CENTER FOR HEALTH LAW
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THE STATE OF THE MARKETPLACES FOR PEOPLE LIVING WITH HIV:

WHAT HAS BEEN ACCOMPLISHED AND NEXT STEPS

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QHP Assessment Project

- Began this fall in sixteen states, including:
  - Alabama, Georgia, Illinois, Louisiana, Minnesota, Mississippi, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, and Wisconsin

Fall 2015/Winter 2016

- CHLPI identified and trained state partners
- State partners analyzed all silver QHPs
- CHLPI reviewed analysis
- CHLPI compiled report with state-level summaries

Spring 2016/Summer 2016

- CHLPI and state partners review results
- CHLPI and state partners agree on advocacy plan
  - Educate community on report
  - Produce advocacy, including OCR complaints
- CHLPI to publish national report

Assessment Tool: Marketplace Health Plans Template Assessment Worksheet

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Marketplace Health Plans Assessment Worksheet
Fall 2015

Plan Assessor: _____

The following chart is intended to be used to assess the adequacy of any given qualified health plan on a federally facilitated, partnership, or state-run Marketplace.

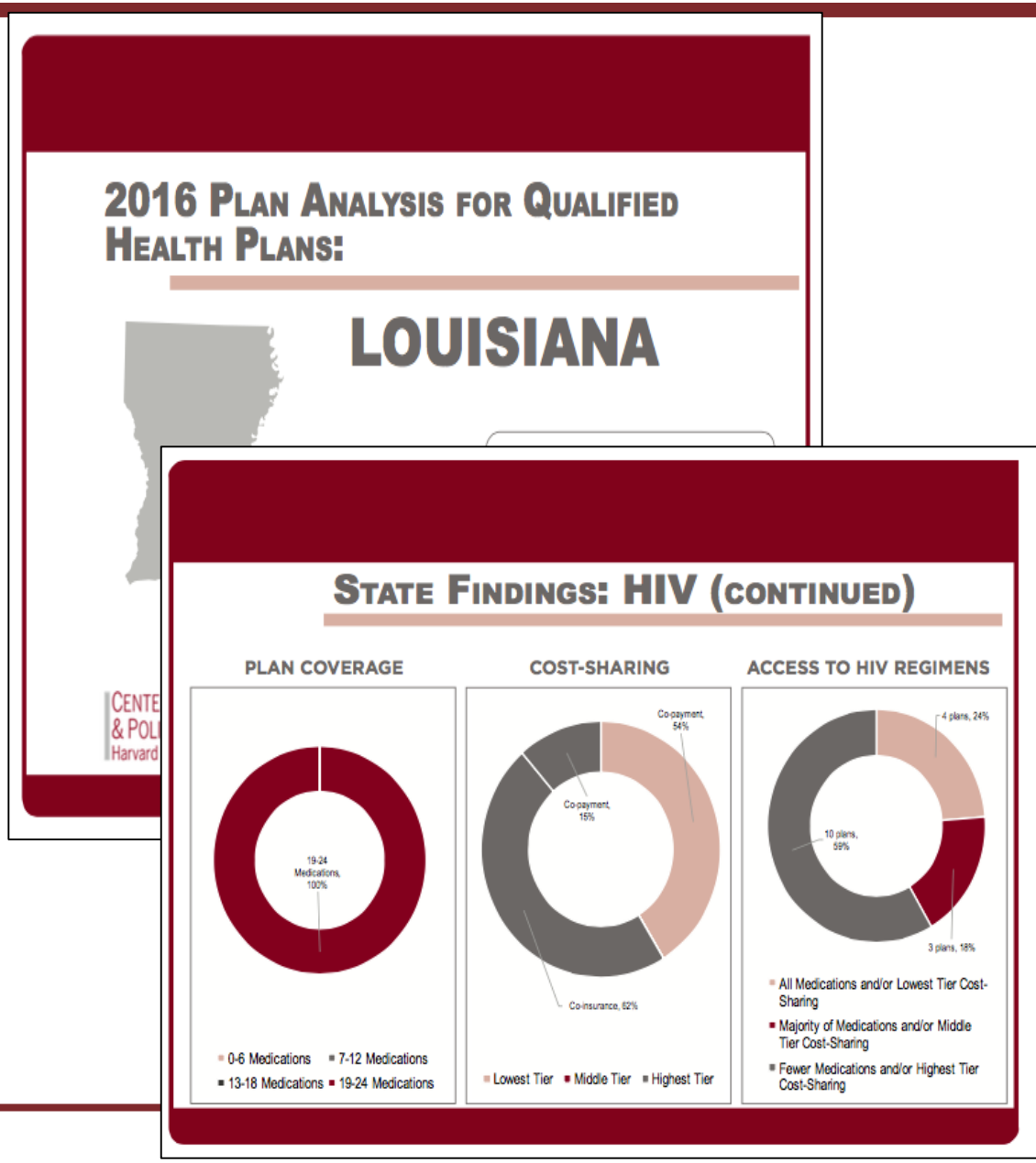
Overall Plan Information				
Issuer Name:				
Plan Name:				
Plan Type:	☐PPO	☐POS	☐HMO	☐Other
Coverage Area (counties):				
Link to Summary of Benefits:				
Individual Deductibles:	Medical: $	Prescription: $	Out of Pocket Cap: $	
Family Deductibles:	Medical: $	Prescription: $	Out of Pocket Cap: $	
Out of Network Deductibles:	Medical: $	Prescription: $	Out of Pocket Cap: $	

Annotation on Overall Plan Information:

- Most of this information will be found on the plan's summary of benefits document. This document can be found on your State's Marketplace website or healthcare.gov.
- *Issuer's Name*: This is the name of the insurance company
  - Example: Blue Cross Blue Shield
- *Plan Name*: This is the full name of the specific plan
  - Example: Blue Advantage Silver HMO 004
- *Plan Type*: This information will usually be in the Plan Name
  - Example: HMO

Individual QHP State Reports

- Each report includes all silver QHP assessments
- Reports focus on HIV and HCV treatment access
- Metrics used include coverage, cost, and access
- Recommendations for individuals selecting plans included



The Good News:
ACA Significantly Reforms Private Health Insurance

Reforms to All Private Health Insurance Plans

- Cannot be denied insurance because of pre-existing conditions
- Cannot drop people from coverage when they get sick, and no annual or lifetime limits on coverage
- Young adults can stay on parents health plan until age 26

Additional Reforms through Federal and State Marketplaces

- Marketplaces to ensure all consumer friendly requirements are met and to support patient-centered navigation programs and comparative shopping opportunities
- Plans can't charge higher premium based on health status (or gender)
- Plans include Essential Health Benefits
- Plans include essential community providers, including Ryan White providers
- Plans provide subsidies to those with income between 100-400% FPL

The Bad News:
Lack of Transparency in Marketplace Health Insurance Plans

- ACA Marketplaces fail to provide consumers with the ability to review plans, compare them and make informed decisions
- Several trends undermine transparency objectives:
  - Inadequate drug coverage or essential provider information
  - Failure to include adequate information as to cost of covered services and medications
  - Lack of standardization of plan formulary information
  - Inconsistencies between Marketplace and insurer websites
  - Changing plan design and cost-sharing subsequent to enrollment
  - Hidden requirements such as mail order pharmacy only

Progress to Date and Next Step for Addressing Transparency

Administrative/Regulatory Progress

- In general, HHS cautions insurers to avoid discouraging enrollment of people with chronic conditions
  - All formulary drug lists must be up-to-date and accurately list all covered drugs
  - Formulary link must be accessible to the general public through a clearly identified link or tab on the plan website
  - Discourages plans from mid-year formulary changes, while recognizing that changes related to availability may be necessary

Next Steps: Federal/State Administrative and Regulatory Advocacy

- Monitor and enforce new Marketplace transparency rules
- Stricter limits on ability of plans to change formularies after close of open enrollment period OR allow beneficiaries to change plans under "qualifying event" provisions if substantive change

Inadequate Coverage in Private Health Insurance Plans

- In 2014, 28% of all HIV drugs and 19% of STRs not covered
- In 2015, only 46% included the ten most commonly prescribed HIV regimens on their formularies
  - 12% covered six or fewer top ten regimens
  - Recently approved treatments have lowest rates of coverage (i.e., Triumeq, approved in 2014, covered only 50%)
  - Comparing 2014 and 15 data shows some plans moving in the wrong direction
- Increased utilization management (prior authorization and step therapy) also reduce access
- Should have 2016 data by the end of the summer

Avalere Health, "Coverage of Top HIV Regimens in 2015 Exchange Plans," November 11, 2015; Avalere Health, "Review of Formulary Coverage, Cost Sharing and Access in Top Exchange Plans," March 2014.

Progress to Date and Next Step for Addressing Coverage

Administrative/Regulatory Progress

- CMS will review to identify outlier plans that are excluding large number of treatments or subjecting them to prior authorization or step therapy
    - CMS recently acknowledged outlier approach won't work if majority of plans employ discriminatory plan design, but has not yet identified an alternative monitoring and enforcement approach
    - CMS also acknowledged that insurers who refuse to cover STR might effectively discourage enrollment and as such discriminate
- New rules require plans to create a standardized 72 hour exceptions process, with an independent external review for denials

Next Steps: Federal/State Administrative and Regulatory Advocacy

- Amend EHB rule to require coverage of drugs (where no generic alternative exists) accepted in treatment guidelines or best practices
- Promulgate regulations to clearly define discriminatory plan design

Lack of Affordability

- Many plans are placing all HIV medications on formulary tiers with very high levels of cost-sharing
- In 2015, 30% of plans placed all10 of the most commonly prescribed treatment regimens on the highest formulary tier
- 50% of HIV/AIDS drugs covered are subject to an average of 36% co-insurance
- Some plans are placing all HIV and HCV medications on 50% co-insurance
  - Individuals living with HIV enrolled in a plan with HIV-based adverse tiering spend $3,000 more per year
  - This practice isn't just happening to people living with HIV, but is widely utilized in the context of HIV

Coverage of Many Medications Unaffordable

PLAN: Capital Blue Cross BlueCross Value 0.50, A Multi-State Plan STD; Plan Id: 53789PA004001								
Product Name	**Average Wholesale Unit Price***	**Unit**	**Dose****	**% Coinsurance**	**Monthly Total Cost**	**Monthly Cost to Patient**	**Yearly Total Cost**	**Yearly Cost to Patient**
Atripla	$95.66	1 tablet	1 tablet/day	50%	$2,869.80	$1,434.90	$34,915.90	$17,457.95
Tivicay	$56.91	50 mg	50 mg/day	50%	$1,707.26	$853.63	$20,771.66	$10,385.83
Triumeq	$96.31	1 tablet	1 tablet/day	50%	$2,889.30	$1,444.65	$35,153.15	$17,576.58
Stribild	$108.16	1 tablet	1 tablet/day	50%	$3,244.80	$1,622.40	$39,478.40	$19,739.20
Complera	$93.84	1 tablet	1 tablet/day	50%	$2,815.20	$1,407.60	$34,251.60	$17,125.80

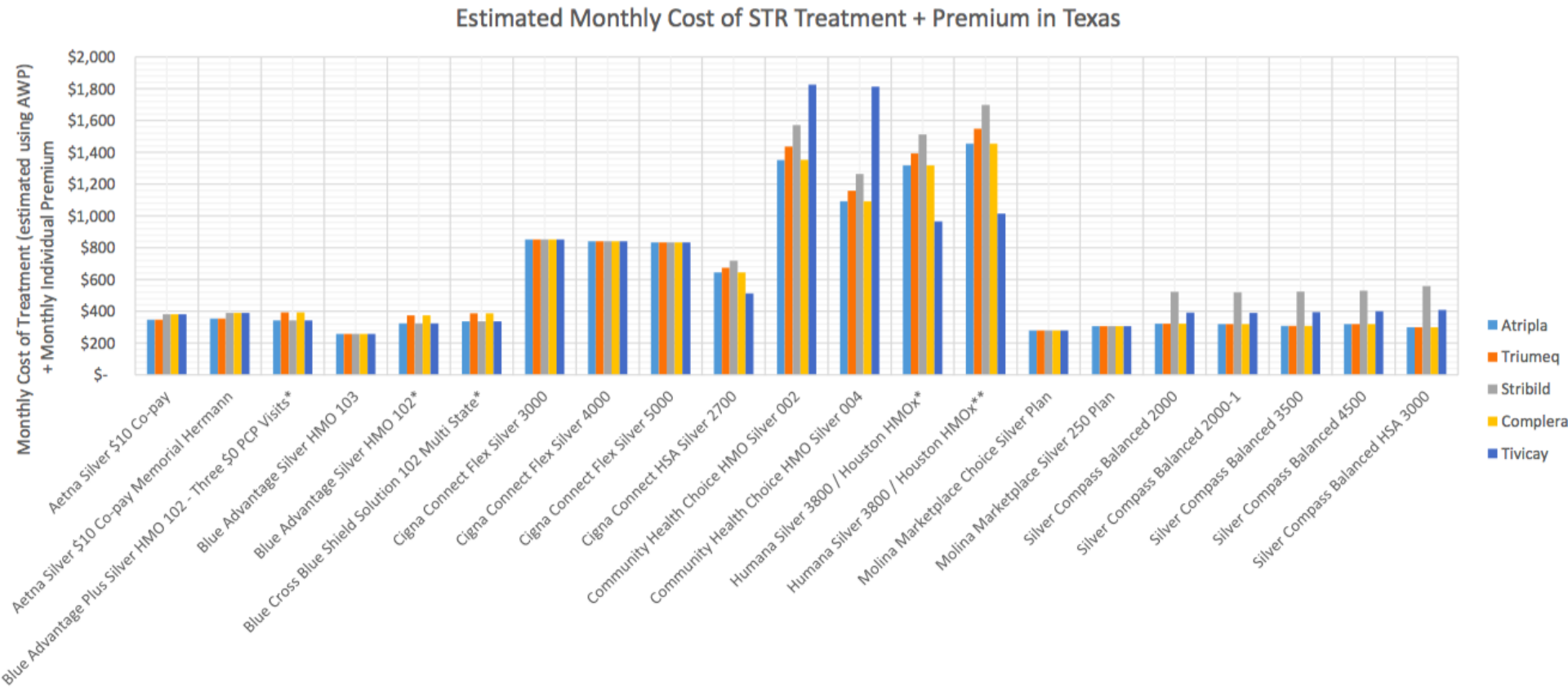
PLAN: Capital Blue Cross BlueCross Value 0.50, A Multi-State Plan STD; Plan Id: 53789PA004003								
Product Name	**Average Wholesale Unit Price***	**Unit**	**Dose****	**% Coinsurance**	**Monthly Total Cost**	**Monthly Cost to Patient**	**Yearly Total Cost**	**Yearly Cost to Patient**
Atripla	$95.66	1 tablet	1 tablet/day	50%	$2,869.80	$1,434.90	$34,915.90	$17,457.95
Tivicay	$56.91	50 mg	50 mg/day	50%	$1,707.26	$853.63	$20,771.66	$10,385.83
Triumeq	$96.31	1 tablet	1 tablet/day	50%	$2,889.30	$1,444.65	$35,153.15	$17,576.58
Stribild	$108.16	1 tablet	1 tablet/day	50%	$3,244.80	$1,622.40	$39,478.40	$19,739.20
Complera	$93.84	1 tablet	1 tablet/day	50%	$2,815.20	$1,407.60	$34,251.60	$17,125.80

PLAN: Capital Blue Cross Healthy Benefits HMO 1500.30 STD; Plan ID 53789PA0100017								
Product Name	**Average Wholesale Unit Price***	**Unit**	**Dose****	**% Coinsurance**	**Monthly Total Cost**	**Monthly Cost to Patient**	**Yearly Total Cost**	**Yearly Cost to Patient**
Atripla	$95.66	1 tablet	1 tablet/day	30%	$2,869.80	$860.94	$34,915.90	$10,474.77
Tivicay	$56.91	50 mg	50 mg/day	30%	$1,707.26	$512.18	$20,771.66	$6,231.50
Triumeq	$96.31	1 tablet	1 tablet/day	30%	$2,889.30	$866.79	$35,153.15	$10,545.95
Stribild	$108.16	1 tablet	1 tablet/day	30%	$3,244.80	$973.44	$39,478.40	$11,843.52
Complera	$93.84	1 tablet	1 tablet/day	30%	$2,815.20	$844.56	$34,251.60	$10,275.48

PLAN: Capital Blue Cross Healthy Benefits PPO 0.0 (coinsurance after deductible is met)								
Product Name	**Average Wholesale Unit Price***	**Unit**	**Dose****	**% Coinsurance**	**Monthly Total Cost**	**Monthly Cost to Patient**	**Yearly Total Cost**	**Yearly Cost to Patient**
Atripla	$95.66	1 tablet	1 tablet/day	10%	$2,869.80	$286.98	$34,915.90	$3,491.59
Tivicay	$56.91	50 mg	50 mg/day	10%	$1,707.26	$170.73	$20,771.66	$2,077.17
Triumeq	$96.31	1 tablet	1 tablet/day	10%	$2,889.30	$288.93	$35,153.15	$3,515.32
Stribild	$108.16	1 tablet	1 tablet/day	10%	$3,244.80	$324.48	$39,478.40	$3,947.84
Complera	$93.84	1 tablet	1 tablet/day	10%	$2,815.20	$281.52	$34,251.60	$3,425.16

- Focusing on cost sharing for five common and/or newer STRs
- Every state has at least one insurer whose cost sharing would have individuals hit the OOP maximums
  - Issue for individuals trying to pay the OOP max within the first few months
  - Siphoning off Ryan White dollars

Disparities in Insurers Cause Problems for the HIV Community



- Some insurers are better than others
  - But in 2016, insurers across several states pulled the best plans for people living with HIV
    - Examples: Alabama and South Carolina
  - Creating “death spirals” as people living with HIV flock to certain plans

Progress to Date and Next Step for Addressing Affordability

Administrative/Regulatory Progress

- CMS has said that insurers who place all drugs that treat a particular condition on higher-cost tier may discriminate against enrollees

Next Steps: Federal/State Legislative or Regulatory Advocacy

- HHS should amend the EHB rule to prohibit excessive coinsurance for specialty drugs (where no generic) accepted in treatment guidelines
- States should enact laws that limit cost-sharing for specialty drugs
  - Current state laws limit copayment for specialty tier drugs at $150 for 30 days; require appeals process; and prohibit placement of all drugs of a class on specialty tier
- Congress should also enact legislation to limit cost-sharing

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