

ACCESS TO HIV/AIDS MEDICATIONS IN EXCHANGE PLANS

Prescription medicines are a crucial component of treatment for HIV/AIDS. Multidrug regimens have substantially reduced HIV progression to AIDS, opportunistic infections, hospitalizations, and deaths. Even so, early ART regimens often required patients to ingest several large pills multiple times per day. New formulations, such as single-tablet regimens, reduced the pill burden dramatically, improving adherence and slowing disease progression. This fact sheet offers insight into access to these medicines in the new health insurance exchanges. Key findings are primarily based on an analysis of 84 plans in the 15 states with the highest expected exchange enrollment for 2014.¹

COVERAGE AND ACCESS FOR HIV/AIDS MEDICINES



Exchange plans are less likely to cover combination medicines than other brand HIV/AIDS medicines.

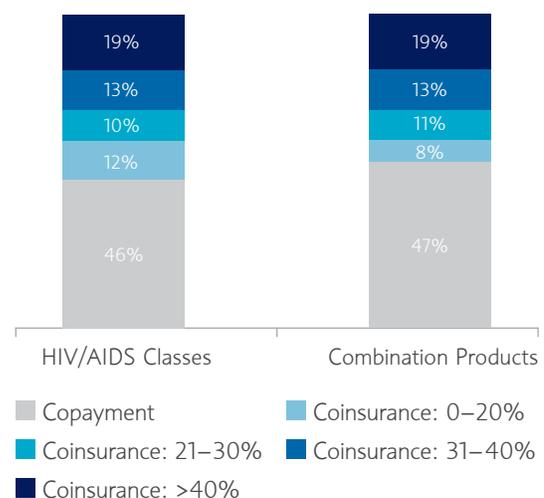
Formulary Coverage: Certain types of medicines are often excluded from the formulary.

- Compared to brand medicines that treat other conditions, HIV/AIDS medications are more likely to be on the formulary; however, combination therapies—which increasingly represent the standard-of-care in treatment of HIV/AIDS—are less likely than single-ingredient HIV/AIDS medications to be covered.
 - Exchange plans cover single-source brand HIV/AIDS medicines² (defined as medicines for which a generic equivalent is not available) 81% of the time, but only cover combination medicines³ 67% of the time.
- The essential health benefits (EHB) rules governing coverage of medicines under the Affordable Care Act do not count combination medicines towards meeting EHB standards if the individual component medicines are already covered by a plan. This leaves plans with less incentive to cover combination medicines.

Cost-Sharing: Medicines to treat HIV/AIDS are sometimes subject to high coinsurance.

- HIV/AIDS medicines are subject to coinsurance in about 55% of plans, with an average coinsurance of 35% for all medications and 37% for combination medicines.
- For a single HIV/AIDS medication subject to coinsurance rate of 35%, out-of-pocket costs could range from \$1,100 to over \$6,350 annually.⁴
- Also, unlike most employer plans,⁵ many silver and bronze plans in exchanges subject prescription medicines to a single global deductible for both medicines and other services. Those deductibles average about \$2,500 in silver plans and \$4,300 in bronze plans.⁶
- These cost-sharing details do not reflect subsidies for enrollees with incomes below 250% of poverty; however, exchange plans have flexibility in implementing cost-sharing reductions and are not required to apply reductions to medicines.

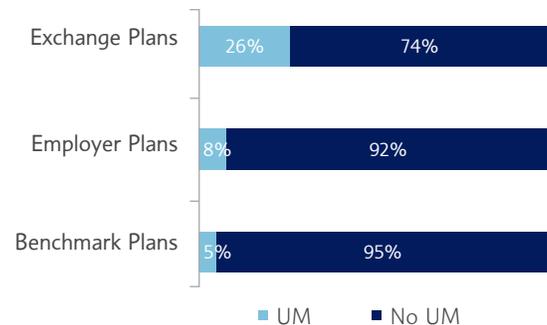
Frequency of Copayment vs. Coinsurance by Amount for HIV/AIDS Medicines in Silver Plans



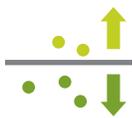
Access Limits: Medicines are more likely to be subject to step therapy or prior authorization in exchange plans than in employer or benchmark plans.

- HIV/AIDS medicines have fairly open access compared to medicines for other conditions, such as cancer and rheumatoid arthritis.
- An analysis of 2014 versions of essential health benefit benchmark formularies in 12 states found that these benchmark formularies were less likely to require utilization management (UM) for HIV/AIDS medicines compared to exchange plans (5% compared to 26% for single-source medicines in the 4 HIV/AIDS classes).
- Utilization management for these 4 classes is also more common in exchange plans than in employer plans (26% compared to 8% of the time).
 - Exchange plans impose UM on combination medicines 29% of the time, compared to employer plans which require UM on these combination medicines 6% of the time.

Utilization Management of HIV/AIDS Medicines



VARIATION ACROSS STATES



Some plans appear to not be meeting the essential health benefit benchmark requirements for coverage of HIV/AIDS medicines.

Coverage for HIV/AIDS therapies varies by state, despite benchmark requirements for HIV/AIDS classes being fairly consistent. Notably, in several states, at least one plan does not cover as many medicines as the state's standard. Though these plans appear non-compliant with benchmarks, publically-available formularies may not be inclusive of all covered medicines. Either situation raises concerns about how patients can make informed enrollment decisions.

- 4 of 8 plans in Michigan appear to not meet the benchmark for at least 1 of the 4 HIV/AIDS classes and 2 of 8 plans fall short for 2 classes.
- In New York, 1 of 6 plans analyzed appears to not meet the benchmark in 2 classes. Plans also fall short for at least 1 class in Florida (1 of 9 plans), Illinois (1 of 6 plans), and Texas (1 of 8).
- Some plans cover fewer than half of brand HIV/AIDS medicines. For non-nucleoside reuptake inhibitors, 22% of plans cover less than 50% of branded medicines. For nucleoside and nucleotide reuptake inhibitors, 14% of plans cover less than half of medicines, and 16% of plans cover less than half of protease inhibitors.

¹ Silver plans in AR, CA, FL, GA, IL, IN, MI, NC, NJ, NY, OH, PA, TX, VA, WI

² Includes medicines in four USP classes: Non-nucleoside Reuptake Inhibitors, Nucleoside and Nucleotide Reuptake Inhibitors, Protease Inhibitors, and HIV-Other.

³ Truvada, Epzicom, Combivir, Trizivir, Atripla, Complera, Stribild

⁴ Single-source HIV/AIDS medicines covered under the pharmacy benefit

⁵ Kaiser/HRET Survey of Employer Sponsored Health Benefits 2013.

⁶ Avalere Health PlanScape,™ a proprietary analysis of exchange plan features. Data as of October 31, 2013

⁷ Employer-sponsored insurance (ESI) data based on 2013 formularies from the following plans: the largest federal employee health plan (FEHBP); a large public, non-governmental, self-insured employer plan; a large, self-insured employer plan; a national carrier plan sponsored by a large employer; and a national carrier plan sponsored by a mid-size employer.