



Testimony Submitted by

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Representing the Hepatitis Appropriations Partnership

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Human Services, and Education

On the Fiscal Year 2011 budget including:  
Centers for Disease Control and Prevention's Viral Hepatitis Prevention Program  
and 317 Vaccine Program;  
Health Resources and Services Administration's Community Health Centers and  
Ryan White Program; and  
Substance Abuse and Mental Health Services Administration

Wednesday, May 12, 2:00PM

As the Adult Viral Hepatitis Prevention Coordinator and epidemiologist in the Department of Public Health for the Commonwealth of Massachusetts, member of the Hepatitis Appropriations Partnership (HAP), and member of the National Alliance of State and Territorial AIDS Directors (NASTAD), I respectfully submit testimony for the record on behalf of HAP and NASTAD regarding federal funding for viral hepatitis in the FY2011 Labor, HHS and Education Appropriations legislation.

Viral hepatitis refers to a group of contagious liver viruses such as hepatitis B and C that are the leading causes of liver disease, liver cancer, liver transplantation and premature death in about 15,000 Americans annually. It is also the most common cause of death in Americans co-infected with hepatitis and HIV where as many as 25% of HIV-positive Americans are living with hepatitis C and 10% with hepatitis B. These diseases impose a chronic disease burden on Americans where over 5 million people are living with lifelong hepatitis B or C infection and 65-75% do not know it. Chronic hepatitis B and C infections cost the United States approximately \$16 billion each year. If left unchecked, the projected direct and indirect cost in the next decade of just the current hepatitis C epidemic—not including the hepatitis B epidemic—is \$85 billion. Especially given that baby boomers account for two out of every three cases of chronic hepatitis C, we know millions of Americans will be progressing in their liver disease and aging into Medicare within the decade. In addition, chronic viral hepatitis disproportionately affects racial and ethnic communities. African Americans have the highest rate of acute hepatitis B infections in the United States. African Americans and Hispanics have higher rates of hepatitis C infection than Caucasians. Finally, chronic hepatitis B is a leading cause in death in Asian Americans, with as many as 1 in 10 living with chronic hepatitis B.

Despite these burgeoning diseases and the ramifications of mortality and cost, viral hepatitis is one of the most underfunded and neglected diseases compared to other chronic diseases. States receive on average only \$90,000 annually for hepatitis prevention in adults. This provides for little more than one staff position—I am that staff person in the Massachusetts Department of Public Health. In the states, there is typically no funding for actual core public health services such as hepatitis outreach and education, screening and testing, or management and care. There is almost no funding for a surveillance system to capture the prevalence and incidence of these diseases. Because of this, there is no funding for community-based organizations to provide these and other services.

In Massachusetts, it is estimated that over 100,000 people are living with hepatitis C virus alone, most of whom have not been diagnosed and may not be aware of their infection. Since 2002, we have received reports of 8,000-10,000 newly diagnosed cases of chronic hepatitis C and 2,000 newly diagnosed cases of chronic hepatitis B each year. Since 2005, there has been a striking increase in the numbers of people under the age of 25 being reported with chronic hepatitis C infection, indicating a new epidemic of disease, largely due to heroin use among youth. Despite this remarkably high volume of morbidity and mortality, the public health response has been greatly constrained by limited awareness and subsequent low funding to support prevention, screening and medical management programs. The Massachusetts Department of Public Health has had a Viral Hepatitis Program in place since 1999. Currently, there is no state funding available directly for the program and we rely on federal funding—especially under the current economic climate of state budget cuts, state furloughs, and a diminishing and aging public health workforce. In addition, due to the limited funds for viral hepatitis, many hepatitis programs rely

on other funding streams such as HIV prevention funding and we have seen in the past year a significant decrease in funding to these programs as well. Given these funding challenges, states can do little to effectively prevent, control and manage the hepatitis epidemics in their jurisdictions.

The Institute of Medicine recently issued a report *Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C*. I was a member of the panel that authored the report and the report has attributed the lack of knowledge and awareness among the American public and health providers, the large health disparities, and the high mortality rates, to the lack of dedicated resources. Without concerted efforts to respond, Americans will continue to be infected and fail to be identified, diminishing their quality of life and life expectancy, as well as increasing labor and health costs, especially to Medicaid and Medicare.

As you craft the FY2011 Labor-HHS-Education Appropriations legislation, HAP and NASTAD urge you to consider the following critical funding needs of viral hepatitis programs:

**Specific funding needs:**

- We are requesting an increase of \$30.7 million for a total of \$50 million for the Centers for Disease Control and Prevention (CDC) Division of Viral Hepatitis (DVH);
- At least \$20 million for an adult hepatitis B vaccination initiative through the CDC Section 317 Vaccine Program;
- \$10 million for the Substance Abuse and Mental Health Services Administration (SAMHSA) to fund a project within the Programs of Regional and National Significance (PRNS) to reach persons who use drugs with viral hepatitis prevention services;

**General funding needs:**

- Increase funding for Community Health Centers to increase their capacity to serve people with chronic viral hepatitis and provide coordinated care;
- Increase funding for the Ryan White Program to adequately cover persons co-infected with HIV and viral hepatitis through additional case management, provider education and coverage of viral hepatitis drug therapies;
- Increase funding for the National Institutes of Health to support their *Action Plan for Liver Disease Research*

**Specific funding needs**

*Division of Viral Hepatitis*

FY2011 Request: \$30.7 million

The recently released Institute of Medicine (IOM) report, *Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C* found that the public health response needs to be significantly ramped up. The IOM report attributes low public and provider awareness to the lack of public resources. Seventeen of the 22 recommendations in the report are specific to CDC DVH and state health departments. In order to implement these recommendations to improve the federal response, resources must be increased to health departments which are the backbone of the nation's public health system and coordinate the response to these epidemics.

President Obama's budget proposal includes a \$1.8 million increase for a total of \$21.1 million for the Division of Viral Hepatitis (DVH) at CDC, which is woefully insufficient to address infectious diseases of this magnitude. States and cities receive \$5 million total that averages to \$90,000 per jurisdiction. This is only enough for a single staff position and is not sufficient for the provision of core surveillance and direct care services. These services are essential to preventing new infections, increasing the number of people who know they are infected, and following up to help those identified to remain healthy and productive. We believe at a minimum funding to health departments should double to \$10 million. This increase is an important first step to making hepatitis prevention services more widely available. The expanded services should include hepatitis B and C education, counseling, testing, and referral in addition to delivering hepatitis A and B vaccine, and establishing a surveillance system of chronic hepatitis B and C.

#### *Section 317 Vaccine Program*

FY2011 Request: \$20 million

CDC identified funds through program cost savings in the Section 317 Vaccine Program, allocating \$20 million in FY2008 and \$16 million in FY2009 for purchase of the hepatitis B vaccine for high-risk adults. We commend CDC for prioritizing high-risk adults with this initiative, but relying on the availability of these cost savings is not enough. Additionally, this initiative does not support any supplies, infrastructure or personnel and health departments need additional funding to support the delivery of this vaccine. We request a continuation of \$20 million in FY2011 for an adult hepatitis B vaccination initiative through the CDC's Section 317 Vaccine Program.

#### *Substance Abuse and Mental Health Services Administration*

FY2011 Request: \$10 million

Persons who use drugs are disproportionately impacted by hepatitis B and C. The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention (CSAP) and Center for Substance Abuse Treatment (CSAT) are uniquely positioned to reach populations at risk for hepatitis B and C. The existing infrastructure of substance abuse prevention and treatment programs in the United States provides an important opportunity to reach Americans at risk or living with viral hepatitis. We urge you to provide \$10 million to SAMHSA to fund a project within the Programs of Regional and National Significance (PRNS) to reach persons who use drugs with viral hepatitis prevention services.

### **General funding needs**

#### *Medical Management and Treatment*

Access to medical care, available treatments and support services are critical to combat viral hepatitis mortality. While we are supportive of the President's efforts to modernize and expand access to health care, we also support increased funding for existing safety net programs. Low-income patients who are uninsured or underinsured can and do seek services at Community Health Centers (CHCs). Even for those with health insurance, treatment of viral hepatitis is complex and requires care coordination among many different providers and services. With the growing importance of CHCs as a safety net in providing frontline support for these individuals, we support increasing resources for CHCs to increase their capacity to serve people with chronic viral hepatitis.

Many low-income individuals co-infected with viral hepatitis and HIV can obtain services through the Ryan White Program, however only half of the state AIDS Drug Assistance Programs (ADAPs) are able to provide viral hepatitis treatments to co-infected clients. We urge you to increase Ryan White funding so states can provide adequate coverage for co-infected clients. Increased resources are also needed to improve provider education on viral hepatitis medical management and treatment, to cover additional case management for patients undergoing treatment and to allow more states to add viral hepatitis therapies and viral load tests to their ADAP formularies. While Ryan White providers offer lifesaving care to co-infected clients, they also have the expertise and infrastructure to provide limited services to viral hepatitis mono-infected clients.

### *Research*

Finally, research is needed to increase understanding of the pathogenesis of hepatitis B and C. Further research to improve hepatitis B and C treatments that are currently difficult to tolerate and have low “cure” rates are also needed. The development of clinical strategies to slow the progression of liver disease among persons living with chronic infection, especially to those who may not respond to current treatment must be addressed. With effective vaccines against hepatitis A and B, it is important to continue to work towards the development of a vaccine against hepatitis C infection.. The Liver Disease Branch, located within the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) at the National Institutes of Health (NIH), has developed an *Action Plan for Liver Disease Research*. We request full funding for NIH to support the recommendations and action steps outlined in this *Action Plan for Liver Disease Research*. Until a vaccine for hepatitis C is available, enhanced prevention services for people at-risk are needed. These need to be evaluated and expanded to ensure that effective prevention programs are available nationally.

It is absolutely essential and urgent that we act aggressively to address the threat of viral hepatitis in the United States. In 2007 alone, the CDC estimated that 43,000 Americans were newly infected with hepatitis B and 17,000 with hepatitis C. Unfortunately, it is believed that these estimates of hepatitis B and C infections are just the tip of the iceberg. Most people living with hepatitis B and over three-fourths of people living with hepatitis C do not know that they are infected. It is estimated that the baby boomer population currently accounts for two out of every three cases of chronic hepatitis C. It is also estimated that this epidemic will increase costs by billions of dollars to our private insurers and public systems of health such as Medicare and Medicaid, and account for billions lost due to decreased productivity from the millions of American workers suffering from chronic hepatitis B and C.

As you continue to draft the FY2011 Labor-HHS Appropriations bill, we ask that you consider an increased federal response to viral hepatitis to diminish the costly impact of these diseases on our health care system and individual’s health. A strong public health response is needed to meet the challenges of these costly infectious diseases. The viral hepatitis community welcomes the opportunity to work with you and your staff on this important issue.