Written Testimony for the Record to the House Subcommittee on Labor, Health and Human Services, Education and Related Agencies regarding FY 2018 Appropriations for HIV/AIDS Programs
Submitted by Dr. Wendy Armstrong, FIDSA, on behalf of the HIV Medicine Association (HIVMA)
March 8, 2017

The HIV Medicine Association (HIVMA) of the Infectious Diseases Society of America (IDSA) represents more than 5,000 physicians, scientists and other health care professionals working on the frontlines of the HIV/AIDS pandemic. Our members provide medical care and treatment to people with HIV/AIDS in the U.S. and globally, lead HIV prevention programs and conduct research that has led to the development of effective HIV prevention and treatment options. As you work on the FY2018 appropriations process, we urge you to **sustain robust funding for the Ryan White Program at the Health Resources and Services and Administration (HRSA); support adequate funding for the Centers for Disease Control and Prevention's (CDC) HIV and STD prevention programs; and to invest in HIV/AIDS research supported by the National Institutes of Health (NIH).**

Early access to effective HIV treatment helps patients with HIV live healthy and productive lives and is cost effective.[1] Treatment not only saves the lives of individuals with HIV but directly benefits public health by reducing HIV transmission risk to near zero.[2] However, despite our remarkable progress in HIV prevention, diagnosis and treatment, the HIV/AIDS epidemic is far from over. HIV/AIDS continues to pose a serious disease burden and public health threat in the United States with more than 1.2 million people living with HIV infection. Almost 1 in 8 (12.8%) individuals living with HIV are not aware of their HIV infection and there have been nearly 40,000 new infections occurring each year as of 2014.[3] As a public health issue, the federal government plays a significant role in leading our nation's response to the epidemic. In the U.S. HIV infection disproportionately impacts racial and ethnic minority communities and

low income people who depend on public services for their life-saving health care and treatment. The rate of new HIV infections in African Americans is 8 times that of whites.[4] Globally, there are more than 35.3 million people living with HIV, the great majority of them in Sub-Saharan Africa.

The funding requests in our testimony largely reflect the consensus of the Federal AIDS Policy Partnership (FAPP), a coalition of HIV organizations from across the country, and are estimated to be the amounts necessary to mount an effective response to the domestic HIV epidemic.

Health Resources and Services Administration (HRSA)– HIV/AIDS Bureau (HAB): With uncertainty in the healthcare insurance market, HRSA's Ryan White HIV/AIDS Program (RWP) will be more important than ever to sustain our progress in treating and preventing HIV in the U.S. The RWP has enjoyed overwhelming bipartisan support since August 1990 when Congress enacted it and President Reagan signed it into law, and today it provides care and treatment services to more than 50% of individuals with HIV in care.

It is essential to maintain overall funding levels for the Ryan White Program at this critical time in the HIV/AIDS epidemic, when research has confirmed that early access to HIV care and treatment not only saves lives and keeps patients engaged and working, but prevents new infections by reducing the risk of transmission from virally suppressed patients to near zero. In particular, HIVMA urges an allocation of $225.1 million, or a $20 million increase over current funding, for Ryan White Part C programs in FY 18. Part C-funded HIV medical clinics currently struggle to meet the demand of increasing patient

caseloads. The expert, team-based and patient-centered Ryan White care model has been highly successful at achieving positive clinical outcomes with a complex patient population. Patients with HIV who receive Ryan White services are more likely to be prescribed HIV treatment and to be virally suppressed.[5] In 2015, the viral suppression rate for all Ryan White clients rose to more than 83%. ***We also know that the annual health care costs for HIV patients who are not able to achieve viral suppression (often due to delayed diagnosis and care) are nearly 2.5 times that of healthier HIV patients.***[6]

CDC - National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP):

Tuberculosis causes more deaths than any other infectious disease, with 9.6 million new illnesses and 1.5 million deaths in 2014. Approximately 480,000 of those cases were multidrug-resistant tuberculosis, including 9.7% that were extensively drug-resistant. **Sustained funding of at least $157.3 million is necessary for TB, HIV and STD prevention and surveillance.**

There are nearly 55,000 new hepatitis transmissions each year, and the CDC estimates that between 2010 and 2014 the country saw a more than 150 percent increase in new hepatitis infections. Similar to the factors that resulted in the 2015 HIV and hepatitis C (HCV) outbreak in Scott County, Indiana, these new hepatitis infections are largely driven by increases in injection drug use. Co-infection levels among people living with HIV and HCV are 25 percent and 10 percent among individuals with HIV and HBV. **We request an increase of $28.8 million above the FY2016 level, for a total of $62.8 million for the CDC's Division of Viral Hepatitis.**

We also support sustained funding for HIV and STD prevention and surveillance, as well as the Division of Adolescent School Health (DASH). We are additionally especially concerned about flat funding of CDC's global HIV programs, and request an increase of at least $3.3 million for a total of $132 million in FY18, which includes resources for the agency's essential role in implementing PEPFAR programs in developing nations.

<u>NIH – Office of AIDS Research (OAR):</u> HIVMA strongly supports an overall FY2018 budget request level of at least $2 billion above the Fiscal Year 2017 appropriation for the National Institutes of Health (NIH). Consistent with the most recent Trans-NIH AIDS Research By-Pass Budget Estimate for FY2017, we ask that at least $3.225 billion be allocated for HIV research at the NIH in FY2018, an increase of $225 million. This level of funding is vital to sustain the pace of research that will improve the health and quality of life for millions of people in the U.S. and in the developing world. Flat funding of HIV/AIDS research since FY2015 threatens to slow progress toward a vaccine and a cure, erode our capacity to sustain our nation's historic worldwide leadership in HIV/AIDS research and innovation, and discourage the next generation of scientists from entering the field.

The NIH-Wide Strategic Plan[7] identifies criteria for setting the NIH's research priorities, including consideration of the value of permanently eradicating a disease. Such an investment makes good economic sense: every new case of HIV diagnosed in the United States translates into a lifetime cost of approximately $350,000 for treatment with antiretroviral drugs. Getting to zero new cases of HIV/AIDS would save our nation an estimated $17.5 billion annually.[8] In

addition, HIV/AIDS research has contributed to the development of effective treatments for other diseases, including cancer and Alzheimer's disease. Congress should ensure our nation does not delay vital HIV/AIDS research progress.

Policy Riders – Continue Progress on Federal Funding for Syringe Exchange Programs:

HIVMA applauds the subcommittee's work in advancing report language that allows for the judicious use of federal funding for syringe exchange programs (SEPs) as an important prevention and public health intervention. We support the continuation of this policy.

Conclusion: We are at serious risk of losing ground against the HIV pandemic if we fail to prioritize HIV public health, treatment and research programs. We must fully leverage and invest in HIV prevention, care and treatment and research to save the lives of millions who are infected or at risk of infection here in the U.S. and around the globe, and ultimately to end the HIV/AIDS epidemic.

---

[1] Kitahata, Gange, Abraham, et al. Effect of early versus deferred antiretroviral therapy for HIV on survival. New Engl J Med 2009;360:1815-26.

[2] Cohen, Myron S., et al. Prevention of HIV-1 Infection with Early Antiretroviral Therapy. 2011 New England Journal of Medicine 493-505: V365, no 6, http://www.nejm.org/doi/full/10.1056/NEJMoa1105243

[3] CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, February 14, 12017 (accessed online at: https://www.cdc.gov/nchhstp/newsroom/2017/croi-hiv-incidence-press-release.html)

[4] CDC Fact Sheet, February, 2014, accessed online at: http://www.cdc.gov/hiv/risk/racialethnic/aa/facts/index.html

[5] Bradley, H., et al. Ryan White HIV/AIDS Program Assistance and HIV Treatment Outcomes in the United States. CROI 2015. Abstract: 1064. Accessed online at: http://www.croiconference.org/sessions/ryan-white-hivaids-program-assistance-and-hiv-treatment-outcomes-united-states.

[6] Based on data from Gilman BH, Green, JC. Understanding the variation in costs among HIV primary care providers. AIDS Care.2008:20;1050–6.

[7] *NIH-Wide Strategic Plan, Fiscal Years 2016–2020: Turning Discovery Into Health*, (December, 2015).

[8] Ibid, p. 32.