

**Testimony to the House Labor, Health and Human Services,
Education and Related Agencies Subcommittee**

Submitted on behalf of CAEAR Coalition:

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On behalf of the tens of thousands of individuals living with HIV/AIDS to whom members of the Communities Advocating Emergency AIDS Relief (CAEAR) Coalition provide care, I thank Chairman Rogers and Subcommittee Chairman Kingston and Ranking Member Lowey and Subcommittee Ranking Member DeLauro for affording us the opportunity to submit testimony regarding increased funding for the Ryan White HIV/AIDS Program.

The Communities Advocating Emergency AIDS Relief (CAEAR) Coalition is a national membership organization which advocates for sound federal policy, program regulations, and sufficient appropriations to meet the care, treatment, support service and prevention/wellness needs of people living with HIV/AIDS and the organizations that serve them, focusing on ensuring access to high quality health care and the evolving role of the Ryan White HIV/AIDS Program.

A Wise Investment in a Program That Works

The Ryan White HIV/AIDS Program works and demonstrates its essential role in securing the health of thousands of low-income, uninsured and underinsured people living with HIV/AIDS. In its Program Assessment Rating Tool (PART), the White House Office of Management and Budget (OMB) gave the Ryan White Program its highest possible rating of “effective”—a distinction shared by only 18% of all programs rated.

According to OMB, effective programs “set ambitious goals, achieve results, are well-managed and improve efficiency.” Even more impressively, OMB’s assessment of the Ryan White Program found it to be in the top 1% of all federal programs in the area of “Program Results and Accountability.” **Out of the 1,016 federal programs rated—98% of all federal programs—the Ryan White HIV/AIDS Program was one of seven that received a score of 100% in “Program Results and Accountability.”**

The Patient Protections and Affordable Care Act (ACA) is being implemented in states and jurisdictions across the United States. The impact of ACA coverage and the ways in which the Ryan White HIV/AIDS Program will need to integrate and compliment public and private health insurance coverage is still a work in progress. Until ACA implementation is more uniform and systems integration is complete, Ryan White will continue to serve as the indispensable safety net for thousands of low-income, uninsured or underinsured people living with HIV/AIDS.

- Part A provides much-needed funding to the 56 major metropolitan areas hardest hit by the HIV/AIDS epidemic with severe needs for additional resources to serve those living with HIV disease in their communities.
- Part B assists states and territories in improving the quality, availability, and organization of health care and support services for individuals and families with HIV.
- The AIDS Drug Assistance Program (ADAP) in Part B provides life-saving, urgently needed medications to people living with HIV/AIDS in all 50 states and the territories.
- Part C provides grants to 444 faith- and community-based primary care health clinics and public health providers in 49 states, Puerto Rico and the District of Columbia. These clinics play a central role in the delivery of HIV-related medical services to underserved communities, people of color, and rural areas where Part C funded clinics provide the only HIV specific medical services available in the region.
- Part F AETC supports training for health care providers to identify, counsel, diagnose, treat, and manage individuals with HIV infection and to help prevent high-risk behaviors that lead to infection. It has 11 regional centers and 130 local community sites with coverage in all 50 states.

CAEAR Coalition’s FY 2015 funding requests for Part A, Part B base and ADAP, and Part C reflect the amounts authorized by Congress in the most recent authorization of the program.

There continues to be an increasing gap between the number of people living with HIV/AIDS in the U.S. in need of care and the federal resources available to serve them. Between 2001 and 2009 the number of people living with AIDS grew 44% and yet funding for medical care and support services in communities with the greatest burden of HIV disease grew less than 12% between 2001 and 2011.

Similarly, funding for Part C–funded, faith and community-based primary care clinics, which provide medical care for people living with HIV/AIDS in remote, rural and geographically isolated, urban communities nationwide, grew by only 11% between 2001 and 2012 as the number of people they care for grew by 52%. The authorized amounts we request would not fully address these funding deficiencies, but would begin to reduce the still growing gaps in funding.

We thank you in advance for your consideration of our comments and our request for:

- \$686.7 million for Part A to support grants to the cities where most people with HIV/AIDS live and receive their care and treatment.
- \$427.5 million for Part B base to provide additional needed resources to the states to bolster the public health response statewide regardless of location.
- \$943.3 million in funding for the AIDS Drug Assistance Program (ADAP) line item in Part B so uninsured and underinsured people with HIV/AIDS can access the anti-HIV and other prescribed medications they need to survive and insurance premiums, co-pays and co-insurance costs for treatment can be supported.
- \$225.1 million for Part C to support grants to faith- and community-based organizations, health care agencies, and clinics.

- \$34.5 million to fund the 11 regional centers funded under by Part F AETC to offer specialized clinical education and consultation to frontline providers.

Sufficient Funding for Ryan White Programs Saves Money and Saves Lives

Increased funding for Ryan White Programs will reap a significant health return for minimal investment. Data show that Part A and Part C programs have reduced HIV-related hospital admissions by 30% nationally and by up to 75 % in some locations. The programs supported by the Ryan White HIV/AIDS Program also have been critical in reducing AIDS mortality by 70 %. The Ryan White Program works, resulting in both economic stimulus and social savings by keeping people healthy and productive.

Growing Needs as More Tested and Entering Care

The Centers for Disease Control and Prevention (CDC) estimates that as of 2008 there were 1,178,350 persons living with HIV/AIDS in the U.S. This represents an increase of approximately 7% from the previous estimate in 2006. Among persons initially diagnosed with HIV infection during 2008, one-third (33%) received an AIDS diagnosis within 12 months. These late diagnoses represent missed opportunities for treatment and prevention.

The FY 2015 appropriation presents a crucial opportunity to provide the Ryan White Program with the levels of funding needed to address a growing epidemic in young men, as the CDC continues to increase efforts to expand HIV testing so people living with HIV know their status, control their health, and protect others.

CAEAR Coalition supports efforts to help individuals infected with HIV learn their status at the earliest possible time. The White House HIV Care Continuum Initiative is focused on improving the health outcomes and well being for people living with HIV by ensuring that more individuals are tested and identified as HIV positive, then linked to care, retained in care, offered antiretroviral treatment and then supported in their treatment regimen to achieve improved health and viral suppression—making an individual living with HIV dramatically less infectious to others.

Research clearly shows that averting a single HIV infection saves \$221,365 in lifetime health care costsⁱ, and getting people on anti-HIV treatment early lowers levels of HIV circulating in the body and reduces potential transmissionsⁱⁱ—saving lives and money in the long term—but we must invest now in care and treatment to reap those rewards. Caring for individuals early in their disease will increase the cost of care by \$2.7 billion over five years and the majority of those costs will fall to federal discretionary programs like the Ryan White Program and will not be offset by entitlement programs.ⁱⁱⁱ

Community-based providers are stretched to provide high-quality care with the scarce resources available. CAEAR Coalition is concerned that many HIV expert medical staff are scheduled to retire and the persistent financial pressures may accelerate the loss of trained professionals in the field. This additional pressure on an already overburdened system will leave many of the more than 200,000 HIV-infected individuals who do not know their HIV status without access to the care they need.

State budget cuts to health services create a continuing and growing challenge for ADAPs especially in states that are not expanding their Medicaid programs and the cost of medications continue to increase. In states that are implementing ACA through state marketplaces or the federal exchange, the need for insurance premium and co-insurance support is important to real access and affordability. Additional resources are needed to reduce and prevent further use of cost-containment measures to limit access to ADAPs and to allow all state ADAPs to provide a full range of HIV antiretrovirals and treatment for opportunistic infections.

The number of clients entering the 444 community health centers and outpatient clinics has consistently increased over the last five years and will rise significantly as ACA implementation is fully realized. Part C-funded federally qualified health centers, with access to HIV care and treatment expertise, will play an increasing role in providing HIV health care for individuals coming into to the health care system through ACA. Over 255,000 unduplicated persons living with HIV/AIDS receive medical care in Part C-funded community health centers and clinics each year. These faith- and community-based HIV/AIDS providers are staggering under the burden of treatment and care after years of funding cuts prior to the modest increase in recent years. The decision of the U.S. Preventive Services Task Force to give an A grade to routine HIV testing combined with earlier guidance from the CDC, which recommended routine HIV testing for individuals 15-65, has had the intended impact and identified thousands of new clients for Part C-funded health centers and clinics. Additional service funding and training support will be required to serve these additional clients. CAEAR Coalition is encouraged by the partnership between the Bureau of Primary Care and the HIV/AIDS Bureau at the Health Resources and Services Administration to effectively address this new influx of clients and to enhance the provision of high-quality health care services and treatment access for people with HIV/AIDS.

Ryan White-Funded Programs are Economic Engines in their Communities

Ryan White-funded programs, including many community health centers, are small businesses providing jobs, vendor contracts and other types of economic development to low-income, urban and rural communities, frequently serving as anchors for existing and new businesses and investments. These organizations employ people in their communities, providing entry-level jobs, community-based training and career building.

For example, a large, urban community health center brings an estimated economic impact of \$21.6 million, employing 281 people, and a small, rural health center has an estimated economic impact of \$3.9 million, employing 52 people. Investing in AIDS care and treatment is an investment in jobs in communities that need it most.

Ryan White Program Key to Meeting the Goals of the National HIV/AIDS Strategy

CAEAR Coalition is eager to work with Congress to meet the challenges posed by the HIV/AIDS epidemic. In 2014, we have the collective chance to implement the community-embraced health care goals and policies in the National HIV/AIDS Strategy (NHAS). The National Strategy is an opportunity to reinvigorate the nation's response to the HIV/AIDS epidemic and stop its relentless movement into our communities. The Ryan White HIV/AIDS Program is key to reaching the NHAS goals of reducing new HIV infections, increasing access to care and improving health outcomes for people living with HIV/AIDS, and reducing HIV-related health disparities. Ryan White provides HIV/AIDS care and treatment services to a significantly

higher proportion of racial/ethnic minorities and women than their representation among reported AIDS cases—suggesting the programs and resources are targeted to underserved and marginalized populations. Early care and treatment are more critical than ever because we can help those infected learn their status and get them into care and treatment in order to improve their own health and the health of their communities.

The Ryan White Program’s history of accomplishments for public health and people living with HIV/AIDS is a wonderful legacy for the U.S. Congress. There continues to be a vast need for additional resources to address the health care and treatment needs of people living with HIV across the country. In recognition of its high level of effectiveness and validation over time from credible federal government institutions, CAEAR Coalition urges the committee to provide the Ryan White HIV/AIDS Program with the funding levels authorized by Congress for Fiscal Year 2015.

ⁱ Holtgrave DR, Briddell K, Little E, Bendixen AV, Hooper M, Kidder DP, et al. Cost and threshold analysis of housing as an HIV prevention intervention. *AIDS & Behavior*.(2007)11(Suppl 2), S162-S166.

ⁱⁱ Montaner J, Lima VD, Barrios R, et al. Association of highly active antiretroviral therapy coverage, population viral load, and yearly new HIV diagnoses in British Columbia, Canada: a population-based study. *The Lancet* (2010) 376(9740): 532-539.

ⁱⁱⁱ Martin EG, Paltiel AD, Walensky, RP, Schackman BR, Expanded HIV Screening in the United States: What Will It Cost Government Discretionary and Entitlement Programs? A Budget Impact Analysis. *Value in Health* (2010) 13: 893–902.