

Good morning Mr. Chairman, and Members of the Committee. I am Dr. Marsha A. Martin, executive director of AIDS Action. I am pleased to have the opportunity to address the members of this committee on the importance of adequate funding for fiscal year 2005 for the HIV/AIDS portfolio. The federal government's commitment to funding research, prevention, and care and treatment for those living with HIV and AIDS is critical. We would not be where we are today in responding to this epidemic without the 23-year commitment of the federal government to fund HIV and AIDS programs.

Our goals are simple: effective, evidence-based HIV treatment and prevention services, an unrelenting pursuit for a cure and a vaccine for HIV infection, and a public health system that ensures that services are available to all those in need. Our commitment is clear: AIDS Action is here *Until It's Over*.

On behalf of AIDS Action's diverse membership of community-based AIDS service organizations, public health departments, researchers, educators, and advocates, I would like to share with you some of the salient issues impacting the funding picture for fiscal year 2005. AIDS Action, through its member organizations and the greater public health community, has worked to enhance HIV/AIDS prevention programs, research protocols, and care and treatment services; and to secure comprehensive resources to address community needs. Since 1984, AIDS Action has been committed to this important work.

Despite the good news of improved treatments for HIV disease, and longer and healthier lives for many people living with HIV and AIDS, stark realities remain:

- There is no cure, and there is no vaccine.
- There are more people living with HIV and AIDS today than ever before.
- Access to health care remains, at best, unequal.
- Even the best treatments do not work for everyone, and some have debilitating side-effects.
- HIV remains 100% preventable, if we have the will to implement effective, evidence-based HIV prevention programs.

I was fortunate to be at the White House on January 31, 2003, along with the Presidential Advisory Council on HIV/AIDS, leaders in the HIV/AIDS advocacy and faith communities, and providers of services for HIV positive individuals, when President Bush offered details of the global AIDS plan that he announced in his January 28th State of the Union address.

We applaud the President's statement that, "There's no doubt we can bring hope in all parts of the world, not only in Africa, but in neighborhoods in our own country where people wonder what the American Dream means," but unfortunately, it is not being supported with action from the President's fiscal year 2005 budget request for the HIV/AIDS portfolio. It is my hope that the Congress, through the good work of this subcommittee, will address the true needs of the HIV/AIDS federal funding portfolio here at home.

Even before beginning the next fiscal year, providers of HIV/AIDS services are already working from a deficit. The .59% rescission that was executed on all non-defense discretionary spending during the final negotiations for FY 2004 had a devastating impact on the HIV/AIDS portfolio.

Today, the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act provides services to more than 533,000 people infected with and affected by HIV throughout the United States and its territories. It is the single largest source of federal funding solely focused on the delivery of HIV/AIDS services and it provides the framework for our national response to HIV/AIDS epidemic.

This year, there was an overall increase of 14.5% in the estimated number of living AIDS cases among the fifty-one hardest hit eligible metropolitan areas (EMA) in the United States, with increases as high as 22.6% in some areas. Funds from Title I of the Ryan White CARE Act, designed to provide services in these areas were reduced. Forty of the fifty-one jurisdictions experienced a decrease in funding, with some decreases as high as 15%.

- Seven of the nine EMAs in California (Los Angeles, Oakland, Orange County, Riverside-San Bernardino, San Diego, San Francisco, and San Jose) saw an increase of 13.8% in estimated living AIDS cases, yet lost 8.7% of their funding (\$9.3 Million).
- Two of the three EMAs in New York (Dutchess County and Nassau) saw an increase of 11.9% in estimated living AIDS cases, yet lost 8% of their funding (\$624,603).
- Four of the five Texas EMAs (Austin, Dallas, Fort Worth, and Houston) saw an increase of 14% in estimated living AIDS cases, yet lost more than 5% of their funding (\$2.1 million).
- Four of the six EMAs in Florida (Jacksonville, Miami, Tampa-St. Petersburg, and West Palm Beach) saw an increase of 13.1% in estimated living AIDS cases, yet lost 4.7% of their funding (\$2.4 Million).
- Cleveland, the only EMA in Ohio, saw an increase of 12.7% in estimated living AIDS cases, yet lost 3% of its funding (\$106,767).
- Philadelphia, the only EMA in Pennsylvania, saw an increase of 15.2% in estimated living AIDS cases, yet lost 1.2% of its funding (\$295,817).

Some of the services provided under Title I include physician visits, laboratory services, case management, home-based and hospice care, nutrition services, substance abuse and mental health services. According to the most recent data available from the Health Resources and Services Administration (HRSA), more than half (51.8%) of Title I funds are allocated to core health care services, and more than one-third (35.0%) are allocated to services closely associated with medical care (including care coordination and referral, medically-based housing, and the like). These services are critical to ensuring patients have access to, and effectively utilize, life-saving therapies.

Title II of the CARE Act ensures a foundation for services in each state and territory, including the critically important AIDS Drug Assistance Program (ADAP) and Emerging Communities Program. Funding for the Title II base grants (excluding ADAP and Emerging Communities) decreased from \$296,412,000 in FY 2003 to \$292,279,000 in FY 2004 for a total decrease of over \$4 million (\$4,133,000).

Funding for Emerging Communities remained stable at \$10 million, but it was divided among an increased number of communities. Of the fifteen states represented by members of this subcommittee, twelve states received decreases in Title II funding in the current fiscal year, totaling nearly \$3.5 million (\$3,429,403).

We applaud the President's recommended \$35 million (\$34,999,570) increase in his FY 2005 budget for the AIDS Drug Assistance Program. ADAP provides medications for the treatment of individuals with HIV who do not have access to Medicaid or other health insurance. According to the National ADAP Monitoring Project approximately 80,035 clients received medications through ADAP in June 2002. In the fifteen states represented by this subcommittee 54,032 people with HIV were served that month.

A regimen of highly active antiretroviral therapy (HAART) comprised of multiple drugs, the standard of care for HIV disease, may cost as much as \$15,000 annually for each drug. Drugs for additional infections and treatments may bring the annual cost for a single HIV patient to \$40,000. With the increased number of people living with AIDS, a continuing domestic infection rate of 40,000 people per year, and cuts in funding to state Medicaid programs, funding pressures on ADAP have increased. Over the years, ADAP has proven to be a remarkable program for allowing people to receive the care and treatment they need. Consequently, AIDS Action urges Congress both to fully fund ADAP and to consider restructuring ADAP to ensure universal access to all needed drugs, regardless of state of residence. Moreover, many of the medicines supplied through ADAP reach maximum efficacy only in conjunction with proper nutrition. Therefore, we urge Congress to continue funding for Ryan White CARE Act nutrition programs.

The Title III portion of the Ryan White CARE Act is awarded under the Early Intervention Services program. Grant recipients include community-based clinics and medical centers, hospitals, public health departments, and universities in 22 states and the District of Columbia. The grants are targeted toward new and emerging sub-populations in the HIV epidemic. The Title III funds are particularly needed in rural areas where HIV care and treatment is still relatively new. Urban areas also continue to need Title III funds to ensure that the emerging populations are not shortchanged as they struggle to meet the needs of previously identified HIV positive populations.

The Title IV portion of the Ryan White CARE Act is awarded under the Comprehensive Family Services Program to provide comprehensive HIV/AIDS care for women, infants, children, and youth, as well as their affected families. These grants are utilized to plan for services that provide overall HIV comprehensive care and treatment and to strengthen the safety net for HIV positive individual and their families.

If we are to comprehensively address the HIV care and treatment crisis in the United States, we must never forget the smaller—but nonetheless significant—programs in the CARE Act: AIDS Education and Training Centers (AETC), dental reimbursement, and special projects of national significance (SPNS). These programs have been affected by diminished federal funding just as the rest of the CARE Act titles have. While the President proposes increased funding and reliance on community health centers nationwide to provide care to the uninsured and under insured, we are simultaneously faced with a dearth of knowledge about proper HIV care on the

part of community providers. The role of the AETCs is invaluable to ensuring that proper education is available to physicians who are being asked to treat increasing numbers of HIV positive patients depending on them for care. Furthermore, dental care is a crucial part of the spectrum of services needed by people living with HIV disease. Oral health is one of the first aspects of healthcare to be neglected by those who cannot afford, or do not have access to, proper medical care. Oral health problems are often one of the first manifestations of HIV disease. Reimbursement offered by this CARE Act program allows dental education institutions to offer their much needed services to people living with HIV. And finally, in this time of rising infections and strapped care systems, we need to find more innovative models of care, which testifies to the importance of the SPNS programs. SPNS – the research and development arm of the CARE Act – provides the funding for these models.

AIDS Action believes the entire Ryan White CARE Act portfolio needs \$3.1 billion for FY 2005 to address the true needs of the 850,000 to 950,000 people that the Centers for Disease Control and Prevention (CDC) estimates are living with HIV and AIDS in the United States. President Bush has only requested just over \$2 billion (\$2,079,967,030).

HIV continues to be an ongoing public health crisis. Despite treatment advances, there was a 2% increase in progression of HIV to AIDS from in 2001 to 2002 – the first such increase in several years. AIDS-defining conditions are the leading cause of death among African-American women between ages 25 and 34 and they are the third leading cause of death among all African Americans in this age group. It is the sixth leading cause of death for Latinos and Whites in this age group.

According to the CDC's December 2002 HIV/AIDS Surveillance Report, 886,575 cumulative cases of AIDS have been diagnosed in the United States, with a total of 501,669 deaths since the beginning of the epidemic. The CDC also estimates that between 850,000 and 950,000 people are living with HIV and AIDS in the United States, and approximately one-quarter of them, or 180,000 – 280,000 people, are unaware of their status and therefore may unknowingly transmit the virus to another person.

For several years, estimates of new infections have remained at 40,000 per year, compared to an estimated 180,000 new infections in the mid 1980s: an extraordinary achievement in efforts against HIV. However, newer estimates suggest that annual infections may be climbing back up, to as high as 60,000 per year.

To reduce even further the number of new infections, the CDC implemented a new initiative last April called Advancing HIV Prevention: New Strategies for a Changing Epidemic (AHP), consisting of four key strategies:

- Make HIV testing a routine part of medical care.
- Implement new models for diagnosing HIV infection outside medical settings.
- Prevent new infections by working with persons diagnosed with HIV and their partners
- Decrease mother-to-child transmission of HIV.

The Urban Coalition for HIV/AIDS Prevention (UCHAPS), which represents the six cities that are directly funded by the CDC and is an AIDS Action board member, has responded positively to the AHP Initiative. UCHAPS members are working with the CDC to implement the Initiative effectively in their respective communities.

This Initiative, however, does not supersede the HIV Prevention Strategic Plan that was published by the CDC in 2001 and stated a goal of reducing by half the number of new HIV infections by 2005. These strategies, though innovative, do require additional funding for implementation. AIDS Action is concerned that the President has only requested \$1,000,491,000 for fiscal year 2005 for the CDC HIV/AIDS, Sexually Transmitted Disease (STD), and Tuberculosis (TB) Prevention program. This request is \$4,546,000 less than what the CDC received in the current fiscal year. AIDS Action believes that the CDC HIV/AIDS, STD, and TB Prevention programs actually need \$2 billion to address the true unmet needs of prevention in HIV/AIDS, STDs, and TB.

How do we continue to strive for the goal of cutting new infections to 20,000 by 2005 without new resources, new partnerships, and new funding? It is important to note that funding that is well spent on successful, prevention programs now will prevent higher cost dollars associated with the care and treatment of HIV positive people in the future.

Research on the domestic HIV epidemic is vital to the control of this disease. Research that includes biomedical, behavioral, and social services is the cornerstone of HIV prevention research. The research agenda for HIV prevention science at the Office of AIDS Research's (OAR), part of the National Institutes of Health (NIH) targets interventions to both infected and uninfected at-risk individuals to reduce HIV transmission. It is essential that OAR continues its groundbreaking research to secure a vaccine that will keep HIV negative people negative as well as its research on treatment vaccines that will help HIV positive people maintain optimal health. The research on microbicides for vaginal and anal sexual intercourse is critical as well. The use of microbicides by the receptive partner will give them power over their personal health when they cannot negotiate condom use with their partner to protect themselves from HIV transmission.

The research at NIH on new medications for drug resistant strains of HIV is also critical. The current success of treatment for people living with HIV and AIDS is due in large part to early research investments in new drugs that now have improved the health of HIV positive individuals. The United States must continue to take the lead in the research and development of new medicines to treat current and future strains of HIV. Primary prevention of new HIV infections must remain a high priority in the field of research.

Behavioral research to help individuals delay the initiation of sexual relations, limit the number of sexual partners, limit the consumption of alcohol and drugs prior to sexual relations, and move from drug use to drug treatment are all critically important in finding a solution to the spread of HIV in the United States. NIH's Office of AIDS Research is critical in all of these research arenas. Increased funding is necessary to ensure the resources that are needed to address all the research concerns are available both now and in the future. Commitment in research will ultimately decrease the care and treatment dollars needed if HIV continues to spread at the current rate.

AIDS Action is, once again, concerned that President Bush has only requested \$2.93 billion for the AIDS portfolio at NIH. AIDS Action believes the National Institutes of Health AIDS portfolio must be funded at \$3.327 billion for fiscal year 2005. We are also concerned about President Bush's budget proposal to cut \$2.6 billion over the next five years at NIH in an effort to reduce the federal budget deficit in half.

On behalf of all Americans living with HIV and AIDS and those affected by it, AIDS Action asks that you carefully consider all the ramifications of these domestic cuts to the HIV/AIDS portfolio, and help us to help others save lives by allocating sufficient funds to address our challenges.

Respectfully submitted,

Marsha A Martin, Executive Director
AIDS Action
1906 Sunderland Place, NW
Washington, DC 20036
Phone: 202-530-8030