Outside Witness Testimony – Fiscal Year 2016 Appropriations

Submitted by
Christine Rodriguez, Public Policy Manager, crodriguez@nvhr.org
National Viral Hepatitis Roundtable

Prepared for
The United States Senate Committee on Appropriations
Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies
Agency: Centers for Disease Control and Prevention, Division of Viral Hepatitis

April 3, 2015

The National Viral Hepatitis Roundtable (NVHR) respectfully submits this testimony to the U.S. Senate Appropriations Subcommittee on Labor, Health and Human Services, and 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 many 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 current 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***, given the critical role syringe services programs (SSPs) play in hepatitis C prevention 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 both timely and urgent, given: 1) the vital need for a robust surveillance infrastructure; 2) the overwhelming contribution of hepatitis B and C to the rising incidence of liver cancer; and 3) the current state of the hepatitis C epidemic, with unique challenges in addressing prevalence and incidence among two distinct generations, 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, the 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 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 the nearly 5 million individuals thought to be living with hepatitis B and/or C, up to 75% of them do not know they are infected with a potentially life-threatening, communicable virus, as both hepatitis B and C most often present with no symptoms 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 significant disparities among various communities for both of these viruses as well. While comprising less than 5% of the US population, Asian Americans and Pacific Islander communities comprise over 50% of all hepatitis B prevalence.[5] As hepatitis B is also endemic in many regions of the world, particularly in 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, particularly for infectious disease. The current system of surveillance for hepatitis B and hepatitis C is woefully underfunded, and as such the 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. 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 several potential long-term consequences of chronic hepatitis B and C infection, and is one of the most aggressive and deadliest cancers with a devastatingly low 15%

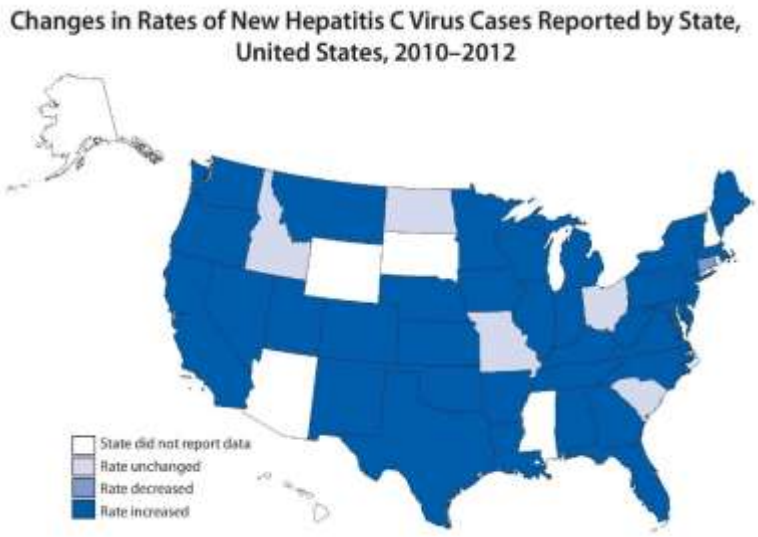
[1] http://www.cdc.gov/hepatitis/Statistics/2012Surveillance/Commentary.htm
[2] http://www.cdc.gov/fmo/topic/Budget%20Information/appropriations_budget_form_pdf/FY2016_CDC_CJ_FINAL.pdf, p. 85-91.
[3] http://www.cdc.gov/fmo/topic/budget%20Information/FY-2016-Fact-Sheets/FY2016_Pres_Budget_Final_VHHMP.pdf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

five-year survival rate for all stages combined.[9] Despite a downward trend in incidence of various cancers, unfortunately we see the reverse with liver cancer where rates are rising. In fact, hepatitis C infection alone leads all causes of liver cancer burden.[10] Not only can the debilitating consequences of hepatitis B and hepatitis C be avoided with effective intervention – including 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 presents in two fairly distinct waves. First is the majority of prevalence, existing among the baby boomer cohort which comprises about 75% of those currently living with hepatitis C. While this population by and large is not continuing to transmit the virus, the majority do not know they are infected and have likely been living with hepatitis C for decades. As this community ages, the long term impacts of the disease are going to become more apparent as patients 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 individuals in this birth cohort already have severe liver scarring and are in need of immediate treatment.[11] As baby boomers rapidly age into Medicare, it is vital to identify those living with hepatitis C and link them to appropriate care and treatment.

A second and recently emerging wave of the epidemic drives current transmission. As Americans across the nation have been devastated by the current crisis of prescription opioid addiction – particularly 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 the Centers for Disease Control and Prevention (CDC) reporting a 75% increase in new infections from 2010-2012[13] (likely a significant underestimate due to lack of



[9] http://www.cancer.org/cancer/livercancer/detailedguide/liver-cancer-survival-rates
[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

surveillance infrastructure). As illustrated in the map above, while new infections in just three states –Tennessee, West 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]

Decades of research have proven syringe services programs to be an effective prevention intervention for hepatitis C, serving also to connect people who inject drugs to medical, mental health, and social services, overdose prevention, as well as drug treatment.[15] It is critical that states have full control over their existing federal prevention grant funding to address the unique circumstances of local epidemics; as such, lifting the ban on the use of federal funds for SSPs is an urgent and cost-neutral policy fix.[16]

Despite the many challenges currently facing us in catching up to this epidemic, this is also a time of tremendous opportunity for those living with hepatitis C. In just the past several years, new direct-acting antivirals have entered the market that offer cure rates of over 90%, as well as 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. 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 the strategic priorities DVH intends to address 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 Blunt, Ranking Member Murray, and members of the Subcommittee for their thoughtful consideration of our request.

[14] http://www.cdc.gov/hepatitis/Statistics/2012Surveillance/Commentary.htm
[15] http://www.amfar.org/uploadedFiles/_amfarorg/Articles/On_The_Hill/2013/IB%20SSPs%20031413.pdf
[16] Please see separate testimony on this issue submitted by NVHR and allied organizations to this Subcommittee.