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HCV Health Policy Developments in Response to the National Viral Hepatitis Action Plan: A Brief Update

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ABSTRACT
Hepatitis C virus (HCV) kills 366,000 people worldwide and 17,000 people in the United States each year. In 2011, the U.S. Department of Health and Human Services (HHS) published a national viral hepatitis action plan to control and combat HCV in the United States. This article provides a brief update of HCV health policy developments that have emerged since publication of HHS’s national viral hepatitis action plan and concludes with a discussion of the public health impact of these recent HCV health policy developments.

KEYWORDS
Hepatitis C; health policy; testing

Introduction
Worldwide, more than 185 million are infected with hepatitis C virus (HCV; Mohd Hanafiah, Groeger, Flaxman, & Wiersma, 2013), and HCV causes as an estimated 366,000 deaths each year (Perz, Armstrong, Farrington, Hutin, & Bell, 2006). In the United States, more than five million are HCV infected (Chak, Talal, Sherman, Schiff, & Saab, 2011), and more than 17,000 people annually die from HCV (Ly, Xing, Klevens, Jiles, & Holmberg, 2013). The HCV epidemic is expected to peak in the United States between years 2030 and 2035 with 35,000 annual HCV-related deaths, 25,000 annual incident cases of decompensated cirrhosis, and 15,000 annual incident cases of hepatocellular carcinoma caused by HCV (Rein et al., 2011).

In 2010, the Institute of Medicine issued a report recognizing HCV as an important public health problem in the United States and issued a challenge for the U.S. federal government to take action to reduce HCV morbidity and mortality (Mitchell, Colvin, & Palmer Beasley, 2010). In response, in 2011 the U.S. Department of Health and Human Services (HHS; 2011) published a national viral hepatitis action plan titled Combating the Silent Epidemic of Viral Hepatitis: Action Plan for the Prevention, Care and Treatment of Viral Hepatitis. This action plan was ground-breaking in that it was one of the first efforts initiated by an industrialized country to convene a national action plan to combat the HCV epidemic.

Subsequently, the Centers for Disease Control and Prevention (CDC) and the U.S. Preventive Services Task Force (USPSTF) developed and implemented two novel health policies to facilitate HCV testing, and affordability and access to HCV testing in the United States: birth-cohort (baby boomer) HCV testing and a grade B designation for HCV testing. It is advantageous for public health social workers to be knowledgeable of these health policy developments. The purpose of this article is to provide a brief update of HCV health policy developments that have emerged since publication of HHS’s national viral hepatitis action plan.
Birth cohort (baby boomer) HCV testing for persons born between 1945–1965

In 2012, the CDC recommended and implemented a new testing policy for primary care physicians to test all persons born during 1945 and 1965 for HCV (Smith et al., 2012). The policy is known as birth-cohort (baby boomer) HCV testing. The purpose of birth-cohort testing is to identify undiagnosed cases of HCV among those with high HCV prevalence and to mobilize them into care and treatment for HCV.

The new policy was implemented due to limited success of the CDC’s 1998 risk-based testing policy for HCV (Alter et al., 1998). Risk-based HCV testing was the CDC’s first strategic policy to increase the number of patients unaware of their HCV infection in the United States (Alter et al., 1998). With risk-based HCV testing, medical providers were only required to test patients for HCV who had the following known risk factors: injection drug use histories, blood transfusion or organ transplantation recipients prior to 1992, elevated liver enzymes, histories of long-term hemodialysis, occupational exposures, or HIV infection.

However, it was later determined risk-based HCV testing was suboptimal because epidemiologic data from the 1999 to 2008 National Health and Nutrition Examination Survey estimated 45% to 85% of those living with HCV infection in the United States were still unaware of their infection (Denniston, Klevens, McQuillan, & Jiles, 2012). Furthermore, stratifying HCV prevalence across birth cohorts, the 1999 to 2008 data revealed baby boomers born during 1945 and 1965 alone accounted for nearly 80% of all HCV prevalence in the United States (Ward, 2013). To increase HCV detection and awareness in the general population, the CDC implemented universal HCV testing for all persons born during 1945 to 1965.

Grade B designation for HCV testing

Subsequently, in 2013 the United States Preventive Services Task Force (USPSTF) endorsed the CDC’s birth-cohort HCV testing policy by upgrading HCV testing from a grade D designation to a grade B designation (Moyer, 2013). With this policy change, health plans and payers are now required to cover HCV testing performed in primary care settings without charging copayments and coinsurance to patients (Ngo-Metzger, Ward, & Valdiserri, 2013). The new grade B designation provides testing coverage for all persons born between 1945 and 1965, irrespective of having or not having a HCV risk factor.

For nearly a decade, since 2004, USPSTF (2004) relegated HCV testing to a grade D designation. Health plans and payers were not required to cover testing in patients who were asymptomatic or patients without risk factors for HCV. This created a barrier because the CDC’s newly recommended birth-cohort HCV testing policy required HCV testing among patients without HCV risk factors, including those who were asymptomatic. However, a year later USPSTF recognized the public health benefit of birth-cohort HCV testing and upgraded testing to a grade B designation. The grade B designation facilitates implementation of birth-cohort testing and improves accessibility and affordability of HCV testing.

Discussion

It is estimated birth-cohort HCV testing will identify nearly 1.1 million new cases of HCV, and if linked to care and treatment, avert more than 80,000 HCV-related deaths (Rein et al., 2012). To overcome patient and provider barriers to birth-cohort HCV testing, the USPSTF’s grade B designation for HCV testing eliminates out-of-pocket expenses for patients receiving HCV testing, and it in turn increases the likelihood of physicians integrating birth-cohort HCV testing in their standard of care. Due to recent passing of the Affordable Care Act, grade B testing designations are considered clinical preventive services and prohibits against health plans charging patients for clinical preventive services (Haley & Kreek, 2015). Health plans must now cover one-time HCV testing for all adults born between

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1945 and 1965, including those without a notable history of HCV risk behaviors. Altogether, these policy developments will allow more people to know their status and seek treatment.

The effectiveness of birth-cohort testing in combination with the grade B designation is well documented in primary care settings (Aspinall et al., 2015; Chapko et al., 2015; Jewett, Al-Tayyib, Ginnett, & Smith, 2013; Smith et al., 2011; Zuure et al., 2014). Many patients have been diagnosed, linked to care and treatment, and cured of HCV—who otherwise would not have been due to testing affordability, insurance denial, or not having HCV risk factors. Given recent success in primary care clinics, several emergency departments (Galbraith et al., 2015; White, Anderson, Pfeil, Trivedi, & Alter, 2015), colorectal cancer clinics (Lattimer, Kumar, Sekaran, & Borum, 2014; Sears, Cohen, Ackerman, Ma, & Song, 2013; Torres & Harrison, 2013), mobile medical clinics (Morano et al., 2014), HIV clinics (Yehia et al., 2014), and substance abuse treatment programs (Bachhuber & Cunningham, 2013; Schackman et al., 2015) have adopted birth-cohort testing.

Although the United States has taken formal steps to control HCV, global reductions in HCV morbidity and mortality cannot be realized until other countries with high HCV prevalence consider creation and implementation of health policies to control HCV. For example, HCV prevalence is highest in Egypt (14%), and China alone has more persons infected with HCV (>29 million) than Europe, and North and South America combined (Lavanchy, 2011). Unfortunately, the majority of countries heavily burdened with HCV, particularly throughout Asia and the Middle East, do not have dedicated health policies or formal national action plans to combat HCV. If other countries sought to identify and target their own respective birth-cohorts with increased HCV prevalence and consider health policies to facilitate HCV testing, it will likely enhance HCV awareness, access to care, and linkage to care and treatment.

It is important for public health social workers and social workers advocating and providing care to HCV patients in public health and health care settings to be informed of the viral hepatitis action plan and of subsequent health policies that have materialized in response to the action plan. Advocacy for adoption and implementation of these recent HCV health policies in health care systems and clinical settings, particularly among vulnerable and underserved populations (i.e., injection drug users, those living in rural settings, and those aging with HCV infection), has the potential to curb HCV morbidity and mortality. Public health social workers played key roles in dissemination and implementation of HIV-related health policies in public health and health care settings and can have similar success with HCV-related health policies.

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