**Special Committee on Aging**
**United States Senate**
**113th Congress, 1st Session**

**Hearing:**
**Older Americans: The Changing Face of HIV/AIDS in America**
**September 18, 2013, 2:00 p.m., Dirksen 562**

**ORAL TESTIMONY**
**of**
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Chairman Nelson, Senator Collins and distinguished Members of the Committee, on behalf of my colleagues at ACRIA, I thank you for holding this hearing. ACRIA has long conducted and participated in research on older adults with HIV in the U.S. and abroad. We have also delivered training, technical assistance and capacity building services to HIV and senior services providers across the U.S., including in Miami/Dade and Broward counties in Florida. I am pleased for the opportunity to join you.

From the epidemic's start, most people diagnosed with AIDS faced death within a few years, if not a few months. With the effective antiretroviral treatments available since the mid-1990s, HIV infection has become a manageable chronic illness, best demonstrated by the "graying" of the epidemic. The CDC predicts that half of all Americans diagnosed with HIV will be age 50 or older by 2015. That proportion will rise to more than 70% by 2020.

In 2000, a 20 year old infected with HIV could, on average, expect to live to age 36. Today, that same 20 year old can expect to live to age 71. This extraordinary success is a result of the remarkable commitment of scientists, clinicians, and activists, and the investments made by the American people. But that success has also brought new and ever-increasing prevention and care challenges for those aging with HIV.

People with HIV who are in their 50s and early 60s have the same number of age-associated comorbidities as an uninfected person 10-20 years older. These may include cardiovascular disease, cancers, osteoporosis, hypertension, and depression. Older adults with HIV have a host of health and services needs that neither HIV nor aging services providers are fully prepared to meet. And their significantly greater disease burden is often complicated by social isolation and stigma.

Older adults with HIV have rates of depression that are five times higher than their HIV-negative peers. Depression is arguably the most reliable predictor of medication non-adherence and is associated with poorer treatment outcomes. Much of this depression is fueled by HIV- and LGBT-related stigma and social isolation. Studies, including ACRIA's research, show that

almost 70% live alone and less than 15% have a partner or spouse. With often distant families and fragile social networks, they lack instrumental and emotional support. Moreover, many of these older adults have disabling conditions that limit employment and often live at, or below, the poverty line.

In the context of the National HIV/AIDS Strategy, and the new HIV Continuum of Care Initiative announced by the White House in July, I believe we won't reach the end of AIDS unless we effectively address the barriers to routine HIV testing and consistent engagement in HIV treatment among middle-aged and older adults. As with younger people, HIV disproportionately affects older gay and bisexual men, especially men of color, and African-American and Latino women. These disparities are fueled by homophobia, HIV stigma, racism and ageism. We need targeted, evidence-based efforts, including cultural competency training, to address these alarming disparities.

Therefore, I urge you and your colleagues in the Senate and the House to promptly reauthorize the Older Americans Act (OAA) and to include people with HIV and LGBT persons as groups with "greatest social need." This would lead state and regional aging services agencies to explicitly incorporate the unique needs of these populations into their five-year planning efforts. The National Resource Center on LGBT Aging, which is funded by the Administration on Aging in a reauthorized OAA, would continue to fight HIV and LGBT stigma and discrimination among providers. Likewise, I urge adequate support for the Health Resources and Services Administration for targeted demonstration projects and other funding for training HIV and aging services providers.

I further urge adequate resources for the HIV initiatives of the CDC. Research shows that most older adults, including those with HIV, remain sexually active. One in every six new HIV diagnoses occurs in adults 50 and older. And fully half of older adults first diagnosed with HIV above age 50 are sick enough to be concurrently diagnosed with AIDS. In other words, they have had HIV for some time but were never tested and treated. Older adults rarely seek HIV testing, and many providers are unaware that current CDC guidelines recommend routine HIV testing up to age 65. Therefore, we need CDC-funded HIV primary and secondary prevention campaigns for older adults.

For older adults living with HIV today, ensuring the success of the Affordable Care Act is critical. This includes the expansion of Medicaid in all states and robust HIV medication coverage as part of the Essential Health Benefits packages as defined by the Centers for Medicare and Medicaid Services – for both the new health insurance marketplaces and expanded Medicaid programs. Unfortunately, about 40% of Americans with HIV live in states that are not presently planning to expand Medicaid. These include several states with the highest new HIV infection rates, lowest rates of overall insurance coverage, and worst health disparities. Today, half of all Americans with HIV rely on Medicaid to cover their health services. The Kaiser Family Foundation notes that people with HIV are about three times more likely to be covered by Medicaid than the U.S. population overall. Almost 75% of Medicaid beneficiaries with HIV qualify because they are both low-income and permanently disabled. And nearly a third are

dually-eligible for Medicaid and Medicare. As they develop multiple chronic conditions at a relatively young age, most will require long-term care.

In a related vein, older adults with HIV need the Ryan White CARE Act to be fully funded to meet current needs or, at the very least, to the level requested by the President in his FY14 budget. In inflation-adjusted dollars Ryan White has been essentially flat-funded for the last decade, even as the number of people with HIV continues to grow. Ryan White is vital for many reasons, not least because the median age for older adults with HIV is 58, meaning many are not eligible for Medicare or other services funded through the Older Americans Act. Most older adults with HIV rely on Ryan White-funded programs, including the AIDS Drug Assistance Program. Ryan White-funded completion services, such as transportation support and case management, are also vital to ensure sustained engagement in care and treatment success. With about half the states choosing not to expand Medicaid, the Ryan White program will remain vitally important for essential services.

In sum, if we are to effect real improvements in the HIV treatment cascade, particularly the very large gap between those initially linked to care and those retained in care, we will need to pay close attention to the intersection of the Affordable Care Act and the Ryan White program.

In addition, we must not only maintain, but increase funding for NIH-targeted research on HIV and aging. The NIH Office of AIDS Research Special Working Group on HIV and Aging, convened in April 2011, was a unique gathering of scientific experts from bio-medical, clinical, and social science disciplines tasked with identifying critical research areas to better inform the treatment and care of this growing population. One of the four subgroups, which included ACRIA's Dr. Mark Brennan-Ing, focused on societal infrastructure, mental health and substance use issues, and the care giving challenges that have been identified as critical to better treatment outcomes for these older adults. Specific recommendations included prioritizing research into co-morbidity management, behavioral health needs, and caregiving social support resources. The program announcements issued by NIH in April 2012 were sponsored by seven NIH institutes in recognition of the complex nature of aging with HIV and the multidisciplinary expertise necessary for relevant research. As will be further discussed by my amfAR colleague, Dr. Rowena Johnston, HIV research has and will continue to inform our understanding of other diseases, including age-related diseases.

Similarly, older adults with HIV need the FDA to support and encourage pharmaceutical companies to conduct combination drug trials for people with resistance to most HIV medications. A significant proportion of individuals with such resistance are above age 50. We also need the FDA and industry to examine the impact of long-term antiretroviral use in an older adult population.

Lastly, it is our hope that HHS will soon develop formal guidelines for providers treating older adults with HIV. Last year, ACRIA, the American Academy of HIV Medicine, and the American Geriatrics Society issued a report entitled *The HIV and Aging Consensus Project: Recommended Treatment Strategies for Clinicians Managing Older Patients with HIV*

(http://www.aahivm.org/Upload_Module/upload/HIV%20and%20Aging/Aging%20report%20working%20document%20FINAL%2012.1.pdf). These treatment strategies were developed by an expert national panel, which included ACRIA's Dr. Stephen Karpiak, and could serve as a starting point for formal guidance from HHS.

Again, I greatly appreciate this opportunity to speak on the subject of HIV and aging. I'm happy to answer any questions.