

Outside Witness Testimony – Fiscal Year 2016 Appropriations

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Prepared for
The United States 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, and Education, and Related Agencies (LHHS) regarding the Fiscal Year (FY) 2017 Appropriations bill. As a broad national coalition representing approximately 350 public and private organizations committed to ending the hepatitis B (HBV) and hepatitis C (HCV) epidemics domestically, we are gravely concerned about the missed opportunities and public health consequences resulting from a lack of urgency and resources to adequately address these communicable viruses in the U.S.

We therefore urge the Subcommittee to increase the appropriation for the Division of Viral Hepatitis (DVH) at the Centers for Disease Control and Prevention (CDC) to no less than \$62.8 million in FY2017, an increase of \$28.8 million over FY2016. Further, particularly due to the dramatic rise in HCV and, increasingly, HBV cases that are interconnected with the opioid/heroin addiction crisis, we also urge the Subcommittee to maintain modified language regarding the use of federal funds as outlined in the FY2016 LHHS Appropriations Bill, given the critical role syringe services programs (SSPs) play in viral hepatitis prevention and linkage to healthcare and drug treatment. NVHR further encourages the committee to appropriate additional funds specifically to support SSPs in FY2017 given the current crises driven by the syndemic of opioid

and heroin addiction, overdose death, and chronic viral hepatitis infection (which may additionally serve as an early harbinger of an HIV outbreak, as seen in Scott County, Indiana in early 2015).

This request is timely and urgent, given: 1) preventable health disparities; 2) the vital need for robust surveillance; 3) the role of HBV and HCV infection in the rising incidence of liver cancer; and 4) the state of the hepatitis C epidemic, with unique challenges and tremendous opportunity.

Scope of the Epidemics

Despite a safe, effective vaccine for HBV, and revolutionary curative treatments for HCV, CDC conservatively estimates that approximately 1.2 million Americans are living with chronic HBV, and 3.2 million are living with chronic HCV.¹ These are likely underestimates however, as surveillance systems across the nation 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 those living with HBV and/or HCV, at least 50-66% do not know they are infected with a potentially life-threatening, communicable virus, as most often no symptoms present until the liver is already significantly damaged.³ On average, HBV and/or HCV will shorten one's lifespan by 15-20 years.⁴

Health Inequity

There are alarming and unacceptable disparities among various communities for both of these viruses as well. While comprising less than 5% of the U.S. population, Asian American and Pacific Islander (AAPI) bear over 50% of domestic HBV prevalence.⁵ As HBV is also endemic in many regions globally, particularly in Asia and Africa, the foreign-born and their children are also at

¹ <http://www.cdc.gov/hepatitis/abc/index.htm>

² <http://www.cdc.gov/hepatitis/statistics/2013surveillance/commentary.htm>

³ <http://www.cdc.gov/hepatitis/abc/index.htm>

⁴ <http://cid.oxfordjournals.org/content/58/8/1047.full.pdf+html>

⁵ <http://www.cdc.gov/hepatitis/Populations/api.htm>

high risk.⁶ Many diverse communities are highly and disproportionately impacted by HCV also, including veterans; the “baby boomer” birth cohort (born 1945-1965); communities of color, particularly tribal communities; the incarcerated/returning citizens; and people who inject drugs.

Strengthening Surveillance

Surveillance is the core public health service driving effective interventions, particularly for infectious disease. The current system of surveillance for HBV and HCV is woefully underfunded, and as such available data provides merely a snapshot of the epidemics, albeit an alarming one. Without significantly bolstering states’ ability to leverage existing systems of surveillance, these epidemics will remain ahead of our efforts to eliminate them – a goal achievable in the coming decades with dedicated resources. Of particular concern is that, despite a dearth of surveillance resources, increases in perinatal transmission of HCV are now being identified.^{7,8}

Hepatitis B, Hepatitis C, and Liver Cancer

Liver cancer is one of several potential long-term consequences of chronic HBV and HCV infection, and is one of the most aggressive and deadliest cancers with a devastatingly low 15% five-year survival rate.⁹ Despite a downward trend in incidence of various cancers, liver cancer rates are increasing faster than any other cancer site.¹⁰ The *2016 Annual Report to the Nation on the Status of Cancer* further found that HCV alone accounts for 22% of the liver cancer burden in the U.S.¹¹ Not only can the many debilitating consequences of HBV and HCV be avoided with vaccination and treatment for HBV and curative treatment for HCV, addressing these epidemics can serve the

⁶ Ibid.

⁷ <http://slideplayer.com/slide/8867285/>

⁸ http://mcaap.org/wp2013/wp-content/uploads/2014-MIAP-Conference-PM-session4_HCV-among-infants-in-MA_Kerri-Barton.pdf

⁹ <http://www.cancer.org/cancer/livercancer/detailedguide/liver-cancer-survival-rates>

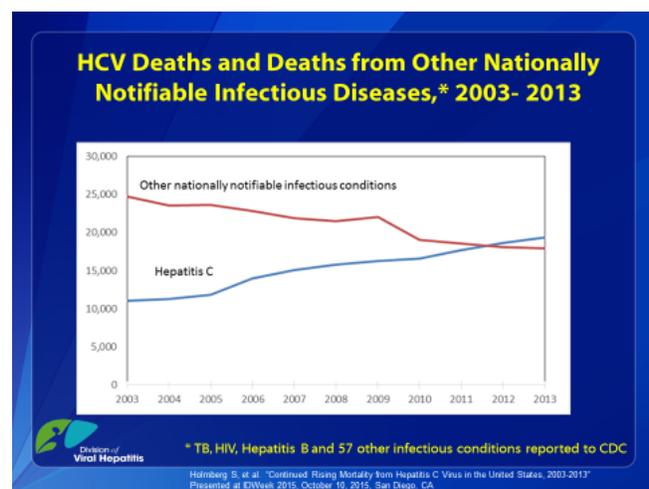
¹⁰ <http://onlinelibrary.wiley.com/doi/10.1002/cncr.29936/pdf>

¹¹ Ibid.

secondary purpose of preventing a substantial proportion of primary liver cancer cases. Indeed, treatment for HBV and HCV is associated with 50-80% and 75% reductions in the risk of developing liver cancer, respectively. Outcomes also show that the AAPI community historically has been most affected by liver cancer, and African Americans and Latinos are the youngest to die from liver cancer (median age).¹² Further, preventable perinatal transmission of HBV stubbornly remains; about 90% of infected infants will develop chronic infection, experiencing such consequences far earlier.¹³

Hepatitis C – Unique Challenges and Opportunities

The HCV epidemic presents in two fairly distinct waves. First is the majority of prevalence affecting the baby boomer birth cohort, which comprises about 75% of those currently living with HCV, and the majority does not know they are infected. As this community ages, patients will increasingly present with cirrhosis (scarring) of the liver, end-stage liver disease, liver cancer, and the need for liver transplantation. A recent study suggests that nearly half of those in this birth cohort already have severe liver scarring and need immediate treatment.¹⁴ As baby boomers rapidly age into Medicare, it is vital to identify those living with HCV and link them to care and treatment. Strikingly, as indicated in the chart at right, CDC data show that as of 2012, *mortality attributable to HCV alone now surpasses that of all other 59 nationally notifiable infectious diseases combined.*



¹² Ibid.

¹³ https://blog.aids.gov/wp-content/uploads/Perinatal_HBV_Report_FINAL_12-21-15-508.pdf

¹⁴ <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>

Of equal concern is current and ongoing transmission of HCV. As Americans nationwide are devastated by the crises of opioid/heroin addiction, there have been parallel increases in HCV, with CDC reporting a 151% increase in new infections from 2010-2013, predominantly among young people and increasingly in non-urban regions.¹⁵ Further, early 2016 CDC data also indicate a 114% increase in acute cases of HBV from 2009-2013 in Kentucky, West Virginia, and Tennessee.¹⁶

Despite the many challenges currently facing us, this is also a time of tremendous opportunity for those living with HCV. In the past several years, new direct-acting antivirals have come to market offering cure rates of over 90%, with much shorter regimens and few to no side effects compared to previous treatments. With this medical innovation has come hope for millions, and an effective intervention can be offered to those who test positive.

While such options have revolutionized HCV treatment, and there is a safe, effective vaccine and treatment to successfully control HBV, a number of natural barriers to treating everyone who needs it remain; most significantly, the majority of those living with HBV and HCV are unaware of their status, there is a significant lack of provider capacity particularly in rural areas and those serving immigrant and refugee communities, and surveillance is still piecemeal at best.

Again, we strongly urge the Subcommittee to increase the appropriation for CDC's DVH to no less than \$62.8 million for FY2017, to maintain language permitting use of federal funding under specific circumstances for syringe services programs as outlined in the FY2016 LHHS Appropriations bill, and to further appropriate additional funds specifically to support SSPs in FY2017. We thank Chairman Cole, Ranking Member DeLauro, and members of the Subcommittee for their thoughtful consideration of our request.

¹⁵ <http://www.cdc.gov/hepatitis/statistics/2013surveillance/commentary.htm#hepatitisC>

¹⁶ <http://www.cdc.gov/mmwr/volumes/65/wr/mm6503a2.htm>