

Congress of the United States

Washington, DC 20515

April 17, 2007

The Honorable David Obey
Chairman
Appropriations Subcommittee on Labor,
Health and Human Services, and Education
H-218 the Capitol
Washington, D.C. 20515

The Honorable James T. Walsh
Ranking Member
Appropriations Subcommittee on Labor,
Health and Human Services and Education
1016 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Obey and Ranking Member Walsh:

We are writing to urge you to support a \$232.9 million increase in the 2008 Fiscal Year Appropriation for the AIDS Drug Assistance Program (ADAP). The current ADAP budget does not sufficiently meet the needs of United States citizens living with HIV/AIDS. The requested increase in funding would provide the means for an additional 17,663 ADAP patients to receive the medical care that they desperately need.

In response to the development of combination HIV drug therapies, Congress developed the ADAP as an independent funding line under the Ryan White CARE act. Since its founding, the ADAP has proven to be an indispensable program for the more than 1,185,000 Americans living with HIV/AIDS. There is no federal increase for ADAP in the FY07 Budget. More than 20 states have actually gotten decreases in ADAP funding. The ADAP funding line for FY 08 will directly assist Americans with HIV/AIDS in obtaining life-saving and extending therapies between 1 April 1, 2008 and 1 March 1, 2009.

Between the calendar years of 2003 and 2004, the ADAP experienced a participation increase of 12%, and an increase in drug cost of 29%. Despite growth in popularity, funds granted to the ADAP have remained relatively unchanged. The ADAP is under funded by the federal government, and has been for the past five years. The FY 06 budget resulted in a mere \$2.22 million increase for the ADAP, which translates to a less than 1% increase over moneys allocated in the FY05 budget. As a result the ADAP has become dependent upon assistance from drug manufacturers, as well as financing from individual state budgets. As outlined in the FY 08, *ADAP Need Projection*, by the National ADAP Working Group, inadequate resources throughout the recent past have resulted in a "structural deficit" of \$145 million in ADAPs throughout the nation. The affects of the deficit have been reflected through reduced ADAP eligibility, inadequate drug formularies, ADAP waiting lists and other ADAP restriction which prevent HIV-positive Americans from accessing medications.

Previous ADAP funding has provided the means for astounding medical success. Since the development of drug therapies in 1996, deaths due to HIV/AIDS have decreased from nearly

50,000 per year to fewer than 20,000 in 2004. Yet, in many ways ADAP is a victim of its own accomplishments. The number of people living longer with HIV/AIDS, in conjunction with the 40,000 + people in the United States that are infected each year, has increased the demand for ADAP services. The costly nature of the care provided, makes funding essential to the continuation of ADAP services.

Our African-American communities are disproportionately affected by this nation's HIV/AIDS epidemic. More than 33% of existing ADAP clients are African-American. Because we lack solid, universal data, we can only guess the true percentage of African Americans who are among the several hundred thousand HIV-positive Americans known or estimated to be living with HIV disease. Given the noted and extensive disparities in access to health care confronting African-American communities, and – for that matter – all racial and ethnic minority communities, we can, unfortunately, be sure that a very large number of African-Americans who SHOULD be benefiting from access to today's HIV/AIDS treatments are unable to do so due to inadequate federal funding that directly decreases their access to medications and other HIV care. Not only has the AIDS Drug Assistance Program helped address these needs, but ADAPs also have helped alleviate the public from the costs associated with inpatient care given to people who can not afford hospitalization on their own.

The statistics are as staggering as they are unacceptable, and include the following:

- ❖ In 2005, 50% of the AIDS cases diagnosed were among African-Americans, yet we are only 12% of the total U.S. population;
- ❖ In 2005, the AIDS rate per 100,000 for African-Americans was 75.0 compared to Latinos at 26.4 and Whites at 7.5;
- ❖ Black women accounted for 67% of the new AIDS cases in 2005; and
- ❖ Washington, DC – our nation's Capitol – with a total population that is predominantly African American and totals just under 600,000, had 8,050 estimated living AIDS cases, compared to 11,107 in the ENTIRE State of California in 2006.

It is long past time to insure access to ADAP not only for all American communities of color, but for all Americans period. It is estimated that 33% of HIV-positive people are not receiving the drug therapy and care that they need. Disproportionately, these are HIV-positive African Americans, who without medications do not live with HIV as a chronic condition, and instead are at risk of dying prematurely from AIDS as an acute condition.

While this is dangerous to the health and quality of life of persons infected, it also has a negative affect on public health as a whole. Without funding, the AIDS virus can not be met with preventative measures and therefore requires more costly interventions will be forthcoming in federal, state, local and private funding streams.

These reasons provide the foundation of our concern about the lack of ADAP resources for 2008. As of January 2007, 588 people were on ADAP waiting lists and six states have been forced to enact new cost containment measures. More states are expected to implement similar restrictions in the coming months. An emergency appropriation of \$145 million could be used **immediately** to curtail and prevent states from further restricting enrollment, by expanding or establishing new waiting lists.

All applicable FY 08 funding becomes available on April 1, 2008 – almost a year from now – and “emergency funding” becomes available when signed into law. Why should many of the poorest, underserved, and sickest among us have to wait a full year for help from Congress?

These funds will increase the accessibility patients have to needed medication, as we await the arrival of FY 08 funds on April 1, 2008. There have been several attempts – many of which were bipartisan – to increase ADAP funding in the Senate in the last session of Congress. It is long past time that we stood up for low-income, uninsured HIV-positive people of color in the normal appropriations process.

The access to care and medication that ADAP provides to low-income and uninsured Americans is critical to the health of all HIV-positive Americans, but none more than those in our African-American communities. We must enable ALL of our communities to make full use of the system provided by the Ryan White CARE Act. The provisions laid out in the Ryan White CARE Act deserve the highest level of funding. Let us start by getting successful treatments into the hands of those who need them now.

Thank you for your consideration of this request.

Sincerely,

Conrad C. Helgeson

Eddie Bennett Johnson

Barbara Lee

Bob A. Champion

James E. Cleburne

Shirley Lee

John J. Warner

Tom J. Blunt

Al H. Johnson

Richard L. Shelby

Alfred L. Hastings

Al B. Brown

Hank Johnson

Covine Brown

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Danny Dennis

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