The Cost of HIV/AIDS Treatment in the United States

United States Senate

Committee on Health, Education, Labor and Pensions

Subcommittee on Primary Health and Aging

The Honorable Bernard Sanders, Chairman

The Honorable Rand Paul, Ranking Member

District of Columbia

Department of Health

Mohammad N. Akhter, MD, MPH

Director

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Chairman Sanders, Ranking Member Paul and distinguished subcommittee members, I am honored to testify before you today on the Costs of HIV/AIDS Treatment in the United States, and the Medical Innovation Prize Fund Act: S. 1137, also referred to as the "prize bill" and the Prize Fund for HIV/AIDS Act: S. 1138, the "prize fund."

Thank you, Chairman Sanders, for convening this hearing and for your tireless work on behalf of the American people to make health care more accessible and more affordable. You have upheld for many years the belief that every American should be guaranteed comprehensive medical care as a right of citizenship so that they can live healthy lives. I believe that the prize fund concept will support and encourage innovations that will lead to better health outcomes.

I am very proud to share with this Committee a success story for a federal and local partnership that is truly making a difference in the lives of people living in our nation's capital and in the fight against the HIV epidemic. Today, thirty years into the fight against the epidemic, we have the tools and experience to make a difference. Death rates in the District of Columbia due to AIDS have precipitously fallen, in part due to the generosity of Congress in the provision of medication and

medical care. The number of deaths among persons with HIV/AIDS decreased by more than 50% from 326 in 2005 to 153 in 2009. Treatment is now also understood as prevention – an HIV positive person successfully treated with antiretroviral is very unlikely to spread HIV to others. Along with our other highly successful prevention programs, we are beginning to see a slowing of new cases in the District of Columbia. This federal-local partnership is paying off.

I am proud to report that DC is a national leader in HIV testing and set a new record for publically funded HIV testing last year. Testing is done routinely in emergency rooms and in major clinics throughout the city. HIV testing is also administered in our Department of Motor Vehicles and in one of our Economic Security Offices, where city residents apply for TANF and other services. In 2011, we set a new record of 122,000 publicly supported HIV tests, up from 110,000 in 2010 and triple the total of 43,000 tests in 2007.

We are also very proud of our efforts to link people early into treatment to ensure healthy outcomes for people living with HIV. Over 75% of those who are diagnosed with HIV were connected to care within three months, which is also a new record for the District of Columbia.

We have also promoted successful large-scale prevention strategies. We distributed an unprecedented 5 million free condoms last year and made national news on a very successful female condom program. We are also proud of our award winning social marketing program that promotes condom use and protection against the spread of HIV.

The synergy of our efforts has led to a decline in infant mortality in the District. While many factors have led to the decline in infant mortality, the contribution of the condom and safe sex program is clear. Access to condoms decreased our teen pregnancy rate by 10%, which further decreased our infant mortality rate, a double win for the District.

Through our efforts, no baby has been born HIV positive in the District of Columbia since 2009. Likewise, through the leadership of our Mayor and City Council, we have been able to ensure treatment on demand for HIV care and for drug treatment. The city has been an early adopter of the Affordable Care Act and as a result, now has the second highest insurance coverage level in the nation, with 93% of adults insured. In addition, 96% of District of Columbia children are insured, which represents the highest level of children's health insurance coverage in the nation.

In the District, like the rest of the nation, we have focused on reducing disparities as part of our implementation of the National HIV/AIDS Strategy. As part of that effort, DC provided free Sexually Transmitted Disease (STD) testing for 4,300 youth, ages 15 to 19, through the school- based STD screening and community screening programs, up from 3,000 in 2010.

Under the National Strategy, we have also improved coordination and integration of services. I sent a letter to more than 4,000 doctors in DC, highlighting the District's policy of offering routine HIV tests to all adults and adolescents. The Department of Health is also collaborating with the Department of Insurance, Securities and Banking to enforce District law on insurance reimbursement of HIV testing in emergency rooms. The Mayor's Host Committee for the International AIDS Conference coordinates District government support for the AIDS2012 conference, which takes place in July 2012.

The District of Columbia government works in partnership with many fine community based organizations such as Whitman Walker Health, La Clinica del Pueblo, Unity Health Care, and others. These groups have gained invaluable experience with our very diverse population in DC and more importantly, have gained their trust. Our many accomplishments are the result of strong partnerships and shared goals.

We also extend gratitude to our partners at the Centers for Disease Control and Prevention (CDC), particularly Dr. Kevin Fenton, for his leadership. Of note, our city has developed a significant research capacity to contribute to the fight against HIV and AIDS. We could not have done this without the leadership of Dr. Tony Fauci at the National Institutes of Health (NIH), who has taken a personal interest in our city.

I have emphasized our progress in prevention and care of HIV, but our work in health information, monitoring and evaluation has also improved. DC is one of three jurisdictions in the United States that has viral suppression data on a population basis. In partnership with the George Washington University School of Public Health and Health Services, the District has become a national leader in the epidemiology of HIV.

Despite our many successes, the District still has a serious HIV epidemic; in fact, all of urban America has a serious epidemic. Metropolitan DC is very much like other metropolitan areas in the United States in its high levels of the virus infecting the population. The composition of our epidemic is, however, a bit more complex than some cities. We actually have three epidemics: one among men who have sex with men, another among IV drug users and a third among African American heterosexuals, making our challenge more complex even though DC rates, as a metropolitan area, are not as high as some.

In the District of Columbia, we had 755 new cases of HIV in 2009. Two or three persons are newly diagnosed in the District every day. The route of transmission has remained somewhat stable over the past years. In 2009, men who have sex with men (MSM) account for the greatest number of HIV/AIDS cases diagnosed each year. However, the number of MSM cases decreased by approximately 27% since 2005. Heterosexual contact was the second most common mode of transmission for HIV/AIDS cases diagnosed during the last five years. HIV/AIDS cases attributed to heterosexual contact declined from 335 cases in 2005 to 234 cases in 2009, a decrease of 30%. The number of newly diagnosed cases attributable to injection drug use decreased by 60% from 153 in 2007 to 62 in 2009. We credit the locally funded DC Needle Exchange Program, which started in 2008, for this significant decline.

We are very proud of the work we have done with our HRSA Ryan White program, where residents in our eligibility area have excellent access to life saving services. An important trend has been the transfer of clients from ADAP (AIDS Drug Assistance Program/HRSA) onto Medicaid, made possible by the expanded eligibility of Medicaid. We are now able to offer full health insurance to residents, expanding coverage beyond HIV services. This is very important in the District, given the fact that our population of HIV positive individuals is increasingly older. Well over half of the persons infected with HIV in the District are over 45 years of

age, and that trend will continue. People with HIV are increasingly living with other chronic disease – diabetes, and hypertension – like the rest of our population. The Affordable Care Act has made it possible for the District to move more than 1,000 persons from Ryan White CARE Act services to Medicaid, thereby decreasing some of the pressure on the Ryan White Program.

While there is much good news, it all comes at a huge cost. Medical care, specifically lifesaving anti-retrovirals, is very expensive. Currently, our average cost per ADAP patient is about $9,400 per year. (It is estimated that discounted drug costs for anti-retrovirals are approximately $303,100 per person[1] over the course of a lifetime for drugs alone). That estimate is low because new recommendations are for people to start on medication as soon as they are diagnosed, and not wait for their CD4 count to drop. This both preserves the health of the patient (protecting the immune system) and decreases the likelihood that a person will spread the virus, because the treatment suppresses HIV, making it undetectable in body fluids when taken properly. If there are two to three new diagnoses a day in the District, that means we are adding just under a million dollars to the long term health expenditure in our city every day. A large part of that cost is taxpayer dollars. Though ultimately, we all pay into some insurance program or another. The increase in the number of people who were District residents at the time of their HIV diagnosis increased from 16,513 reported in 2008

to 16,721 in 2009. That increase adds over $228 million to the long term health care costs in the District of Columbia.

We need a cure and we need a vaccine. While we await those discoveries, the need for new treatments is clear. Our current medication, even if it was less expensive, creates a daunting challenge. To preserve life and to stop the transmission of the virus, patients need to take medication accurately every day for the rest of their lives. This is a major challenge for many of our residents, even if free drugs are available. So, we need new research into practical, patient-centered treatment approaches to fight the epidemic. We need to consider the affordability of new treatments, new drugs, and new approaches. To halt the HIV epidemic in the United States and around the world, we need a far more efficient approach. For generations, tuberculosis ravaged our country. Through combined effective medications and treatment protocols, the nation eliminated the tuberculosis epidemic. We need to do the same for HIV.

We welcome discussion on the "prize bill" because it provides a fresh way to think about incentivizing innovations. New drugs and new treatments that are inexpensive from the outset are highly preferable. The inequitable situation we have faced for decades, in which new, high-priced medication and treatment are only available to those who can pay, makes our battle very difficult. We

encourage any new incentives that will promote new treatment for HIV and other illnesses in the District of Columbia.

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[1] Medical Care: November 2006 - Volume 44 - Issue 11 - pp 990-997
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