

11-03

STATEMENT OF POLICY

Viral Hepatitis

Policy

Viral hepatitis is a leading public health threat in the United States, contributing to liver cancer and transplants, and more deaths than all other reportable infectious diseases combined.¹ The National Association of County and City Health Officials (NACCHO) calls on federal, state, and local policymakers and public health agencies to scale up the response to hepatitis A (HAV), B (HBV), and C (HCV), including by vaccinating vulnerable populations against HAV and HBV; detecting and stopping ongoing transmission of HAV, HBV, and HCV; expanding surveillance capacity; and assuring testing, linkage to care, and affordable treatment for persons with chronic 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 funding to support a comprehensive, coordinated response to viral hepatitis. Federal programs for control and prevention of viral hepatitis are significantly underfunded, which translates to insufficient resources at the state, tribal, local, and territorial levels. Not only are current funding levels inadequate – at less than 10% of the estimated per-year need to put the U.S. on the path to eliminate HBV and HCV – but public health agencies need flexible funding to enable them to respond to local trends and priorities.² Federal agencies and other funders should also consider how they can unite and leverage resources for a coordinated response to the syndemics of viral hepatitis, HIV, STIs and injection drug use, which is exacerbated by the opioid crisis.

In addition to robust, sustained, and flexible funding, NACCHO recommends the following strategies to enhance local capacity to prevent and respond to viral hepatitis:

- Federal, state, and local policymakers should invest in local hepatitis surveillance activities, infrastructure, and workforce to enable local health departments (LHDs) to use real-time data to respond to local trends, identify priority populations for prevention, testing, and linkage to care, and ultimately to address inequities in morbidity and mortality associated with viral hepatitis. To bolster these efforts, CDC should improve its capacity to provide direct technical assistance for surveillance to state and local health departments and support the enhancement of electronic laboratory reporting processes to ensure local surveillance data is complete and timely. Additionally, all states and jurisdictions should enact laws to make acute and chronic HCV a reportable condition.
- Recognizing the significant burden of viral hepatitis among people engaged in the criminal justice system, state and local health departments should strengthen relationships with correctional facilities to ensure access to vaccination, testing, and treatment for those incarcerated and support continuity of care for people returning to the community.



- Policymakers should allocate additional resources to prevent and respond to viral hepatitis outbreaks, including the expansion of HAV and HBV vaccination recommendations and services to increase immunization coverage. As people experiencing homelessness and those engaged in drug use are disproportionately impacted by viral hepatitis, LHDs should proactively partner with organizations that serve these populations. CDC should also expand eligibility for the Section 317-funded immunization program to improve capacity to routinely vaccinate for HAV and HBV in high-risk settings such as STD clinics and harm reduction site for people who inject drugs.
- Federal, state, and local policymakers must remove barriers that undermine evidence-based strategies to address viral hepatitis, including syringe services programs (SSPs), a critical strategy for the prevention of HBV and HCV. NACCHO urges Congress to remove all restrictions on the use of federal funding for syringe services and recommends policymakers at all levels ensure sufficient funding to expand and scale up SSPs. NACCHO furthermore objects to Medicaid and other insurers' prescribing restrictions for the highly effective HCV treatment, which are not medically based and pose barriers to treatment and prevention.
- Local health departments should educate policymakers and other decision-makers about the efficacy of SSPs and the consequences of existing laws and regulations that restrict access to harm reduction services and stigmatize people who inject drugs. LHDs should also establish linkages between SSPs, other harm reduction services, and viral hepatitis prevention, testing, and treatment. Notably, LHDs need additional funding to conduct this work.
- Local health departments should utilize academic detailing and other strategies to ensure that providers in their community are aware of and implementing updated screening, vaccination, and treatment guidelines and reporting cases to the appropriate agencies. These efforts will also require additional investments in local hepatitis programs.

Finally, the broader health system must be equipped to serve those living with and at risk for viral hepatitis. NACCHO opposes efforts that would weaken public health and healthcare infrastructure or reduce access to prevention and care, including the repeal of the Affordable Care Act.

Justification

In the United States, viral hepatitis is on the rise. In 2017, there were an estimated 44,300 new cases of HCV and 22,100 new cases of HBV.³ Increasing injection drug use (IDU) associated with the opioid epidemic has catalyzed the spread of HCV, with incidence increasing 3.5-fold between 2010 and 2017.³ HBV cases have remained stable: while higher vaccination rates have decreased HBV cases among younger populations, HBV is increasing among Americans aged 40 and older. Moreover, regions hardest hit by the opioid epidemic have experienced state-level increases in acute HBV cases.³ Since 2016, more than 30 states have reported HAV outbreaks, resulting in more than 31,000 cases, nearly 19,000 hospitalizations, and 314 deaths (as of February 2020).⁴ The outbreaks have primarily spread through person-to-person contact and have disproportionately impacted people who use drugs, people experiencing unstable housing or homelessness, men who have sex with men (MSM), and people who are currently or were

recently incarcerated.⁴ Given the availability of highly effective vaccines against HAV and HBV and curative treatments for HCV, we have the tools to eliminate HBV and HCV in the U.S. and prevent future outbreaks of HAV. 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 responding to outbreaks. Strong viral hepatitis surveillance, particularly the capacity to follow up on lab reports and do case investigations, allows health departments to distinguish between acute and chronic infections and identify screening gaps; absence of surveillance data, especially for HCV, can lead to underreporting of acute infections where baseline testing data is not collected. Unfortunately, hepatitis surveillance is dramatically underfunded in the United States. Recognizing the syndemic of viral hepatitis and HIV, there is also a need to strengthen connections between surveillance systems and equip local health departments and other stakeholders with information on HIV and hepatitis co-infection. Additional resources and funding will be required to implement new guidance and information related to surveillance.

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—less than 10%—among adults.^{5,6} In 2020, CDC and the Advisory Committee on Immunization Practices published new recommendations for HAV vaccination that reflect the need to increase HAV vaccination coverage in the U.S. The recommendations call for expanded vaccination during HAV outbreaks and in settings where a high proportion of persons have risk factors for HAV infection, such as those serving people who inject drugs.⁷ The HBV vaccine is more than 90% effective, yet only 25% of adults in the U.S. are vaccinated.^{8,6} Approximately 1,000 perinatal transmissions of HBV occur every year, which raises infected infants' risk of developing chronic HBV over time.⁹ While there is no vaccine for HCV, harm reduction strategies can prevent the spread 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.^{10,11} Syringe service programs are associated with a 50% reduction in HCV incidence, and when combined with medication-assisted treatment for opioid use disorder, these interventions can reduce HCV incidence by two-thirds.¹⁰ Additionally, treatment as prevention is a promising strategy, recognizing the availability of highly-effective cures for HCV.¹² Increasing vaccination, testing, and treatment coverage and expanding harm reduction services can stop further transmission, reduce healthcare costs associated with hepatitis, and save lives.

Testing

Half of people living with chronic HCV and two-thirds of people living with chronic HBV are unaware of their status, demonstrating the importance of routine testing.¹³ CDC currently recommends HCV testing for Baby Boomers (people born between 1945-1965), who account for three-fourths of chronic HCV infections in the United States; people currently or formerly engaged in IDU; and people with certain medical conditions, including people living with

HIV.^{14,15} 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.¹⁶ HBV testing is recommended for people currently or formerly engaged in IDU, people born in or whose parents are from geographic regions with high prevalence of HBV, men who have sex with men, pregnant people, people living with HIV, and household and sexual contacts of people living with HBV.¹⁷

Linkage to Care

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 are not properly referred to care, only 10-15% of those eligible for antiretroviral therapy for HBV receive it.¹⁸ Hepatitis screening for recommended populations in both clinical and non-traditional, high-prevalence settings, such as medication-assisted treatment (MAT) programs, can support linkage to care.

HCV can now be cured with limited side effects in less than three months for more than 95% of people.¹⁹ However, people living with HCV continue to face barriers to treatment, including finding a provider and obtaining insurance coverage. More than half of state Medicaid programs require that these medicines are prescribed by or in consultation with a specialist, despite comparable cure rates in generalist practices and similar success in non-traditional clinic settings such as SSPs and medication-assisted treatment (MAT) programs for people who inject drugs.²⁰⁻²² Low provider awareness of the importance of HCV screening and the availability of a cure contributes to stigma and barriers to treatment experienced by people who inject drugs.²³ For example, only 10% of providers report willingness to prescribe curative medicines for people who inject drugs.²⁴ Additionally, both private and public insurers place restrictions on treatment coverage, such as sobriety requirements and limiting treatment to those with severe liver damage.²⁰ These restrictions are not evidence-based and limit our ability to stop HCV transmission and prevent chronic infections. 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.²⁵

Federal funding for hepatitis remains limited. 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.² However, funding levels for the CDC Division of Viral Hepatitis remain far lower at just \$39 million in fiscal year 2020, less than 10% of the estimated per-year need.²⁶ Investing in viral hepatitis would offer significant returns, as eliminating HCV alone would save the US \$6.5 billion annually.²⁷

Local health departments are leaders in the prevention and control of viral hepatitis. The United States has the tools to eliminate hepatitis B and C and prevent future outbreaks of hepatitis A, but to achieve our national goals, we must ensure that local public health has the resources to lead this work in their communities.

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Record of Action

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