



Treating Hepatitis C

By Karmen Hanson

The hepatitis C virus (HCV), a leading cause of liver disease—including liver cancers and failure—affects between 3.2 million and 5.2 million Americans, according to the Centers for Disease Control and Prevention (CDC). [Research](#) by the University of Texas MD Anderson Cancer Center in Houston, published in the *Annals of Internal Medicine*, indicates that chronic hepatitis C infections currently incur about \$6.5 billion annually in medical costs nationwide. The hepatitis C virus also is responsible for at least 17,000 U.S. deaths each year. Although treatments are available, hepatitis C is often referred to as a “silent killer” because approximately 50 percent of those with the disease have no symptoms until they have significant liver damage.

Of those affected with hepatitis C, 75 percent were born between 1945 and 1965, baby boomers infected in the 1970s or 1980s when rates of exposure to the virus were at an all-time high. Many received contaminated blood or blood products before widespread screening of the blood supply began in the United States in 1992. Even now, nearly 20,000 Americans are infected with hepatitis C every year. About 15 percent to 20 percent of those infected with HCV recover without treatment; in others, the disease typically progresses slowly and may not cause cirrhosis—severe liver scarring that replaces healthy liver cells—for 20 to 40 years.

New and emerging treatments are leading to cures for many with chronic hepatitis C infection. In March 2014, the American Association for the Study of Liver Diseases (AASLD) and the Infectious Diseases Society of America (IDSA) announced new hepatitis C treatment [guidelines](#) for clinicians, followed in August by additional information about “[prioritizing patients under limited resources](#).” The guidelines call for prioritizing treatments for people most in need based on severity of their disease and for those for whom treatment will most effectively limit further HCV transmission. It is important to understand how treatments may affect public programs that provide care for people with chronic hepatitis C infection, including Medicaid, Medicare, state and federal employee insurance programs, and prison populations.

Federal Action

Both the CDC and the [U.S. Preventive Services Task Force](#) (USPSTF) recommend offering a one-time screening—with no insurance copayment—for hepatitis C infection for baby boomers who have no other risk factors beyond their birth dates. The recommendation also applies to other adults who are at high risk of being infected, including those who have ever injected illicit drugs and anyone who received a blood transfusion or blood product before 1992.

Did You Know?

- New treatments for hepatitis C are curing more people than before.
- Baby boomers make up an estimated 75 percent of all cases of hepatitis C.
- Medicare and some insurance plans cover screening for hepatitis C as a preventive service without a copayment.

In June, the Centers for Medicare and Medicaid Services published a [Medicare Decision Memo for Screening for Hepatitis C Virus in Adults](#). The memo indicates that, based on the USPSTF recommendation, Medicare parts A and B will cover hepatitis C screening for beneficiaries.

The Veterans Administration also is screening and treating a large number of veterans. In early 2014, the Veterans Administration National Hepatitis C Resource Center Program and the Office of Public Health released [treatment considerations](#) for chronic hepatitis C virus infection. It provides a detailed approach to help in clinical decision making about hepatitis C treatment protocols, based on the hepatitis genotype, presence of cirrhosis, and treatment history and eligibility.

State Action

Since 2010, states have considered nearly 40 hepatitis C-related bills and resolutions, mainly focusing on screening requirements and recommendations, resolutions to Congress and awareness campaigns. Approximately 10 bills and resolutions have been adopted. State policymakers also are considering ways to increase awareness and screenings in key populations and in state-supported programs such as Medicaid and employee health insurance plans. Some states have recently updated their hepatitis C-related screening and treatment policies and practices within Medicaid.

Connecticut, Massachusetts and New York now require providers to offer—and Colorado recommends that providers offer—hepatitis C screening to those born between 1945 and 1965. Some states have developed prior authorization requirements before new hepatitis C treatments are prescribed for those enrolled in state-supported programs. [Colorado](#), [Idaho](#), [Illinois](#), [Maryland](#), [Minnesota](#) and [New York](#), among others, currently use specific criteria to qualify people for new treatments. The most common criteria include a diagnosis of chronic hepatitis C infection, a minimum age of 18 and severity of liver disease. In addition, treatment candidates may not be pregnant or have a pregnant partner. Upon qualification, treatment is typically approved for between 12 weeks and 24 weeks for people who are not awaiting liver transplant; or for up to 48 weeks for those awaiting a liver transplant.

California and Oregon sponsored studies to attempt to evaluate the cost-effectiveness and budget implications of the new treatments. The [California Technology Assessment Forum report](#) concludes that, “Treating all eligible patients with hepatitis C with the new drug regimens is not clinically required nor is it feasible, given constraints on clinical infrastructure and financial resources. Under these circumstances, it is reasonable to consider prioritizing coverage for the new drugs for patients who have advanced [disease] or cirrhosis.” The [Oregon Health and Science University Center for Evidence-based Policy report](#) cites the AASLD’s guiding principle in selecting patients for treatment: “Antiviral treatment should be considered in patients who are at greatest risk of progressing to cirrhosis or serious hepatic complications from HCV.” These studies calculated or approximated the effect of using new treatments in various state-supported programs such as Medicaid. Results may vary based on actual physician prescribing practices and treatment protocols followed.

NCSL Contacts and Resources

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[NCSL Hepatitis C Overview](#)

Additional Resources

Bornschlegel, K., D. Holtzman, R. Monina Klevens and J. Ward. “Vital Signs: Evaluation of Hepatitis C Virus Infection Testing and Reporting—Eight U.S. Sites, 2005–2011.” *Morbidity and Mortality Weekly Report* (May 2013).

Moorman, A., et al. “Baseline Characteristics and Mortality among People in Care for Chronic Viral Hepatitis: The Chronic Hepatitis Cohort Study.” *Clinical Infectious Diseases* (January 2013).

Rein, D. “The Costs and Benefits of HCV Testing and Treatment in Perspective.” Presented at the U.S. CDC/Viral Hepatitis Action Coalition (VHAC) National Summit on Hepatitis C Prevention and Cure, Atlanta, Ga., June 2014.

The information contained in this LegisBrief does not necessarily reflect NCSL policy.