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Subject: Estimated Impacts of Proposed National Hepatitis C Elimination Program on Medicaid and Medicare

The Office of the Actuary (OACT) in the Centers for Medicare & Medicaid Services (CMS) has estimated the budgetary impacts on Medicaid and Medicare of the *Establish the National Hepatitis C Elimination Program* proposal included in the President's Budget for Fiscal Year 2025 (PB 2025), which aims to eliminate hepatitis C in the United States. As explained below, this proposal consists of five components, two of which would have direct effects on the Medicare and Medicaid programs. Specifically, the proposal would:

(i) create a subscription model for hepatitis C drugs whereby the Federal Government purchases and distributes these drugs to eligible individuals—including, but not limited to, Medicaid enrollees who reside in States that elect to participate in the model; and

(ii) eliminate all Medicare Part D beneficiary cost sharing for these drugs for 5 years, and increase testing for hepatitis C, thereby increasing the number of Medicare enrollees who use hepatitis C drugs.

The proposed program, including the two components above, would be enacted over 5 years, while this memo shows 10-year impacts to Medicaid and Medicare, following standard practice for these programs.

Background

The proposal is described in more detail in the Department of Health and Human Services's (HHS's) "Justification of Estimates for Appropriations Committees" for FY 2025.[1] As noted in the report:

> This Program aims to bolster HHS's activities to address hepatitis C in the U.S. by significantly expanding screening, testing, treatment, prevention, and monitoring of

[1] Department of Health and Human Services' "Justification of Estimates for Appropriations Committees," pp. 165–167. https://www.hhs.gov/sites/default/files/fy-2025-gdm-cj.pdf.

hepatitis C infections in the United States, with a specific focus on populations with high infection levels. If enacted, this program will substantially increase the number of people treated for hepatitis C, preventing hundreds of thousands of severe illnesses, avoiding tens of thousands of serious complications, and saving many thousands of lives over the next 5 years and beyond.

The proposal has five components, including (i) expanded access to curative hepatitis C medications; (ii) expanded access to screening, treatment, and linkage to care; (iii) expanded testing options; (iv) expanded prevention capabilities and access; and (v) expanded preparedness.

Medicaid

Under current law, drugs to treat hepatitis C are covered by Medicaid if a state opts to cover prescription drugs (all states currently do) and the hepatitis C drug manufacturer participates in the Medicaid Drug Rebate Program. Under this proposal, the costs of the antiviral drugs would be paid entirely by the Federal Government, separate from Medicaid, for Medicaid enrollees who live in States that elect to participate in the subscription model. In addition, expanded screening, testing, and access to care would likely lead to additional individuals being diagnosed with hepatitis C and receiving treatment.

We used data on Medicaid drug spending from the Medicaid Drug Rebate Program and State Drug Utilization Data to estimate the cost per treatment round and number of Medicaid enrollees who received hepatitis C drugs. For fiscal year 2021, total Medicaid spending (net of rebates) on hepatitis C drugs was about $709 million, and an estimated 39,000 Medicaid enrollees received these drugs. Medicaid spending and utilization of hepatitis C drugs are projected to grow consistently, following the PB 2025 projected expenditure and enrollment growth rates.

We also estimate that individuals with hepatitis C had Medicaid costs that were about 180 percent higher than those without the infection, and that the average cost for an enrollee with hepatitis C was about $18,800 in 2021.[2] We project that these costs would increase at the same rate as projected Medicaid per enrollee spending in the PB 2025. These costs do not include dispensing fees, but we believe the fees are relatively small compared to the costs of the drugs.

We assumed that all State Medicaid programs would elect to participate in the subscription model, as it would reduce State Medicaid spending on hepatitis C drugs by transferring the entire cost of the drugs to the Federal Government and likely decreasing cases of the virus. Given these benefits and the fact that there are no obvious disadvantages, we believe it is likely that States would want to participate.

To estimate the impact of the proposal on Medicaid, we considered two effects. The first is the savings that would result from shifting the cost of hepatitis C drugs from Medicaid to the subscription model; such savings represent the expected costs under current law. As shown in

[2] Roebuck, MC, "Impact of Direct-Acting Antiviral Use for Chronic Hepatitis C on Health Care Costs in Medicaid: Economic Model Update," American Journal of Managed Care. 2022;28(12):630–631. https://doi.org/10.37765/ajmc.2022.89273.

table 1, we estimate that this shift would decrease total Medicaid spending by $4,820 million ($3,680 million Federal share) for the 5 years that the program would be in effect.

Table 1. Medicaid fiscal impacts of shifting hepatitis C drug costs to national program
(in millions)

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2025–34
Total	−$870	−$910	−$960	−$1,010	−$1,070	$0	$0	$0	$0	$0	−$4,820
Federal	−$660	−$700	−$730	−$770	−$820	$0	$0	$0	$0	$0	−$3,680

The second effect is the impact that would result from more beneficiaries using hepatitis C drugs. The savings to Medicaid would depend largely on two factors: (i) how many additional enrollees would use these drugs under the subscription model and (ii) the level of savings that would be achieved for people who were cured of the infection. We assumed that use of hepatitis C drugs would double under the model. (We note that there may be greater or lesser usage than we assumed here; we discuss this assumption later in this memorandum.)

For those who receive treatment, as shown in table 2, savings are estimated to increase as a percentage of per enrollee costs over the first 5 years and then to decrease over the following 5-year period, following a pattern similar to the one described in the Medicare analysis below.

Table 2. Percentage reduction in costs by year after hepatitis C treatment

Year after treatment	1	2	3	4	5	6	7	8	9	10
Reduction in costs	−8%	−27%	−34%	−40%	−40%	−37%	−27%	−18%	−8%	−8%

As shown in table 3, we assume that about 35,000 to 36,000 additional enrollees would use hepatitis C drugs each year during the program.

Table 3. Number of Medicaid enrollees who received hepatitis C drugs by year

(in thousands)

Number of enrollees treated	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2025–34
Baseline	35	35	36	36	36	36	36	36	36	36	357
Proposed	71	71	71	71	71	36	36	36	36	36	534
Impact	35	35	36	36	36	0	0	0	0	0	177

Table 4 shows the estimated financial impacts of the proposal on Medicaid. We estimate that treatments would reduce Medicaid spending by $12,200 million ($9,460 million Federal share) over 10 years. Savings would increase over time as more people are treated, and as savings for each individual treated would be expected to increase during the first several years after treatment.

Table 4. Medicaid fiscal impacts of additional hepatitis C drug usage

(in millions)

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2025–34
Total	–$50	–$250	–$500	–$810	–$1,140	–$1,460	–$1,720	–$1,930	–$2,090	–$2,250	–$12,200
Federal	–$40	–$190	–$390	–$620	–$870	–$1,120	–$1,320	–$1,480	–$1,600	–$1,830	–$9,460

In total, we estimate that this proposal would reduce Medicaid spending by $17,020 million ($13,140 million Federal share) over 10 years, as shown in table 5.

Table 5. Total Medicaid fiscal impacts of hepatitis C drug program

(in millions)

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2025–34
Total	–$920	–$1,160	–$1,460	–$1,820	–$2,210	–$1,460	–$1,720	–$1,930	–$2,090	–$2,250	–$17,020
Federal	–$700	–$890	–$1,120	–$1,390	–$1,690	–$1,120	–$1,320	–$1,480	–$1,600	–$1,830	–$13,140

Medicare

For Medicare, under this proposal, the Federal Government would, separately from Medicare, cover 100 percent of the cost sharing of the antiviral drugs for Medicare Part D beneficiaries but would not directly provide these drugs to enrollees. Enrollees will continue to access these drugs through the Part D benefit.To quantify the impact on medical spending that occurs when a beneficiary with hepatitis C receives one of the curative drug treatments, we evaluated historical claims experience for fee-for-service (FFS) beneficiaries with a hepatitis C diagnosis. This new generation of drugs launched in late 2013, allowing us to study the impact since that time.

For this analysis, we examined the medical costs of beneficiaries in the years before and after their hepatitis C drug treatment. Beneficiaries were selected for analysis if they had a hepatitis C diagnosis in their medical claims; had coverage for Parts A, B, and D of Medicare; and were FFS Medicare enrollees (thereby excluding beneficiaries who were enrolled in Medicare Advantage during that period). We chose these criteria to minimize any effects that may have been a result of Medicare Advantage plan selection. Additionally, while Medicare Advantage enrollees will

still be covered by the proposal, the FFS claims were a more consistent source for the period of this study. We did not separately consider the hepatitis C diagnoses in Medicare Advantage.

Once we identified the beneficiary cohort, we trended the historical claims data to put all the cost values into 2023 dollars, a process that allowed comparison of costs across the years. The claims were aggregated by their timing relative to drug treatment (that is, the number of years before or after the beneficiary had received the treatment). Upon examination of the data, we removed all claims experience from the first year of a beneficiary's hepatitis C diagnosis, as this period always showed disproportionately high costs, skewing the results. While a proportion of these costs were likely due to hepatitis C, the remainder may have been influenced by an urgent episode requiring care, which would also have resulted in a hepatitis C diagnosis. Regarding the effect of the drug treatment, we chose a conservative approach and excluded the claims for the first year.

We compared the medical costs in the 3 years before the beneficiary received drug treatment with the costs in the 3 years after treatment. There was a material medical claims cost reduction after the beneficiary had been treated, and this difference was presumed to be the result of that treatment. Savings continued to accrue for several years afterward. There were no corresponding savings to Part D drug costs that were attributable to this factor. The overall savings estimates we relied upon are shown in table 6 below.

Table 6. Estimated Medicare savings per member per month by year

Year after treatment	1	2	3	4	5	6	7	8	9
Savings PMPM	$90	$317	$397	$469	$478	$438	$322	$211	$97

To estimate the financial effects of the proposal on Medicare, we assumed that the primary mechanism for change would be to increase utilization of hepatitis C drugs in the Part D population. Because the proposal would eliminate Part D beneficiary cost sharing for 5 years beginning in 2025, as well as increase testing for hepatitis C, we assumed that it would increase the number of beneficiaries treated for hepatitis C, particularly in the non-low-income population. The effect is greater on the non-low-income population because they face substantially higher cost sharing under Part D, which can reduce the percentage of beneficiaries who receive the treatment. We also assumed that, when cost sharing returns to the standard Part D benefit levels, new treatments will still occur due to recent testing patterns, but at a much lower rate. The assumed overall number of newly treated Medicare beneficiaries across both the FFS and Medicare Advantage populations is shown in table 7 below; there may be greater or lesser usage than noted here.

Table 7. Increase in Medicare beneficiaries treated for hepatitis C

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034
Additional treated	14,105	14,335	13,893	13,464	13,049	106	103	100	97	94

The additional Medicare program costs for the proposal include the testing costs, which are covered under Part B, and the drug costs, which are covered under Part D. The drug costs are based on claims data from 2019 and include the impact of manufacturer rebates. We adjusted the drug costs for impacts due to the prescription drug provisions of the Inflation Reduction Act of 2022 (IRA), such as the Part D Redesign, and did not assume other future changes to the drug mix, such as new drugs being released.

Combining these costs with the savings from the analysis described above and trending for cost changes, we obtain the impacts shown in table 8 on a fiscal-year cash basis. Overall, the additional costs for Part D are less than the expected savings over the 10-year projection window. In particular, the direct interventions of the proposal on Medicare and the associated costs taper off quickly in 2030 and later, while the savings for Part A and Part B are still significant in the later years. Overall, we estimate that this proposal would reduce Medicare Part A spending by $1,080 million and Medicare Part B spending by $910 million while increasing Medicare Part D spending by an estimated $1,690 million over a 10-year period.

Table 8. Medicare fiscal impacts of hepatitis C drug program

(in millions)

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2025-34
Part A	–$10	–$10	–$30	–$70	–$110	–$150	–$180	–$190	–$180	–$150	–$1,080
Part B											
Benefits	–$10	–$30	–$70	–$130	–$180	–$200	–$200	–$170	–$130	–$80	–$1,200
Premium offset	$0	$10	$20	$30	$40	$50	$50	$40	$30	$20	$290
Total Part B	–$10	–$20	–$50	–$100	–$140	–$150	–$150	–$130	–$100	–$60	–$910
Part D											
Benefits	$290	$430	$460	$470	$480	$120	$0	$0	$0	$0	$2,250
Premium offset	–$40	–$50	–$60	–$60	–$60	–$20	$0	$0	$0	$0	–$290
Part D, net of premium	$250	$380	$400	$410	$420	$100	$0	$0	$0	$0	$1,960
Clawback offset	–$40	–$60	–$60	–$50	–$50	–$10	$0	$0	$0	$0	–$270
Total Part D	$210	$320	$340	$360	$370	$90	$0	$0	$0	$0	$1,690

Conclusion

It is important to note that actual effects could differ from these estimates. Notably, the number of people who would be treated under this model could be higher or lower than we have assumed. At the time we developed these estimates, there was limited information and analysis available about the broader proposed program and its potential to effectively reach the expected population. There was also little relevant historical experience for a program such as this proposal. Given this, we chose assumptions that we believed were not unreasonable at that time and noted the uncertainty regarding these assumptions. We recognize that there is a wide range of potential outcomes that would have significant effects on these estimates. We understand that HHS more recently has done additional analysis to model the increased use of these drugs under the proposed program, which includes point-of care testing and treatment capacity expansion, and sees a high likelihood of greater coverage through the program than assumed here, but that work is not reflected in these estimates. If the HHS modeling proves to be accurate, treatment costs would increase, but overall costs would decline even more (all relative to our estimates described in this memo), for the reasons explained above.

The costs of treatment and the savings from curing individuals with hepatitis C could be greater or less than we have estimated here, particularly as a result of impacts from the IRA that may increase utilization of these drugs even in the absence of this proposal. In addition, we have only estimated the effects of the proposal for people treated within the Medicaid and Medicare

programs and not considered additional effects. We did not include, for example: (1) savings from treating Medicaid enrollees may result in subsequent savings to Medicare as those individuals later become eligible and enroll in Medicare; and (2) treatment of individuals who are incarcerated or uninsured may lead to savings in Medicaid programs as those persons later become eligible for or enroll in Medicaid. Nor did our methodology, which was based on a cohort of people who were covered prior to hepatitis C diagnosis, account for individuals who only became eligible for Medicare or Medicaid due to disability related to hepatitis C; for such individuals, Medicare or Medicaid costs may be delayed or averted altogether.

Moreover, we have not estimated any effects on future rates of transmission. As hepatitis C is an infectious disease, should the program succeed in treating more people, it is possible that there could be fewer future cases of hepatitis C than we assume under current law. In those cases, there may be future reductions in costs beyond the amounts that we have estimated here. Finally, we have not estimated other costs or savings beyond the Medicare and Medicaid programs, such as savings to disability payments through the Social Security Administration and savings to the Indian Health Service.

It is important to note that these estimates were developed on the proposal and the details, information, and analysis available at that time. Estimates of future proposals and specific legislation may vary based on any differences between this proposal and future such proposals and on additional data and analysis.