diagnosed with Syphilis did not visit the emergency department for

[11] Routine, Opt-Out, Emergency Department Syphilis Testing Increases HIV PrEP Uptake

STI concerns at the time of their visit.[12] Many patients are not aware of the risk factors associated with these conditions, and put off testing because they are asymptomatic (as HIV and Syphilis can be and often are -- until they have progressed).

3. **They are worried at how they will be perceived and treated by others if they disclose their status or that they may be judged by their provider for engaging in risky behaviors.** We have come a long way from the start of the HIV epidemic when AIDS was considered a "gay disease" and when teenager Ryan White was barred from attending school after his diagnosis. HIV and STI-related stigma and discrimination continue to persist, however. And they impede the public health response at every step. HIV stigma is associated with suboptimal clinical outcomes, including viral non-suppression, mental health issues, and compromised interpersonal outcomes like social support and physician trust.[13] Even in cases where a patient has access to care and a high level of awareness, they may hesitate to share information that would be vital toward helping a physician make preventative recommendations.

What's wrong with the traditional models of HIV and STI prevention that we're using now?

Nothing! Existing HIV/STI prevention strategies deliver improved clinical outcomes and should continue to be supported. But **evidence demonstrates there are persistent subsets of people at high risk of HIV and/or Syphilis infection whose only interaction with any kind of medical care is at the emergency department.** People experiencing these barriers are at heightened risk to become positive and transmit to others before they even know their status.

[12] Routine, Opt-Out, Emergency Department Syphilis Testing Increases HIV PrEP Uptake
[13] Experienced HIV-related stigma in healthcare and community settings: Mediated associations with psychosocial health outcomes

How would HB 2943 improve our overarching public health strategies and clinical outcomes?

The three reasons listed above help us identify where traditional methods are falling short *and* emphasize how critical it is that we consider integrating nontraditional prevention methods (such as universal, opt-out screening) into our overarching public health strategies to eliminate existing disparities.

Here's how HB 2943 addresses each of the reasons for the continued spread of HIV and Syphilis:

1. **They lack access to comprehensive, affordable and culturally competent health care.** Doing this intervention in a primary care setting would be the most ideal, holistic,and sustainable solution to the syndemic. The reality is, however, that in spite of the many strides Oregon has taken to increase access to primary care, there are still *many* barriers that prevent a primary care-oriented solution from being feasible at this time. The HIV and Syphilis syndemic is ongoing, and we need to provide public health intervention in spaces where public health is demanding it.

2. **They don't even realize they are at risk for HIV or Syphilis to begin with.** Traditional prevention models engage patients who self-identify as being candidates for routine screening or preventative medications by virtue of seeking out STI testing or reporting activities with risk for transmission to their physician. They are predicated on the assumption that patients have the education they need to independently make proactive decisions about their sexual health, which we know is often not the case. Low levels of sexual health education are synonymous with lower awareness of risk factors and preventative options; as well as an increased risk for HIV or Syphilis transmission. This means that the people who have the highest need for these services are also the *least* likely to receive them.

   Universal opt-out screening helps close the gap left by existing prevention methods by meeting patients where they are at rather than waiting for them

to self-identify and engage with existing systems -- making HIV and Syphilis screening the norm, and increasing the total number of individuals screened. In addition, data demonstrates that a diagnosis of Syphilis leads to increased awareness of HIV risk among patients, who in turn are more likely to uptake HIV PrEP[14] and are therefore less likely to contract HIV -- lessening the amount of intervention needed in the long-run.

3. **They are worried at how they will be perceived and treated by others if they disclose their status or that they may be judged by their provider for engaging in risky behaviors.** HB 2943 helps close the gap left by existing prevention methods by acknowledging existing stigma and the ways in which it may serve as a barrier to accessing care. Studies have demonstrated a higher uptake in HIV/STI screening when conducted without a risk assessment.[15] By normalizing routine screening and not requiring patients to disclose risky behavior, we can change the culture surrounding HIV, STIs, and testing.

Why do we need to do this in emergency departments?

Because as we've learned, lack of access to primary care is causing public health intervention to *already* happen in emergency departments. Breaking down barriers to primary care is going to take years of uninterrupted, incremental policymaking. We have data telling us that this would be the most strategic place to do it. Relevant health authorities think so, too.

- In 2006, the CDC recommended universal, opt-out screening for HIV in acute-care settings.[16]
- In 2021, 25% of new HIV diagnoses in Oregon took place in acute-care settings. This is a 15% increase when compared to 2012. [17]
- In 2023, the Oregon Health Authority recommended universal opt-out screening for HIV and Syphilis.[18]

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[14] Routine, Opt-Out, Emergency Department Syphilis Testing Increases HIV PrEP Uptake
[15] San Francisco City Clinic - Coding guidelines for routine HIV testing in health care settings
[16] U.S. Centers for Disease Control and Prevention - Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings
[17] Oregon Health Authority - End HIV Oregon
[18] Oregon Health Authority - Memorandum to Oregon Emergency Departments and Urgent Care Clinics

- The number of emergency department visits that included an STI diagnosis has increased almost 40% nationally.[19]

Emergency departments have increasingly been recommended as a location for public health interventions because:

- They are the only care setting that is open 24/7 and that won't turn a patient away for an inability to pay for care.
- They have access to a large population that is affected by multiple social and structural factors that may lead to less access to or utilization of primary or special outpatient health care.[20]
- For some of our most vulnerable community members (who are the same individuals at highest risk for HIV or Syphilis), the emergency department is their only touch point with our healthcare system.

Are other states doing this?

Not on a statewide level, but there have been pilot programs and studies across California, in Chicago, and in Cleveland[21] that have yielded positive outcomes and led to recommendations of broad and permanent implementation of these models. Both of these studies were referenced throughout this brief.

In 2022, the California Department of Public Health recommended that EDs consider implementing opt-out screening for HIV, Syphilis, and Hepatitis C.[22] These recommendations came from the findings of a pilot program that was launched in 2019. Over a two-year period, opt-out screening for HIV in just a handful of emergency departments across the state identified almost 1,200 cases -- a substantially higher rate than for federally-funded testing focused on high-risk populations.[23]

[19] An increase in sexually transmitted infections seen in US emergency departments
[20] Routine, Opt-Out, Emergency Department Syphilis Testing Increases HIV PrEP Uptake
[21] A Model for Syphilis Screening in the Emergency Department
[22] HIV Testing in Hospital Emergency Departments: Findings and Recommendations
[23] HIV Testing in Hospital Emergency Departments: Findings and Recommendations

Why does the bill only require this be done on patients who are *already* receiving other bloodwork?

To make the process less burdensome on hospital emergency departments. Rather than sending *every* patient to the lab, we would focus on screening patients who are already going in there for reasons related to their emergency department visit.

Why does the bill not have screening criteria besides HIV status?

The idea behind this was to make the process less burdensome on hospital emergency departments. Having to screen for additional criteria takes time -- more time than it takes to draw an additional vial of blood from a patient who is already getting bloodwork done.

It does, however, inflate the cost of the bill. We plan to amend it so that screening is only being done on HIV-negative individuals, aged 15-65, who have not been tested within the last year. This will lower the cost of the bill significantly given that children and seniors make up a vast majority of emergency department visits each year.

Why does the bill call on public health entities to do the follow-up?

To try and ease the burden on hospital emergency departments which are already spread so thin and who have expressed concerns regarding their ability to carry out this mandate without compromising the quality of care patients receive.

In a 2023 memorandum calling on care-providing organizations to conduct opt-out HIV and Syphilis screening in acute-care settings, the Oregon Health Authority acknowledged the challenges this may pose for hospitals. They *also* recommended partnership with local and state public health authorities.

What are the costs of this bill?

There would be costs associated with the bill that could impact the state, insurers, patients, and the hospitals required to carry out these programs.

- The State would need to allocate a currently undetermined amount of funds from the General Fund to the Oregon Health Authority for purposes of

distributing to local health authorities to have the resources they need to carry-out the responsibilities this bill will task them with.

- Insurers would be required to cover the cost of these screenings.
- Patients with insurance plans that have high deductibles may need to cover the cost of these screenings if they haven't met their out-of-pocket maximums.
- Hospitals would need to make changes to their EMR (Electronic Medical Record) systems to adapt to new protocol, and would need to ensure that their providers have the training they need to carry out these programs successfully.

What would be the cost of *not* passing this bill?

Though passing this bill would come with short-term costs, it would undoubtedly save the state money in the long-run.

From 2007-2010, CDC-funded Expanded Testing Initiative sites provided more than 2.8 million HIV tests. These tests resulted in approximately **18,000 new HIV diagnoses which saved $1.2 billion in direct medical costs.** For every $1 spent on HIV testing, the CDC saved the general public $2 on medical costs.[24]

- The estimated discounted lifetime cost for a person who becomes HIV-infected at age 35 is $326,500 (2012 US dollars).[25]
- For individuals who remain uninfected but at high risk for infection, the discounted lifetime cost is $96,700 (2012 US dollars).[26]
- The medical cost saved by avoiding one HIV infection is $229,800 (2012 US dollars).[27]

Treating HIV *after* immunologic compromise has occurred is far more expensive than screening and early intervention. The economic value of HIV prevention in the U.S. cannot be overstated, especially given the high cost of lifelong HIV treatment.

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[24] Centers for Disease Control and Prevention - HIV Screening and Testing
[25] The Lifetime Medical Cost Savings from Preventing HIV in the United States
[26] The Lifetime Medical Cost Savings from Preventing HIV in the United States
[27] The Lifetime Medical Cost Savings from Preventing HIV in the United States

As more people receive an HIV infection diagnosis, the number of people who are unaware of their infection decreases. **More screening = less transmission. Less transmission = less cases. Less cases = less burden on emergency departments and public health overall.**

Why is there a clause in the bill providing protections for health care professionals from actions for civil damages?

Because health care and public health officials have expressed concerns regarding the difficulty of following up with emergency department patients on Syphilis test results since they will more than likely be discharged before the results come back. Failure to adequately follow-up on test results is a frequent cause for civil suits, and we wanted to make sure that if emergency physicians were going to be required to order HIV and Syphilis screening for many of their patients that there be *some* degree of protection in place for them.