

# United States Conference on AIDS

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Fighting Against Discriminatory Health Insurance Practices

Affordable Care Act Pathway

September 15, 2016

# Overview of Session

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- **Context**
- **NASTAD**
  - **ACA Plan Analysis & Advocacy**
- **AIDS Institute**
  - **Florida – Enforcement → Improvement**
- **Center for Health Law & Policy Innovation**
  - **Rights Enforcement across the U.S.**
- **Next Steps & Questions**

## **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 must 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

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- **Transparency**

- Failure to include adequate information as to medications covered and cost of coverage on marketplace and/or plan websites
- Lack of standardization of plan formulary information
- Changes to plan design and cost-sharing subsequent to enrollment

- **Coverage**

- Failure to cover many/most commonly prescribed HIV regimens

- **Cost**

- Placing medications on high cost-sharing tiers to dissuade enrollment and/or push costs onto those who enroll (adverse tiering = \$3,000 p/y)

- **Increased utilization management**

- **Excluding categories of providers from networks**

# Discriminatory Formulary Design Analysis and Advocacy

USCA 2016

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# Analysis of 2016 QHP Formularies

- Plan Year 2016 saw the release of Public Use Files that required insurers to make their plan and formulary data available in machine-readable format
- NASTAD analyzed plan and formulary data for 91,080 plans; 74% of plans had valid data
- Intend to repeat this analysis for 2017, with plans to release a tool documenting coverage of all ARVs by mid-November to assist QHP enrollment for PLWH
  - Highly dependent on data availability from CMS

# Key Findings

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- 20% of plans only cover one single-tablet regimen, Atripla, the oldest and least-recommended regimen
- One-third of plans place all covered single-tablet regimens on the specialty tier
- Over 45% of Bronze plans subject all covered single-tablet regimens to co-insurance
- 15% of plans do not cover any HIV drugs introduced since 2013
- 34% of plans place Truvada, which can prevent HIV infection as Pre-Exposure Prophylaxis (PrEP), on the specialty tier
- 29% of plans require patients to “fail first” on another HIV drug before taking Stribild, a leading single-tablet regimen

# State Variation

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- Nationwide, 20% of plans only cover Atripla
- That non-coverage, however, comes from only 12 states
- States have varying level of data completeness, so additional review is warranted

State	% Plans that only cover Atripla	% Valid data	State	% Plans that only cover Atripla	% Valid data
AR	11%	100%	NH	28%	95%
GA	46%	99%	NV	100%	79%
IN	47%	87%	OH	31%	78%
ME	48%	100%	TX	18%	21%
MO	43%	100%	VA	68%	100%
MS	54%	100%	WI	20%	55%



# State Variation

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- Substantial variation in the average cost of drugs across states, even accounting for use of co-insurance or co-payment (Silver Plans)

State	Stribild Avg. Co-Ins. \$	Stribild Avg. Co-Pay \$
National	\$826.50	\$65.17
AZ	\$270.40	\$51.07
MS	\$1,351.99	\$41.92
SC	\$946.39	\$36.37
NH	\$970.25	\$168.94

State	% Stribild Co-Ins.
National	46%
VA	15%
WY	17%
ME	100%
AK	100%

# Exclusion Lists

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- Large PBMs create “exclusion lists” that include drugs outside of the PBM’s standard formulary
- If a plan who contracts with the PBM wants to add one of those drugs to formulary, it will face higher costs and other penalties
- Unclear what happens if access is granted through a QHP appeal process, but still remains a possible access route

# Exclusion Lists



Hepatitis C

Daklinza, Olysio, Technivie, Zepatier



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## 2017 Preferred Drug List Exclusions

Drug Class	Excluded Medications	Preferred Alternatives
<b>HEPATITIS</b> Antivirals	ribasphere ribapak, RibaTab	moderiba, ribavirin capsules, ribavirin tablets
Hepatitis C* (genotypes 1 & 4) <i>Note: This category is being reviewed based upon recent product launches.</i>	Daklinza, Olysio, Sovaldi, Zepatier	Viekira Pak (genotype 1), Technivie (genotype 4)

# Exclusion Lists

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- What's going on here? Why is the HCV DAA with the cheapest list price (Zepatier) being so disfavored?
- Manufacturers provide back-end rebates to PBMs and issuers for formulary placement; many of these have penalty clauses that prevent them from adding other drugs in the same class to formulary
- Benefits might not accrue to patients in the form of lower premiums – PBMs may still require high issuer reimbursement even though they receive large rebates

# Invoiced Prices Increased in 2014, BUT WERE OFFSET BY REBATES AND OTHER PRICE CONCESSIONS

Protected Brand Price Spending Growth



# Manufacturer Rebates

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(i) In general The average manufacturer price for a covered outpatient drug shall exclude—

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(IV) payments received from, and rebates or discounts provided to, pharmacy benefit managers, managed care organizations, health maintenance organizations, insurers, hospitals, clinics, mail order pharmacies, long term care providers, manufacturers, or any other entity that does not conduct business as a wholesaler or a retail community pharmacy

**42 U.S. Code § 1396r–8, added as part of ACA**

# Benchmark Plans

- While benchmark plans have been updated from USP 5.0 to USP 6.0, USP 6.0 dates to 2014 and does not include new drugs, only one DAA

Class	NNRTI	NRTI	PI	INSTI	Other
USP 5.0	4	11	9	0	3
USP 6.0	7	11	9	3	2

- Plans can still meet benchmark and exclude new drugs OR exclude more expensive drugs in the same category while including new drugs
- While most states selected strong benchmarks, NM and WI selected benchmarks that disfavor HIV

State	NNRTI	NRTI	PI	Other
Total	5	11	9	3
NM	1	9	4	1
WI	3	4	5	2

# P&T Committees

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- Beginning in 2017, plans will be required to have Pharmacy & Therapeutics Committees
- Requirements for broad clinical specialties, conflicts of interest, quarterly meetings with written documentation of decisions based on scientific evidence, review UM and treatment protocols annually, new drugs and uses w/in 90 days (decision in 180)
- “must cover a range of drugs across a broad distribution of therapeutic categories and classes and recommended drug treatment regimens that treat all disease states and must not discourage enrollment by any group of enrollees.”
- “must also ensure appropriate access to drugs in accordance with widely accepted national treatment guidelines and general best practices at the time.”



# Defining Discrimination

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- CMS has mostly used examples of specific bad practices to define discriminatory plan design
- Plans, however, always find additional ways to discriminate, and CMS and States do not have the tools to analyze plans for problematic design
- Explore other ways to define discrimination
  - Actuarial value of disease state?
  - Relative costs of a disease state?
  - Absolute standard or outlier analysis?