

RESOLUTION OF THE  
NAABIK'ÍYÁTI' COMMITTEE OF THE  
NAVAJO NATION COUNCIL

23<sup>rd</sup> NAVAJO NATION COUNCIL - Second Year, 2016

AN ACTION

RELATING TO NAABIK'ÍYÁTI'; SUPPORTING H.R. 1101 AND S. 1287, THE  
VIRAL HEPATITIS TESTING ACT OF 2015

WHEREAS:

- A. The Navajo Nation established the Naabik'íyáti' Committee as a Navajo Nation Council standing committee and as such empowered Naabik'íyáti' Committee to coordinate all federal programs and to assist and coordinate all requests for information, appearances and testimony relating to federal legislation impacting the Navajo Nation. 2 N.N.C. §§ 164 (A) (9), 700 (A), 701 (A) (4), 701 (A) (6) (2012); *see also* CO-45-12.
- B. The Navajo Nation has a government-to-government relationship with the United States of America, Treaty of 1868, Aug. 12, 1868, 15 Stat. 667.
- C. H.R. 1101, the Viral Hepatitis Testing Act of 2015 and S. 1287, the Viral Hepatitis Testing Act of 2015, are identical pieces of legislation in the House and Senate of the United States 114th Congress, 1st Session, that amend the Public Health Service Act to revise and extend the program for viral hepatitis surveillance, education, and testing in order to prevent deaths from chronic liver disease and liver cancer, and for other purposes. See attached Exhibit "A" and "B".
- D. The Hepatitis C Virus (HCV) affects approximately 6-million Americans most of whom do not know their status.
- E. American Indians and Alaska Natives have the highest rates of HCV acquisition out of any population in the United States.
- F. From 2011-2012, acute HCV rates increased by 86.2% among American Indians/Alaska natives (source: <http://www.cdc.gov/hepatitis/statistics/2013surveillance/index.htm>).

G. H.R. 1101 and S.1287 would provide \$80 million over three years for expanded hepatitis B and C surveillance, education and testing programs; prioritize diagnosis and education for at-risk populations; help ensure that veterans are screened for hepatitis B and C and linked to care and treatment; encourage additional education among health professionals and the public on hepatitis and increase care services for individuals with Hepatitis B or C.

H. H.R. 1101 and S. 1287 were introduced in the Senate in May 2015 and are now being considered by the Senate Subcommittee on Health.

I. It is in the best interest of the Navajo Nation to support the enactment of H.R. 1101 and S. 1287.

**NOW THEREFORE, BE IT RESOLVED:**

A. The Navajo Nation supports the Congressional bills, H.R. 1101 and S. 1287, the Viral Hepatitis Testing Act of 2015.

B. The Navajo Nation hereby authorizes the Navajo Nation President, the Navajo Nation Speaker, and their designees, to advocate for the passage of the Viral Hepatitis Testing Act of 2015.

**CERTIFICATION**

I hereby certify that the foregoing resolution was duly considered by the Naabik'íyáti' Committee of the 23<sup>rd</sup> Navajo Nation Council at a duly called meeting in Window Rock, Navajo Nation (Arizona), at which a quorum was present and that the same was passed by a vote of 12 in favor, 0 oppose, this 12<sup>th</sup> day of May, 2016.



LoRenzo Bates, Chairperson  
Naabik'íyáti' Committee

Motion: Honorable Lee Jack, Sr.  
Second: Honorable Norman M. Begay

**NAVAJO NATION**

RCS# 395

Naa'bik'iyati Committee

5/12/2016

04:26:03 PM

Amd# to Amd#

Legislation NO. 0116-16

PASSED

MOT Jack

SEC Begay, NM

**Yea : 12**

**Nay : 0**

**Not Voting : 12**

**Yea : 12**

Begay, NM  
BeGaye, N  
Bennett

Chee  
Crotty  
Damon

Daniels  
Hale  
Jack

Perry  
Shepherd  
Slim

**Nay : 0**

**Not Voting : 12**

Bates  
Begay, K  
Brown

Filfred  
Pete  
Phelps

Smith  
Tso  
Tsosie

Vacant  
Witherspoon  
Yazzie

# Viral Hepatitis Testing Act of 2015 - Resolution Template

WHEREAS The Hepatitis C Virus (HCV) affects approximately 6-million Americans most of whom do not know their status, and

WHEREAS American Indians and Alaska Natives have the highest rates of HCV acquisition out of any population in the US, and

WHEREAS From 2011-2012 acute HCV rates increased by 86.2% amongst American Indians/ Alaska Natives, (source: [cdc.gov/hepatitis/statistics/2013surveillance/index.htm](http://cdc.gov/hepatitis/statistics/2013surveillance/index.htm)), and,

WHEREAS In the United States an estimated 6 million people are affected by one of these chronic, communicable, potentially life-threatening conditions, which are the largest drivers of liver cancer domestically, and,

WHEREAS House Resolution 1101 and its counterpart Senate Bill 1287 would: 1) Provide \$80 million over three years for expanded hepatitis B and C surveillance, education, and testing programs; 2) prioritize diagnosis and education for at-risk populations; 3) help ensure that veterans are screened for hepatitis B and C and linked to care and treatment; 4) encourage additional education amongst health professionals and the public on hepatitis and increase care services for individuals with Hepatitis B or C, and,

WHEREAS H.R. 1101 and S. 1287 are endorsed by the American Liver Foundation, Coalition on Positive Health Empowerment, Crohn's and Colitis Foundation of America, Hepatitis B Foundation, Hepatitis Foundation International, National Alliance of State and Territorial AIDS Directors (NASTAD), National Minority Quality Forum, National Viral Hepatitis Roundtable, and the National Native American AIDS Prevention Center's Indigenous Hepatitis Forum (IHF), and,

Therefore Be It Resolved: The [Name of Tribe(s)] supports the passage of H.R. 1101 and S. 1287, The Viral Hepatitis Testing Act of 2015, to improve Hepatitis B and C surveillance, education, and testing in Native communities, and,

Further Be It Resolved: We request the Senate Committee on Indian Affairs hold a legislative hearing to hear from Tribes about this important legislative issue and to include funding specific for American Indian, Alaska Native, and Native Hawaiian, Hepatitis prevention projects and programs.

For more information about the Viral Hepatitis C Testing Act of 2015 (HR1101/s 1287), contact:



**THE NATIONAL NATIVE AMERICAN  
AIDS PREVENTION CENTER (NNAAPC)**

Patrick Roberts  
Health Policy Fellow  
National Native American AIDS Prevention Center (NNAAPC)  
1031 33<sup>rd</sup> Street, Denver CO, 80218  
(312) 833-2566  
[www.nnaapc.org](http://www.nnaapc.org)



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Lorren Sandt  
Executive Director  
Caring Ambassadors Program, Inc.  
PO Box 1748, Oregon City OR, 97045  
Phone: (503) 632-9032, Direct Line: (503) 632-9030  
[www.caringambassadors.org](http://www.caringambassadors.org)

# Sample Letter to the Senate Committee on Indian Affairs

[INSERT DATE]

The Honorable John Barrasso, MD  
Chairman of the Senate Committee on Indian Affairs  
838 Hart Senate Office Building  
Washington, DC 20510

Dear Senator Barrasso:

The [INSERT NAME OF TRIBE] is requesting the Senate Indian Affairs Committee to conduct a legislative hearing on the Viral Hepatitis C Testing Act of 2015 (HR1101/S1287).

According to the CDC, Native populations have the highest rates of Hepatitis C of any other ethnic minority in the US. Further, American Indians, Alaska Natives and Native Hawaiians, along with millions of Americans cannot obtain treatment for Hepatitis C. The following quote was published in the July 2015 edition of HIV Specialist, American Academy of HIV Medicine's Institute for Hepatitis C:

"Ultimately, we have found that access restrictions are not based on scientific evidence, current treatment guidelines or clinical data," said co-author and Harvard Law School's Center for Health Law and Policy Innovation Director Robert Greenwald. Greenwald adds, "Notably, 74% of the 42 state Medicaid programs for which information is available limit treatment to individuals with advanced fibrosis or cirrhosis."

Native populations that rely on IHS Purchased/Referred Care Funds for services, or Medicaid, are not able to access the expensive hepatitis C treatments. Under the Affordable Care Act, access to these medications is also limited. Please remember hepatitis C is preventable and treatable - there is no reason people should wait until they have either fibrosis or cirrhosis to access treatment.

Please hold a legislative hearing on The Viral Hepatitis Testing Act of 2015 to hear from Native people about the effects of viral hepatitis in Native communities and the need for increased access to testing, treatment and care.

Sincerely,

[INSERT NAME OF CHAIRPERSON, PRESIDENT, GOVERNOR & CHIEF]  
[INSERT TITLE]

CC: The Honorable John Tester  
U.S. Senator, Montana  
311 Hart Senate Office Building  
Washington, DC 20510-2604

For more information about the Viral Hepatitis C Testing Act of 2015 (HR1101/s1287), contact:



THE NATIONAL NATIVE AMERICAN  
AIDS PREVENTION CENTER (NNAAPC)

Patrick Roberts  
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114TH CONGRESS  
1ST SESSION

# H. R. 1101

To amend the Public Health Service Act to revise and extend the program for viral hepatitis surveillance, education, and testing in order to prevent deaths from chronic liver disease and liver cancer, and for other purposes.

## IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 26, 2015

Mr. GUTHRIE (for himself, Mr. HONDA, Mr. DENT, and Mr. JOHNSON of Georgia) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Veterans' Affairs, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

## A BILL

To amend the Public Health Service Act to revise and extend the program for viral hepatitis surveillance, education, and testing in order to prevent deaths from chronic liver disease and liver cancer, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Viral Hepatitis Testing  
5 Act of 2015".

1 **SEC. 2. FINDINGS.**

2 Congress finds the following:

3 (1) Approximately 5,300,000 Americans are  
4 chronically infected with the hepatitis B virus (re-  
5 ferred to in this section as “HBV”), the hepatitis C  
6 virus (referred to in this section as “HCV”), or  
7 both.

8 (2) In the United States, chronic HBV and  
9 HCV are among the most common causes of liver  
10 cancer, one of the most lethal and fastest growing  
11 cancers in the United States. Chronic HBV and  
12 HCV are among the most common causes of chronic  
13 liver disease, liver cirrhosis, and the most common  
14 indication for liver transplantation. More than  
15 15,000 deaths per year in the United States can be  
16 attributed to chronic HBV and HCV. Current infor-  
17 mation indicates these represent a fraction of deaths  
18 attributable in whole or in part to chronic hepatitis  
19 C. From 2007 through 2011, mortality rates of per-  
20 sons with hepatitis C increased 39 percent among  
21 persons aged 55–64 years to a rate of 21.9 deaths  
22 per 100,000 population in 2011. In 2011, the high-  
23 est mortality rates of persons with hepatitis C by  
24 race/ethnicity and sex were observed among Amer-  
25 ican Indians and Alaska Natives (10.6 deaths per  
26 100,000 population) and males (7.1 deaths per

1       100,000 population) respectively. Mortality data  
2       from 2011, the latest year for which these data were  
3       available, reveal the serious health consequences as-  
4       sociated with viral hepatitis: chronic liver disease, in-  
5       cluding cirrhosis, was the 12th leading cause of  
6       death in the United States in 2011. Chronic HCV  
7       is also a leading cause of death in Americans living  
8       with HIV/AIDS. Many of those living with HIV/  
9       AIDS are coinfectd with chronic HBV, HCV, or  
10      both.

11           (3) According to the Centers for Disease Con-  
12      trol and Prevention (referred to in this section as  
13      the "CDC"), approximately 2 percent of the popu-  
14      lation of the United States is living with chronic  
15      HBV, HCV, or both. The CDC has recognized HCV  
16      as the Nation's most common chronic bloodborne  
17      virus infection.

18           (4) HBV is easily transmitted and is 100 times  
19      more infectious than HIV. According to the CDC,  
20      HBV is transmitted through contact with infectious  
21      blood, semen, or other body fluids. HCV is trans-  
22      mitted by contact with infectious blood, particularly  
23      through percutaneous exposures (i.e. puncture  
24      through the skin).



1           (5) The CDC conservatively estimates that in  
2           2011 approximately 16,500 Americans were newly  
3           infected with HCV and more than 18,800 Americans  
4           were newly infected with HBV. These estimates  
5           could be much higher due to many reasons, includ-  
6           ing lack of screening education and awareness, and  
7           perceived marginalization of the populations at risk.  
8           According to the CDC, from 2010 to 2011 there was  
9           a 45 percent increase in the number of reported  
10          acute hepatitis C cases (from 850 to 1,229 cases)  
11          and another 45 percent increase from 2011 to 2012  
12          (from 1,229 to 1,778 cases), representing a 75 per-  
13          cent increase from 2010–2012. In 2012, the rate of  
14          acute hepatitis C increased in every age group when  
15          compared with 2010 and 2011, with the largest in-  
16          creases among persons aged 0–19 years (from 0.05  
17          to 0.11 cases per 100,000 population) and 20–29  
18          years (from 0.75 to 1.73 cases per 100,000 popu-  
19          lation).

20          (6) In 2012, CDC released new guidelines rec-  
21          ommending every person born from 1945 through  
22          1965 receive a one-time HCV test. Among the esti-  
23          mated 102 million (1.6 million chronically HCV-in-  
24          fected) eligible for screening, birth-cohort screening  
25          leads to 74,000 fewer cases of decompensated cir-

1       rhosis, 46,000 fewer cases of hepatocellular car-  
2       cinoma, 15,000 fewer liver transplants and 120,000  
3       fewer HCV-related deaths versus risk-based screen-  
4       ing.

5               (7) In 2013, the United States Preventative  
6       Services Task Force (USPSTF) issued a Grade B  
7       rating for screening for hepatitis C virus (HCV) in-  
8       fection in persons at high risk for infection and  
9       adults born between 1945 and 1965. In 2009, the  
10      USPSTF issued a Grade A for screening pregnant  
11      women for the hepatitis B virus (HBV) during their  
12      first prenatal visit. In 2014, the USPSTF issued a  
13      Grade B for screening for HBV in individuals at  
14      high risk.

15              (8) There were 35 outbreaks (19 of HBV, 16  
16      of HCV) reported to CDC for investigation from  
17      2008–2012 related to health care acquired infection  
18      of HBV and HCV, 33 of which occurred in nonhos-  
19      pital settings. There were more than 99,975 patients  
20      potentially exposed to one of the viruses.

21              (9) Chronic HBV and chronic HCV usually do  
22      not cause symptoms early in the course of the dis-  
23      ease, but after many years of a clinically “silent”  
24      phase, CDC estimates show more than 33 percent of  
25      infected individuals will develop cirrhosis, end-stage

1 liver disease, or liver cancer. Since most individuals  
2 with chronic HBV, HCV, or both are unaware of  
3 their infection, they do not know to take precautions  
4 to prevent the spread of their infection and can un-  
5 knowingly exacerbate their own disease progression.

6 (10) HBV and HCV disproportionately affect  
7 certain populations in the United States. Although  
8 representing about 6 percent of the population,  
9 Asian and Pacific Islanders account for over half of  
10 up to 1,400,000 domestic chronic HBV cases. Baby  
11 boomers (those born between 1945 and 1965) ac-  
12 count for more than 75 percent of domestic chronic  
13 HCV cases. In addition, African-Americans, Latinos  
14 (Latinas), and American Indians/Alaskan Natives  
15 are among the groups which have disproportionately  
16 high rates of HBV infections, HCV infections, or  
17 both in the United States.

18 (11) For both chronic HBV and chronic HCV,  
19 behavioral changes can slow disease progression if a  
20 diagnosis is made early. Early diagnosis, which is  
21 determined through simple diagnostic tests, can also  
22 reduce the risk of transmission and disease progres-  
23 sion through education and vaccination of household  
24 members and other susceptible persons at risk.

1           (12) Advancements have led to the development  
2       of improved diagnostic tests for viral hepatitis.  
3       These tests, including rapid, point-of-care testing  
4       and others in development, can facilitate testing, no-  
5       tification of results and posttest counseling, and re-  
6       ferral to care at the time of the testing visit. In par-  
7       ticular, these tests are also advantageous because  
8       they can be used simultaneously with HIV rapid  
9       testing for persons at risk for both HCV and HIV  
10      infections.

11          (13) For those chronically infected with HBV  
12      or HCV, regular monitoring can lead to the early de-  
13      tection of liver cancer at a stage where a cure is still  
14      possible. Liver cancer is the second deadliest cancer  
15      in the world; however, liver cancer has received little  
16      funding for research, prevention, or treatment.

17          (14) Treatment for chronic HCV can eradicate  
18      the disease in approximately 95 percent or more of  
19      those currently treated. The treatment of chronic  
20      HBV can effectively suppress viral replication in the  
21      overwhelming majority (over 80 percent) of those  
22      treated, thereby reducing the risk of transmission  
23      and progression to liver scarring or liver cancer,  
24      even though a complete cure is much less common  
25      than for HCV.

1           (15) To combat the viral hepatitis epidemic in  
2           the United States, in May 2011, the Department of  
3           Health and Human Services released, “Combating  
4           the Silent Epidemic of Viral Hepatitis: Action Plan  
5           for the Prevention, Care & Treatment of Viral Hepa-  
6           titis”.

7           (16) The annual health care costs attributable  
8           to viral hepatitis in the United States are signifi-  
9           cant. For HBV, it is estimated to be approximately  
10          \$2,500,000,000 (\$2,000 per infected person). In  
11          2000, the lifetime cost of HBV—before the avail-  
12          ability of most current therapies—was approximately  
13          \$80,000 per chronically infected person, totaling  
14          more than \$100,000,000,000. For HCV, medical  
15          costs for patients are expected to increase from  
16          \$30,000,000,000 in 2009 to over \$85,000,000,000  
17          in 2024. Avoiding these costs by screening and diag-  
18          nosing individuals earlier—and connecting them to  
19          appropriate treatment and care will save lives and  
20          critical health care dollars. Currently, without a  
21          comprehensive screening, testing, and diagnosis pro-  
22          gram, most patients are diagnosed too late when  
23          they need a liver transplant costing at least  
24          \$314,000 for uncomplicated cases or when they have  
25          liver cancer or end-stage liver disease which costs be-



1       tween \$30,980 to \$110,576 per hospital admission.  
2       As health care costs continue to grow, it is critical  
3       that the Federal Government invests in effective  
4       mechanisms to avoid documented cost drivers.

5               (17) According to the Institute of Medicine re-  
6       port in 2010, "Hepatitis and Liver Cancer: A Na-  
7       tional Strategy for Prevention and Control of Hepa-  
8       titis B and C", chronic HBV and HCV infections  
9       cause substantial morbidity and mortality despite  
10      being preventable and treatable. Deficiencies in the  
11      implementation of established guidelines for the pre-  
12      vention, diagnosis, and medical management of  
13      chronic HBV and HCV infections perpetuate per-  
14      sonal and economic burdens. Existing grants are not  
15      sufficient to address the scale of the health burden  
16      presented by HBV and HCV.

17              (18) The Secretary of Health and Human Serv-  
18      ices has the discretion to carry out this Act directly  
19      and through whichever of the agencies of the Public  
20      Health Service the Secretary determines to be ap-  
21      propriate, which may (in the Secretary's discretion)  
22      include the Centers for Disease Control and Preven-  
23      tion, the Health Resources and Services Administra-  
24      tion, the Substance Abuse and Mental Health Serv-  
25      ices Administration, the National Institutes of

1 Health (including the National Institute on Minority  
2 Health and Health Disparities), and other agencies.

3 (19) For over a decade, the Centers for Disease  
4 Control and Prevention's Viral Hepatitis Prevention  
5 Coordinator (VHPC) Program has been the only na-  
6 tional program dedicated to the prevention and con-  
7 trol of the viral hepatitis epidemics administering  
8 the duties currently specified by section 317N of the  
9 Public Health Service Act (42 U.S.C. 247b-15) at  
10 State and local health departments. VHPCs provide  
11 the technical expertise necessary for the manage-  
12 ment and coordination of activities to prevent viral  
13 hepatitis infection and disease with little to no Fed-  
14 eral funding for program implementation or develop-  
15 ment. Further, these coordinators help integrate  
16 viral hepatitis prevention services into health care  
17 settings and public health programs that serve  
18 adults at risk for viral hepatitis.

19 **SEC. 3. REVISION AND EXTENSION OF HEPATITIS SURVEIL-**  
20 **LANCE, EDUCATION, AND TESTING PROGRAM.**

21 (a) IN GENERAL.—Section 317N of the Public  
22 Health Service Act (42 U.S.C. 247b-15) is amended—

23 (1) by amending the section heading to read as  
24 follows: “**SURVEILLANCE, EDUCATION, TESTING,**

1       **AND LINKAGE TO CARE REGARDING HEPATITIS**  
2       **VIRUS”;**

3           (2) by redesignating subsections (b) and (c) as  
4       subsections (d) and (e), respectively; and

5           (3) by striking subsection (a) and inserting the  
6       following:

7       “(a) **IN GENERAL.**—The Secretary shall, in accord-  
8       ance with this section, carry out surveillance, education,  
9       and testing programs with respect to hepatitis B and hep-  
10      atitis C virus infections (referred to in this section as  
11      ‘HBV’ and ‘HCV’, respectively). The Secretary may carry  
12      out such programs directly and through grants to public  
13      and nonprofit private entities, including States, political  
14      subdivisions of States, territories, Indian tribes, and pub-  
15      lic-private partnerships.

16       “(b) **NATIONAL SYSTEM.**—In carrying out subsection  
17      (a), the Secretary shall, in consultation with States and  
18      other public or nonprofit private entities and public-pri-  
19      vate partnerships described in subsection (d), establish a  
20      national system with respect to HBV and HCV with the  
21      following goals:

22           “(1) To determine the incidence and prevalence  
23           of such infections, including providing for the report-  
24           ing of acute and chronic cases.

1           “(2) With respect to the individuals who are  
2       tested for such an infection, to demonstrate success  
3       in increasing the number of individuals tested and  
4       made aware of their status, including those who test  
5       positive.

6           “(3) To develop and disseminate public infor-  
7       mation and education programs for the detection  
8       and control of such infections.

9           “(4) To improve the education, training, and  
10      skills of health professionals in the detection, con-  
11      trol, and care and treatment, of such infections.

12          “(5) To provide appropriate referrals for coun-  
13      seling and medical care and treatment of infected in-  
14      dividuals and to ensure, to the extent practicable,  
15      the provision of appropriate followup services.

16          “(c) HIGH-RISK POPULATIONS; CHRONIC CASES.—

17          “(1) IN GENERAL.—The Secretary shall deter-  
18      mine the populations that, for purposes of this sec-  
19      tion, are considered at high-risk for HBV or HCV.  
20      The Secretary shall include the following among  
21      those considered at high-risk:

22               “(A) For HBV, individuals born in coun-  
23               tries in which 2 percent or more of the popu-  
24               lation has HBV or who are a part of a high-  
25               risk category as identified by the Centers for

1 Disease Control and Prevention and the United  
2 States Preventive Services Task Force.

3 “(B) For HCV, individuals born between  
4 1945 and 1965 or who are a part of a high-risk  
5 category as identified by the Centers for Dis-  
6 ease Control and Prevention and the United  
7 States Preventive Services Task Force.

8 “(C) Those who have been exposed to the  
9 blood of infected individuals or of high-risk in-  
10 dividuals or who are family members of such in-  
11 dividuals.

12 “(2) PRIORITY IN PROGRAMS.—In providing for  
13 programs under this section, the Secretary shall give  
14 priority—

15 “(A) to early diagnosis of chronic cases of  
16 HBV or HCV in high-risk populations under  
17 paragraph (1); and

18 “(B) to education, and referrals for coun-  
19 seling and medical care and treatment, for indi-  
20 viduals diagnosed under subparagraph (A) in  
21 order to—

22 “(i) reduce their risk of dying from  
23 end-stage liver disease and liver cancer,  
24 and of transmitting the infection to others;



1                   “(ii) determine the appropriateness  
2                   for treatment to reduce the risk of progres-  
3                   sion to cirrhosis and liver cancer;

4                   “(iii) receive ongoing medical manage-  
5                   ment, including regular monitoring of liver  
6                   function and screenings for liver cancer;

7                   “(iv) receive, as appropriate, drug, al-  
8                   cohol abuse, and mental health treatment;

9                   “(v) in the case of women of child-  
10                  bearing age, receive education on how to  
11                  prevent HBV perinatal infection, and to al-  
12                  leviate fears associated with pregnancy or  
13                  raising a family; and

14                  “(vi) receive such other services as the  
15                  Secretary determines to be appropriate.

16                  “(3) CULTURAL CONTEXT.—In providing for  
17                  services pursuant to paragraph (2) for individuals  
18                  who are diagnosed under subparagraph (A) of such  
19                  paragraph, the Secretary shall seek to ensure that  
20                  the services are provided in a culturally and linguis-  
21                  tically appropriate manner.

22                  “(d) ACTION PLAN IMPLEMENTATION.—

23                  “(1) BENCHMARKS.—The Secretary shall de-  
24                  velop benchmarks for evaluating the effectiveness of  
25                  the programs and activities conducted under the ‘Ac-

1       tion Plan for the Prevention, Care, & Treatment of  
2       Viral Hepatitis' of the Department of Health and  
3       Human Services and make determinations as to  
4       whether such benchmarks have been achieved.

5               “(2) ANNUAL REPORTING.—

6               “(A) IN GENERAL.—The Secretary shall  
7       report annually to the Congress on the bench-  
8       marks developed under paragraph (1), including  
9       the amount of funding used by each agency of  
10      the Department of Health and Human Services  
11      to achieve each benchmark.

12              “(B) CONTENTS.—Each report under sub-  
13      paragraph (A) shall include reporting on—

14              “(i) the number of people tested for  
15      hepatitis B and hepatitis C;

16              “(ii) the number of individuals who  
17      test positive for hepatitis B and C;

18              “(iii) the number of individuals who  
19      are tested and then made aware of their  
20      health status;

21              “(iv) the number of individuals re-  
22      ferred to care or treatment followup;

23              “(v) improvements in surveillance ac-  
24      tivities;

1 “(vi) provider and community edu-  
2 cation activities;

3 “(vii) the reduction in the number of  
4 infants born with hepatitis B;

5 “(viii) estimates on the reduction, as  
6 a result of prevention measures, in the  
7 number of new hepatitis B and hepatitis C  
8 infections; and

9 “(ix) estimates on the reduction in  
10 liver cancer resulting from hepatitis B or  
11 hepatitis C infection.

12 “(e) PUBLIC-PRIVATE PARTNERSHIPS.—

13 “(1) IN GENERAL.—In carrying out this sec-  
14 tion, and not later than 60 days after the date of  
15 the enactment of the Viral Hepatitis Testing Act of  
16 2015, the Secretary shall, in consultation with the  
17 Assistant Secretary for Health, the Director of the  
18 Centers for Disease Control and Prevention, the  
19 Health Resources and Services Administration, the  
20 Substance Abuse and Mental Health Services Ad-  
21 ministration, the Office of Minority Health, the In-  
22 dian Health Service, other relevant agencies, and  
23 nongovernment stakeholder entities, establish and  
24 support public-private partnerships that facilitate

1 the surveillance, education, screening, testing, and  
2 linkage to care programs authorized by this section.

3 “(2) DUTIES.—Public-private partnerships es-  
4 tablished or supported under paragraph (1) shall—

5 “(A) focus primarily on the surveillance,  
6 education, screening, testing, and linkage to  
7 care programs authorized by this section;

8 “(B) generate resources, in addition to the  
9 funds made available pursuant to subsection  
10 (f), to carry out the surveillance, education,  
11 screening, testing, and linkage to care programs  
12 authorized in this section by leveraging Federal  
13 funding with non-Federal funding and support;

14 “(C) allow for investments in such pro-  
15 grams of financial or in-kind resources by each  
16 of the partners involved in the partnership;

17 “(D) include corporate and industry enti-  
18 ties, academic institutions, public and nonprofit  
19 organizations, community and faith-based orga-  
20 nizations, foundations, and other governmental  
21 and nongovernmental organizations; and

22 “(E) advance the core goals of each of the  
23 partners of the partnership as determined by  
24 the Secretary in development of the partner-  
25 ship.

1           “(3) ANNUAL REPORTS.—The Secretary shall  
2       provide to the Congress an annual report on the  
3       public-private partnerships established under this  
4       subsection. Each such report shall include—

5           “(A) the number of public-private partner-  
6       ships established;

7           “(B) specific and quantifiable information  
8       on the surveillance, education, screening, test-  
9       ing, and linkage to care activities conducted as  
10      well as the outcomes achieved through each of  
11      the public-private partnerships;

12          “(C) the amount of Federal funding or re-  
13      sources dedicated to the public-private partner-  
14      ships;

15          “(D) the amount of non-Federal funding  
16      or resources leveraged through the public-pri-  
17      vate partnerships; and

18          “(E) a plan for the following year that out-  
19      lines future activities.

20          “(4) LIMITATION.—No more than 25 percent of  
21      the funds made available to carry out this section  
22      may be used for public-private partnerships estab-  
23      lished or supported under this subsection.

24          “(5) LINKAGE TO CARE.—For purposes of this  
25      section, the term ‘linkage to care’ means, with re-



1 spect to an individual with a diagnosis of HBV or  
2 HCV, the referral of such individual to clinical care  
3 for a thorough evaluation of their clinical status to  
4 determine the need for treatment, vaccination for  
5 HBV, or other therapy.

6 “(f) AGENCY FOR HEALTHCARE RESEARCH AND  
7 QUALITY HBV AND HCV GUIDELINES.—Due to the rap-  
8 idly evolving standard of care associated with diagnosing  
9 and treating viral hepatitis infection, the Director of the  
10 Agency for Healthcare Research and Quality shall convene  
11 the United States Preventive Services Task Force under  
12 section 915(a) to review its recommendation for screening  
13 for HBV and HCV infection every 3 years.

14 “(g) FUNDING.—

15 “(1) IN GENERAL.—In addition to any amounts  
16 otherwise authorized by this Act, there are author-  
17 ized to be appropriated to carry out this section—

18 “(A) \$25,000,000 for fiscal year 2016;

19 “(B) \$35,000,000 for fiscal year 2017; and

20 “(C) \$20,000,000 for fiscal year 2018.

21 “(2) GRANTS.—Of the amounts appropriated  
22 pursuant to paragraph (1) for a fiscal year, the Sec-  
23 retary shall reserve not less than 80 percent for  
24 making grants under subsection (a).

1           “(3) SOURCE OF FUNDS.—The funds made  
2           available to carry out this section shall be derived  
3           exclusively from the funds appropriated or otherwise  
4           made available for planning and evaluation under  
5           this Act.”.

6           (b) SAVINGS PROVISION.—The amendments made by  
7           this section shall not be construed to require termination  
8           of any program or activity carried out by the Secretary  
9           of Health and Human Services under section 317N of the  
10          Public Health Service Act (42 U.S.C. 247b–15) as in ef-  
11          fect on the day before the date of the enactment of this  
12          Act.

13   **SEC. 4. HEPATITIS B AND HEPATITIS C SCREENING AND**  
14                   **EVALUATION OF NEEDED CARE FOR VET-**  
15                   **ERANS.**

16          (a) IN GENERAL.—Subchapter II of chapter 17 of  
17          title 38, United States Code, is amended by adding at the  
18          end the following:

19   **“§ 1720H. Hepatitis B and Hepatitis C screening and**  
20                   **evaluation of needed care for veterans**

21          “(a) IN GENERAL.—(1) The Secretary shall establish  
22          and carry out a plan to provide veterans described in para-  
23          graph (2) with—

24                  “(A) a risk assessment for the hepatitis B and  
25          hepatitis C virus; and

1           “(B) if a veteran is diagnosed with such virus—

2                   “(i) a thorough evaluation of the clinical  
3           status of the veteran to determine the need for  
4           treatment, vaccination, or other therapy; and

5                   “(ii) information with respect to the needs  
6           determined under clause (i).

7           “(2) Veterans described in this paragraph are vet-  
8   erans who—

9                   “(A) are enrolled in the health care system es-  
10          tablished under section 1705(a) of this title;

11                   “(B) were born between 1945 and 1965; and

12                   “(C) are considered a high-risk group for hepa-  
13          titis B or hepatitis C infection.

14           “(b) COMPLIANCE.—(1) The Secretary shall use the  
15   plan established under subsection (a)(1) as a key measure  
16   in determining performance under the VA Handbook Per-  
17   formance Management System, or the successor to such  
18   handbook, to ensure the compliance of such plan.

19           “(2) If the Secretary determines that a medical facil-  
20   ity of the Department complies with the plan established  
21   under subsection (a)(1) at a rate less than 100 percent,  
22   the Secretary shall treat the director of such medical facil-  
23   ity as ‘less than fully successful’ with respect to the per-  
24   formance appraisal that is used for the basis for deter-

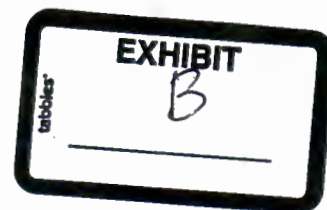
1 mining performance awards under the handbook described  
2 in paragraph (1).

3 “(c) ANNUAL REPORT.—The Secretary shall submit  
4 annually to Congress a report on the compliance of each  
5 medical facility of the Department with the plan estab-  
6 lished under subsection (a)(1).”.

7 (b) CLERICAL AMENDMENT.—The table of sections  
8 at the beginning of such chapter is amended by inserting  
9 after the item relating to section 1720G the following new  
10 item:

“1720H. Hepatitis B and Hepatitis C screening and evaluation of needed care  
for veterans.”.

○



II

114TH CONGRESS  
1ST SESSION

# S. 1287

To amend the Public Health Service Act to revise and extend the program for viral hepatitis surveillance, education, and testing in order to prevent deaths from chronic liver disease and liver cancer, and for other purposes.

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## IN THE SENATE OF THE UNITED STATES

MAY 12, 2015

Mr. KIRK (for himself, Ms. HIRONO, Mr. CASSIDY, Mr. SCHUMER, and Mr. MERKLEY) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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## A BILL

To amend the Public Health Service Act to revise and extend the program for viral hepatitis surveillance, education, and testing in order to prevent deaths from chronic liver disease and liver cancer, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Viral Hepatitis Testing  
5 Act of 2015".

6 **SEC. 2. FINDINGS.**

7 Congress finds the following:



1           (1) Approximately 5,300,000 Americans are  
2           chronically infected with the hepatitis B virus (re-  
3           ferred to in this section as “HBV”), the hepatitis C  
4           virus (referred to in this section as “HCV”), or  
5           both.

6           (2) In the United States, chronic HBV and  
7           HCV are among the most common causes of liver  
8           cancer, one of the most lethal and fastest growing  
9           cancers in the United States. Chronic HBV and  
10          HCV are among the most common causes of chronic  
11          liver disease, liver cirrhosis, and the most common  
12          indication for liver transplantation. More than  
13          15,000 deaths per year in the United States can be  
14          attributed to chronic HBV and HCV. Current infor-  
15          mation indicates these represent a fraction of deaths  
16          attributable in whole or in part to chronic hepatitis  
17          C. From 2007 through 2011, mortality rates of per-  
18          sons with hepatitis C increased 39 percent among  
19          persons aged 55–64 years to a rate of 21.9 deaths  
20          per 100,000 population in 2011. In 2011, the high-  
21          est mortality rates of persons with hepatitis C by  
22          race/ethnicity and sex were observed among Amer-  
23          ican Indians and Alaska Natives (10.6 deaths per  
24          100,000 population) and males (7.1 deaths per  
25          100,000 population) respectively. Mortality data

1 from 2011, the latest year for which these data were  
2 available, reveal the serious health consequences as-  
3 sociated with viral hepatitis: chronic liver disease, in-  
4 cluding cirrhosis, was the 12th leading cause of  
5 death in the United States in 2011. Chronic HCV  
6 is also a leading cause of death in Americans living  
7 with HIV/AIDS. Many of those living with HIV/  
8 AIDS are coinfectd with chronic HBV, HCV, or  
9 both.

10 (3) According to the Centers for Disease Con-  
11 trol and Prevention (referred to in this section as  
12 the "CDC"), approximately 2 percent of the popu-  
13 lation of the United States is living with chronic  
14 HBV, HCV, or both. The CDC has recognized HCV  
15 as the Nation's most common chronic bloodborne  
16 virus infection.

17 (4) HBV is easily transmitted and is 100 times  
18 more infectious than HIV. According to the CDC,  
19 HBV is transmitted through contact with infectious  
20 blood, semen, or other body fluids. HCV is trans-  
21 mitted by contact with infectious blood, particularly  
22 through percutaneous exposures (i.e. puncture  
23 through the skin).

24 (5) The CDC conservatively estimates that in  
25 2011 approximately 16,500 Americans were newly

1 infected with HCV and more than 18,800 Americans  
2 were newly infected with HBV. These estimates  
3 could be much higher due to many reasons, includ-  
4 ing lack of screening education and awareness, and  
5 perceived marginalization of the populations at risk.  
6 According to the CDC, from 2010 to 2011 there was  
7 a 45 percent increase in the number of reported  
8 acute hepatitis C cases (from 850 to 1,229 cases)  
9 and another 45 percent increase from 2011 to 2012  
10 (from 1,229 to 1,778 cases), representing a 75 per-  
11 cent increase from 2010–2012. In 2012, the rate of  
12 acute hepatitis C increased in every age group when  
13 compared with 2010 and 2011, with the largest in-  
14 creases among persons aged 0–19 years (from 0.05  
15 to 0.11 cases per 100,000 population) and 20–29  
16 years (from 0.75 to 1.73 cases per 100,000 popu-  
17 lation).

18 (6) In 2012, CDC released new guidelines rec-  
19 ommending every person born from 1945 through  
20 1965 receive a one-time HCV test. Among the esti-  
21 mated 102 million (1.6 million chronically HCV-in-  
22 fected) eligible for screening, birth-cohort screening  
23 leads to 74,000 fewer cases of decompensated cir-  
24 rhosis, 46,000 fewer cases of hepatocellular car-  
25 cinoma, 15,000 fewer liver transplants and 120,000

1 fewer HCV-related deaths versus risk-based screen-  
2 ing.

3 (7) In 2013, the United States Preventative  
4 Services Task Force (USPSTF) issued a Grade B  
5 rating for screening for hepatitis C virus (HCV) in-  
6 fection in persons at high risk for infection and  
7 adults born between 1945 and 1965. In 2009, the  
8 USPSTF issued a Grade A for screening pregnant  
9 women for the hepatitis B virus (HBV) during their  
10 first prenatal visit. In 2014, the USPSTF issued a  
11 Grade B for screening for HBV in individuals at  
12 high risk.

13 (8) There were 35 outbreaks (19 of HBV, 16  
14 of HCV) reported to CDC for investigation from  
15 2008–2012 related to health care acquired infection  
16 of HBV and HCV, 33 of which occurred in nonhos-  
17 pital settings. There were more than 99,975 patients  
18 potentially exposed to one of the viruses.

19 (9) Chronic HBV and chronic HCV usually do  
20 not cause symptoms early in the course of the dis-  
21 ease, but after many years of a clinically “silent”  
22 phase, CDC estimates show more than 33 percent of  
23 infected individuals will develop cirrhosis, end-stage  
24 liver disease, or liver cancer. Since most individuals  
25 with chronic HBV, HCV, or both are unaware of

1        their infection, they do not know to take precautions  
2        to prevent the spread of their infection and can un-  
3        knowingly exacerbate their own disease progression.

4            (10) HBV and HCV disproportionately affect  
5        certain populations in the United States. Although  
6        representing about 6 percent of the population,  
7        Asian and Pacific Islanders account for over half of  
8        up to 1,400,000 domestic chronic HBV cases. Baby  
9        boomers (those born between 1945 and 1965) ac-  
10       count for more than 75 percent of domestic chronic  
11       HCV cases. In addition, African-Americans, Latinos  
12       (Latinas), and American Indians/Alaskan Natives  
13       are among the groups which have disproportionately  
14       high rates of HBV infections, HCV infections, or  
15       both in the United States.

16           (11) For both chronic HBV and chronic HCV,  
17        behavioral changes can slow disease progression if a  
18        diagnosis is made early. Early diagnosis, which is  
19        determined through simple diagnostic tests, can also  
20        reduce the risk of transmission and disease progres-  
21        sion through education and vaccination of household  
22        members and other susceptible persons at risk.

23           (12) Advancements have led to the development  
24        of improved diagnostic tests for viral hepatitis.  
25        These tests, including rapid, point-of-care testing

1 and others in development, can facilitate testing, no-  
2 tification of results and posttest counseling, and re-  
3 ferral to care at the time of the testing visit. In par-  
4 ticular, these tests are also advantageous because  
5 they can be used simultaneously with HIV rapid  
6 testing for persons at risk for both HCV and HIV  
7 infections.

8 (13) For those chronically infected with HBV  
9 or HCV, regular monitoring can lead to the early de-  
10 tection of liver cancer at a stage where a cure is still  
11 possible. Liver cancer is the second deadliest cancer  
12 in the world; however, liver cancer has received little  
13 funding for research, prevention, or treatment.

14 (14) Treatment for chronic HCV can eradicate  
15 the disease in approximately 95 percent or more of  
16 those currently treated. The treatment of chronic  
17 HBV can effectively suppress viral replication in the  
18 overwhelming majority (over 80 percent) of those  
19 treated, thereby reducing the risk of transmission  
20 and progression to liver scarring or liver cancer,  
21 even though a complete cure is much less common  
22 than for HCV.

23 (15) To combat the viral hepatitis epidemic in  
24 the United States, in May 2011, the Department of  
25 Health and Human Services released, "Combating



1 the Silent Epidemic of Viral Hepatitis: Action Plan  
2 for the Prevention, Care & Treatment of Viral Hepa-  
3 titis”.

4 (16) The annual health care costs attributable  
5 to viral hepatitis in the United States are signifi-  
6 cant. For HBV, it is estimated to be approximately  
7 \$2,500,000,000 (\$2,000 per infected person). In  
8 2000, the lifetime cost of HBV—before the avail-  
9 ability of most current therapies—was approximately  
10 \$80,000 per chronically infected person, totaling  
11 more than \$100,000,000,000. For HCV, medical  
12 costs for patients are expected to increase from  
13 \$30,000,000,000 in 2009 to over \$85,000,000,000  
14 in 2024. Avoiding these costs by screening and diag-  
15 nosing individuals earlier—and connecting them to  
16 appropriate treatment and care will save lives and  
17 critical health care dollars. Currently, without a  
18 comprehensive screening, testing, and diagnosis pro-  
19 gram, most patients are diagnosed too late when  
20 they need a liver transplant costing at least  
21 \$314,000 for uncomplicated cases or when they have  
22 liver cancer or end-stage liver disease which costs be-  
23 tween \$30,980 to \$110,576 per hospital admission.  
24 As health care costs continue to grow, it is critical

1       that the Federal Government invests in effective  
2       mechanisms to avoid documented cost drivers.

3           (17) According to the Institute of Medicine re-  
4       port in 2010, "Hepatitis and Liver Cancer: A Na-  
5       tional Strategy for Prevention and Control of Hepa-  
6       titis B and C", chronic HBV and HCV infections  
7       cause substantial morbidity and mortality despite  
8       being preventable and treatable. Deficiencies in the  
9       implementation of established guidelines for the pre-  
10      vention, diagnosis, and medical management of  
11      chronic HBV and HCV infections perpetuate per-  
12      sonal and economic burdens. Existing grants are not  
13      sufficient to address the scale of the health burden  
14      presented by HBV and HCV.

15           (18) The Secretary of Health and Human Serv-  
16      ices has the discretion to carry out this Act directly  
17      and through whichever of the agencies of the Public  
18      Health Service the Secretary determines to be ap-  
19      propriate, which may (in the Secretary's discretion)  
20      include the Centers for Disease Control and Preven-  
21      tion, the Health Resources and Services Administra-  
22      tion, the Substance Abuse and Mental Health Serv-  
23      ices Administration, the National Institutes of  
24      Health (including the National Institute on Minority  
25      Health and Health Disparities), and other agencies.

1           (19) For over a decade, the Centers for Disease  
2       Control and Prevention's Viral Hepatitis Prevention  
3       Coordinator (VHPC) Program has been the only na-  
4       tional program dedicated to the prevention and con-  
5       trol of the viral hepatitis epidemics administering  
6       the duties currently specified by section 317N of the  
7       Public Health Service Act (42 U.S.C. 247b-15) at  
8       State and local health departments. VHPCs provide  
9       the technical expertise necessary for the manage-  
10      ment and coordination of activities to prevent viral  
11      hepatitis infection and disease with little to no Fed-  
12      eral funding for program implementation or develop-  
13      ment. Further, these coordinators help integrate  
14      viral hepatitis prevention services into health care  
15      settings and public health programs that serve  
16      adults at risk for viral hepatitis.

17   **SEC. 3. REVISION AND EXTENSION OF HEPATITIS SURVEIL-**  
18                           **LANCE, EDUCATION, AND TESTING PROGRAM.**

19       (a) IN GENERAL.—Section 317N of the Public  
20   Health Service Act (42 U.S.C. 247b-15) is amended—

21           (1) by amending the section heading to read as  
22       follows: “**SURVEILLANCE, EDUCATION, TESTING,**  
23       **AND LINKAGE TO CARE REGARDING HEPATITIS**  
24       **VIRUS**”;

1           (2) by redesignating subsections (b) and (c) as  
2       subsections (d) and (e), respectively; and

3           (3) by striking subsection (a) and inserting the  
4       following:

5       “(a) IN GENERAL.—The Secretary shall, in accord-  
6       ance with this section, carry out surveillance, education,  
7       and testing programs with respect to hepatitis B and hep-  
8       atitis C virus infections (referred to in this section as  
9       ‘HBV’ and ‘HCV’, respectively). The Secretary may carry  
10      out such programs directly and through grants to public  
11      and nonprofit private entities, including States, political  
12      subdivisions of States, territories, Indian tribes, and pub-  
13      lic-private partnerships.

14      “(b) NATIONAL SYSTEM.—In carrying out subsection  
15      (a), the Secretary shall, in consultation with States and  
16      other public or nonprofit private entities and public-pri-  
17      vate partnerships described in subsection (d), establish a  
18      national system with respect to HBV and HCV with the  
19      following goals:

20           “(1) To determine the incidence and prevalence  
21       of such infections, including providing for the report-  
22       ing of acute and chronic cases.

23           “(2) With respect to the individuals who are  
24       tested for such an infection, to demonstrate success  
25       in increasing the number of individuals tested and

1       made aware of their status, including those who test  
2       positive.

3           “(3) To develop and disseminate public infor-  
4       mation and education programs for the detection  
5       and control of such infections.

6           “(4) To improve the education, training, and  
7       skills of health professionals in the detection, con-  
8       trol, and care and treatment, of such infections.

9           “(5) To provide appropriate referrals for coun-  
10      seling and medical care and treatment of infected in-  
11      dividuals and to ensure, to the extent practicable,  
12      the provision of appropriate followup services.

13      “(c) HIGH-RISK POPULATIONS; CHRONIC CASES.—

14           “(1) IN GENERAL.—The Secretary shall deter-  
15      mine the populations that, for purposes of this sec-  
16      tion, are considered at high-risk for HBV or HCV.  
17      The Secretary shall include the following among  
18      those considered at high-risk:

19           “(A) For HBV, individuals born in coun-  
20      tries in which 2 percent or more of the popu-  
21      lation has HBV or who are a part of a high-  
22      risk category as identified by the Centers for  
23      Disease Control and Prevention and the United  
24      States Preventive Services Task Force.

1           “(B) For HCV, individuals born between  
2           1945 and 1965 or who are a part of a high-risk  
3           category as identified by the Centers for Dis-  
4           ease Control and Prevention and the United  
5           States Preventive Services Task Force.

6           “(C) Those who have been exposed to the  
7           blood of infected individuals or of high-risk in-  
8           dividuals or who are family members of such in-  
9           dividuals.

10          “(2) PRIORITY IN PROGRAMS.—In providing for  
11          programs under this section, the Secretary shall give  
12          priority—

13               “(A) to early diagnosis of chronic cases of  
14               HBV or HCV in high-risk populations under  
15               paragraph (1); and

16               “(B) to education, and referrals for coun-  
17               seling and medical care and treatment, for indi-  
18               viduals diagnosed under subparagraph (A) in  
19               order to—

20                       “(i) reduce their risk of dying from  
21                       end-stage liver disease and liver cancer,  
22                       and of transmitting the infection to others;

23                       “(ii) determine the appropriateness  
24                       for treatment to reduce the risk of progres-  
25                       sion to cirrhosis and liver cancer;



1                   “(iii) receive ongoing medical manage-  
2                   ment, including regular monitoring of liver  
3                   function and screenings for liver cancer;

4                   “(iv) receive, as appropriate, drug, al-  
5                   cohol abuse, and mental health treatment;

6                   “(v) in the case of women of child-  
7                   bearing age, receive education on how to  
8                   prevent HBV perinatal infection, and to al-  
9                   leviate fears associated with pregnancy or  
10                  raising a family; and

11                  “(vi) receive such other services as the  
12                  Secretary determines to be appropriate.

13                  “(3) CULTURAL CONTEXT.—In providing for  
14                  services pursuant to paragraph (2) for individuals  
15                  who are diagnosed under subparagraph (A) of such  
16                  paragraph, the Secretary shall seek to ensure that  
17                  the services are provided in a culturally and linguis-  
18                  tically appropriate manner.

19                  “(d) ACTION PLAN IMPLEMENTATION.—

20                  “(1) BENCHMARKS.—The Secretary shall de-  
21                  velop benchmarks for evaluating the effectiveness of  
22                  the programs and activities conducted under the ‘Ac-  
23                  tion Plan for the Prevention, Care, & Treatment of  
24                  Viral Hepatitis’ of the Department of Health and

1 Human Services and make determinations as to  
2 whether such benchmarks have been achieved.

3 “(2) ANNUAL REPORTING.—

4 “(A) IN GENERAL.—The Secretary shall  
5 report annually to the Congress on the bench-  
6 marks developed under paragraph (1), including  
7 the amount of funding used by each agency of  
8 the Department of Health and Human Services  
9 to achieve each benchmark.

10 “(B) CONTENTS.—Each report under sub-  
11 paragraph (A) shall include reporting on—

12 “(i) the number of people tested for  
13 hepatitis B and hepatitis C;

14 “(ii) the number of individuals who  
15 test positive for hepatitis B and C;

16 “(iii) the number of individuals who  
17 are tested and then made aware of their  
18 health status;

19 “(iv) the number of individuals re-  
20 ferred to care or treatment followup;

21 “(v) improvements in surveillance ac-  
22 tivities;

23 “(vi) provider and community edu-  
24 cation activities;

1 “(vii) the reduction in the number of  
2 infants born with hepatitis B;

3 “(viii) estimates on the reduction, as  
4 a result of prevention measures, in the  
5 number of new hepatitis B and hepatitis C  
6 infections; and

7 “(ix) estimates on the reduction in  
8 liver cancer resulting from hepatitis B or  
9 hepatitis C infection.

10 “(e) PUBLIC-PRIVATE PARTNERSHIPS.—

11 “(1) IN GENERAL.—In carrying out this sec-  
12 tion, and not later than 60 days after the date of  
13 the enactment of the Viral Hepatitis Testing Act of  
14 2015, the Secretary shall, in consultation with the  
15 Assistant Secretary for Health, the Director of the  
16 Centers for Disease Control and Prevention, the  
17 Health Resources and Services Administration, the  
18 Substance Abuse and Mental Health Services Ad-  
19 ministration, the Office of Minority Health, the In-  
20 dian Health Service, other relevant agencies, and  
21 nongovernment stakeholder entities, establish and  
22 support public-private partnerships that facilitate  
23 the surveillance, education, screening, testing, and  
24 linkage to care programs authorized by this section.

1           “(2) DUTIES.—Public-private partnerships es-  
2       tablished or supported under paragraph (1) shall—

3           “(A) focus primarily on the surveillance,  
4       education, screening, testing, and linkage to  
5       care programs authorized by this section;

6           “(B) generate resources, in addition to the  
7       funds made available pursuant to subsection  
8       (f), to carry out the surveillance, education,  
9       screening, testing, and linkage to care programs  
10      authorized in this section by leveraging Federal  
11      funding with non-Federal funding and support;

12          “(C) allow for investments in such pro-  
13      grams of financial or in-kind resources by each  
14      of the partners involved in the partnership;

15          “(D) include corporate and industry enti-  
16      ties, academic institutions, public and nonprofit  
17      organizations, community and faith-based orga-  
18      nizations, foundations, and other governmental  
19      and nongovernmental organizations; and

20          “(E) advance the core goals of each of the  
21      partners of the partnership as determined by  
22      the Secretary in development of the partner-  
23      ship.

24          “(3) ANNUAL REPORTS.—The Secretary shall  
25      provide to the Congress an annual report on the

1 public-private partnerships established under this  
2 subsection. Each such report shall include—

3 “(A) the number of public-private partner-  
4 ships established;

5 “(B) specific and quantifiable information  
6 on the surveillance, education, screening, test-  
7 ing, and linkage to care activities conducted as  
8 well as the outcomes achieved through each of  
9 the public-private partnerships;

10 “(C) the amount of Federal funding or re-  
11 sources dedicated to the public-private partner-  
12 ships;

13 “(D) the amount of non-Federal funding  
14 or resources leveraged through the public-pri-  
15 vate partnerships; and

16 “(E) a plan for the following year that out-  
17 lines future activities.

18 “(4) LIMITATION.—No more than 25 percent of  
19 the funds made available to carry out this section  
20 may be used for public-private partnerships estab-  
21 lished or supported under this subsection.

22 “(5) LINKAGE TO CARE.—For purposes of this  
23 section, the term ‘linkage to care’ means, with re-  
24 spect to an individual with a diagnosis of HBV or  
25 HCV, the referral of such individual to clinical care

1 for a thorough evaluation of their clinical status to  
 2 determine the need for treatment, vaccination for  
 3 HBV, or other therapy.

4 “(f) AGENCY FOR HEALTHCARE RESEARCH AND  
 5 QUALITY HBV AND HCV GUIDELINES.—Due to the rap-  
 6 idly evolving standard of care associated with diagnosing  
 7 and treating viral hepatitis infection, the Director of the  
 8 Agency for Healthcare Research and Quality shall convene  
 9 the United States Preventive Services Task Force under  
 10 section 915(a) to review its recommendation for screening  
 11 for HBV and HCV infection every 3 years.

12 “(g) FUNDING.—

13 “(1) IN GENERAL.—In addition to any amounts  
 14 otherwise authorized by this Act, there are author-  
 15 ized to be appropriated to carry out this section—

16 “(A) \$25,000,000 for fiscal year 2016;

17 “(B) \$35,000,000 for fiscal year 2017; and

18 “(C) \$20,000,000 for fiscal year 2018.

19 “(2) GRANTS.—Of the amounts appropriated  
 20 pursuant to paragraph (1) for a fiscal year, the Sec-  
 21 retary shall reserve not less than 80 percent for  
 22 making grants under subsection (a).

23 “(3) SOURCE OF FUNDS.—The funds made  
 24 available to carry out this section shall be derived  
 25 exclusively from the funds appropriated or otherwise



1       made available for planning and evaluation under  
2       this Act.”.

3       (b) SAVINGS PROVISION.—The amendments made by  
4       this section shall not be construed to require termination  
5       of any program or activity carried out by the Secretary  
6       of Health and Human Services under section 317N of the  
7       Public Health Service Act (42 U.S.C. 247b–15) as in ef-  
8       fect on the day before the date of the enactment of this  
9       Act.

10   **SEC. 4. HEPATITIS B AND HEPATITIS C SCREENING AND**  
11                   **EVALUATION OF NEEDED CARE FOR VET-**  
12                   **ERANS.**

13       (a) IN GENERAL.—Subchapter II of chapter 17 of  
14       title 38, United States Code, is amended by adding at the  
15       end the following:

16   **“§ 1720H. Hepatitis B and Hepatitis C screening and**  
17                   **evaluation of needed care for veterans**

18       “(a) IN GENERAL.—(1) The Secretary shall establish  
19       and carry out a plan to provide veterans described in para-  
20       graph (2) with—

21               “(A) a risk assessment for the hepatitis B and  
22       hepatitis C virus; and

23               “(B) if a veteran is diagnosed with such virus—

1           “(i) a thorough evaluation of the clinical  
2           status of the veteran to determine the need for  
3           treatment, vaccination, or other therapy; and

4           “(ii) information with respect to the needs  
5           determined under clause (i).

6           “(2) Veterans described in this paragraph are vet-  
7           erans who—

8           “(A) are enrolled in the health care system es-  
9           tablished under section 1705(a) of this title;

10          “(B) were born between 1945 and 1965; and

11          “(C) are considered a high-risk group for hepa-  
12          titis B or hepatitis C infection.

13          “(b) COMPLIANCE.—(1) The Secretary shall use the  
14          plan established under subsection (a)(1) as a key measure  
15          in determining performance under the VA Handbook Per-  
16          formance Management System, or the successor to such  
17          handbook, to ensure the compliance of such plan.

18          “(2) If the Secretary determines that a medical facil-  
19          ity of the Department complies with the plan established  
20          under subsection (a)(1) at a rate less than 100 percent,  
21          the Secretary shall treat the director of such medical facil-  
22          ity as ‘less than fully successful’ with respect to the per-  
23          formance appraisal that is used for the basis for deter-  
24          mining performance awards under the handbook described  
25          in paragraph (1).

1       “(c) ANNUAL REPORT.—The Secretary shall submit  
2 annually to Congress a report on the compliance of each  
3 medical facility of the Department with the plan estab-  
4 lished under subsection (a)(1).”.

5       (b) CLERICAL AMENDMENT.—The table of sections  
6 at the beginning of such chapter is amended by inserting  
7 after the item relating to section 1720G the following new  
8 item:

“1720H. Hepatitis B and Hepatitis C screening and evaluation of needed care  
for veterans.”.

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