[**DATE**]

The Honorable \_\_\_\_\_\_\_\_\_\_\_\_\_

**[OFFICE LOCATION OF SENATOR OR HOUSE MEMBER]**

Washington, DC 20515

**RE: Funding for Hepatitis C (HCV) Elimination in Indian Country**

Dear \_\_\_\_\_\_\_\_\_\_\_\_\_,

On behalf of the [**INSERT NAME OF TRIBE OR ORGANIZATION]**, and someone who knows first-hand the tremendous burden that Hepatitis C (HCV) places on Tribal communities, I am writing to ask for your support for formula-based and recurring funding for the Indian Health Service, Tribes, and urban Indian organizations (I/T/Us) to prevent, treat, and eliminate HCV. In the wake of the national opioid overdose epidemic, there has been little attention to co-occurring infections of HCV that have skyrocketed as a result of increased injection drug use.

American Indians and Alaska Natives (AI/AN) have been disproportionately impacted by both the opioid overdose epidemic, and acute and chronic HCV infections. In 2016, the Centers for Disease Control and Prevention (CDC) declared that AI/ANs have the second highest opioid overdose fatality rate at 13.9 deaths per 100,000[[1]](#footnote-1), while drug overdose deaths overall increased by 519% from 1999 to 2015 – the sharpest increase among all groups nationwide.[[2]](#footnote-2)

Similarly, incidence rates of acute HCV have been higher among AI/ANs compared to other groups since at least 2001. In 2016, AI/ANs had the highest HCV-related mortality rate at 10.8 deaths per 100,000, compared to a national average of 4.5 deaths per 100,000.[[3]](#footnote-3) Age-adjusted rates of chronic liver disease and cirrhosis deaths are 2.3 times higher among AI/ANs compared to non-Hispanic Whites[[4]](#footnote-4), with AI/ANs also 2.5 times more likely than Whites to receive a chronic liver disease diagnosis.[[5]](#footnote-5) [**INSERT LOCAL STATISTICS IF APPLICABLE**]

In recent years, advancements in medical research have significantly improved cure rates for people being treated for HCV. Whereas only a few years ago cure rates hovered around 60%, newer drugs on the market have been shown to cure HCV in up to 99% of people.[[6]](#footnote-6) In fact, the cost of HCV medications have plummeted in recent years – going from nearly $95,000 for a full treatment regimen using older medications to roughly $26,400 for a full regimen using newer medications. However, treatment access remains severely limited for several reasons.

1. In FY 2017, per capita health expenditures at the IHS were at $3,332 compared to $9,207 nationally.[[7]](#footnote-7) With limited funding, many IHS facilities are forced to prioritize coverage for life and limb services at the expense of preventative and treatment-based care.
2. While the Veterans Administration (VA) received $1.5 billion in supplemental funding for HCV elimination[[8]](#footnote-8), the IHS has received no such matching funds. Without these extra dollars, IHS is unable to cover the cost of medications for treatment.
3. Roughly 26% of AI/ANs live in poverty with median household incomes at roughly $39,500[[9]](#footnote-9), making the out-of-pocket costs for HCV medications nearly insurmountable.
4. Many state Medicaid agencies have imposed harsh coverage restrictions for treatment, including sobriety requirements, prescriber limitations, and coverage for only the most advanced cases of liver fibrosis. Not only does this leave many patients behind, it also contradicts national HCV guidelines developed by the American Association for the Study of Liver Disease (AASLD) and the Infectious Diseases Society of America (ISDA).[[10]](#footnote-10)
5. Private insurance coverage of HCV is also limited. In one study of commercially insured individuals from 2014 to 2017, over 52% of private payers denied coverage for HCV medications, citing the high cost for medications.[[11]](#footnote-11)

Unlike many other infectious diseases, advancements in modern medicine have led to the availability of curative treatments for HCV. The federal trust and treaty obligations to provide health services to Tribal Nations must include prevention and treatment for HCV. We ask that you demonstrate your support for advancing the health of all AI/ANs by supporting base funding for HCV elimination throughout the I/T/U system. [**INSERT COMMENT THANKING REPRESENTATIVE FOR THEIR SUPPORT**]. Should you have any questions or comments, please feel free to contact us at [**INSERT CONTACT INFO**]

Sincerely,

[**INSERT NAME OF TRIBE OR ORGANIZATION**]

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3. Centers for Disease Control and Prevention. Surveillance for Viral Hepatitis: United States, 2016. Retrieved from <https://www.cdc.gov/hepatitis/statistics/2016surveillance/commentary.htm> [↑](#footnote-ref-3)
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<http://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65_04.pdf>  [↑](#footnote-ref-4)
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7. National Tribal Budget Formulation Workgroup. Recommendations on the Indian Health Service Fiscal Year 2020 Budget. Retrieved from <https://www.nihb.org/docs/03012018/TBFWG%20FY%202020%20Recommendations%20Brief.pdf> [↑](#footnote-ref-7)
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9. U.S. Census Bureau. 2017. American Indian and Alaska Native Heritage Month: November 2017. Retrieved from <https://www.census.gov/newsroom/facts-for-features/2017/aian-month.html> [↑](#footnote-ref-9)
10. AASLD & IDSA. 2018. HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C. Retrieved from <https://www.hcvguidelines.org/sites/default/files/full-guidance-pdf/HCVGuidance_May_24_2018b.pdf> [↑](#footnote-ref-10)
11. Gowda, C., Lott, S., Grigorian, M., Carbonari, D., Saine, M., Trooskin, S., … Lo Re, V. (2018). Absolute Insurer Denial of Direct-Acting Antiviral Therapy for Hepatitis C: A National Specialty Pharmacy Cohort Study. *Open Forum Infectious Diseases*, *5*(6), ofy076. https://doi.org/10.1093/ofid/ofy076 [↑](#footnote-ref-11)