MASSACHUSETTS PLAN ANALYSIS

An Assessment of Infectious Disease Coverage in the Commonwealth in the Spring of 2015

Prepared by the Center for Health Law and Policy Innovation of Harvard Law School

HEALTH LAW & POLICY CLINIC
Center for Health Law & Policy Innovation
Harvard Law School

About the Authors

The Center for Health Law and Policy Innovation of Harvard Law School (CHLPI) advocates for legal, regulatory, and policy reforms to improve the health of underserved populations, with a focus on the needs of low-income people living with chronic illnesses. CHLPI works with consumers, advocates, community-based organizations, health and social services professionals, food providers and producers, government officials, and others to expand access to high-quality healthcare and nutritious, affordable food; to reduce health disparities; to develop community advocacy capacity; and to promote more equitable and effective healthcare and food systems. CHLPI is a clinical teaching program of Harvard Law School and mentors students to become skilled, innovative, and thoughtful practitioners as well as leaders in health, public health, and food law and policy.

Massachusetts Plan Analysis: An Assessment of Infectious Disease Coverage in the Commonwealth in the Spring of 2015 is researched and written by Matthew Kien-Meng Ly, Kristen Hayashi, Katie Garfield, Amy Rosenberg, and Robert Greenwald.

INTRODUCTION

Massachusetts has a long history of innovative healthcare and public health reforms, and is consistently a national leader in access to health coverage and care. However, serious and often stigmatized diseases such as HIV/AIDS (HIV), hepatitis C (HCV), tuberculosis (TB), and sexually transmitted infections (STIs) continue to pose a challenge to the Commonwealth, especially within marginalized and minority populations. The Massachusetts Department of Public Health (MDPH) reported that "85% of TB cases in 2014 were diagnosed in members of minority groups."[1] Gonorrhea and syphilis—with 3,151 and 701 cases in 2013, respectively—are reported in African Americans and Latinos at least three times more frequently than their Caucasian counterparts.[2] Chlamydia remains the most reported infection in Massachusetts overall, with cases nearly doubling in the last decade to 23,579 in 2013.[3] Despite declining HIV diagnoses in the state, the number of people living with HIV continues to grow as the diagnosis rate exceeds the death rate, with 694 reported cases and 208 deaths in 2012.[4] Overall HCV numbers are on the decline, but with an upswing in youth diagnoses and an estimated 7,000-10,000 reported cases per year, it remains a considerable public health issue for the state.

Over the last decade, Massachusetts health reform and the passage of the Affordable Care Act (ACA) have extended new healthcare opportunities to many Massachusetts residents, allowing citizens across the economic continuum to access quality care through federal, state-based, and private programs regardless of HIV status or other preexisting conditions. Depending on income and other eligibility factors, low-income Massachusetts residents now have several state-based plan categories to choose from, including:

- ***Silver Level Marketplace Plans***: Plans available on the Massachusetts state-based marketplace, which allow low-income residents to benefit from federal cost-sharing and premium tax subsidies,
- ***ConnectorCare Plans***: Plans which allow Massachusetts residents at or below 300% of the Federal Poverty Level (FPL) to receive private insurance coverage while benefiting from further reductions in cost-sharing,[5] and
- ***Massachusetts Medicaid Plans (MassHealth Plans):*** Plans which are available to Massachusetts residents who meet eligibility requirements for Medicaid benefits (*e.g.*, those residents at or below 138%[6] of FPL).[7]

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[1] *Summary Tuberculosis Statistics for the Year 2014,* MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH, *available at* http://www.mass.gov/eohhs/docs/dph/cdc/tb/summary-data-2014.pdf.

[2] *Massachusetts STD, HIV/AIDS and Viral Hepatitis Surveillance Report: 2013*, MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH, *available at* http://www.mass.gov/eohhs/docs/dph/cdc/aids/std-surveillance-2013.pdf.

[3] *Massachusetts STD, HIV/AIDS and Viral Hepatitis Surveillance Report: 2013*, MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH, *available at* http://www.mass.gov/eohhs/docs/dph/cdc/aids/std-surveillance-2013.pdf.

[4] *Massachusetts STD, HIV/AIDS and Viral Hepatitis Surveillance Report: 2013*, MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH, *available at* http://www.mass.gov/eohhs/docs/dph/cdc/aids/std-surveillance-2013.pdf.

[5] *ConnectorCare Plans*, MASSACHUSETTS HEALTH CONNECTOR, *available at* https://betterhealthconnector.com/learn/plan-information/connectorcare-plans.

[6] While the ACA Medicaid expansion limit is 133% of FPL, a 5% income disregard brings the effective income level to 138% FPL.

[7] Many low-income Massachusetts residents also obtain health coverage through Medicare, which is a federal healthcare program. As our focus is on the state-based plan, Medicare plans are not discussed in this report.

Despite improved access to insurance coverage, individuals coping with infectious disease may still encounter significant barriers in accessing the care they need. For example, reports indicate that insurers across the United States may be discouraging certain groups from enrolling in their plans through a practice called “adverse tiering,”[8] in which drugs for specific diseases are routinely placed on the highest cost-sharing tiers, are not covered, and/or have additional restrictions that create substantial barriers to access. Such practices translate into negative consequences for underprivileged populations, as they find themselves barred from medications that improve quality of life, may prevent more costly complications, and might even be life-saving.

This report seeks to determine the prevalence and severity of adverse tiering practices found in silver level, ConnectorCare, and MassHealth plans pertaining to medications for HIV, HCV, TB, and select STIs. Our analysis is set out in the following sections:

- **SECTION I: RESEARCH METHODOLOGY**
- **SECTION II: LIMITATIONS**
- **SECTION III: KEY FINDINGS REGARDING COVERAGE PRACTICES**
- **SECTION IV: KEY FINDINGS REGARDING TRANSPARENCY**
- **SECTION V: RECOMMENDATIONS**

Section I of the report outlines our research methodology, including data collection processes and the rationale behind our analysis parameters. **Section II** offers a brief summary of the limitations regarding the scope and precision of this report. **Section III** examines our findings in terms of tiering and restrictions based on quantitative analysis of formulary data, while **Section IV** highlights transparency issues uncovered through interviews with stakeholders and our own experiences in the research process. Finally, in **Section V**, we conclude with several key recommendations regarding the steps that Massachusetts policymakers can take in order to increase systems-level efficiency and improve public health outcomes within our target research population. Through this analysis, we hope to draw attention to the current provision of medical services to low-income Massachusetts residents coping with infectious disease and ultimately inform policy decisions that facilitate healthcare accessibility and affordability for this group.

[8] Douglas Jacobs and Benjamin Sommers, *Using Drugs to Discriminate —Adverse Selection in the Insurance Market*, 372 N ENGL J MED no. 5, 399, 400 (Jan. 2015).

Glossary

Category	Acronym	Definition
Disease States	HCV	Hepatitis C virus
	HIV	Human immunodeficiency virus
	STI	Sexually transmitted infections
	TB	Tuberculosis
Tiering Levels	NC	Not covered drug
	NPB	Non-preferred brand drug
	SP	Specialty drug
Utilization Management Mechanisms	NMS	No mail service
	PA	Prior authorization
	QL	Quantity limit
	SPO	Specialty pharmacy only
Organizations	CHLPI	Center for Health Law and Policy Innovation
	CRI	Community Research Initiative of New England
	HDAP	HIV Drug Assistance Program
	MDPH	Massachusetts Department of Public Health
Miscellaneous Terms	ACA	Affordable Care Act
	FFS	Fee-for-service
	FPL	Federal poverty level
	NRTI	Nucleoside Reverse Transcriptase Inhibitors

SECTION I: RESEARCH METHODOLOGY

Selection of Prescription Drugs

To begin our analysis, we conducted research to identify the generic and branded forms of commonly-prescribed drugs used in the treatment of each of four primary infectious disease states (HIV, HCV, TB, and STIs). Using this research, we developed a plan analysis tool that categorizes the identified drugs by disease state, disease (*e.g.,* chlamydial infections as a disease within the disease state of STIs), and, where relevant, drug type (*e.g.*, protease inhibitors as a drug type within the category of HIV drugs).[9]

Assessment of Plans

Identification of Plans

After developing our list of relevant HIV, HCV, TB, and STI prescription drugs, we identified relevant public and private plans available in Massachusetts. These plans included: (1) silver level plans available on Massachusetts's state-run marketplace, (2) ConnectorCare plans, and (3) MassHealth plans.[10]

- ***Silver Level Plans:*** Massachusetts provides information regarding the plans available on its state-run marketplace on the Massachusetts Health Connector website (https://betterhealthconnector.com/). Consumers can browse these plans anonymously by providing information regarding their zip code, date of birth, tobacco usage, and coverage start date.[11] We used this tool to identify silver plans for our analysis. While this tool allowed us to identify all silver plans available in a specific zip code, the Health Connector site did not have a state-wide listing of silver plans available, nor could site administrators provide us with one. Therefore, in an attempt to ensure that our analysis was sufficiently comprehensive, we consulted with Massachusetts Enrollment Assisters[12] and conducted a series of "spot checks" using the plan browser tool.[13] Based on this analysis, we were able to identify 19 distinct silver level plans available on the Massachusetts marketplace. These plans were provided by 10 insurance companies.

- ***ConnectorCare Plans:*** Massachusetts provides a complete list of the insurance companies offering ConnectorCare plans on the Health Connector website, along with several brochures specifying basic plan benefits and eligibility requirements.[14] The list includes seven insurance companies offering three different ConnectorCare plans each, for a total of 21 ConnectorCare plans.

[9] For more information regarding the plan analysis tool, please contact the authors at arosenbe@law.harvard.edu and kgarfield@law.harvard.edu.
[10] For more information regarding the reviewed plans, please contact the authors at arosenbe@law.harvard.edu and kgarfield@law.harvard.edu.
[11] *See View Health and Dental Plans Anonymously,* MASSACHUSETTS HEALTH CONNECTOR, https://mahealthconnector.optum.com/individual/ (last visited June 22, 2015).
[12] Specifically, we contacted individuals at Health Care for All, an organization which is listed as an official enrollment assister on the Health Connector website.
[13] To this end, we chose five zip codes intended to represent five distinct regions of the state and documented the silver plans in each region.
[14] *ConnectorCare Plans*, MASSACHUSETTS HEALTH CONNECTOR, https://betterhealthconnector.com/learn/plan-information/connectorcare-plans (last visited June 22, 2015).

- ***MassHealth Plans:*** The MassHealth website does not appear to provide a current list of MassHealth plans.[15] However, the Massachusetts Association of Health Plans recently released a white paper on Massachusetts Medicaid reform, which includes a discussion of the current plans available under the MassHealth program.[16] According to this report, as of November 2014, MassHealth members received coverage under six managed care plans, as well as the MassHealth fee-for-service (FFS) plan.

Data Collection

To assess the adequacy of infectious disease coverage under each of the identified silver level, ConnectorCare, and MassHealth plans, we reviewed formulary and cost-sharing information available via the Health Connector and MassHealth websites as well as via individual insurer websites.[17] For all plans, we assessed the tiering and associated cost-sharing for the drugs contained in our assessment tool. Additionally, we assessed whether each plan applied common utilization management mechanisms—such as prior authorization requirements—to each drug. Notably, while our assessment included generic and brand forms for HIV, HCV, and TB medications, we limited our STI analysis to generic forms, as most STI medications consist of medications widely available as generics.

Additionally, for silver and ConnectorCare plans, we assessed a number of key plan provisions outside of formulary coverage, including plan deductibles, specialist referral requirements, and cost-sharing related to laboratory testing. Research for all three plan categories was conducted between February and June of 2015.[18] For this reason, reported data and analysis may not reflect current plan coverage, as formulary coverage is subject to change. *See* **Section II: Limitations** for more details on this issue.

Analysis

Key Trends Analyzed

After completing data collection for all relevant plans, we conducted an analysis of key trends in the data. This analysis is summarized in **Section III: Key Findings Regarding Coverage Practices**. The analysis focuses on the following three coverage tiers, which are most often associated with increased cost—and therefore more limited access—to the patient:

- ***Non-preferred brand (NPB):*** Refers to drugs that are typically more expensive than generics and preferred brand drugs but cheaper than specialty drugs, and often makes up the highest cost-sharing tier in three-tier formularies,

[15] *See MassHealth*, MASS.GOV, http://www.mass.gov/eohhs/gov/departments/masshealth/ (last visited June 22, 2015).
[16] *The MassHealth Managed Care Program: Opportunities to Encourage Innovation and Improve Efficiency and Stability in the Program*, MASSACHUSETTS ASSOCIATION OF HEALTH PLANS, *available at* http://www.mahp.com/unify-files/MAHP-HMAMedicaidReformWhitePaper.pdf.
[17] Notably, while the anonymous browsing tool on the Health Connector website provides benefit coverage information and formulary links relevant to silver level plans, it provides no such specific information for each of the ConnectorCare plans. Similarly, MassHealth provides formulary information relevant to the state-run FFS program, but no information specific to the MassHealth managed care plans. Therefore for ConnectorCare and MassHealth managed care plans, we visited individual insurer websites to gather data.
[18] For more information regarding the plan analysis, please contact the authors at arosenbe@law.harvard.edu and kgarfield@law.harvard.edu.

- ***Specialty (SP)[19]:*** Generally refers to drugs which require a specialty pharmacy and which are placed on the highest cost-sharing tier when applicable, and
- ***Not covered (NC):*** Refers to drugs that are not covered by the plan and therefore may need to be paid for in-full by the patient.[20]

When applying these categories in our trend analysis, we utilized the "best case scenario" for each medication, considering the generic and brand as a single medication entity. For example, if the generic HIV drug abacavir is listed as a low-cost Tier 1 medication and its brand name counterpart Ziagen is listed as a higher-cost Tier 3 medication in a given formulary, we assume that patients can obtain this drug at the Tier 1 level and thus use that data to evaluate coverage.

The analysis of MassHealth plans differs slightly, in that it focuses on coverage[21] and utilization management mechanisms rather than drug tiering. Our trend analysis does not provide a discussion of drug tiering under MassHealth because state and federal Medicaid regulations limit cost-sharing to nominal amounts for prescriptions drugs, and cost-sharing is generally consistent across the drugs examined in our analysis.[22]

In our summary analysis of MassHealth utilization management mechanisms, we included the following restrictions, which may have an adverse impact on patient access:[23]

- ***Prior authorization (PA):*** Stipulates that the patient and/or provider must request authorization from the insurer before the drug can be prescribed,[24]

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[19] Note that the Specialty tier (SP) is not the same as the Specialty Pharmacy Only restriction (SPO). While it is true that most Specialty drugs require a specialty pharmacy, drugs listed as SPO may be listed under a different cost-sharing bracket, such as NPB.

[20] In many (but not all) cases, a NC drug may be covered if the patient and/or provider fills out prior authorization paperwork and procures documentation substantiating medical necessity for the drug in question. If approved, the drug is often priced at the highest cost-sharing level.

[21] In reviewing our analysis of which drugs are covered under MassHealth, readers should note that MassHealth does provide coverage for prescription drugs not listed as covered in its formulary, provided that the drug is approved by the U.S. Food and Drug Administration (FDA) and manufactured by a company that has entered into a rebate agreement with the Department of Health and Human Services (HHS). Patients must, however, receive prior authorization in order to access such drugs. *See* 130 C.M.R. § 406.412(A)(1) (2015) (coverage of FDA-approved drugs produced by manufacturers who participate in the HHS rebate program); 130 C.M.R. § 406.413(C)(1) (2015) (prior authorization requirement).

[22] 42 C.F.R. § 447.52(b) (2014) (limiting cost-sharing for preferred drugs to $4, and cost-sharing for non-preferred drugs to $8 for individuals with incomes under 150% of FPL); 130 C.M.R. § 450.130(B)(1) (2015) (limiting cost-sharing for pharmacy services to $1 for antihyperglycemics, antihypertensives, and antihyperlipidemics and to $3.65 for all other generic and brand-name drugs); see also 130 C.M.R. § 450.130(A)(3) (2015) (stating that cost-sharing under MassHealth MCO plans cannot exceed the cost-sharing limits for standard MassHealth).

[23] Insurance companies take different approaches to formulary restrictions and do not appear to have collaborated on a uniform labeling framework. For example, prior authorization was often implied in labels such as "PA," "GO," "GR," "brand not covered, generic preferred," and even "NC," depending on the insurance company. Moreover, some designations only pertained to a particular population segment, such as PA required only for adults 18 years of age and up. In our assessment tool, we attempted to capture each restriction in its most unequivocal form and to account for restrictions wherever they appeared, even if they only applied to a specific patient profile. Therefore, we may not have captured every drug that required prior authorization, unless it was specifically designated with the "PA" label. Other restrictions were found in the formularies but were not relevant for our final analysis. For a complete list of drug restrictions and explanations, *see* **Appendix 2**.

[24] Note that we placed drugs in the PA category even if they only required PA for a certain patient profile. For example, a drug listed as "PA if older than 18 years" was considered a general PA drug in our analysis.

- ***Specialty Pharmacy Only (SPO):*** Requires that the drug be obtained through a predetermined network of pharmacies,
- ***Quantity Limit (QL):*** Restricts the amount of medication that the patient can receive within a given timeframe, and
- ***No Mail Service (NMS):*** Excludes the drug from any mail order services available.

<u>Drugs Identified for Detailed Analysis</u>

Our analysis describes trends across all drugs associated with each disease, as well as a more detailed assessment of the coverage of certain drug categories and medications that we identified as particularly crucial to current infectious disease care. Specifically, we identified certain HIV and HCV drugs—or categories of drugs—that warranted specific assessment, based on current clinical guidelines. These drugs include: Nucleoside Reverse Transcriptase Inhibitors (NRTIs), combination drugs, and, in particular, Triumeq, Atripla, Stribild, Truvada, Sovaldi, Harvoni, and Viekira Pak. The reasons for highlighting these drugs are described below.

- ***NRTIs:*** NRTIs constitute some of the most commonly prescribed HIV medications.[25] Guidelines published by the Department of Health and Human Services (HHS) state that treatment for a newly diagnosed HIV patient generally begins with a regimen including two NRTIs and a third drug from another category.[26]
- ***Combination Drugs:*** Combination drugs are key to effective HIV treatment because they allow HIV patients to consolidate their multi-drug regimen (thus improving treatment adherence), making them another commonly recommended and prescribed type of medication.[27]
- ***Triumeq, Atripla, Stribild, and Truvada*:** These four combination drugs appear in Recommended or Alternative treatment regimens in current HHS HIV treatment guidelines.[28][29] Within this group, Triumeq is one of the most recently approved HIV medications (approved August 22, 2014) yet has already received HHS endorsement as part of the Recommended regimen.[30] Truvada is also distinguished here for its use in pre-exposure prophylaxis (PrEP) to actually prevent, rather than just treat, HIV infection.[31]

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[25] Douglas Jacobs and Benjamin Sommers, *Using Drugs to Discriminate —Adverse Selection in the Insurance Market*, 372 N ENGL J MED no. 5, 399, 401 (Jan. 2015).

[26] *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents*, AIDSINFO, F-1, *available at* https://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf.

[27] *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents*, AIDSINFO, F-1, *available at* https://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf.

[28] *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents*, AIDSINFO, F-1 & F-3, *available at* https://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf.

[29] Two new combination HIV medications, Evotaz (atazanavir and cobicistat) and Prezcobix (darunavir and cobicistat), were approved by the FDA in January, 2015, and appear in the HHS HIV guidelines as part of Alternative regimens. Due to the newness of these drugs, we were not able to capture them in our analysis.

[30] *HIV Treatment: FDA-Approved HIV Medicines*, AIDSINFO, *available at* https://aidsinfo.nih.gov/education-materials/fact-sheets/21/58/fda-approved-hiv-medicines.

[31] *Pre-Exposure Prophylaxis (PrEP)*, CENTERS FOR DISEASE CONTROL AND PREVENTION, *available at* http://www.cdc.gov/hiv/prevention/research/prep/.

- ***Sovaldi, Harvoni, and Viekira Pak:*** Between November 2013 and October 2014, the FDA approved these three drugs as the first curative treatments for HCV.[32] Current treatment guidelines recommend that most individuals living with HCV receive these drugs.

[32] *FDA approves Viekira Pak to treat hepatitis C*, FOOD AND DRUG ADMINISTRATION, available at http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm427530.htm.

SECTION II: LIMITATIONS

While performing our research and data analysis, we encountered a number of obstacles which may have impacted our data. These obstacles include:

- ***Variation in Naming/Listing of Drugs:*** At times, we were unable to determine whether certain drugs — particularly those associated with STI treatment — were referred to by other names. Coupled with the often limited search capabilities in certain formularies, the ambiguity around medication names could have prevented us from capturing the full spectrum of drug coverage under each plan.
- ***Timing of Analysis:*** As noted above, we collected formulary data from February to June of 2015. Insurance companies alter and update their formularies on a rolling basis, a trend we observed even within this short timeframe. Our analysis is meant to represent coverage at a particular moment in time and may not be consistent with current benefits and drug coverage under some plans.
- ***Lack of Comprehensive State-Level Data:*** Lastly, we previously noted that obtaining a definitive list of silver level plans was difficult. Although we believe that the measures taken resulted in a complete list, it is still possible that we did not account for other individual/family silver level plans that may exist in the state.

SECTION III: KEY FINDINGS REGARDING COVERAGE PRACTICES

Executive Summary of Trends

Though most plans utilized distinct tiering and restriction methods, our analysis revealed broad, category-specific trends that spanned across nearly all silver, ConnectorCare, and MassHealth plans, namely the following:

- ***TB:*** In general, almost all plans assigned at least a quarter of assessed TB medications to NPB, SP or NC status; however, very few plans put over half of all assessed TB drugs into those categories.
- ***STI:*** Overall STI drug coverage, which includes medications for all four STI diseases analyzed, was characterized by a pattern similar to that of TB: most plans did not appear to cover at least 25% of assessed STI drugs, but there were few that declined to cover more than 50% of them. However, it should be noted that, due to transparency issues, it is likely that these figures underestimate coverage of STI medications in some instances.[33] Drugs for syphilis (along with congenital syphilis) tended to be the most restricted, while chlamydia medications were most associated with lower-cost tiers.
- ***HIV:*** HIV drug coverage as a whole was found to be fairly comprehensive within all three groups of plans. However, we did note some problematic practices with respect to combination HIV medications, which were more prevalent on the highest cost-sharing tiers than total HIV drugs. MassHealth proved to be the exception, offering comparatively thorough coverage of all HIV medications, including combination drugs. We found that plans often listed newly FDA-approved HIV medications (*e.g.*, Triumeq) as NPB, SP, or NC.
- ***HCV:*** Across all private and public plans, we observed the most troubling adverse tiering practices in HCV medications. When combined, over half of all silver and ConnectorCare plans listed 75% or more of assessed HCV drugs on the highest tier or offered no coverage at all. Sovaldi, Harvoni, and Viekira Pak were considered NPB, SP, or NC on the majority (about 75-85%) of private plans, and often required PA or SPO to obtain them. All MassHealth plans either required PA for these drugs or did not cover them.
- ***Overall Cost-sharing:*** There were no drug-specific deductibles on any plan analyzed. Moreover, no ConnectorCare plans featured plan deductibles or any cost-sharing for lab work. Of 19 silver plans, eight plans had copayments for lab work ranging from $10-75, while two others had a 20% coinsurance fee for lab work. In-network silver plan annual deductibles ranged from $1,750-$2,000 per person.[34] All MassHealth plans offered copayment caps on out-of-pocket costs for prescription drugs, which ranged from $200-$250 per person per year.

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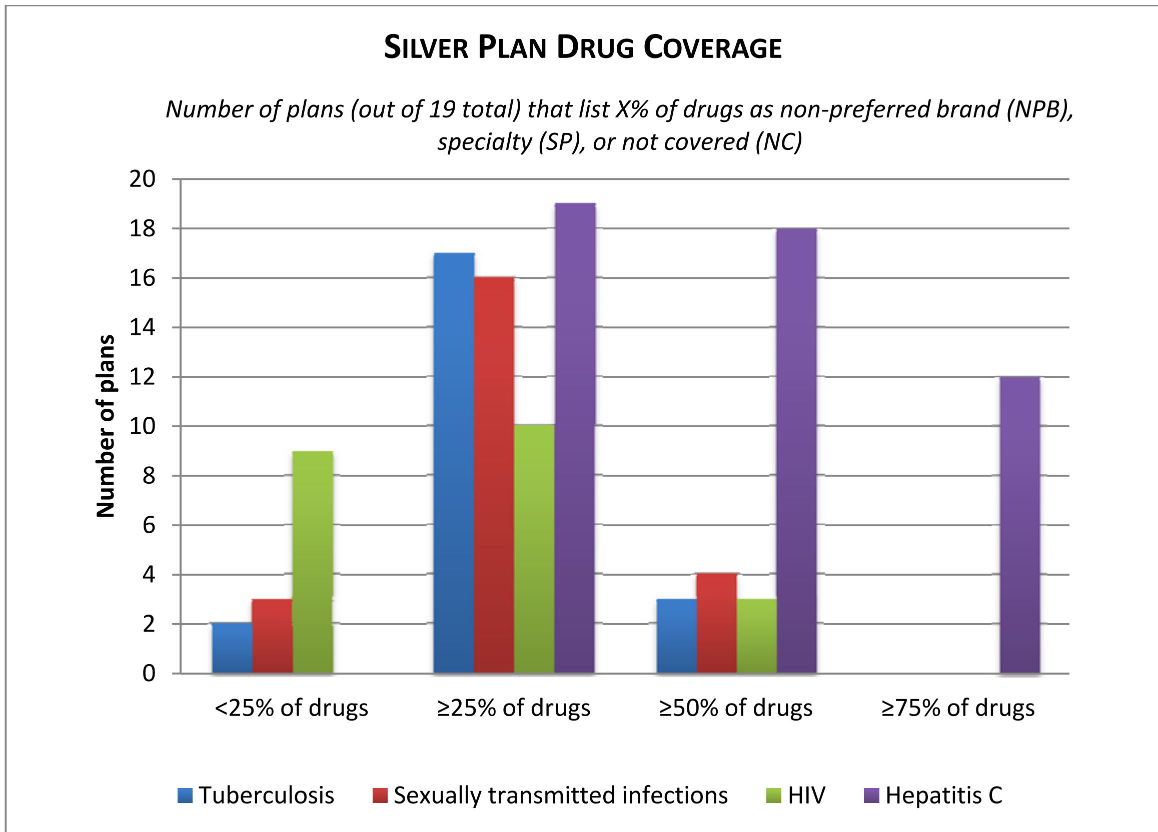
[33] We decided to group STI formulary data by disease state rather than conflating medication coverage of various STIs, with the understanding that the former would be far more helpful to patients with medication needs related to a specific STI. However, this necessarily stipulated the duplication of drugs in our analysis, as certain antibiotics are prescribed for both gonorrhea and syphilis, for example. Due to these duplicate entries, it is likely that total STI findings are less robust than those of HIV, HCV, and TB.

[34] Note that these figures are based upon the standard plan cost-sharing amounts and do not take into account cost-sharing subsidies available for many low-income individuals who are covered by silver plans.

Silver Plans



<u>*TB and STI Medications*</u>

Overall, we observed some adverse tiering techniques imposed on TB and STI medications within silver level marketplace plans.[35] Out of 19 plans, three listed at least half of the assessed TB medications as NPB, SP, or NC. STI drug coverage depended on the specific disease state, but overall, 16 out of 19 plans listed at least 25% of STI medications as NPB, SP, or NC, and four of these plans placed 50% or more of STI drugs in those categories.[36]

<u>*HIV Medications*</u>

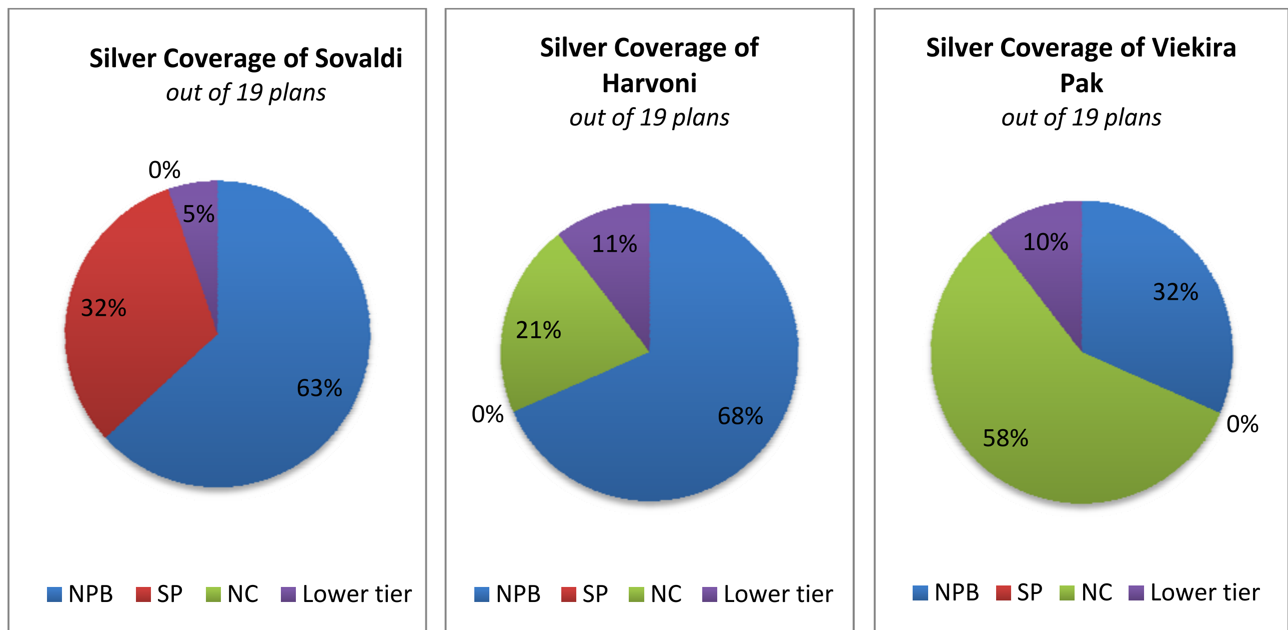
As shown in the above chart, nine out of 19 silver plans placed less than 25% of total assessed HIV drugs on one of the three restrictive tiers. A more detailed analysis is available in **Appendix 1**. As explained in **Appendix 1** (though not reflected in the chart above), most NRTIs were

[35] The analysis refers to the medications pertaining to each respective disease state that our team deemed appropriate to examine. There may be other drugs covered by these plans for which we did not account. For more information on the drugs assessed please contact the authors at arosenbe@law.harvard.edu and kgarfield@law.harvard.edu.

[36] Please note that the analysis is cumulative. A plan that lists 50% or more of its HCV drugs as NPB, SP, or NC also necessarily places 25% or more of its HCV drugs into those categories. Therefore, plans may fall into multiple percentage categories.

covered and placed on lower-cost tiers. However, five out of 19 plans listed 50% or more of assessed combination drugs as NPB, SP, or NC, and three of those plans placed over 75% of them into those categories. Triumeq and Stribild were listed as NPB, SP, or NC on 14 and 11 plans out of 19 plans, respectively, though neither drug was subjected to widespread use of utilization management mechanisms, such as prior authorization.

HCV Medications

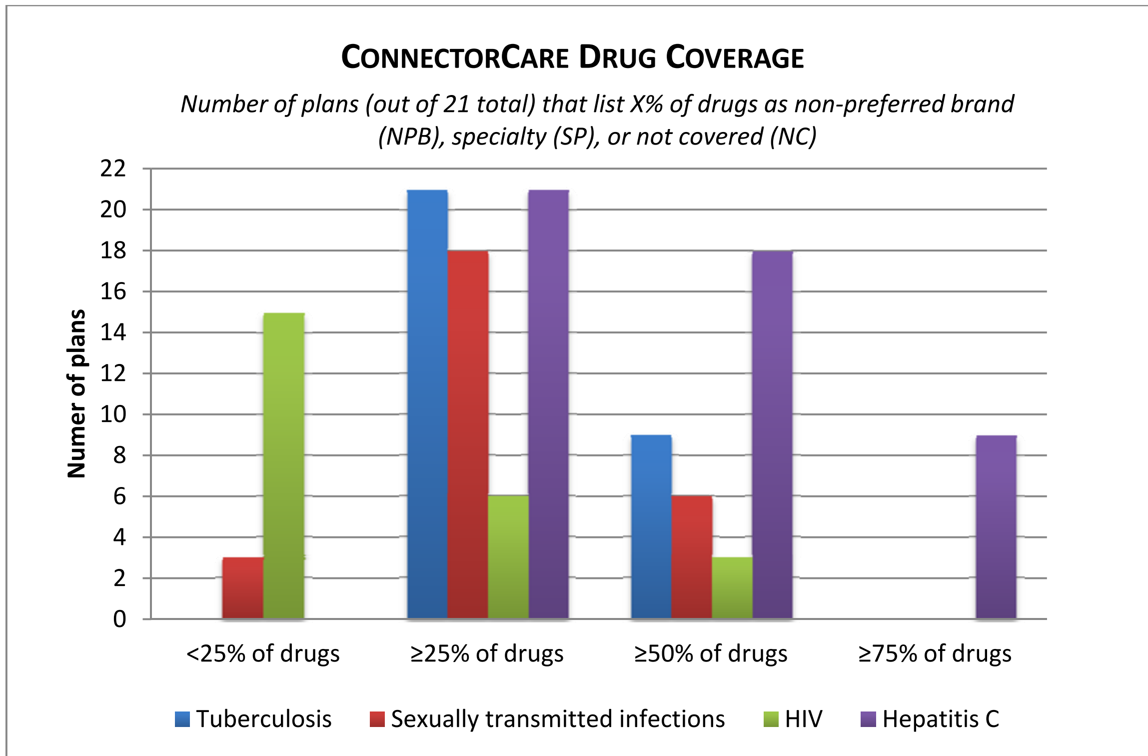


The most alarming adverse tiering trends emerged with respect to the eight HCV medications included in our assessment tool. Of the 19 plans examined, 18 relegated at least half of these eight HCV medications to NPB, SP, or NC status, while 12 of them listed 75% or more of these drugs on those tiering levels. All three of the individual curative HCV medications that we evaluated—Sovaldi, Harvoni, and Viekira Pak—were placed on the highest tier or not covered at all on at least 17 out of 19 plans. Viekira Pak, in particular, had extremely low levels of coverage, with 11 plans failing to cover it at all.

Although not reflected in the charts above, our analysis also indicated noteworthy trends in the use of utilization management mechanisms to restrict access to key HCV drugs. For example, 15 silver plans required patients to obtain Sovaldi through a specialty pharmacy, while *all* silver plans required patients to receive prior authorization for Sovaldi. Similarly, 15 plans required prior authorization for patients to access Harvoni, while eight required prior authorization for Viekira Pak.[37]

[37] Note that the difference in prior authorization requirements between Sovaldi, Harvoni, and Viekira Pak is likely largely due to the fact that fewer plans provide coverage for Harvoni and Viekira Pak than for Sovaldi.

ConnectorCare Plans



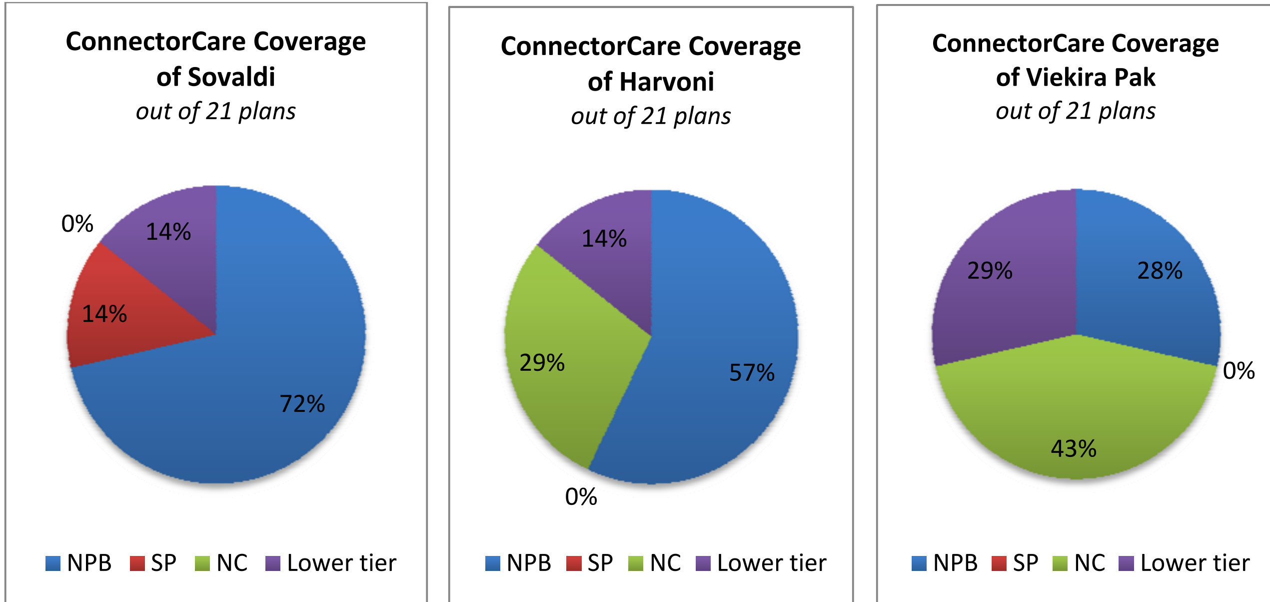
TB and STI Medications

As with silver level plans, almost all ConnectorCare plans listed at least a quarter of assessed STI and TB drugs as NPB, SP, or NC (18 and 21 plans, respectively, out of 21 total ConnectorCare plans available). Six of these plans placed 50% or more of assessed STI drugs in these restrictive groups while nine plans did the same for TB medications.

HIV Medications

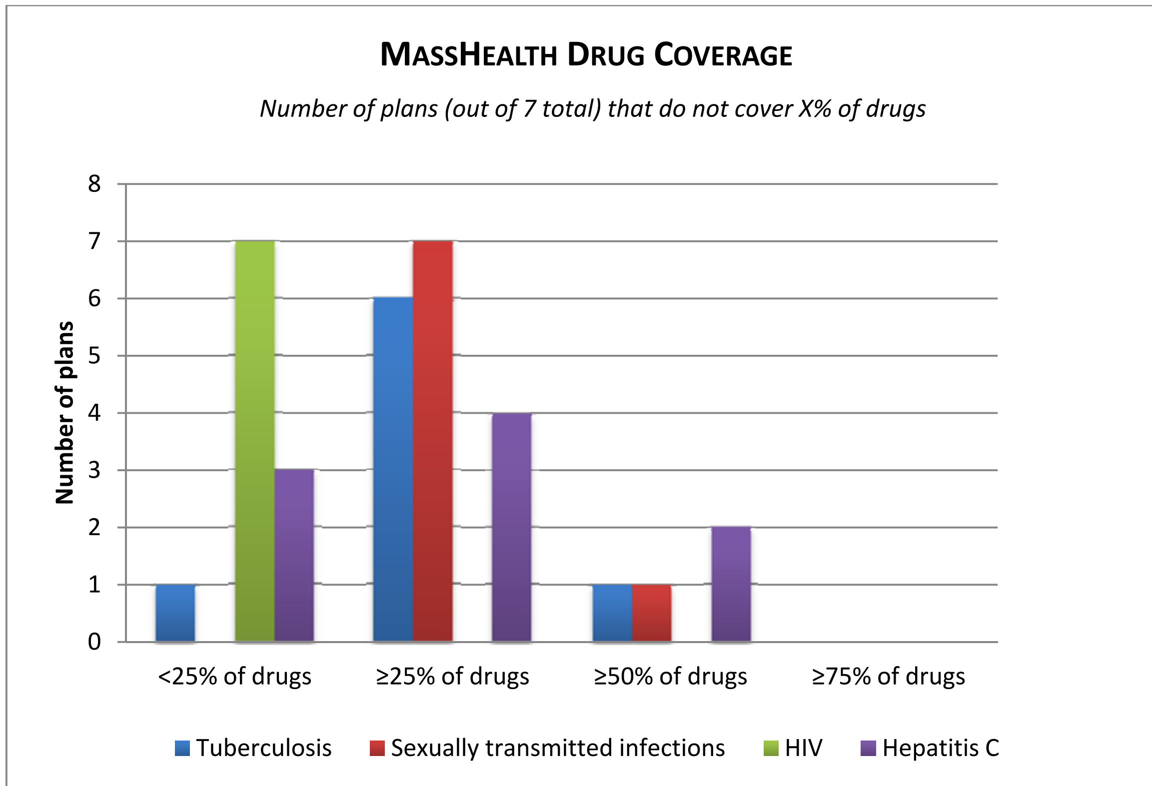
Six out of 21 ConnectorCare plans listed 25% or more of total assessed HIV medications as NPB, SP, or NC, and three of those plans placed 50% or more of total HIV drugs into those categories. While not reflected in the chart above, when only looking at combination drug coverage, the coverage trend is even more alarming. *See* **Appendix 1.** Combination drugs are listed as NPB, SP, or NC at least 50% of the time on six out of the 21 plans and over 75% of the time on three of those plans. This trend was particularly concerning when looking at one of the most recently approved combination drugs—Triumeq. Triumeq was placed in one of the three restrictive tiers on 15 out of 21 plans; in nine of those 15 instances, it was not covered at all.

HCV Medications



HCV medications again proved to be the most restricted and least covered drug group in our analysis. Among ConnectorCare plans, Sovaldi and Harvoni were listed as NPB, SP, or NC on 18 out of 21 plans, while Viekira Pak was listed as NPB, SP, or NC on 15 out of 21 plans. All plans provided coverage of Sovaldi. However, *all* of these plans required patients to receive prior authorization and 85% of plans required patients to obtain the drug from a specialty pharmacy. These restrictions were slightly less common for Harvoni and Viekira Pak, most likely due to a complete lack of coverage of these drugs on six and nine plans, respectively.

MassHealth Plans



TB and STI Medications

In general, MassHealth coverage appeared to be relatively extensive at the time of research, although some drug inclusion discrepancies were noted between the MassHealth fee-for-service plan and the managed care plans, as the former tended to be more inclusive. We noticed that most plans (six out of seven) left 25% or more of assessed TB medications without coverage,[38] while one of those plans did not cover 50% or more of these drugs; a very similar tendency was found in STI medications.

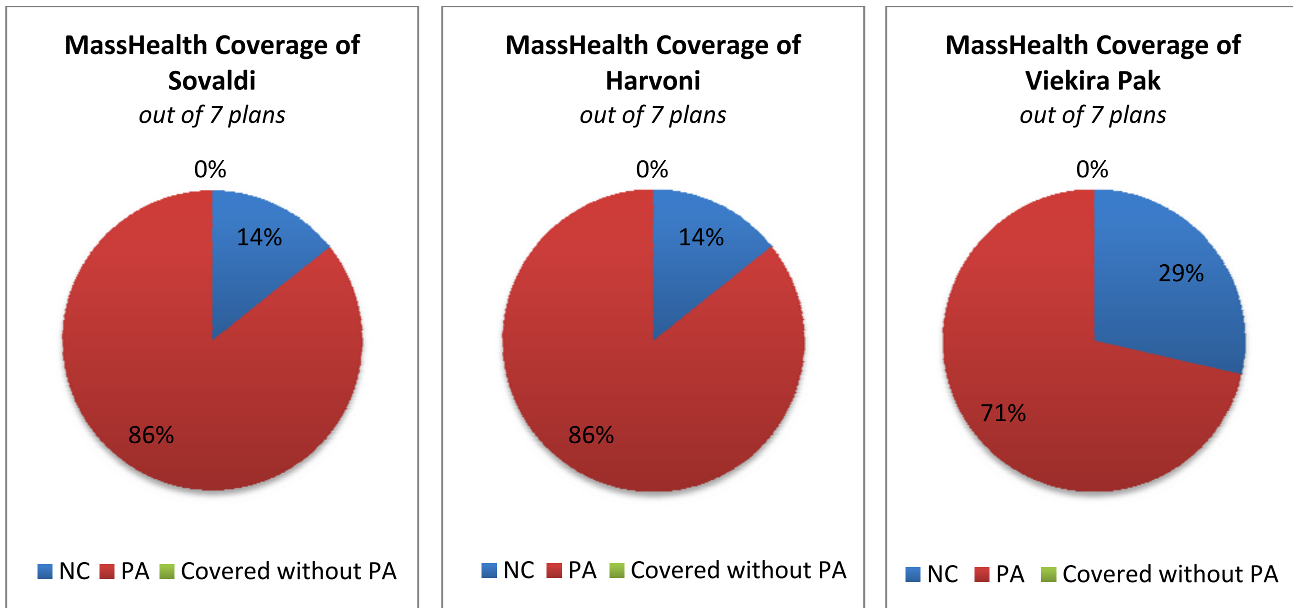
HIV Medications

MassHealth generally offered comprehensive and affordable coverage for HIV medications across the board, with all fee-for-service and managed care plans listing less than 25% of HIV medications as NC. Similarly, although not reflected in the chart above, no plan labeled over 25% of total assessed HIV-related drugs with PA or SPO restrictions, and most HIV medications were available to patients at a cost-sharing rate of $3.65 per prescription. Even combination HIV

[38] Again, it should be noted that lack of coverage in MassHealth formularies generally indicates that the patient must receive prior authorization to obtain coverage because Medicaid plans must cover all FDA-approved drugs that are produced by pharmaceutical companies that participate in the HHS rebate program.

medications—which appeared to be disproportionately restricted in silver and ConnectorCare plans—were ubiquitously covered with only minor restrictions.

HCV Medications



However, we still observed glaring restriction divergence between HCV drugs and all other medications analyzed. Nearly every MassHealth plan (six out of seven, including the MassHealth fee-for-service plan and five managed care plans) required PA on at least half of the HCV drugs assessed, and two of those plans required PA on all of them. Most plans covered Sovaldi, Harvoni, and Viekira Pak; however, they all required PA when covered.

Recent CHLPI research regarding the Sovaldi coverage has also revealed additional barriers to HCV medications within the MassHealth fee-for-service and managed care options. As noted in CHLPI's recent report on HCV treatment access, in late 2014, the MassHealth fee-for-service plan required prior authorization for Sovaldi, but did not appear to use substance use or fibrosis levels as criteria for drug eligibility.[39] On the other hand, all four of the MassHealth managed care plans that made prior authorization requirements available at the time of the report required patients to abstain from substance use for six months and to obtain a prescription from a gastroenterologist, hepatologist, or infectious disease specialist. Most managed care plans also required documentation of substantial liver damage (fibrosis at a Metavir level of F3-F4 or equivalent) or co-infection with HIV.

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[39] *Examining Hepatitis C Virus Treatment Access: A Review of Select State Medicaid Fee-for-Service and Managed Care Programs*, CENTER FOR HEALTH LAW AND POLICY INNOVATION OF HARVARD LAW SCHOOL, 24-25.

SECTION IV: KEY FINDINGS REGARDING TRANSPARENCY

In the course of our research we encountered a number of issues related to plan transparency that warrant further examination. In particular, we encountered difficulties related to: (1) accessing key information online; (2) using drug search features; (3) and interpreting tiering and restriction listings. In order to understand how these and other transparency-related issues were impacting patients on the ground, we consulted with local stakeholders involved in providing access to HIV treatment. These stakeholders expressed similar concerns and also noted issues related to the design of the Health Connector website as well as to the customer service and correspondence practices employed by entities such as the Health Connector and MassHealth.

Web Page Issues

Important Information Difficult to Access Online

As mentioned above in **Section I: Research Methodology**, we were unable to obtain a comprehensive list of silver level marketplace plans, largely because a state-wide list of silver plans and providers did not appear to be available online. Several calls to the Health Connector help line suggested that even Health Connector representatives were unsure if such a list existed. This barrier prevented us from confirming a complete dataset and also suggested that key information was not accessible to the public or all Health Connector representatives.

Unlike silver plans, a complete list of ConnectorCare providers was prominently displayed on the Health Connector website. However, direct links to providers' formularies were not displayed on the website when using the anonymous browsing tool; this was not the case for silver level plans, which offered links to providers' pharmacy pages directly when browsing the Health Connector website. For ConnectorCare plans, patients attempting to assess specific drug coverage could not do so through the Health Connector site without creating an account. Instead, patients would have had to visit each insurance company's website separately, creating unnecessarily and often difficult, if not impossible, steps to locate this critical information.

Formulary Issues

Drug Search Limitations

In searching for coverage of specific medications, we encountered several problems within provider drug lists that needlessly impeded access to drug coverage information. As noted in **Section II: Limitations**, multiple names for the same medication and drug name misspellings (e.g., "Vitekta" listed as "Viteka") within private and public formularies led to less robust research findings in this report; it also could have limited a patient's ability to find cost-sharing information on drugs vital to their health.

The MassHealth fee-for-service online drug list also stated that those searching for coverage of a particular drug could "select a letter to see drugs listed by that letter, or enter the name of the drug [they] wish to search for."[40] However, the latter search option often only worked for brand name drugs. In order to find coverage information on generics, the more time-consuming letter

[40] *MassHealth Drug List A-Z*, HEALTH AND HUMAN SERVICES, *available at* https://masshealthdruglist.ehs.state.ma.us/MHDL/pubdruglist.do.

option was required. As this caveat was not publicly displayed in the online formulary, beneficiaries could have erroneously been led to believe that their generic medications were not covered.

Inconsistent Tiering and Labeling

Across all three plan groups, we noticed a pattern of highly confusing labels used to designate utilization management mechanisms. For example, the "brand not covered, generic preferred" label found in Minuteman and Health New England formularies signified that the brand drug in question had a covered generic form, therefore the former would only be covered if medical necessity was established and prior authorization was approved. Other insurance providers offered their own unique codes or even listed the drug as "not covered" to convey the same idea, with slight variations in authorization processes.[41] Incoherent or contradictory labeling may have resulted in patient confusion, hindering access for the average beneficiary seeking to compare drug coverage across plans.

In addition to confusing labeling, the unconventional tiering structures utilized in MassHealth plans also might have created confusion for beneficiaries. Several plans, including those from Tufts Health Plan and Boston Medical Center, represented two cost-sharing prices on a single tier. In such cases, Tier 1 covered generic antihyperglycemics, antihypertensives, and antilipidemics with a $1.00 copay as well as generic drugs for all other conditions with a $3.65 copay. In another instance, Fallon Health set up a three-tier formulary for its MassHealth plan in which Tier 2 represented most generic and over-the-counter (OTC) drugs. In practice, however, every medication chosen for analysis—brand and generic alike—was placed on Tier 2.

Issues Identified by Stakeholders

As part of our analysis, we reached out to the Community Research Initiative of New England (CRI) — Massachusetts's HIV Drug Assistance Program (HDAP) contractor — in order to learn about their "on the ground" experience working with the Massachusetts healthcare system and accessing plans for clients. Interviews with HDAP employees revealed disconcerting transparency issues with respect to all three plan groups, particularly MassHealth.

Website Ambiguities

CRI reported that vague messaging on the Health Connector website — particularly the online sign-up tool — tended to complicate insurance processes for beneficiaries, case managers, and the community-based groups aiming to support them. For instance, the online application asked applicants if they would like to find out if they could "get help paying for some or all of [their] health insurance," instead of asking them whether they would like to be considered for MassHealth, ConnectorCare, or any healthcare subsidies.[42] Many applicants were confused by the question and clicked "no," which subsequently removed all lower-cost options from their plan search results. Ambiguities like these may have prevented qualified individuals from obtaining lower-cost care.

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[41] *See* **Appendix 2** for a complete list of labels and their respective definitions by insurance provider.
[42] *May 8, 2015, Boston Public Stakeholder Session Letter,* MASSACHUSETTS HIV DRUG ASSISTANCE PROGRAM (on file with CHLPI).

Stakeholders also reported that it was difficult to identify plans on the Health Connector website with low cost-sharing for the medical services most utilized by individuals coping with infectious disease. This difficulty sometimes stemmed from uncertainty around whether the Health Connector website was accounting for subsidies in its calculations and presentation of costs — an important piece of information that should have been clearly delineated on the plan comparison page.

Problematic Customer Service

Overall customer service for both MassHealth and the Health Connector was also reported to be problematically uninformed, disorganized, and/or encumbered by the sheer volume of beneficiaries who required assistance. Consumers recounted incredibly long wait times on customer service help lines, frequent disconnections, transfers to numerous departments, and receiving conflicting and sometimes inaccurate information. When beneficiaries called with inquiries regarding their status or coverage, they were often transferred back and forth between MassHealth and the Health Connector, each claiming that the other entity should provide the answers they sought. Even HDAP and CHLPI researchers reported receiving "courtesy disconnections" from MassHealth, only to be called back weeks later or not at all. Some stakeholders believed that the customer service departments had been contracted out to an outside entity (Maximus), and it was unclear whether the employees of that entity received adequate training.

Lack of Accountability to Public Regarding Critical Correspondence

As a payer of last resort for HIV patients, HDAP depends on prompt receipt of MassHealth determination letters in order to confirm client eligibility and comply with applicable HRSA rules and policies. During the 2015 enrollment period, CRI reported that some beneficiaries waited months to receive MassHealth determination notices while others simply did not receive them at all. Moreover, eligibility notices that denied MassHealth coverage to prospective participants often did not offer a clear reason for coverage denial. These issues not only created serious setbacks for CRI but also could have adversely impacted health outcomes in already vulnerable groups.

A lack of clear and consistent communication to beneficiaries also led to misunderstandings that jeopardized their health insurance status. CRI employees reported that network glitches on the Health Connector website offered ConnectorCare plans to residents who already had insurance (employer-based or otherwise), which should have rendered them ineligible for ConnectorCare enrollment. It was not apparent that the public was notified of the error, which may have resulted in beneficiaries discarding their viable insurance plans under the erroneous assumption that they qualified for lower-cost ConnectorCare plans. This apparent lack of communication occurred in MassHealth as well, most notably when customers were provided with letters of MassHealth coverage confirmation that did not specify whether the coverage was temporary or regular; many of those unaware that they received temporary coverage lost their insurance without notice.

SECTION V: RECOMMENDATIONS

In recent years, Massachusetts has endeavored to pioneer progressive reforms that expand healthcare coverage and to that end, the state has succeeded: as of 2012, nearly all state residents were covered and constituents reported greater access to quality health services.[43] Nevertheless, our quantitative and qualitative research into the Massachusetts healthcare system indicates that there is room for improvement, particularly with respect to coverage of newly-approved HIV and HCV medications, providing consumers with easily accessible sources of information, and facilitating communication among MassHealth, the Health Connector, and consumers.

Access to Innovative Drugs

While Massachusetts plans appear to be providing more comprehensive access to many drugs than other states,[44] we continue to experience issues with respect to certain HIV and HCV medications. In particular, we recognize a pattern of adverse tiering and enhanced utilization management pertaining to new drugs such as the Triumeq, Stribild, and the recently approved cures for HCV. This trend is likely due to the nature of the pharmaceutical market, with pharmaceutical companies imposing higher prices for new and innovative medications. Over time, these costs decline as additional new drugs are brought to market that are capable of competing with these innovative medications. However, in the interim, both private and public plans in Massachusetts show a tendency towards restricting access, likely in an attempt to keep costs down. This trend is problematic, as many of these new drugs—including drugs such as Sovaldi, Harvoni, Viekira Pak, Stribild and Triumeq—are part of the recommended course of treatment under relevant guidelines, and often cost-effective in the long-term.

We therefore recommend that Massachusetts policymakers examine this issue and make efforts to ensure that new and medically recommended drugs are not inaccessible to low-income individuals. Specifically, we recommend that MassHealth make efforts to ensure that prior authorization requirements accurately reflect current treatment guidelines and that managed care plans do not place greater restrictions upon these medications than are allowed under the fee-for-service system. In order to fully understand the burden that prior authorization places on individuals, we also suggest that the state obtain concrete data on the rate at which prior authorization requests are approved, as well as the average wait time from submission to approval. Additionally, we recommend that the Department of Insurance (DOI) examine marketplace treatment of these plans. In particular, the DOI should ensure that private insurers are not using scientifically unfounded requirements to discriminate against consumers on the basis of health condition. Other Massachusetts policymakers and stakeholders, such as MDPH, community health centers, provider associations, and consumer groups, should support these efforts and devote resources to educating insurers on the importance of maintaining access to these drugs.

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[43] *Massachusetts Healthcare Reform: Six Years Later*, KAISER FAMILY FOUNDATION, *available at* https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8311.pdf.

[44] Research pertaining to adverse tiering of NRTIs in 12 other states revealed severe and pervasive adverse tiering practices that were not observed in Massachusetts for NRTI medications. For more details, see Douglas Jacobs and Benjamin Sommers, *Using Drugs to Discriminate —Adverse Selection in the Insurance Market*, 372 N ENGL J MED no. 5, 399-402, (Jan. 2015).

User-Friendly Sources of Information for Consumers

Improving the availability and clarity of healthcare information resources, including relevant websites and the customer service help line, could ameliorate much of the consumer doubt and frustration that plagues the current system. Simplifying and clarifying overly technical or ambiguous wording on related web pages would be a boon to consumers, especially to the less educated and those who speak English as a second language. We therefore recommend that the state examine its Health Connector and MassHealth websites in order to identify and address potentially confusing language and processes. For example, the state should alter its online application question regarding financial aid to specifically ask if the applicant would like to be screened for MassHealth.

Additionally, we recommend that Massachusetts devote additional resources to ensuring that their customer service departments are adequately staffed and that representatives receive sufficient and on-going training, as each enrollment period produces new challenges to address. The state should also encourage communication and coordination among employees of all Massachusetts health entities—including MassHealth, MDPH, and the Health Connector—so that each entity is aware of their specific duties and responsibilities in order to serve the consumer in the most efficient way possible.

As with our recommendation regarding innovative drugs, we recommend that other Massachusetts stakeholders take steps to support the efforts to address these issues. For example, stakeholders working with individual patients should work to ensure that policymakers are aware of key issues that patients encounter when attempting to access coverage.

Streamlined Communication from Healthcare Programs to Consumers

Given available resources and capabilities, Massachusetts should oversee the correspondence of critical documents to consumers, as the delay of such notices can interrupt patients' access to vital medications and healthcare services. Most notably, the state must be vigilant to ensure the prompt dispatch of Health Connector and MassHealth determination letters so that organizations such as HDAP can distribute funds promptly.

Moreover, MassHealth and the Health Connector would do well to collaborate on a more unified eligibility notification system, emphasizing intelligible explanations and "next steps" for accepted beneficiaries. The state should also ensure that MassHealth denial letters explicitly state the reason for rejection in language that is accessible to the average beneficiary.

APPENDIX 1: FORMULARY DATA ANALYSIS DETAILS

Our analysis of key trends in formulary coverage is summarized above in **Section III: Key Findings Regarding Coverage Practices**. The charts in this appendix provide a more detailed summary of the underlying data that supports that analysis.

Silver Plans

MA SILVER PLAN ANALYSIS: DRUG CATEGORIES			# of plans with X% of drugs listed as NPB				# of plans with X% of drugs listed as SP				# of plans with X% of drugs listed as NC				# of plans with X% of drugs listed as NPB, SP, or NC				
DISEASE	CATEGORY	Total # of drugs per category	(out of 19 total plans)																
			≥25%	≥50%	≥75%	100%	≥25%	≥50%	≥75%	100%	≥25%	≥50%	≥75%	100%	<25%	≥25%	≥50%	≥75%	100%
HIV	Nucleoside Reverse Transcriptase Inhibitors	7	3	0	0	0	0	0	0	0	0	0	0	0	15	4	0	0	0
HIV	Combination HIV Medicines	9	4	3	3	0	0	0	0	0	2	0	0	0	9	10	5	3	0
HIV	**HIV TOTALS**	**35**	**4**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**9**	**10**	**3**	**0**	**0**
HCV	Other (all except Solvadi, Harvoni, Viekira Pak)	5	4	4	3	0	2	2	2	0	8	1	0	0	5	14	13	10	0
HCV	**HCV TOTALS** (all including Solvadi, Harvoni, Viekira Pak)	**8**	**16**	**9**	**3**	**0**	**6**	**2**	**0**	**0**	**11**	**1**	**0**	**0**	**0**	**19**	**18**	**12**	**0**
TB	**TB TOTALS**	**15**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**12**	**0**	**0**	**0**	**2**	**17**	**3**	**0**	**0**
STI	Chlamydial Infections (Chlamydia)	7	2	0	0	0	0	0	0	0	0	0	0	0	17	2	0	0	0
STI	Gonococcal Infections (Gonorrhea)	7	0	0	0	0	0	0	0	0	19	12	0	0	0	19	12	0	0
STI	Syphilis	8	1	0	0	0	0	0	0	0	16	13	0	0	2	17	13	0	0
STI	Congenital Syphilis	4	3	1	0	0	0	0	0	0	19	16	13	13	0	19	17	16	13
STI	**STI TOTALS**	**26**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**9**	**3**	**0**	**0**	**3**	**16**	**4**	**0**	**0**

MA SILVER PLAN ANALYSIS: SPECIFIC DRUGS		# of plans with drugs listed NPB		# of plans with drugs listed SP		# of plans with drugs listed NC		# of plans with drugs listed NPB, SP, or NC		# of plans with drug listed PA		# of plans with drug listed QL		# of plans with drug listed SPO		# of plans with drug listed NMS	
DISEASE	SPECIFIC DRUG	(out of 19 total plans)															
		#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
HIV	Triumeq	5	26.3%	9	47.4%	0	0.0%	14	73.7%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
HIV	Atripla	5	26.3%	0	0.0%	0	0.0%	5	26.3%	2	10.5%	2	10.5%	0	0.0%	0	0.0%
HIV	Stribild	9	47.4%	0	0.0%	2	10.5%	11	57.9%	1	5.3%	0	0.0%	0	0.0%	0	0.0%
HIV	Truvada	3	15.8%	0	0.0%	0	0.0%	3	15.8%	2	10.5%	2	10.5%	0	0.0%	0	0.0%
HCV	Sovaldi	12	63.2%	6	31.6%	0	0.0%	18	94.7%	19	100.0%	8	42.1%	15	78.9%	8	42.1%
HCV	Harvoni	13	68.4%	0	0.0%	4	21.1%	17	89.5%	15	78.9%	6	31.6%	8	42.1%	8	42.1%
HCV	Viekira Pak	6	31.6%	0	0.0%	11	57.9%	17	89.5%	8	42.1%	2	10.5%	5	26.3%	3	15.8%

ConnectorCare

CONNECTORCARE PLAN ANALYSIS: DRUG CATEGORIES			# of plans with X% of drugs listed as NPB				# of plans with X% of drugs listed as SP				# of plans with X% of drugs listed as NC				# of plans with X% of drugs listed as NPB, SP, or NC				
DISEASE	CATEGORY	Total # of drugs per category	(out of 21 total plans)																
			≥25%	≥50%	≥75%	100%	≥25%	≥50%	≥75%	100%	≥25%	≥50%	≥75%	100%	<25%	≥25%	≥50%	≥75%	100%
HIV	Nucleoside Reverse Transcriptase Inhibitors	7	0	0	0	0	0	0	0	0	0	0	0	0	21	0	0	0	0
HIV	Combination HIV Medicines	9	3	3	3	0	0	0	0	0	3	0	0	0	15	6	6	3	0
HIV	Other HIV Medications	19	3	3	0	0	0	0	0	0	0	0	0	0	18	3	3	0	0
HIV TOTALS		**35**	**3**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**15**	**6**	**3**	**0**	**0**
HCV	Sovaldi, Harvoni, Viekira Pak	3	15	12	6	6	3	0	0	0	12	3	0	0	0	21	18	12	12
HCV	Other (all except Solvadi, Harvoni, Viekira Pak)	5	3	3	3	0	3	3	3	0	9	3	0	0	6	15	12	9	0
HCV TOTALS		**8**	**15**	**9**	**3**	**0**	**3**	**3**	**0**	**0**	**12**	**3**	**0**	**0**	**0**	**21**	**18**	**9**	**0**
TB TOTALS		**15**	**6**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**12**	**0**	**0**	**0**	**0**	**21**	**9**	**0**	**0**
STI	Chlamydial Infections (Chlamydia)	7	3	0	0	0	0	0	0	0	0	0	0	0	18	3	0	0	0
STI	Gonococcal Infections (Gonorrhea)	7	0	0	0	0	0	0	0	0	21	12	0	0	0	21	12	0	0
STI	Syphilis	8	3	0	0	0	0	0	0	0	18	12	0	0	0	21	12	0	0
STI	Congenital Syphilis	4	6	3	0	0	0	0	0	0	21	18	12	12	0	21	21	18	12
STI TOTALS		**26**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**12**	**6**	**0**	**0**	**3**	**18**	**6**	**0**	**0**

CONNECTORCARE PLAN ANALYSIS: SPECIFIC DRUGS		# of plans with drugs listed NPB		# of plans with drugs listed SP		# of plans with drugs listed NC		# of plans with drugs listed NPB, SP, or NC		# of plans with drug listed PA		# of plans with drug listed QL		# of plans with drug listed SPO		# of plans with drug listed NMS	
DISEASE	SPECIFIC DRUG	(out of 21 total plans)															
		#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
HIV	Triumeq	6	28.6%	0	0.0%	9	42.9%	15	71.4%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Atripla	6	28.6%	0	0.0%	0	0.0%	6	28.6%	3	14.3%	3	14.3%	0	0.0%	0	0.0%
	Stribild	6	28.6%	0	0.0%	3	14.3%	9	42.9%	3	14.3%	0	0.0%	0	0.0%	0	0.0%
	Truvada	3	14.3%	0	0.0%	0	0.0%	3	14.3%	3	14.3%	3	14.3%	0	0.0%	0	0.0%
HCV	Sovaldi	15	71.4%	3	14.3%	0	0.0%	18	85.7%	21	100.0%	6	28.6%	18	85.7%	6	28.6%
	Harvoni	12	57.1%	0	0.0%	6	28.6%	18	85.7%	15	71.4%	3	14.3%	12	57.1%	6	28.6%
	Viekira Pak	6	28.6%	0	0.0%	9	42.9%	15	71.4%	12	57.1%	3	14.3%	9	42.9%	6	28.6%

MassHealth

MASSHEALTH ANALYSIS: DRUG CATEGORIES			# of plans with X% of drugs listed as NC					# of plans with X% of drugs listed as PA				# of plans with X% of drugs listed as SPO			
DISEASE	CATEGORY	Total # of drugs per category	(out of 7 total plans)												
			<25%	≥25%	≥50%	≥75%	100%	≥25%	≥50%	≥75%	100%	≥25%	≥50%	≥75%	100%
HIV	Nucleoside Reverse Transcriptase Inhibitors	7	7	0	0	0	0	0	0	0	0	0	0	0	0
	Combination HIV Medicines	9	7	0	0	0	0	0	0	0	0	0	0	0	0
	Other HIV Medications	19	7	0	0	0	0	0	0	0	0	0	0	0	0
HIV TOTALS		**35**	**7**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
HCV	Sovaldi, Harvoni, Viekira Pak	3	5	2	1	1	1	6	6	6	6	4	4	2	2
	Other (all except Solvadi, Harvoni, Viekira Pak)	5	3	4	1	0	0	7	4	3	2	4	2	1	0
HCV TOTALS		**8**	**3**	**4**	**2**	**0**	**0**	**7**	**6**	**3**	**2**	**4**	**4**	**2**	**0**
TB TOTALS		**15**	**1**	**6**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
STI	Chlamydial Infections (Chlamydia)	7	7	0	0	0	0	0	0	0	0	0	0	0	0
	Gonococcal Infections (Gonorrhea)	7	2	5	2	0	0	0	0	0	0	0	0	0	0
	Syphilis	8	0	7	3	0	0	0	0	0	0	0	0	0	0
	Congenital Syphilis	4	0	7	7	6	3	0	0	0	0	0	0	0	0
STI TOTALS		**26**	**0**	**7**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

MASSHEALTH ANALYSIS: SPECIFIC DRUGS		# of plans with drugs listed NC		# of plans with drugs listed PA		# of plans with drugs listed SPO		# of plans with drug listed NMS		# of plans with drug listed QL	
DISEASE	SPECIFIC DRUG	(out of 7 total plans)									
		#	%	#	%	#	%	#	%	#	%
HIV	Triumeq	1	14.3%	0	0.0%	0	0.0%	1	14.3%	0	0.0%
	Atripla	0	0.0%	0	0.0%	0	0.0%	1	14.3%	0	0.0%
	Stribild	0	0.0%	1	14.3%	0	0.0%	1	14.3%	0	0.0%
	Truvada	0	0.0%	0	0.0%	0	0.0%	1	14.3%	0	0.0%
HCV	Sovaldi	1	14.3%	6	85.7%	4	57.1%	1	14.3%	1	14.3%
	Harvoni	1	14.3%	6	85.7%	4	57.1%	1	14.3%	2	28.6%
	Viekira Pak	2	28.6%	5	71.4%	2	28.6%	1	14.3%	1	14.3%

APPENDIX 2: FORMULARY LABELS

Across all plans, we found that insurance providers tended to create unique labeling frameworks that identified the utilization management mechanisms applied to certain drugs. For the purposes of this report, we only included the most frequently used labels in our analysis. However, we encountered all of the following formulary codes in our research:

FORMULARY LABEL	DEFINITION	EXPLANATION
BNC	Brand Not Covered, Generic Preferred	Found only in Minuteman (silver and ConnectorCare plans) and Health New England (silver, ConnectorCare, and Mass Health plans). This symbol denotes that the brand drug in question has an approved, medically equivalent generic alternative and thus the brand drug will not be covered unless medical necessity is established and prior authorization is granted.
GO	Generic Only	Found only in Tufts Network Health (silver and ConnectorCare plans). Brand drugs listed as GO are not covered by Tufts Network Health. GO denotes that the brand drug in question has an approved, medically equivalent generic alternative and thus the brand drug will not be covered unless medical necessity is established and prior authorization is granted.
GR	Generic Required	Found only in Boston Medical Center Healthnet Plan (MassHealth). Drugs listed as GR indicate that they fall under BMC's Mandatory Generic Substitution Program. The Mandatory Generic Substitution Program requires a member to try an "AB rated" generic drug before its brand counterpart would be covered.
MDD	Maximum Daily Dose	Found only in Celticare Health Plan (MassHealth). MDD refers to the amount of medication that can be taken per day. This is distinct from QL, which is a restriction on the amount that can be prescribed within a longer timeframe.
MFL	Maximum Fill Limit	Found only in Celticare Health Plan (MassHealth). MFL refers to a limit on the number of times this drug can be refilled.
MPL	Maximum Package Limit	Found only in Celticare Health Plan (MassHealth). MPL refers to a limit on the amount of drug covered per prescription.
NC	Not Covered	NC policies vary based on provider and plan type. In some cases, it simply means that the insurance provider will not cover the drug, and thus the patient has to pay out of pocket in order to obtain it. However, depending on the insurance provider and plan type, drugs listed as NC may be covered (generally at the highest cost-sharing level) if patients and providers submit evidence of medical necessity and prior authorization is granted.
NMS	No Mail Service	Found only in Minuteman (silver and ConnectorCare plans) and Health New England (silver, ConnectorCare, and MassHealth plans). NMS denotes that the drug is not available through any mail order services available through the given plan.
NTM	New to Market	NTM policies vary based on provider and plan type. This label could indicate that the new drug requires PA, that it is under review and thus not covered, etc.

FORMULARY LABEL	DEFINITION	EXPLANATION
PA	Prior Authorization	PA signifies that patients and/or providers must request prior authorization before a drug will be covered. This process could entail providing evidence of medical necessity, submitting documentation of additional requirements, etc.
PB	Preferred Brand	Found only in Minuteman (silver and ConnectorCare plans). PB is utilized when multiple brand name drugs exist to address the same medical need. Insurance providers may choose to label one of these medications as PB, which often implies that the drug is covered under a lower tier and/or has fewer restrictions than other medically-equivalent brand drugs.
QL	Quantity Limit	QL refers to a limit on the amount of medication that a patient can receive in a determined timeframe.
SPO	Specialty Pharmacy Only	SPO signals that the drug in question may only be obtained through a specialty pharmacy, as determined by the insurance provider.
ST	Step Therapy	ST generally signifies that the patient must take lower risk or lower cost drugs before moving on to higher risk or higher cost drugs.
#	Prior Authorization	Found only in the MassHealth fee-for-service plan. This symbol designates that the drug in question is a brand name drug with an FDA "A"-rated equivalent, and thus the generic is preferred. However, the MassHealth representative stated that all brand name drugs with covered generics will require prior authorization, regardless of whether they are listed with this symbol or not.