



Discriminatory Plan Design Increasingly Common in Qualified Health Plans Across the Country: New Data Illustrates Alarming Trends in HIV Health Care Access

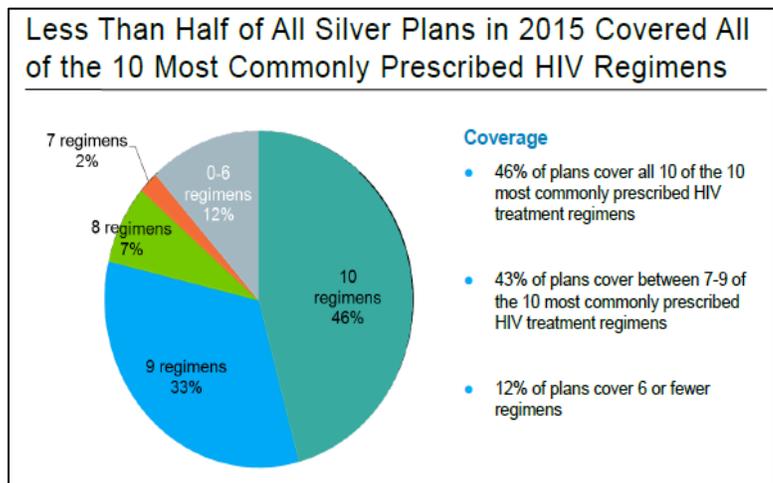
The Center for Health Law and Policy Innovation (CHLPI) has monitored trends in state Marketplaces for the past two years of open enrollment.¹ CHLPI is increasingly alarmed by lower rates of coverage of necessary HIV treatment regimens concurrent with increased cost sharing for those regimes that are covered. A [study released by Avalere Health on November 11, 2015](#), of the 1,494 Affordable Care Act (ACA) Silver Qualified Health Plans (QHPs) offered across the United States for 2015, confirms the alarming trend towards discriminatory plan design CHLPI has observed in the past two years in the health insurance Marketplaces.²

Avalere’s findings, along with CHLPI’s work in health care reform implementation, show that it is increasingly difficult for people living with HIV to obtain meaningful health care coverage through enrollment in Silver QHPs. This is alarming because these plans are meant to be the most cost-effective Marketplace plans for low and moderate income consumers, as cost reduction subsidies are only available for Silver plans. This trend undermines the most basic promise of the ACA and CHLPI applauds Avalere for bringing increased scrutiny to the offerings on the health insurance Marketplaces.

Qualified Health Plans are Increasingly Failing to Adequately Cover HIV Medications

In 2015, according to Avalere, less than half of all Silver level QHPs included all of the ten most commonly prescribed HIV regimens on their formularies. The most recently approved treatments had the lowest rates of coverage with Triumeq (approved in 2014), for example, covered by only 50% of Silver QHPs. 12% of Silver QHPs nation-wide covered six or fewer of the top ten regimens.

The lack of coverage for common and newer HIV regimens is cause for significant concern. Unlike treatment of



¹ CHLPI monitors trends in health care reform implementation in a variety of ways, most notably, in partnership with AIDS Foundation Chicago and other partners in the [Speak Up! Project](#). Speak Up! monitors, catalogs, and analyzes the problems experienced by people living with HIV in a post-health care reform system. The goal of Speak Up! is to gather real experiences, identify issues, bring those concerns to the attention of regulators and policymakers, and advocate for change.

² Avalere Health, “Coverage of Top HIV Regimens in 2015 Exchange Plans,” November 11, 2015. All charts and data are taken from this study unless otherwise noted.



other diseases, HIV treatment regimens are not interchangeable. Beginning with the most cost-effective treatment and then escalating to newer, more expensive treatments is contrary to federal guidelines, which recommend that the “[s]election of a regimen should be individualized.”³ QHPs should be providing access to the full range of commonly prescribed medications in keeping with federal guidelines and best standards of care. The failure to do so unfairly discourages people living with HIV from enrolling in plans, whose practices may rise to the level of discriminatory plan design. In some Marketplaces, consumers living with HIV may not be able to find plans with acceptable coverage levels.

Inadequate insurance coverage is becoming a persistent problem within the ACA QHPs. In 2014, as part of its Speak Up! project, CHLPI identified a significant lack of coverage of single table regimens (STRs) such as Triumeq. At that time CHLPI communicated its concerns directly with insurers and, ultimately, 79% of QHP insurers contacted agreed to cover STRs. However, Avalere’s coverage findings confirm that, in 2015, insurers are again reluctant to cover needed medications, including several insurers reverting back to failing to cover STRs. Coverage trends reflect an ongoing unwillingness of many insurers to provide acceptable coverage that meets the federal government’s HIV standard of care as articulated in the federal guidelines.

Covered HIV Medications are Increasingly Unaffordable Due to High Cost Sharing Structures

Coverage of medications is not the only criteria for assessing meaningful health care access. Insurers must also make HIV medications affordable to their plan beneficiaries by keeping out of pocket costs reasonable. QHPs fail to make medications affordable when they place HIV medications on high cost sharing tiers in their formularies.

Unfortunately, Avalere’s findings confirm that QHPs are increasingly placing many if not all of their covered HIV medications on formulary tiers that require high levels of cost sharing. In 2015, according to Avalere, 30% of all Silver QHPs placed all of their HIV medications on the highest cost sharing tier in their formularies. Such high cost sharing renders access to medications in these plans unaffordable for many consumers living with HIV. Individuals without sufficient financial resources may find that although they technically have health insurance covering their needed medications, the out of pocket cost requirements form too great a barrier to actually access needed care.

Avalere’s findings once again confirm CHLPI’s findings that plans are falling far short in providing affordable health care coverage for people living with HIV, thereby creating significant barrier to access to care. For example, in 2014 and 2015, CHLPI analyzed 29 Silver QHPs offered by eight different insurers in Georgia. All of those plans except one required high out of pocket expenditures for individuals living with HIV. Of those QHPs, 63% placed more than half of their HIV medications on

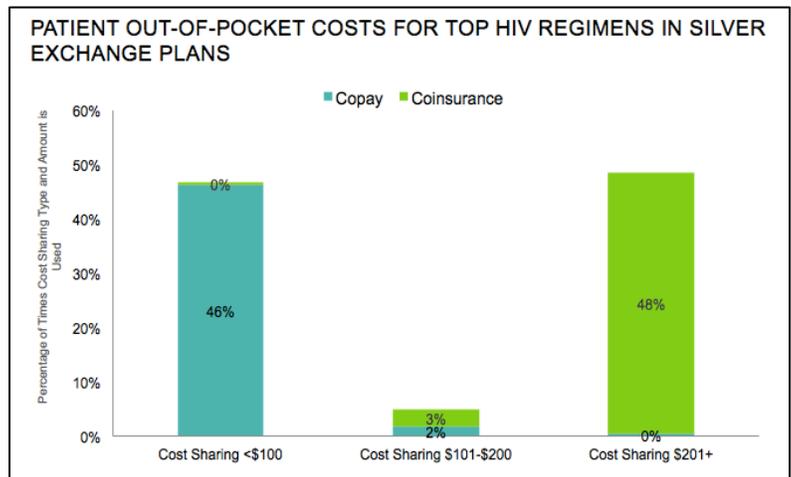
³ The Office of AIDS Research Advisory Council, “Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents,” F-3 (April 8, 2015), available at <http://aidsinfo.nih.gov/guidelines>.



the highest cost sharing tier. One insurer placed 97% of HIV medications in its highest cost sharing tier. Another insurer moved 32.9% of HIV medications onto its highest cost sharing tier between 2014 and 2015, reflective of a national trend identified by CHLPI in which insurers move HIV medications to higher cost sharing structures to compete with insurers already offering such discriminatory plan designs. On 66% of the Georgia QHPs an enrollee on Atripla—one of the most commonly prescribed HIV medications—would hit the out of pocket regulated maximum of \$6,600 for an individual well before the end of the year.

Additionally, further exacerbating cost-related concerns, CHLPI has seen a trend to coinsurance over

copayments for cost sharing. Avalere’s study demonstrates that this trend typically results in higher out of pocket costs for consumers. Avalere documented that the estimated average out of pocket cost was \$200 or more per regimen per month in 48% of the 2015 Silver QHPs. Of those plans, all charged coinsurance instead of copayments as their cost sharing structure. In contrast, the average out of pocket cost was under \$100 per month in 46% of the 2015 Silver QHPs. These QHPs all charged copayments instead of coinsurance for



cost sharing. CHLPI’s plan assessment experience highlights the stark financial reality of the move from a copayment to coinsurance. In 2015, through Speak Up! CHLPI learned that a Louisiana insurer moved HIV medications from a copayment to coinsurance—creating an average out of pocket payment that changed from \$60 per month to \$760 per month.

Coinsurance is not appropriate when it serves as a gatekeeper to access to life saving medications, nor when it is designed to disproportionately burden people living with HIV with unreasonable cost sharing. Plans that practice such benefit design cost individuals living with HIV an average of \$3,000 more per year than plans with more equitable out of pocket cost structures.⁴ This requires people living with HIV to shoulder a significantly larger percentage of their health care costs than other consumers. The failure to effectively regulate such unfair and discriminatory practices is increasingly undermining access to care for many people living with HIV, and this trend will likely continue without strong state or federal oversight by insurance regulators

⁴ Douglas Jacobs and Benjamin Sommers, “Using Drugs to Discriminate – Adverse Selection in the Insurance Marketplace.” *New England Journal of Medicine* (January 29, 2015).



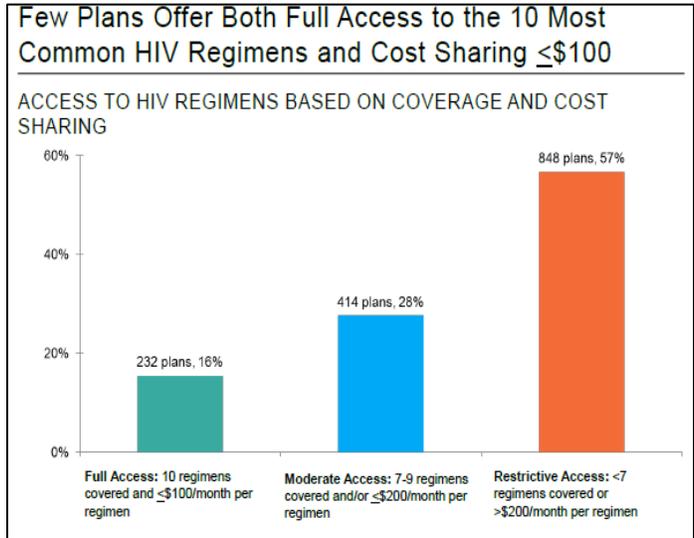
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Consumers Living with HIV Struggle to Find Qualified Health Plans that Meet their Needs

Coverage and cost trends converge to raise serious concerns about the ability of people living with HIV to have their medical needs met while enrolled in Silver QHPs.

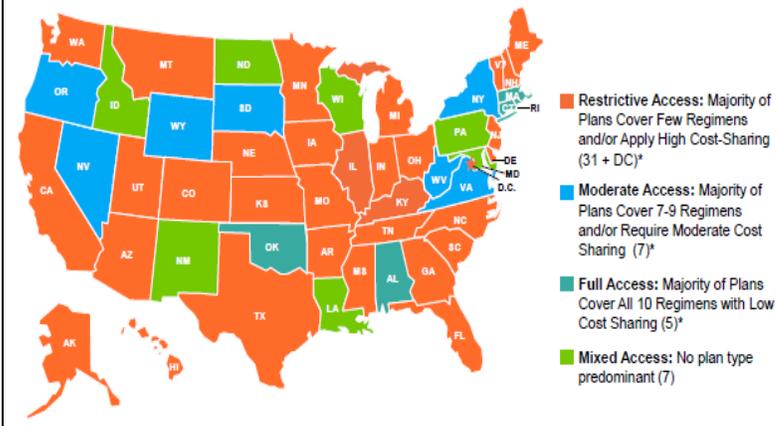
According to Avalere’s study, only 16% of the Silver QHPs offered nation-wide provided individuals living with HIV with full access to their needed medications. The majority of the Silver QHPs, 57%, had restrictive access for their enrollees living with HIV. These findings confirm that too many QHPs are offering restrictive access only to HIV medications, a reality all too familiar to CHLPI and HIV health and social service providers. As an example, as reported by CHLPI’s partners through the Speak Up! project, the Illinois AIDS Drug Assistance Program (ADAP) each year chooses to cover

QHP premiums for its enrollees, but is only permitted by federal law to purchase plans that provide coverage equivalent to that offered by the Illinois ADAP and at equal or lower cost. In 2014, the first year of open enrollment, four plans qualified. In 2015, only two plans met the criteria.



National Distribution of Plans Shows Potential Barriers to Access (1 of 2)

MAJORITY OF PLANS IN 31 STATES COVER FEW REGIMENS OR REQUIRE SIGNIFICANT COST SHARING



Finally, the Avalere study demonstrates that access to appropriate plans is also limited by geography. In only five states did the majority of the plans offered on their Marketplaces meet full access criteria. In contrast, in 31 states the majority of plans had restrictive access to needed HIV medications. While individual states have some discretion in regulating their insurance market, the geographic distribution of full access plans raises serious questions regarding geographic disparities when it comes to meaningful health care access for individuals living with HIV.



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Next Steps

CHLPI applauds Avalere for [assessing national trends in insurance coverage of HIV](#) care in Silver QHPs. The findings confirm discriminatory plan design trends in the health insurance Marketplaces across the country as reported by consumers and advocates and as documented by CHLPI.

To further define the extent of the problem, CHLPI is partnering with state based advocates to analyze all the 2016 Silver QHPs available on twenty state Marketplaces. The assessment will help to determine if current trends identified in Avalere's 2015 findings are ongoing and provide specific, detailed information on the QHPs offerings of these states.

In addition, CHLPI will go beyond documenting HIV treatment coverage trends by partnering with state based advocates to engage state Department of Insurance Commissioners to address ongoing unfair and discriminatory practices in Silver QHPs. If necessary, CHLPI and its state based partners are prepared to launch a litigation initiative, based in part on the newly created private right of action found under the anti-discrimination regulations of the ACA to ensure that the alarming trends found in 2015 and continued into 2016 do not become the norm in 2017 and onwards. The promise of the ACA must become a reality for people living with HIV.

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