Statement of NASTAD (National Alliance of State and Territorial AIDS Directors) to the United States House of Representatives Committee on Oversight and Reform

Hearing on:
"HIV Prevention Drug: Billions in Corporate Profits after Millions in Taxpayer Investments"

May 16, 2019

Presented by:
Tim Horn
Director, Medication Access and Pricing
NASTAD

Chairman Cummings, Ranking Member Jordan, and Members of the Committee, my name is Tim Horn and I am Director of Medication Access and Pricing at NASTAD – the National Alliance of State and Territorial AIDS Directors. I am pleased to be here today to offer testimony on pre-exposure prophylaxis (PrEP) access and pricing in the United States.

NASTAD is a leading non-partisan non-profit association that represents public health officials who administer HIV and hepatitis programs in the U.S. and around the world. We represent public health officials in all 50 U.S. states, the District of Columbia, the U.S. territories, and several local jurisdictions receiving direct funding from the Centers for Disease Control and Prevention (CDC).

I'd like to focus my comments today on the intersection of the high cost of Truvada as PrEP and the need for effective, comprehensive, affordable – and, importantly, sustainable – public health approaches to HIV prevention in the United States.

Our ability to respond to the needs of people living with HIV is one of the greatest examples of effective public health in the United States. The Ryan White HIV/AIDS Program ensures access not only to comprehensive, state-of-the-art care, but importantly low- or no-cost treatment, made possible with significant price cuts provided to AIDS Drug Assistance Programs, or ADAPs. ADAPs ensure treatment for nearly a quarter of all people living with HIV in the U.S., the vast majority of whom live at or below the Federal Poverty Level. There is no such comprehensive federal medication program for people vulnerable to HIV infection. And I just want to be clear – the only difference between someone living with HIV and someone at risk for HIV is a diagnosis.

Those vulnerable to HIV infection face the exact same barriers to affordable treatment in the United States.

We are failing populations at highest risk for HIV infection, including young Black and Latino gay men, women, and transgender individuals. We are failing them because we have not built the payment and culturally appropriate delivery systems that are best able to reach them. There are many reasons for the low uptake of PrEP in this country, but financing and pricing – the subject of today's hearing – are undoubtedly among them. In order to end the HIV epidemic, we must build systems that provides access to PrEP for all populations.

Our current PrEP system, particularly for uninsured and under-insured people vulnerable to HIV infection, is built on the back of Gilead's Medication Assistance Program for those who are uninsured and meet strict financial eligibility criteria, along with the company's Copay Assistance Program for individuals who are commercially insured.

While these programs have been generous and have undoubtedly helped expand access to the medication component of comprehensive PrEP services, they have also succeeded in largely masking the impact of the high price of Truvada. To be clear, these programs are not a substitute for functioning public health and healthcare systems. Partnerships with pharmaceutical manufacturers will always be important, but outsized dependency on their generosity – which, in turn, is dependent on their bottom line – is by no means a solution.

The 340B Drug Pricing Program has also played an important role in allowing public health programs and their community partners – including Federally Qualified Health Centers – to afford PrEP while extending federal resources as far as possible. But it doesn't go far enough. Even if we assume that the price available to 340B entities is 75% to 80% below the list price, this still translates into approximately $400 per month per person – a price that is at least four times higher than what can be reasonably expected with robust generic competition. Additionally, 340B pricing of Truvada as PrEP is only available to some health departments and family planning clinics – those receiving Section 330 funding to support sexually transmitted infection prevention and control – and is not available to other institutions where PrEP may be of significant benefit.

Gilead's assistance programs, 340B program discounting, and the recent announcement of donated PrEP will continue to help expand access to PrEP. However, a long-term sustainable approach to PrEP access requires a competitive generic market. To this end, we believe federal, state, and community partners should be cautious not to allow the present and future of existing patchwork measures to build an artificial market for Gilead's Descovy, which is expected to be approved for PrEP by the end of this year. Doing so will undercut the ability of the generic market for TDF/FTC to bring down costs – for our public payers, our commercial payers, and, most importantly, people vulnerable to HIV infection.

Importantly, a lower cost form of PrEP would allow for more affordable procurement and expanded access across a variety of settings – including state and local health department programs, family planning clinics, and STD clinics. Not only has the high cost of Truvada been a barrier in scaling up affordable access to PrEP by these programs, they have required some programs to reallocate funding from other public health initiatives to meet HIV prevention priorities.

I want to conclude by thanking the Committee for the opportunity to testify today and for initiating a dialog that, hopefully, will be to the betterment of people vulnerable to HIV infection and other intersecting conditions.