Outside Witness Testimony – Fiscal Year 2016 Appropriations

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Prepared for
The United Stated House Committee on Appropriations
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies

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The National Viral Hepatitis Roundtable (NVHR) respectfully submits this testimony to the U.S. House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies (LHHS) regarding the Fiscal Year (FY) 2016 Appropriations hearing. As a broad national coalition representing over 200 organizations committed to fighting, and ultimately ending, the hepatitis B and hepatitis C epidemics, we are gravely concerned about the missed opportunities and negative public health consequences resulting from the lack of resources to adequately address these two communicable viruses in the United States. ***We therefore urge the Subcommittee to increase the allocation for the Division of Viral Hepatitis (DVH) at the Centers for Disease Control and Prevention (CDC) to the full $62.8 million requested by the Administration for FY2016***, an increase of $31.3 million over FY2015.

Further, particularly due to the steep rise in hepatitis C cases that is interconnected with the opioid and heroin addiction crisis, ***we also urge the Subcommittee to prevent policy riders prohibiting the use of federal funds for any program for the purpose of distributing needles or syringes for the purpose of preventing the spread of blood borne pathogens from the FY2016 LHHS Appropriations Bill***, a cost-neutral request, given the critical role syringe services programs (SSPs) play in hepatitis C prevention, screening, and linkage to healthcare and drug treatment. For

more detailed information regarding the ban on federal funds for SSPs, please see separate testimony on the issue submitted by NVHR and allied organizations to this Subcommittee.

This request is especially urgent given: 1) the vital need for robust surveillance infrastructure; 2) the overwhelming contribution of hepatitis B and C to the rising incidence of liver cancer; and 3) the state of the hepatitis C epidemic, with unique challenges in tackling prevalence and incidence, and tremendous opportunity created by new curative treatment.

Scope of the Epidemics

Despite a safe, effective vaccine for hepatitis B, and new curative treatments for hepatitis C, CDC conservatively estimates that approximately 1.4 million Americans are living with chronic hepatitis B, and 3.2 million are living with chronic hepatitis C.[1] These are likely underestimates however, as surveillance systems nationwide are disjointed at best, with only five states and two jurisdictions (Florida, Massachusetts, Michigan, New York, Washington, Philadelphia, and San Francisco) federally funded for such activities.[2] Of primary concern is that of the nearly 5 million individuals thought to be living with hepatitis B and/or C, up to 75% do not know they are infected with a potentially life-threatening and communicable virus, as both hepatitis B and C are most often asymptomatic until the liver is already significantly damaged.[3] On average, hepatitis B and/or C will shorten one's lifespan by 15-20 years.[4]

There are substantial disparities among various communities for both viruses as well. While comprising less than 5% of the U.S. population, Asian American and Pacific Islander communities comprise over 50% of all hepatitis B prevalence.[5] As hepatitis B is endemic in many regions of the

[1] http://www.cdc.gov/hepatitis/Statistics/2012Surveillance/Commentary.htm
[2] http://www.cdc.gov/fmo/topic/Budget%20Information/appropriations_budget_form_pdf/FY2016_CDC_CJ_FINAL.pdf, p. 85-91.
[3] http://www.cdc.gov/fmo/topic/budget%20Information/FY-2016-Fact-Sheets/FY2016_Pres_Budget_Final_VHHMP.pdf
[4] http://cid.oxfordjournals.org/content/58/8/1047.full.pdf+html
[5] http://www.cdc.gov/hepatitis/Populations/api.htm

world, particularly Asia and Africa, the foreign-born and their children are also at risk.[6] Many diverse communities are highly and disproportionately impacted by hepatitis C compared to the general population, including veterans, especially Vietnam-era service members; the "baby boomer" birth cohort (born 1945-1965); communities of color, including tribal communities; the incarcerated/returning citizens; and people who inject drugs.

Strengthening Surveillance

Surveillance – the "continuous, systematic collection, analysis and interpretation of health-related data needed for the planning, implementation, and evaluation of public health practice"[7] – is the core public health service driving effective interventions, and particularly vital for infectious disease. The current surveillance system for hepatitis B and C is woefully underfunded, so available data offers merely a snapshot of the epidemics, albeit an alarming one. Without significantly bolstering states' ability to leverage existing systems of surveillance, the epidemics will stay ahead of our efforts to eliminate them – a goal achievable in coming decades with dedicated resources. CDC's Division of Viral Hepatitis has identified strengthening surveillance as one of its primary strategic goals given an increase in appropriations.[8]

Hepatitis B, Hepatitis C, and Liver Cancer

Liver cancer is one of the potential long-term consequences of chronic hepatitis B and C, and among the most aggressive and deadliest cancers with a devastatingly low 15% five-year combined survival rate.[9] Despite a downward trend in the incidence of many cancers, we unfortunately see the reverse with liver cancer where rates are rising. In fact, hepatitis C infection alone leads all causes of

[6] Ibid.
[7] http://www.who.int/topics/public_health_surveillance/en/
[8] http://www.cdc.gov/fmo/topic/Budget%20Information/appropriations_budget_form_pdf/FY2016_CDC_CJ_FINAL.pdf, p. 85-91.
[9] http://www.cancer.org/cancer/livercancer/detailedguide/liver-cancer-survival-rates

liver cancer.[10] Not only can the debilitating consequences of hepatitis B and C be avoided – with vaccination for hepatitis B and curative treatment for hepatitis C – addressing these epidemics can serve the secondary purpose of preventing a substantial proportion of primary liver cancer cases.

Hepatitis C – Unique Challenges and Opportunities

The hepatitis C epidemic exists in two fairly distinct waves. The majority of prevalence is among the baby boomer birth cohort, who comprise about 75% of those currently living with hepatitis C. While this population by and large is not transmitting the virus, the majority do not know they are infected and have likely been living with hepatitis C for decades. As this community ages, hepatitis C's long-term impacts will become more apparent as patients increasingly present with cirrhosis (scarring) of the liver, end-stage liver disease, liver cancer, and the need for liver transplants. A recent study suggests that nearly half of baby boomers with hepatitis C already have severe liver scarring and need immediate treatment.[11] As they rapidly age into Medicare, it is vital to identify those living with hepatitis C and link them to appropriate care and treatment.

A second emerging wave of the epidemic drives current transmission. As Americans nationwide are devastated by the current crisis of prescription opioid addiction – particularly among youth under 30 in rural and suburban communities – the trend begins with misuse of oral opioid painkillers, to experimenting with injecting, followed often by a transition to heroin.[12] Directly on the heels of this crisis is a new, sustained spike in hepatitis C, with CDC reporting a 75% increase in new cases from 2010-2012[13] (likely a significant underestimate due to lack of surveillance infrastructure, as discussed above). While new infections in just three states – Tennessee, West

[10] http://www.cdc.gov/fmo/topic/budget%20Information/FY-2016-Fact-Sheets/FY2016_Pres_Budget_Final_VHHMP.pdf
[11] http://www.hivandhepatitis.com/hepatitis-c/hepatitis-c-topics/hcv-disease-progression/5086-croi-2015-liver-disease-progression-is-common-among-baby-boomers-with-hepatitis-c
[12] https://www.aids.gov/pdf/hcv-and-young-pwid-consultation-report.pdf
[13] http://www.cdc.gov/hepatitis/Statistics/2012Surveillance/Commentary.htm#hepC

Virginia, and Kentucky – comprise 20% of overall incidence, a distressing 35 of 41 states reporting data to CDC saw increases in hepatitis C infection rates.[14] States urgently need existing federal prevention grant funding to utilize and sustain syringe services programs as part of a comprehensive prevention response; lifting the ban on the use of federal funds for SSPs is a crucial and cost-neutral policy fix.[15]

Despite the many challenges in catching up to this epidemic, it is also a time of tremendous opportunity for those living with hepatitis C. In the past several years, new direct-acting antivirals entered the market, with cure rates over 90%, far shorter regimens, and few to no side effects compared to previous treatments. With this medical innovation has come hope for millions, and a cure can be offered to those who test positive. Although these new options have revolutionized hepatitis C treatment, there are a number of natural barriers to treating everyone who needs it; most significantly, up to 75% of those living with hepatitis C do not know it as most will not experience symptoms, and there is a significant lack of provider capacity. Building the capacity of providers and scaling efforts to identify those with hepatitis C are among DVH's strategic priorities given a modest increase in resources.

Again, we strongly urge the Subcommittee to increase the allocation for CDC's DVH to $62.8 million for FY2016, an increase of $31.3 million over FY2015, as well as to prevent policy riders prohibiting the use of federal funds for syringe access in the FY2016 LHHS Appropriations bill. We thank Chairman Cole, Ranking Member DeLauro, and members of the Subcommittee for their thoughtful consideration of our request.

[14] http://www.cdc.gov/hepatitis/Statistics/2012Surveillance/Commentary.htm

[15] Please see separate testimony on this issue submitted by NVHR and allied organizations to this Subcommittee.