Too Few People with Hepatitis C Receive Timely Curative Treatment

Joan Stephenson, PhD

Fewer than one-third of people who are diagnosed with hepatitis C virus (HCV) infections receive treatment that cures nearly all cases of the disease, according to a new study from the Centers for Disease Control and Prevention (CDC). This treatment gap exists for people with both private insurance and coverage through Medicare or Medicaid.

Direct-acting antiviral (DAA) treatment, recommended for most individuals with HCV infection, saves lives, prevents transmission, and is cost saving, notes the CDC. Eight to 12 weeks of such treatment is recommended to cure 95% or more of HCV cases, but it is costly. When it first became available in 2014, a course of treatment cost as much as $94 500, though it now can be substantially less expensive thanks to the availability of competing drugs and generic versions.

Despite treatment costs that remain hefty, however, the authors noted research indicates that “treating all eligible patients without restriction would result in substantially reducing downstream negative clinical outcomes, decreasing the proportion of total costs attributable to future care, and producing considerable cost savings.”

More than 2 million US adults have HCV infection, causing about 14 000 deaths per year. The incidence of new infections continues to increase, with the highest rates of new infections occurring in adults younger than 40 years, most commonly spread through injection drug use, driven by the nation’s opioid crisis.

Chronic HCV infection can result in cirrhosis and liver cancer, and when symptoms arise, they often are a sign of advanced liver disease that could have been prevented by timely DAA treatment. In addition, because there is no vaccine for HCV, treating and curing people with the infection is an important way to curb the spread of new infections.

The study found that treatment rates are low overall but vary by age and insurance payor.

Initiation of DAA treatment within 1 year of HCV diagnosis among persons continuously enrolled in Medicaid, Medicare, or private insurance was 23% for those in Medicaid, 28% for Medicare beneficiaries, and 35% for those with private insurance. Among patients who received treatment, approximately 84% of private insurance recipients began treatment within 180 days of diagnosis, compared with 75% of Medicaid and 77% of Medicare recipients.

Compared with adults aged 50 to 59 years, adults younger than 40 years (a group that also has the highest rates of new HCV infection) were less likely to start DAA treatment, regardless of insurance type.

Within Medicaid, compared with White or Asian recipients, individuals who were Black or of another race were less likely to receive DAA treatment within a year of diagnosis. Timely treatment was also less likely among people enrolled in Medicaid plans in states that imposed restrictions before authorizing DAA treatment, such as requiring patients to have liver fibrosis, sobriety or abstinence from alcohol or drugs for at least 1 month, or a prescription by or in consultation with a specialist.

Only about 1.2 million individuals initiated DAA treatment during 2014 to 2020, which remains far below the national elimination goal of treating everyone diagnosed with HCV and reducing new infections by 90% and HCV deaths by 65% by 2030. Although current costs are considerably lower than when these medications first became available in 2014, cost might still be an important factor in why more people who would benefit from treatment are not receiving it.

Open Access. This is an open access article distributed under the terms of the CC-BY License.

For example, a new report from the US Department of Health and Human Services' Office of Inspector General (OIG) found that Medicare beneficiaries with Medicare Part D plans—plans for outpatient prescription drug coverage offered to Medicare beneficiaries by private companies known as Part D plan sponsors—are much less likely to receive either lower-cost authorized generic versions of 2 brand-name HCV drugs (Epclusa and Harvoni) or other widely used lower-cost HCV drugs compared with higher-cost ones. In 2020, some Part D plans did not cover the generic HCV drugs, limiting access to less-expensive options, and Medicare beneficiaries also were less likely to use other lower-cost brand-name options in 2020 compared with Medicaid beneficiaries.

Manufacturer rebates reduced overall Part D spending for higher-cost HCV drugs. However, such rebates only lower a drug's cost to Part D sponsors and pharmacy benefit managers (in exchange for favoring the manufacturer’s drug over competing therapies on plan formularies), and “provided little relief to beneficiaries or the Medicare program,” the report found.

The structure of the Part D program “may lead to plan sponsors preferring higher-cost versions,” the OIG report notes, resulting in beneficiaries paying thousands more out of pocket and Medicare paying millions more than if generics and other less-expensive options were used. The OIG recommended that the Centers for Medicare & Medicaid Services encourage Part D plans to increase access to and use of the authorized HCV generics and pursue strategies such as educating clinicians and pharmacies to increase use of lower-cost HCV therapies.

For their part, the CDC authors also suggested measures for increasing access to treatment regardless of insurance type, such as removing eligibility restrictions and preauthorization requirements and provision of treatment in places where patients already receive services, such as primary care offices, community clinics, syringe services programs, substance use treatment centers, and correctional facilities. In addition, they said that treatment should be provided in as few visits as possible and urged expansion of the number of primary care clinicians who can treat HCV infection.

“People shouldn't have to jump over hurdles to access lifesaving, cost-effective treatment,” said Carolyn Wester, MD, MPH, director of the CDC’s Division of Viral Hepatitis, in a statement. “Removing barriers to treatment is a critical step, as is increasing screening for hepatitis C.”