

Submitted on behalf of CAEAR Coalition:

**Ernest Hopkins, Chair
CAEAR Coalition
1718 ½ Florida Avenue NW
Washington, DC 20009
(202) 789-3565
info@caear.org**

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 Harkin and Ranking Member Shelby 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 Program.

A Wise Investment in a Program That Works

The Ryan White Program works. 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 Program was one of seven that received a score of 100% in “Program Results and Accountability.”**

The Ryan White Program serves 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 52 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 349 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 130 program sites with coverage in all 50 states.

CAEAR Coalition’s FY 2012 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 2008 the number of people living with AIDS grew 35% 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 2011 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:

- \$751.9 million for Part A to support grants to the cities where most people with HIV/AIDS live and receive their care and treatment.
- \$495 million for Part B base to provide additional needed resources to the states to bolster the public health response statewide regardless of location.
- \$991 million in funding for the 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.
- \$272.2 million for Part C to support grants to faith- and community-based organizations, health care agencies, and clinics.
- \$50 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 percent nationally and by up to 75 percent in some locations. The programs supported by the Ryan White HIV/AIDS Program also have been critical in reducing AIDS mortality by 70 percent. The Ryan White Program works, resulting in both economic stimulus and social savings by helping keep people, stable, healthy and productive.

Growing Needs as More Tested and Entering Care

The Centers for Disease Control and Prevention (CDC) estimates that as of 2006 there were 1,106,400 persons living with HIV/AIDS in the U.S. Approximately one-half were not in care and receiving treatment. New CDC recommendations for routine HIV testing have increased the

influx of newly diagnosed individuals into care, but with 56,000 newly diagnosed individuals per year, the federal resources have not kept pace with the burgeoning need.

The FY 2012 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. However, CAEAR Coalition is concerned about the unmet demand for services created by insufficient resources at the federal level. Researchers estimate that CDC's expanded HIV testing guidelines will bring an additional 46,000 people into care over five years and significantly reduce the 21% of people living with HIV who do not know they are infected and therefore are not in care. Bringing these individuals into care will save large sums of money in the long run, but requires an initial investment now. **Research clearly shows that averting a single HIV infection saves \$221,365 in lifetime health care costs¹, and getting people on anti-HIV treatment early lowers levels of HIV circulating in the body and reduces potential transmissions²—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.³

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 have created a continuing and growing ADAP funding crisis as a record number of people are in need of ADAP services due to the economic downturn. As of May 2011, there are 8,100 people on ADAP waiting lists in 13 states. Additionally, ADAP waiting lists and other cost-containment measures, including limited formularies, reducing eligibility, or removing already enrolled people from the program, are clear evidence that the need for HIV-related medications continues to outstrip availability. ADAPs are forced to make difficult trade-offs between serving a greater number of people living with HIV/AIDS with fewer services or serving fewer people with more services. 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.

¹Holtgrave 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.

²Montaner 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.

³ 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.

The number of clients entering the 349 Part C community health centers and outpatient clinics has consistently increased over the last five years. Over 247,000 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 success of the CDC’s routine HIV testing recommendations has generated new clients for Part C–funded health centers and clinics too, but unfortunately with no increase in funding to provide the high quality health care services and treatment access people with HIV/AIDS require.

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 critical 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 and community development 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 2012, 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 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 urges the committee to provide the Ryan White HIV/AIDS Program with the funding levels authorized by Congress for Fiscal Year 2012.