Subscription-Based Payment Models May Increase Access to Hepatitis C Treatment

Louisiana saw a bump-up in HCV prescriptions after the alternate model was introduced.

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Subscription-based payment models for hepatitis C treatment may improve access to costly direct-acting antiviral therapy, according to results published in JAMA Health Forum.

Antiviral therapy can cure almost everyone with hepatitis C virus (HCV), but access to treatment is limited. Since these drugs are expensive, state Medicaid programs have restrictions in place to limit who makes the cut for treatment. Sobriety and liver damage requirements may restrict access to people with substance use disorders and other ailing individuals.

Subscription-based payer models (SBPMs) involving exclusive contracts for drugs curtail high prices. States are able to broker lower prices with a drug manufacturer in exchange for the promise of exclusive treatment access for the state's Medicaid population.

Both Louisiana and Washington implemented dual pricing payer models in 2019. Initially, both states pay a lower price until a specific price cap is reached; at that point, the states pay a per-prescription price that is minimized through additional deductions.

"With subscription-based payment models, there's no incentive to ration access because there is almost no cost of additional prescriptions after the threshold," Samantha Auty, of the Boston University School of Public Health, said in a press release. "This model actually incentivizes states to treat as many individuals who would benefit from HCV treatment as possible, which improves population health in a group of individuals who face structural barriers to care and aligns with the goals of the WHO to eradicate this virus by 2030."

Auty and colleagues studied the impact of SBPMs on HCV prescription refills covered by Medicaid, looking at trends in Louisiana and Washington, two states that recently implemented such models.

For a period of five years, Louisiana has a payer program set up with Asegua Therapeutics for reduced-price access to the generic version of Gilead Science's Epclusa (sofosbuvir/velpatasvir), while Washington has access to Mavyret (glecaprevir/pibrentasvir) through AbbVie.

The researchers compared states that did and did not implement these payment models. They used Medicaid State Drug Utilization Data on outpatient direct-acting antiviral prescriptions between January 2017 and June 2020 for all 50 states and the District of Columbia. The main outcome was the number of prescriptions filled per 100,000 Medicaid enrollees.

Prior to the implementation of SBPMs in Louisiana and Washington, the average rates of prescription refills per 100,000 Medicaid enrollees were 43.1 and 50.1, respectively. After July 2019, the average rates rose to 206.0 and 53.9 prescriptions per 100,000 enrollees, respectively.

There was a relative increase of 534% in quarterly prescription refills in Louisiana. However, the increase in prescription refills in Washington was not significant. According to the researchers, these differences may be due to variations in program implementation or differences in HCV populations that qualified for treatment coverage under state Medicaid rules as well as testing and treatment delays due to the COVID-19 pandemic.

Further, Louisiana's sobriety and liver damage restrictions were lifted along with subscription-based payment implementation, while Washington's restrictions had been lifted in 2016. When taking this into account in their analysis, the researchers found that Louisiana still saw a 180% increase in HCV prescriptions after implementation.

"Our results are evidence that SBPMs can work, and there are other epidemics in the U.S. that could benefit from this type of model," Auty says. "My hope is that these results provide support for the use of SBPMs not just for HCV, but for other high-value medications as well."

Click here to read the study in the JAMA Health Forum.

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