

11-03

STATEMENT OF POLICY

Viral Hepatitis

Policy

Viral hepatitis is a major public health threat in the United States, contributing to liver damage, cirrhosis, liver cancer, and thousands of preventable deaths each year.¹ The National Association of County and City Health Officials (NACCHO) calls on federal, state, and local policymakers and public health agencies to invest in and strengthen capacity for hepatitis surveillance, prevention, detection, and treatment—in particular for hepatitis A (HAV), B (HBV), and C (HCV). This should include expanding surveillance capacity (including detection and response to hepatitis cases and outbreaks); implementing prevention strategies, including vaccination against HAV and HBV; and increasing access to and uptake of testing and treatment for HBV and HCV. Collectively, these efforts will significantly contribute to the goal of viral hepatitis elimination in the U.S.

Federal, state, and local policymakers must ensure that public health agencies have adequate and flexible funding to support a comprehensive, coordinated response to viral hepatitis. Federal programs for prevention and control of viral hepatitis are significantly underfunded, which translates to insufficient resources at the state, tribal, local, and territorial levels.² Policymakers, funders, and public health agencies should also consider how they can unite and leverage resources for a coordinated response to the syndemic—or intersecting epidemics—of viral hepatitis, HIV, sexually transmitted infections (STIs) and substance use disorder (SUD).

In addition to robust, sustained, and flexible funding, NACCHO recommends federal, state, and local policymakers and public health agencies support the following strategies to enhance local capacity to prevent and respond to viral hepatitis:

- Increase capacity for hepatitis surveillance, case investigation, and outbreak response to equip local health departments (LHDs) with more comprehensive, real-time data to monitor and respond to local trends, detect outbreaks, ensure people diagnosed with viral hepatitis are promptly linked to treatment, and inform outreach and prevention efforts.
- Strengthen viral hepatitis reporting and data-sharing by:
 - Enacting laws to make acute and chronic HCV a reportable condition;
 - Modernizing electronic laboratory reporting processes;
 - Supporting bidirectional data sharing and ensuring timely access to viral hepatitis surveillance data for local, state, tribal, territorial, and federal public health agencies; and
 - Developing and maintaining interoperable, integrated surveillance systems that support linkage of data across viral hepatitis, HIV, STIs, substance use disorder, and other syndemic diseases and conditions.
- Ensure prevention, testing, and treatment guidelines are evidence-based and support national goals for hepatitis prevention and elimination, including maintaining the universal birth dose vaccination recommendation for HBV regardless of maternal status.

- Expand eligibility for the Section 317-funded immunization program to improve capacity to routinely vaccinate for HAV and HBV, including in high-risk settings.
- Remove policy barriers that undermine implementation of evidence-based strategies to prevent and treat viral hepatitis. In particular, remove policy barriers related to programs that address the infectious disease consequences of substance use and eliminate Medicaid and other insurers' prescribing restrictions for HCV treatment.
- Support innovative funding and delivery models for HCV treatment. This may include negotiating with manufacturers and leveraging subscription-based purchasing models; and purchasing and distributing "starter packs" to facilitate rapid treatment initiation.
- Expand access to hepatitis services through implementation in non-clinical and innovative settings by:
 - Supporting and implementing community-based and street medicine models, including through point-of-care testing and telehealth;
 - Strengthening partnerships with correctional facilities to increase access to services within correctional facilities and after release;
 - Utilizing standing orders and collaborative practice agreements to allow pharmacists to prescribe and administer hepatitis vaccines, tests, and treatment;
 - Enacting laws and regulations that allow pharmacists to bill Medicaid and other insurers for providing hepatitis services; and
 - Implementing syndemic approaches, including integrating services for hepatitis, HIV, STIs, and SUD.

Justification

State of Hepatitis in the United States

In the United States, viral hepatitis continues to be a major public health concern. In 2023, there was an estimated 69,000 new cases of HCV and 14,400 new cases of HBV.¹

All ethnic and racial groups, excluding non-White Hispanic persons, experienced increased rates of HCV. The rate of reported acute HCV cases was highest among non-Hispanic American Indian/Alaska Native persons.¹ In 2023, the most reported risk factor for HCV was injection drug use (IDU).¹

HBV rates were relatively stable between 2019 and 2023.¹ The rate of reported acute cases of HBV was highest among non-Hispanic Black persons and lowest among Non-Hispanic Asian/Pacific Islander persons.¹ Commonly reported risk factors included IDU, having multiple sexual partners, and male-to-male sexual contact.¹ While HBV rates for persons aged 40-49 were the highest in 2023, rates among children and adolescents aged 0-19 were lowest.¹ These low rates are driven in large part by the universal infant hepatitis B vaccination recommendation introduced in 1991, resulting in a significant reduction in disease burden among those born in the years following its adoption.

Between 2016 to 2024, 37 states experienced HAV outbreaks, resulting in more than 44,000 cases, nearly 30,000 hospitalizations, and 424 deaths.³ These outbreaks primarily spread through

person-to-person contact and disproportionately impacted people who use drugs, people experiencing unstable housing or homelessness, men who have sex with men, and people who are currently or were recently incarcerated.³ After annual increases from 2015-2019, HAV cases began to decline in 2020.⁴ While there was a 28% decrease in the number of newly reported cases of HAV between 2022-2023, the number of cases in 2023 was still 1.2 times as high as in 2015.⁴

Given the availability of highly effective vaccines against HAV and HBV and curative treatments for HCV, we have the tools to eliminate viral hepatitis in the U.S. However, eliminating viral hepatitis will require investments in surveillance, prevention, testing, linkage to care, and treatment.

Surveillance

Surveillance data is critical to inform public health priorities, including assessing the burden of disease; targeting prevention, testing, and treatment strategies; and detecting and responding to outbreaks. Strong viral hepatitis surveillance systems, supported by trained personnel and modern interoperable data systems, provide local health departments with accurate, timely, and actionable information needed to monitor trends, distinguish between acute and chronic infections, connect people to care, prevent further transmission, and improve population health outcomes. In the United States, three major surveillance systems—the National Notifiable Diseases Surveillance System (NNDSS), the National Health and Nutrition Examination Survey (NHANES) and the National Vital Statistics System (NVSS)—were selected to monitor progress towards the elimination of Hepatitis C by 2030. Unfortunately, these systems are limited by changes in methods, lags in data availability, as well as incomplete information on health insurance, race and ethnicity, and health risks.⁵ Data modernization efforts could increase the timeliness, completeness, and quality of case reports through improvements in interoperability between health care and public health information systems.⁵ Recognizing the syndemic of viral hepatitis, HIV, STIs, and SUD, there is also a need to strengthen connections across disease-specific data systems to equip LHDs and other stakeholders with more comprehensive information on co-infection and shared risk factors. Additional resources—including for data infrastructure and workforce capacity—will be required to strengthen hepatitis surveillance and case investigation. Maintaining core epidemiologic and surveillance functions at the local level is essential to achieving national viral hepatitis elimination goals and ensuring that local health departments can effectively assess, prevent, and respond to emerging public health threats.

Prevention

Vaccine coverage is low for HAV and HBV. Less than two-thirds of infants receive both doses of the HAV vaccine and coverage is far lower—about 12%—among adults.⁶ The HBV vaccine is more than 90% effective, yet only 34% of adults in the U.S. are vaccinated.⁷ Approximately 1,000 perinatal transmissions of HBV occur every year putting infected infants at risk of developing chronic HBV over time.⁸ Despite this, the universal HBV vaccination

recommendation within the first 24 hours of birth has significantly improved infant health, helping to address gaps from a variety of factors including lack of access to prenatal care, missed or inaccurate maternal screening, or household transmission.⁹ Since adoption of the universal birth dose recommendation in 1991, the nation has seen a 99% reduction in infant HBV infections.⁹ There have been efforts to weaken the recommendation.^{10,11,12} However, a new analysis conducted by HepVu, the Hepatitis B Foundation, and the National Viral Hepatitis Roundtable found that even short delays in HBV vaccination would lead to substantially more HBV infections and unnecessary health care costs.¹²

Addressing gaps in vaccine coverage will require adequate funding for both the public health workforce and for vaccines and related supplies. Sustained funding of the federal Section 317 Immunization Program—an initiative that disseminates grants to 64 states, cities, and territories—is crucial to maintain many immunization programs as well as to provide resources that support outbreak investigation and control, and support providers through vaccine education.¹⁴

While there is no vaccine for HCV, prevention efforts typically focus on reducing the transmission of HCV through IDU. In the United States, more than half of people who inject drugs have HCV, and the majority of cases are spread through IDU.^{15,16} Community-based programs that address the infectious diseases consequences of substance use are associated with a 50% reduction in HCV incidence. When combined with medication-assisted treatment for opioid use disorder, these interventions can reduce HCV incidence by two-thirds.¹⁵ Additionally, treatment as prevention is a promising strategy, recognizing the availability of highly-effective cures for HCV.¹⁷ Increasing vaccination, testing, and treatment can stop further transmission, reduce healthcare costs associated with hepatitis, and save lives.

Testing

Only sixty percent of people living with HCV and 32% of people living with HBV know their status, demonstrating the importance of routine testing.¹⁸ CDC currently recommends universal HCV screening for all adults 18 years and older as well as all pregnant women during each pregnancy.¹⁹ In March 2020, the U.S. Preventive Services Task Force updated their recommendations to call for one-time HCV testing for all adults ages 18 to 79 years.²⁰ HBV screening is recommended for all adults aged 18 and older at least once in their lifetime.²¹ Periodic HBV testing is recommended for certain populations such as people currently or formerly engaged in IDU, people born in or whose parents are from geographic regions with high prevalence of HBV, pregnant women, and people living with HIV.²¹

Effective treatments for both HBV and HCV exist but are underutilized. Patients linked to care for HBV achieve significant reductions in hepatitis-associated illness and mortality, but because many are unaware of their status or face barriers to care, only 10-15% of those eligible for antiretroviral therapy for HBV receive it.²² Expanding HBV screening for recommended populations in both clinical and non-traditional, high-prevalence settings such as community-

based organizations that serve people who use drugs and correctional facilities can support linkage to care.

Diagnosing HCV has typically involved a two-step diagnostic algorithm in which an HCV antibody screening test was followed by a confirmatory HCV RNA quantitative test for patients with detectable HCV antibodies.²³ This algorithm required multiple clinical visits, resulting in loss to follow up and low treatment initiation. However, in 2024, the Food and Drug Administration (FDA) approved the first point-of-care (POC) RNA test for HCV.²⁴ While further evaluation will be necessary, the POC test has the potential to markedly reduce HCV burden.²³ Importantly, sustained funding will be necessary for LHDs and other organizations to purchase the necessary equipment and supplies to effectively use this test.

Treatment

Direct-acting antiviral (DAA) medications can cure HCV with limited side effects in less than three months for more than 95% of people.²⁵ Yet, treatment initiation rates are low, with approximately one-third of people diagnosed initiating treatment within a year (23% for Medicaid patients, 28% for Medicare patients, and 35% for privately insured patients).²⁶ In order to access treatment, people living with HCV must complete the required testing and lab work, find and access a provider, obtain insurance coverage, and find and access a pharmacy that stocks the medicine. Each additional step in the testing-to-treatment continuum poses additional barriers and increases the likelihood of loss to follow up. While significant progress has been made in eliminating insurance-related barriers to HCV treatment, several state Medicaid programs continue to require prior authorization or impose sobriety, retreatment, and prescriber-related restrictions.²⁷ People who inject drugs face additional barriers to treatment, such as stigma.²⁸ For example, only 10% of providers report willingness to prescribe curative medicines for people who inject drugs.²⁹ Simplifying the testing-to-treatment continuum and addressing barriers to treatment are critical to scaling up HCV treatment and preventing further transmission.

Rapid treatment initiation can limit the progression of HCV, improve treatment outcomes, and prevent transmission. Historically, rapid initiation of HCV treatment has not been the standard of care. This was due, in part, to treatment administration complexity and potential adverse side effects. However, with DAAs, treatment for HCV is both efficient and safe, making rapid treatment a viable option for individuals with HCV.³⁰ Unfortunately, treatment initiation is still often delayed, in part due to the high cost of the medicines, which in turn has contributed to insurance, pharmacy, and other barriers (e.g., prior authorization, limited stock outside of specialty pharmacies).

Providing individuals with a “starter pack” of HCV medication is an innovative approach to rapid treatment initiation. In the No One Waits (NOW) model in San Francisco, CA, participants who had positive HCV RNA results were enrolled in same-day treatment and given a 2-week DAA starter pack.³¹ Almost all participants who returned for their HCV RNA results accepted and initiated treatment at the point of diagnosis (98%). Overall, 90% of participants transitioned to insurance-covered DAAs prior to completing the twelve-week treatment course, with 75% of

participants making this transition within just two weeks.

DAAs, while clinically successful, have a high unit price and may increase short-term spending for payers if the population is large enough.³² Subscription models are an alternative approach to increasing access to DAAs. A subscription model is a type of advanced purchase commitment (APC) that establishes a voluntary partnership between a payer (e.g., state or federal agency) and a pharmaceutical company. In this partnership, the payer commits to purchasing a minimum quantity of a given medication at a specified price, and agrees to pay another price when the use exceeds the pre-determined threshold. A study by Auty *et al.* analyzed the impact of two states' (Louisiana and Washington) subscription models for HCV treatment.³² Promisingly, the researchers found that since implementation of Louisiana's subscription model, more than 9,000 people covered by state insurance initiated HCV treatment. In addition, Louisiana's subscription model was associated with a 534.5% increase in Medicaid-covered DAAs dispensed in the year after implementation when compared to the previous year. While there are challenges associated with evaluating subscription models, such as data lags and lack of generalizability from state to state, subscription models have the potential to improve access to treatment among vulnerable populations.

Despite the high upfront costs of HCV treatment, studies have found that HCV treatment is cost-effective for people who are not at risk of transmitting the virus, and cost saving for people who are, further demonstrating the importance of increasing access to treatment for people who inject drugs.³³

Given persistent gaps in HCV testing and treatment, achieving HCV elimination will require coordinated action across a broad range of stakeholders, including policymakers, public health agencies, healthcare providers, insurers, pharmaceutical companies, social service organizations, and other community partners.³⁴ Tailored strategies are needed to improve the affordability, accessibility, and uptake of services and support patients across the HCV testing-to-treatment continuum.

Syndemic Approaches and the Future of Hepatitis

The United States is currently experiencing a syndemic of viral hepatitis, HIV, STIs, and SUD.³⁵ By integrating hepatitis, HIV, STI, and SUD services, health systems and public health agencies can more effectively reach people at risk for or living with hepatitis, reduce missed opportunities for care, and provide more comprehensive, patient-centered services.³⁵

As 90% of Americans live within 5 miles of a pharmacy, pharmacies could provide an accessible option for those who would not otherwise have access to hepatitis services.³⁶ However, statewide and local protocols and standing orders are needed to authorize pharmacists to provide clinical services. Collaborative practice agreements (CPAs)—formal agreements that establish a collaborative relationship between a pharmacist and a primary care or LHD provider—can also be implemented to authorize pharmacists to order and interpret laboratory test results and administer vaccinations without a patient-specific order. However, authorization alone is insufficient. Because pharmacists are not recognized as health care providers under federal law,

and in almost half of states, they may not be eligible for reimbursement for clinical services. Without reimbursement, pharmacists' ability to provide services is undermined.³⁶

Other evidence-based models to strengthen linkage to care include street medicine and telehealth. These models are especially critical in rural communities where barriers to care are often heightened, including fewer clinicians who treat HCV, limited transportation to providers, and stigma and misinformation.³⁷

Federal funding for hepatitis remains inadequate. According to a 2016 professional judgement budget, a comprehensive national plan to address viral hepatitis and put the United States on the path toward HBV and HCV elimination would require \$3.9 billion over 10 years.³³ However, funding levels for the CDC Division of Viral Hepatitis remain far lower at just \$46 million in fiscal year 2026.³⁸ Increased public funding for viral hepatitis would offer significant returns, as eliminating HCV alone would save the US \$6.5 billion annually.³⁹

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Record of Action

Proposed by NACCHO Infectious Disease Prevention and Control Workgroup

Approved by NACCHO Board of Directors March 18, 2011

Updated July 2014

Updated by NACCHO HIV, STI, Viral Hepatitis Workgroup April 2020

Updated June 2026