Ensuring the ACA Works for People with HIV & Hepatitis

Follow @AIDSSadvocacy | #2016USCA

THE AIDS INSTITUTE
Ensuring the ACA Works for People with HIV & Hepatitis

Panel 1
ACA Marketplace Landscape, Natalie Kean, The AIDS Institute
HIV Rx Coverage & Restrictions, Sean Dickson, NASTAD

Panel 2
Progress Made & Next Steps in Securing Rx Access
Carl Schmid, The AIDS Institute
State Insurance Regulators’ Role, Amy Killelea, NASTAD

Panel 3
ACA’s Impact on Ryan White Program & Beneficiaries in Florida
Michael Ruppal, The AIDS Institute

Panel 4
Successes, Challenges & Goals Shared between Patient Communities
Monica Gonzalez & Ines Alexandra Mosi
Epilepsy Foundation of Florida
ACA Marketplace Landscape

U.S. Conference on AIDS
September 16, 2016

Natalie Kean
Senior Policy Associate
Back in 2014 . . .

- The AIDS Institute reviewed qualified health plans (QHPs) available on the ACA Marketplace in Florida
  - Goal was to inform Ryan White clients about QHP options
  - 10 Issuers/36 Silver-level plans available
  - Looked at formularies for HIV drug coverage & cost-sharing structure
Discovering Discriminatory Design

- 4 Issuers placed all HIV Rx on highest cost-sharing tier, a.k.a. “adverse tiering”
- Patient cost-sharing for all HIV Rx under these issuers’ plans was much higher than under other plans
  - 40% - 50% co-insurance
  - High deductibles
- Restrictive Utilization Management
  - prior authorization
  - Quantity limits
ACA’s Nondiscrimination Provisions

• The Affordable Care Act prohibits discrimination against individuals
  – with disabilities, including HIV/AIDS, and
  – with “significant health needs”

• Insurers barred from
  – Denying coverage to persons with preexisting conditions
  – Excluding coverage of a preexisting conditions
  – Imposing annual or lifetime limits on benefits
  – Using plan benefit designs that discourage enrollment
Discrimination Complaint

• TAI & NHeLP filed complaint with Federal Office for Civil Rights/HHS (OCR)
  – Named 4 Issuers: CoventryOne, Cigna, Humana, and Preferred Medical
  – Alleged discrimination through adverse tiering against PLWHIV in violation of ACA
  – Asked HHS to remedy the unlawful conduct & decertify any QHPs that were in continued non-compliance

• Filed in 2014 but still pending
• HHS wants states to address
Results of Discrimination Complaint

Florida Insurance Commissioner (FOIR) took action

• Used two State laws:
  – Insurance plans cannot discriminate based on AIDS
  – Review plans for compliance with ACA law

• Entered into discussions with issuers

• All 4 issuers agreed to make changes to 2015 formularies
  – Moved generics to lower tiers
  – Lowered co-insurance, capped copays
  – Removed restrictions
Impact beyond FL & HIV

- TAI, NHeLP, AHF met with Aetna & Cigna (Jan. 2015)
- Aetna (Coventry) announced *nationwide* changes (March 2015)
  - Moved all HIV Rx (except Fuzeon) to either generic or non-preferred brand
  - Co-payments of between $5 and $100, after deductible (instead of 50% co-insurance)
  - Mail-order or retail pharmacy option, 90-day supply
- Humana (March 2015)
  - Continuing 10% cap for HIV drugs through 2016 *in Florida*
  - *Nationwide*--moved *all specialty drugs* below a $600 monthly threshold to lowest tiers (generic or brand)
Issuer Follow-Up Continues

• Florida Office of Insurance Regulation conducted market examination of Humana

• Resulting Consent Order (Feb. 2016)
  – Humana agreed to “maintain procedures to ensure that it does not by effect or design treat people living with HIV/AIDS less favorably than any other condition.”
  – Fined $500,000 for failing to cooperate with investigators
2015 Florida Plans

• For HIV--better but still saw issues with some plans:
  – Commonly-prescribed HIV Rx not covered
    • Only 3 plans covered all 4 approved STRs (Triumeq excluded by 10 plans)
    • No plan covered Vitekta, newest integrase inhibitor
  – All HIV Rx or all branded Rx, on highest cost-sharing tiers
    • 30% to 50% coinsurance
    • High Rx deductible ($500 to $1,500)

• Less favorable coverage for hepatitis across plans
  – Some or all curative HCV treatments not covered
  – All hepatitis Rx on highest cost-sharing tiers with coinsurance
  – All or most hepatitis Rx subject to prior authorization
  – Quantity limits
Instructions/Cautions for 2016 Plan Review

– find plans discriminatory if cost-sharing for HIV Rx not as favorable as benchmark plan ($40, $70 or $150 and $200 for Fuzeon)

– review all plans for all Rx for discrimination through formula design, benefit design, or medical management techniques and decertify plans that engage in these practices

– require all plans to attest to non-discrimination
2016 Florida Plans

• HIV Rx Improvement across all plans!
  – No 2016 Florida plans placed *all* HIV Rx in highest tier
  – More affordable cost-sharing, most following FOIR’s directive

• But still have concerns:
  – Some plans not covering all HIV Rx (e.g., new single-tablet regimens)
  – Deductibles are increasing → coinsurance more burdensome
  – Prior authorization for almost all HIV Rx (Florida Blue)
  – Prior authorization for Truvada (several issuers)
  – High co-insurance for other Rx (non-HIV) + impact of high deductibles
2016 Florida Plans

Hepatitis Rx Coverage Issues Persist

• Limited coverage of newer curative HCV Rx
• 6 of 9 issuers charge 20-50% coinsurance for all or most HBV & HCV Rx
  – Humana places almost all HCV Rx on Tier 5 with 40-50% co-insurance after $3,800 deductible
  – Aetna & CoventryOne: Tiers 4 & 5, 40-50% co-insurance after $2,750 deductible
  – HealthFirst, Molina, Florida Health Care: Tiers 4 & 5, 20-30% co-insurance
• Excessive prior authorization, step therapy, quantity limits
• United Healthcare provides the best coverage:
  – Most hepatitis Rx on Tiers 2-4 with $40, $80, $160 co-pays
  – Rx exempt from deductible—first dollar coverage
Florida Advocacy re HCV Rx

• TAI & Alliance for Patient Access sent letter to FOIR in April
  – Issuers discouraging enrollment through adverse tiering, high patient cost-sharing, excessive prior authorization, quantity limits
  – Meetings with FOIR

• Lawsuit against Florida Blue settled in June
  – Florida Blue agreed to provide access to Harvoni to all beneficiaries
  – Removed fibrosis score restrictions

• Lawsuit against United HealthCare settled last week
  – *Nationwide* United agreed to remove
    • fibrosis score restrictions
    • abstinence requirements
  – Court approval still pending
2016 Plans Nationwide

Coverage improvement in some Rx classes but not all QHPs’ coverage less favorable than employer plans

(Sources: Avalere Health)
2016 Plans Nationwide

Adverse Tiering Still an Issue

PERCENTAGE OF SILVER PLANS PLACING ALL COVERED DRUGS IN THE CLASS ON THE SPECIALTY TIER

(Source: Avalere Health)
2016 Plans Nationwide

More than 10% of QHPs require >40% co-insurance for non-generics.

(Source: Avalere Health)
2016 Plans Nationwide

QHPs increased utilization management for hepatitis Rx by nearly 20%

(Source: Avalere Health)
Florida 2017 Plan Review

• FL Insurance Commissioner issued another memo:
  – Renewed 2016 requirements for HIV coverage & benefit design, limited cost-sharing
  – Added review of multiple conditions for formulary adequacy & adverse tiering:
    • HIV
    • hepatitis C
    • breast & prostate cancers
    • rheumatoid arthritis
    • bipolar disorder & schizophrenia
    • Diabetes
    • Multiple Sclerosis
Florida 2017 Plan Review

List all Rx on formulary to treat each condition

<table>
<thead>
<tr>
<th>Chronic Conditions</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
<th>Tier 4</th>
<th>Tier 5+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar Disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis C</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostate Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatoid Arthritis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Conclusion

• We have seen improvement, but room for more

• Filing 2014 Discrimination Complaint made significant impact:
  – Even though no decision by Office for Civil Rights
  – Florida State Insurance Commissioner’s role critical
  – Press coverage
  – Moved Issuers in Florida to improve HIV Rx coverage
  – Prompted change by some issuers nationwide & for other non-HIV Rx
  – Reflected in federal regulations & guidance re nondiscrimination & benefit design

• Advocacy is Key:
  – Filing complaints in other states and for conditions other than HIV
  – Involve state insurance commissioners
  – Meet with Issuers
Thank you!

Natalie Kean
Senior Policy Associate
nkean@theaidsinstitute.org
Discriminatory Design
HIV Treatment in the Marketplace

Sean Dickson
Senior Manager, Health Systems Integration
sdickson@nastad.org
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

- [https://www.nastad.org/resource/discriminatory-design-hiv-treatment-marketplace](https://www.nastad.org/resource/discriminatory-design-hiv-treatment-marketplace)

- 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

- 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 and Issuer Variation

- 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

<table>
<thead>
<tr>
<th>State</th>
<th>% Plans that only cover Atripla</th>
<th>% Valid data</th>
<th>State</th>
<th>% Plans that only cover Atripla</th>
<th>% Valid data</th>
</tr>
</thead>
<tbody>
<tr>
<td>AR</td>
<td>11%</td>
<td>100%</td>
<td>NH</td>
<td>28%</td>
<td>95%</td>
</tr>
<tr>
<td>GA</td>
<td>46%</td>
<td>99%</td>
<td>NV</td>
<td>100%</td>
<td>79%</td>
</tr>
<tr>
<td>IN</td>
<td>47%</td>
<td>87%</td>
<td>OH</td>
<td>31%</td>
<td>78%</td>
</tr>
<tr>
<td>ME</td>
<td>48%</td>
<td>100%</td>
<td>TX</td>
<td>18%</td>
<td>21%</td>
</tr>
<tr>
<td>MO</td>
<td>43%</td>
<td>100%</td>
<td>VA</td>
<td>68%</td>
<td>100%</td>
</tr>
<tr>
<td>MS</td>
<td>54%</td>
<td>100%</td>
<td>WI</td>
<td>20%</td>
<td>55%</td>
</tr>
</tbody>
</table>
State and Issuer Variation

- Of the big issuers, Anthem *always* limits STRs to just Atripla, and *always* places Atripla on Specialty

<table>
<thead>
<tr>
<th>Issuer</th>
<th>Atripla only STR</th>
<th>All STRs Co-Ins</th>
<th>All STRs Specialty</th>
<th>Atripla only STR</th>
<th>All STRs Co-Ins</th>
<th>All STRs Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross</td>
<td>17%</td>
<td>48%</td>
<td>27%</td>
<td>6%</td>
<td>43%</td>
<td>16%</td>
</tr>
<tr>
<td>Moda</td>
<td>0%</td>
<td>80%</td>
<td>0%</td>
<td>0%</td>
<td>74%</td>
<td>0%</td>
</tr>
<tr>
<td>United</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>22%</td>
<td>0%</td>
</tr>
<tr>
<td>Humana</td>
<td>0%</td>
<td>79%</td>
<td>97%</td>
<td>0%</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>Aetna</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Molina</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Kaiser</td>
<td>0%</td>
<td>100%</td>
<td>58%</td>
<td>0%</td>
<td>84%</td>
<td>68%</td>
</tr>
<tr>
<td>Anthem</td>
<td>100%</td>
<td>86%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
State and Issuer Variation

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>$826.50</td>
<td>$65.17</td>
</tr>
<tr>
<td>AZ</td>
<td>$270.40</td>
<td>$51.07</td>
</tr>
<tr>
<td>MS</td>
<td>$1,351.99</td>
<td>$41.92</td>
</tr>
<tr>
<td>SC</td>
<td>$946.39</td>
<td>$36.37</td>
</tr>
<tr>
<td>NH</td>
<td>$970.25</td>
<td>$168.94</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State</th>
<th>% Stribild Co-Ins.</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>46%</td>
</tr>
<tr>
<td>VA</td>
<td>15%</td>
</tr>
<tr>
<td>WY</td>
<td>17%</td>
</tr>
<tr>
<td>ME</td>
<td>100%</td>
</tr>
<tr>
<td>AK</td>
<td>100%</td>
</tr>
</tbody>
</table>
Specialty Tiering

Plans Placing STRs on Specialty Tier

- All Covered STRs - 34%
- Atripla - 33%
- Complera - 21%
- Stribild - 39%
- Triumeq - 28%
Co-Insurance Frequency

- **Atripla**
- **Complera**
- **Stribild**
- **Triumeq**
- **All Covered STRs**
In Alaska, Louisiana, and Maine, over 75% of plans place PrEP on the Specialty tier; 100% of plans in Nevada do.
Cost-Sharing Reduction Plans

STR Co-Insurance Frequency, Silver vs. CSR

- Atripla
  - Silver: 33%
  - CSR-73: 30%
  - CSR-87: 30%
  - CSR-94: 30%

- Complera
  - Silver: 33%
  - CSR-73: 30%
  - CSR-87: 30%
  - CSR-94: 30%

- Stribild
  - Silver: 33%
  - CSR-73: 30%
  - CSR-87: 30%
  - CSR-94: 30%

- Triumeq
  - Silver: 33%
  - CSR-73: 30%
  - CSR-87: 30%
  - CSR-94: 30%

Legend:
- Silver
- CSR-73
- CSR-87
- CSR-94
Relationship of Price to Restrictions

Co-Insurance Frequency vs. Cost

![Graph showing the relationship between co-insurance frequency and cost. The graph plots percentage co-insurance on the y-axis against cost on the x-axis. The data points indicate a general trend of increasing co-insurance frequency with higher costs.]
Relationship of Price to Restrictions

Step Therapy Frequency

- Y-axis: Step Therapy Frequency (%)
- X-axis: Price ($)

The graph shows the relationship between price and step therapy frequency, indicating that as price increases, the frequency of step therapy also tends to increase.
Relationship of Price to Restrictions

Prior Authorization Frequency

- X-axis: Price ($0 to $3,500)
- Y-axis: Frequency of Prior Authorization (0% to 30%)

The graph shows the relationship between price and the frequency of prior authorization. As the price increases, there is a general trend of an increase in the frequency of prior authorization.
Progress Made & Next Steps in Securing Access to Rx:
Ensuring the ACA Works for People with HIV and Hepatitis

USCA 2016
September 16, 2016 | Hollywood FL

Carl Schmid
Deputy Executive Director
The AIDS Institute
Efforts to Ensure ACA Works

• ACA has great benefits
• Ensuring it works for people with HIV, hepatitis and other chronic conditions
  • Coalition efforts
• Concerns with health plans:
  • Transparency
  • Limited Benefits (Rx and Providers)
  • Excessive Utilization Management
  • Patient Cost-sharing
  • Discrimination
Transparency

• CCIIO Requiring Better Transparency
  • Direct Links to formularies
    • Can review in the window shopping & plan selection phases
    • Not all formularies organized the same way
    • Would be great to require a Rx look up tool
      • Some plans and states utilize
      • Healthcare.gov tool allows filtering plans by Rx coverage
        • Only during window shopping
        • Does not show tiering or cost-sharing
  • Formularies must include Tier level
    • But need plan information for cost-sharing amount
    • And with co-insurance, no idea of the dollar amount
Transparency

• CCIIO Requiring Better Transparency (cont.)
  • Must include prior authorization, quantity limits
    • But hard to determine what the prior authorizations are
  • Plans must submit data in machine readable format
    • Outside 3rd parties can use
  • Direct links to Providers
    • Essential Community Providers
Limited Benefits

• Criteria for Rx Coverage
  – A plan must have a minimum of one drug per USP class or at least the same number of drugs per class as the State’s benchmark plan
    • State benchmarks vary
    • USP did not initially cover combination Rx
    • No process to add in newly approved Rx
  – Require Pharmacy and Therapeutics Committee (proposed in 2015 but begins in 2017)
    • Must meet quarterly
    • Must consider scientific evidence & treatment guidelines
    • Review utilization management
    • Must consider new Rx
    • CCIIO saying “Wait and See” on Implementation
Limited Benefits

- CCIIO Will Review for Clinical Appropriateness of Rx Coverage
  - Included in 2017 “Letter to Issuers”
  - Will review covered drugs recommended by nationally-recognized clinical guidelines for:
    - bipolar disorder, breast cancer, diabetes, hepatitis C, HIV, multiple sclerosis, prostate cancer, rheumatoid arthritis, and schizophrenia
  - Will also review for cost-sharing
    - But just 9 conditions!
    - May add more in the future
Other Improvements

• Improved Exceptions Process

• Prohibit Mail-order only Plans (Beginning 2017)

• Monitoring mid-year formulary changes but still need to address
Plan Reviews

• Included in 2017 “Letter to Issuers”
  – Formulary Outlier Review for:
    • High Number of Prior Authorizations
    • Step Therapy
  – Adverse Tiering
    • Placing Rx on high tiers
    • Potentially discriminatory
Solutions to High Cost-Sharing: State Responses

- Limit patient co-pays:
  - DE: $150 limit for Specialty Drug co-pays, prohibits all drugs in one class on Specialty tier
  - LA & MD: $150 co-pay limit
- Standard Benefit Option
  - CA: Limits co-pays depending on Tier and Metal level; $250 limit, except $500 in Bronze Plans
- Prohibit Specialty Tiers
  - NY: patient cost can’t be more than non-preferred brand
Other State Responses

- CO: Allows plans to use co-insurance but issuer also must offer plans that use co-pays; deductible does not apply to Rx, co-pays can be spread out over year.

- MT: Each issuer must offer a plan with co-pays that are exempt from deductible; cost sharing in each plan must be graduated in all tiers.
Cost Sharing Solutions

- CCIIO Proposed Standard Benefit Option
  - Voluntary, plans encouraged to offer & will highlight “Simple Choices” for consumers in 2017
  - Limits co-pays, at reasonable levels, depending on metal level and tier
  - Exempts Rx from deductible (except most Bronze tiers)
  - But, allows co-insurance 25-45% for Specialty Tier and all Bronze (except generics)
- Families USA Milliman Study
  - “New Health Plans Allow People to Visit Doctors and Fill Prescriptions without Paying a Deductible with Little Impact on Premiums”
Proposed “Simple Choices” in 2018

CCIIO Proposed changes in Notice of Benefits and Payment Parameters

• Remain voluntary
• Adds Options for States that Limit Rx co-pays
• Keeps the Basic one
  • Still includes High Co-insurance for specialty tier & most Bronze Rx
  • Subjects specialty tier Rx to the deductible
    • But institutes separate Rx deductible
  • Why not just limit co-pays?
Congressional Efforts

• Patients’ Access to Treatments Act (HR 1600)
  • Bipartisan--Introduced by Reps. David McKinley (R-WV) and Lois Capps (D-CA)
  • 97 co-sponsors
  • Plans can’t charge more for Rx on Specialty Tier than Non-preferred tier

• Senate Bipartisan letter
  • Led by Sens. Chris Murphy (D-CT) & Shelly Moore Capito (R-WV)
  • Signed by 8 additional Senators
  • Asks Senate Health Committee to review patient’s perspective on high cost-sharing
Section 1557

“an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.)...or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance...”
Additional Non-discrimination Requirements

- Qualified Health Plans may “not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs.”

42 U.S.C. § 18031(c)(1)(a)
Discrimination Enforcement

- Issued Section 1557 ACA Non-discrimination rules
  - Plan design can be discriminatory
    - Did not include examples in regulation
    - Cited potential examples in footnote (were in previous CCIIO Announcements)
      - Placing most or all prescription medications that are used to treat a specific condition on the highest cost formulary tiers
      - Requiring prior authorization and/or step therapy for most or all medications in drug classes such as anti-HIV protease inhibitors, and/or immune suppressants regardless of medical evidence
Discrimination Enforcement

• Letter to Issuers (2017):
  • CMS cautions issuers to avoid discouraging enrollment of individuals with chronic health needs. For example, if an issuer does not cover a single-tablet drug regimen or extended-release product that is customarily prescribed for HIV patients and is just as effective as a multi-tablet regimen, absent an appropriate reason for the exclusion (such as a substantial difference in the cost of the two regimens), such a plan design might effectively discriminate against, or discourage enrollment by, such HIV patients who would benefit from such innovative therapeutic options.
Discrimination Enforcement

- No decision on Florida HIV case
- Additional complaints filed in 8 States (September 6th)
- Turn to states to enforce
  - Role of State Insurance Commissioners
- Need Federal Enforcement, as well
  - And Additional Regulations and Guidance
Federal Solutions

- Risk Adjustment:
  - Plans paid for carrying sicker patients
  - In 2014, CCIIO readjusted $4.6 billion among the plans
  - Currently only considers certain diagnoses
  - In 2018, proposing to add Rx usage
    - Limited set of conditions, includes HIV & Hepatitis C
  - Should help better reward plans for sicker patients & hopefully reduce high patient cost-sharing
  - Comments Due October 6
State & Federal Enforcement

• Annual Review of Plans Prior to Certification
  • Adequate Tools and Templates Needed
    • For States and Federal Government
    • Adverse Tiering Tool in development

• CCIIO Grant to States
  • $22 million for State Insurance Regulators
  • Can review for potential discrimination in plan design
  • Who will apply and receive?
The Future?

- 2018 Proposed Benefit and Payment Parameters Rule and “Letter to Issuers”
- 2017 Plan Review
  - CCIIO & States Depend on us to identify issues
- 2016 Elections
  - Ensure Patient Protections Continued & Enforced
- Debate over the ACA
- Debate over Drug Pricing
THANK YOU!

Carl Schmid
cschmid@theaidsinstitute.org
202-462-3042
Prescription Drug Access: The Role State Insurance Regulators

Amy Killelea, NASTAD
Health Insurance Regulation Post ACA... It’s Complicated

Federal Regulation
- New federal Affordable Care Act (ACA) requirements that apply mostly to individual and small group markets
- Array of other federal laws that touch other pieces of commercial insurance markets (e.g., ERISA, HIPAA)

State Regulation
- Health insurance regulation has typically been the purview of state (and emphatically not federal) laws and regulations
- 5 states have refused to enforce new ACA protections (TX, MO, OK, AL, WY)
State Role in ACA Monitoring & Enforcement

- States that are enforcing ACA provisions must first certify QHPs through state department of insurance:
  - Essential Health Benefits protections (including discriminatory plan design prohibitions)
  - Network adequacy
  - Rate review
- CMS/CCIIO reviews QHP submissions for FFM states to ensure compliance with federal rules and regulations and is fairly prescriptive in some areas.
NAIC represents state insurance commissioners and provides support, advocacy, and a convening body across a range of insurance issues (not just health)

Utilizes a Consumer Representative body made up of experts and consumer advocacy groups to inform NAIC members and activities

Convenes regulators, Consumer Representatives, and other interested parties to draft model state laws
  - Including prescription drug coverage – Model Law 22
NAIC Model 22

“Health Carrier Prescription Drug Benefit Management Model Act”

- Sub-committee has formed to update the model law, focusing on:
  - **Transparency**, accuracy, and disclosure of formulary information
  - **Accessibility** of prescription drugs and composition of plan formularies
  - **Non-discrimination protections** and tiering

- Has the potential to impact much broader market than just EHB regulated plans (including large group market in addition to small group and individual market)
State and Federal Priorities for Regulation of Prescription Drug Access

- Non-discrimination requirements
- Pharmacy and Therapeutics (P&T) Committees requirements
- Regulation of Pharmacy Benefit Managers (PBMs)
- Plan transparency requirements
- Models to address emerging and breakthrough therapies
- Continuity of coverage protections
- Consumer friendly and transparent appeals and exceptions processes

NAIC Consumer Representatives Commissioned Report on Prescription Drug Coverage

Promoting Access to Affordable Prescription Drugs:
Policy Analysis and Consumer Recommendations for State Policymakers, Consumer Advocates, and Health Care Stakeholders

AUGUST 2016
Areas to Watch: P&T Committees and Emerging Therapies

- **P&T committee requirements** are a large component of NAIC Model 22 and a new federal ACA requirement for the 2017 plan year
  - Composition - include relevant expertise for formulary decisions
  - Conflict of interest - ensure fair and unbiased decisions
  - Sound basis for decisions - ensure members take into account relevant and timely medical and scientific evidence

- **Emerging and breakthrough therapies** will continue to present access challenges
  - Ensure newly approved drugs are evaluated by P&T committees in a timely fashion
  - Address potential discriminatory plan designs
  - Assess feasibility of value-based pricing models
Resources

- Amy Killelea, NASTAD (akillelea@nastad.org); www.nastad.org


- NAIC Model 22 Sub-Committee (includes call schedules and comments submitted by Consumer Representatives and other interested parties), http://www.naic.org/cmte_b_mod_22_sg.htm
Panel 3

THE AIDS INSTITUTE
Successes, Challenges & Goals Shared between Patient Communities
The Epilepsy Foundation is an unwavering ally for individuals and families impacted by epilepsy and seizures.

We strive to ensure that people with seizures have the opportunity to live their lives to their fullest potential.
I Am Essential Coalition

• Broad group of about 300 patient and community organizations representing millions of patients and their families
• Led by The AIDS Institute, the Epilepsy Foundation and the National Alliance on Mental Illness.
• Formed to ensure quality and affordable essential health benefits and sufficient patient protections in the ACA qualified health plans.
• Focus on limited benefits; high cost-sharing; and lack of transparency and uniformity.
People with Chronic Conditions Face Similar Access Barriers

• Nearly 3 million people living with epilepsy and seizures in the US
• Many individuals living with epilepsy were denied access to health insurance in the past due to pre-existing conditions before the ACA was enacted
• Despite the success of the ACA, access barriers remain, such as restrictive formularies where many medications are placed in the highest cost tier or off formulary altogether
• I Am Essential provides unified voice for patient community to come together on shared access barrier
Navigating the ACA:  
The Florida Experience

• Epilepsy Foundation of Florida has been a navigator site since 2014
• Serves approx., 10,000 people annually with in person marketplace enrollment assistance
• Serve predominantly minority populations consisting of Hispanics, Black African Americans and Haitians.
• Age groups vary from 26 to 65 years of age with the majority of consumers served falling between the ages of 42 and 58.
ACA Marketplace Challenges

What Are Some of the Challenges When Navigating the ACA Marketplace?

• Monica Gonzalez, Epilepsy Foundation of Florida
• Ines Mosi, Epilepsy Foundation of Florida
Q&A

All presentations will be available online at:
www.theaidsinstitute.org/USCA2016

Contact Us: info@theaidsinstitute.org or 202-835-8373

Get Involved:
Twitter @AIDSadvocacy
Facebook @TheAIDSInstitute

#2016USCA