2018 Plan Analysis: Qualified Health Plans

CHLPI
CENTER for HEALTH LAW and POLICY INNOVATION
HARVARD LAW SCHOOL

MISSISSIPPI CENTER FOR JUSTICE

Produced in collaboration with the Mississippi Center for Justice

Table of Contents:

OVERVIEW

The Affordable Care Act (ACA) has improved access to high-quality and affordable private health insurance for people living with chronic health conditions. The law prohibits insurance companies from denying health care coverage to individuals based on preexisting conditions and from charging people higher premiums based on their health status.

The ACA also established state health insurance Marketplaces, where residents can purchase Qualified Health Plans (QHPs) that cover essential health benefits, like prescription drugs and outpatient services. QHPs are prohibited from discriminating on the basis of race, color, national origin, disability, age, sex, gender identity, and sexual orientation.[1] When purchasing a silver-level QHP, low- and middle-income people may also qualify for cost sharing reductions (upfront discounts on the cost of using health care services) and advance premium tax credits (tax credits that can lower the monthly cost of buying a QHP). This financial support has helped over 9.7 million people afford Marketplace private health insurance plans in the United States, including the vast majority of Mississippians enrolled in the Marketplace[2].

Despite these reforms, people living with chronic health conditions still face discrimination throughout the health care system that prevents them from accessing necessary care and treatment. To identify and address these barriers in Mississippi, the Center for Health Law and Policy Innovation of Harvard Law School teamed up with the Mississippi Center for Justice to evaluate QHPs sold on the Mississippi Marketplace. We analyzed insurance plans sold on the Marketplace to determine how insurers design their products and whether insurers use discriminatory tactics, such as not covering necessary medications or requiring excessive cost sharing, to discourage people living with chronic health conditions from enrollment. Such illegal tactics are used largely because these individuals tend to have higher medical costs.

The *Mississippi 2018 Plan Analysis: Qualified Health Plans* report describes our latest findings as to the state of silver-level QHP insurance coverage for people living with chronic health conditions in Mississippi. Silver-level plans must provide cost sharing reductions to increase affordability and are often the more important insurance plans to individuals living with chronic

[1] QHP Issuer Participation Standards, 45 CFR §156.200.
[2] Health Insurance Exchanges 2018 Open Enrollment Period Final Report, Centers for Medicare & Medicaid Services (April 2018), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-03.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=descending.

health conditions.[3] This report demonstrates how challenges to effective coverage persist and that increased insurer accountability is needed to ensure the ACA's promise of equal and affordable coverage for all people. We hope that the report helps others understand the problems people living with serious medical needs face when seeking health insurance options. Hopefully, advocates, consumers, and insurance regulators can then come together to enforce the health care rights of people living with chronic health conditions.

For further questions and inquiries, please contact Maryanne Tomazic at mtomazic@law.harvard.edu.

USING THIS TOOL

The *Mississippi 2018 Plan Analysis: Qualified Health Plans* report assesses the benefit design of silver-level Marketplace QHPs in terms of coverage and cost sharing of medically necessary care and treatment for individuals living with chronic illnesses, including HIV, Hepatitis C (HCV), breast cancer, prostate cancer, and heart failure.

The report is intended to help identify which silver-level QHP best serves the needs of individuals living with chronic illnesses and whether the state Marketplace's only insurer is meeting coverage requirements mandated of Marketplace QHPs. QHPs are required to provide access to the full range of commonly prescribed medications in keeping with federal guidelines and best standards of care.[4] An insurer's failure to cover critical medications is discriminatory in that it discourages enrollment by individuals living with these conditions. Insurers must also make these medications affordable to their plan beneficiaries by keeping out-of-pocket costs reasonable.

When an insurer places all or most medications for the treatment of specific health conditions on the highest cost sharing

[3] At the start of 2018, 3% of the 83,64 people in Mississippi who enrolled in a QHP chose a silver-level plan. 2018 OEP State-Level Public Use File, Centers for Medicare and Medicaid Services (April 2018), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html.

[4] "A health plan does not provide essential health benefits unless . . . [the] formulary drug list: (1) Covers a range of drugs across a broad distribution of therapeutic categories and classes and recommended drug treatment regimens that treat all disease states, and does not discourage enrollment by any group of enrollees; and (2) Provides appropriate access to drugs that are included in broadly accepted treatment guidelines and that are indicative of general best practices at the time." 45 C.F.R. §156.122(a).

tier of their formulary, people living with these chronic conditions are left to shoulder a significantly higher percentage of their health care costs than other enrollees in the same plans. This practice of adverse tiering is an unfair and discriminatory health insurance practice that often prevents individuals from affording critical medications, despite paying premiums for health care coverage.

The information assessed in the *Mississippi 2018 Plan Analysis: Qualified Health Plans* report includes:

- Overall Plan Information, such as geographic coverage area and premium amounts.
- Coverage information, such as the number of provider-recommended medications included in the plan's formulary, drug quantity limits, and prior authorization requirements.
- Cost sharing Information, such as deductibles, co-payments, co-insurance, and drug tiering information.

Information about cost sharing and coverage were derived from materials publicly available on the health insurance Marketplace and the insurer's website, specifically the plan summary of benefits and associated drug formulary. Costs used in this report do not reflect the financial assistance most people will receive when purchasing a health insurance plan on the Marketplace. Approximately 94% of people in Mississippi who enrolled in a silver-level QHP were able to use financial assistance to lower costs associated with their plans.[5] Please see Appendix A for a more detailed description of how financial assistance works, as well as information regarding the methodology of the QHP assessment process.

The Center for Health Law and Policy Innovation of Harvard Law School and the Mississippi Center for Justice note that they are not licensed navigators or insurance brokers and that they do not purport to recommend specific plans for individuals. Additionally, formulary coverage of medications is subject to change throughout the plan year. Individuals should review the information themselves and discuss their health needs with a navigator or certified application counselor.

[5] 2018 OEP State-Level Public Use File, Centers for Medicare and Medicaid Services (April 2018), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html.

MISSISSIPPI'S MARKETPLACE

As we enter our third year of assessing QHPs in Mississippi, the Marketplace has unfortunately offered fewer plan options than ever before. In 2016, the Marketplace had 12 distinct silver-level QHPs. In 2017, the Marketplace had 9 silver-level QHPs from two insurers. In 2018, the Marketplace has a single insurer (Ambetter from Magnolia Health) offering two distinct silver-level plans: Balanced Care 2 and Balanced Care 3.

Balanced Care 2 and Balanced Care 3 use the same formulary to list which prescription drugs the plan will cover. Each plan employs a different cost sharing approach though, which can affect a member's ability to afford necessary medications and care when he or she needs it. Consider the table below comparing key health care plan costs:

QHP Name	Monthly Premium[6]	Deductible	Out-of-pocket Maximum
Balanced Care 2	$451	$7,050	$7,050
Balanced Care 3	$489	$2,350	$6,500

At first glance, Balanced Care 2 appears to be the more economical option as the plan has a lower monthly premium. However, Balanced Care 3 has a lower deductible and out-of-pocket maximum.[7] A lower deductible would allow members to trigger the insurance company's cost sharing responsibility more quickly in Balanced Care 3 than they could in Balanced Care 2. The lower out-of-pocket maximum would also allow consumers to spend less money before Ambetter begins covering the entire cost of covered services.

The differences between these plans' cost sharing structures are important for consumers to note. Individuals who have restricted cash flow may prefer Balanced Care 3 because its lower deductible would allow the insurer's cost sharing mechanisms to kick in more quickly, thereby lowering the personal cost of using covered services. These differences may

[6] See Appendix A for more detailed information on how monthly premium amounts may vary based on income, geography, smoking habits, and age.

[7] A deductible is the amount a member has to pay before certain services are covered by the insurance company. The out-of-pocket maximum is the limit for how much a member personally spends on covered services; the insurance company would pay for all covered services after that predetermined limit.

have a more muted effect, though, for people who know their medical care costs will surpass the out-of-pocket maximums. Consider the chart below that details the annual cost for an individual who knows she will exceed $7,050 in her personal share of covered services:

QHP Name	Monthly Premium	Annual Premium	Out-of-pocket Maximum	Total
Balanced Care 2	$451	$5,412	$7,050	$12,462
Balanced Care 3	$489	$5,868	$6,500	$12,368

Under the two plans' cost sharing structures, Balanced Care 3 would ultimately be about $100 cheaper than Balanced Care 2. With such a small gap between the two plans, people living with chronic conditions should be sure to consider the full range of medical care they will need throughout the year. Specifically, they should determine whether the care they need is a covered service, as out-of-pocket maximums only apply to a consumer's personal costs associated with covered services. People living with chronic conditions would also want to ensure that their preferred providers are in-network. Costs associated with out-of-network care may not count towards the plans' deductibles or out-of-pocket maximums.

Families who expect their medical care costs to surpass their out-of-pocket maximum will also want to take note of the differences between Balanced Care 2 and Balanced Care 3. As shown in the table below, a family of four who does not qualify for federal financial support may find Balanced Care 2 less expensive than Balanced Care 3.

QHP Name	Monthly Premium for a family of 4	Annual Premium	Out-of-pocket Maximum	Total
Balanced Care 2	$1,406	$16,872	$14,100	$30,972
Balanced Care 3	$1,526	$18,312	$13,000	$31,312

Each member of the family would need to meet their own individual out-of-pocket maximums though, before the family maximum is considered met. Thus, families who expect to meet the out-of-pocket maximum should estimate the costs of each family member's care separately to make sure they select a plan that best fits their families' needs.

Ultimately, consumers must consider the types of health care services they will use, the frequency at which they will use those services, and the flexibility of their cash flow when selecting a plan. To help with these considerations (and to determine whether discriminatory trends exist within plans sold on the Mississippi Marketplace), the Center for Health Law

and Policy Innovation and the Mississippi Center for Justice assessed the two Ambetter QHPs for their coverage of care and treatment most relevant to people living with HIV, HCV, breast cancer, prostate cancer, and heart failure.

Because both Ambetter plans use the same formulary, the QHPs have identical coverage of prescription medications. Consumers therefore face a lack of insurance options, which becomes particularly problematic when recommended medications for chronic conditions are all placed on the specialty (and most expensive) tier. Increasing the number of insurers who offer plans on Mississippi's Marketplace would reintroduce competition in the state and could potentially provide consumers with more meaningful choices.

STATE ANALYSIS & TRENDS: HCV

Ambetter's two silver-level QHPs use the same formulary and thus provide identical coverage of HCV medications. The coverage is relatively good as the formulary includes all assessed HCV medications except for Olysio, Viekira Pak, and Zepais.[8]

The Ambetter formulary, however, places all of these medications on the specialty tier, subjecting them to the highest cost sharing in both plans.

- Balanced Care 2 does not cover the cost of specialty medications until the deductible is met ($7,050 for an individual or $14,100 for a family). Because the deductible and the out-of-pocket maximum are the same in this plan, once the deductible is met, Ambetter will pay the entire cost of covered specialty medications.
- Balanced Care 3 does not cover the cost of specialty medications until the deductible is met ($2,350 for an individual or $4,700 for a family). Once the deductible is met, members are responsible for paying 30% of the cost of covered specialty medications. Members will pay up to the out-of-pocket maximum ($6,500 for an individual or $13,000 for a family) before Ambetter pays for the entire cost of covered care.

Affordability is a major concern for people diagnosed with HCV, as nearly all of the assessed medications are listed on specialty tiers and subject to high cost sharing in both plans. While HCV medications can be expensive for insurers to cover, listing all recommended medications on the highest tier leaves members no affordable treatment option. This discriminatory insurer practice discourages people with HCV from enrolling into their plans, and exacerbates an already growing public health crisis.

[8] The *Mississippi 2018 Plan Analysis: Qualified Health Plans* report uses a list of medications created in consultation with HCV specialists. The list of medications includes all available direct-acting antivirals used to treat Hepatitis C.

STATE ANALYSIS & TRENDS: HIV

Ambetter's two silver-level QHPs use the same formulary and thus provide identical coverage of HIV medications. The coverage is relatively good as the formulary includes 22 of the 30 assessed HIV medications, including all component drugs used in the recommended frontline regimen for treatment-naïve patients.[9]

The Ambetter formulary places all of these medications on the bottom three tiers, with varying cost sharing requirements.

The lowest tier, Tier 1, includes prescription drugs that Ambetter has deemed "the greatest value compared to other drugs used to treat similar conditions."[10] This tier includes some over-the-counter, generic, and brand name medications.

- Balanced Care 2 covers the cost of Tier 1 medications before the deductible is met. The required co-payment for Tier 1 drugs is $15.
- Balanced Care 3 covers the cost of Tier 1 medications before the deductible is met. The required co-payment for Tier 1 drugs is $25.

The second tier, Tier 2, includes preferred brand name prescription drugs that are "generally more affordable … compared to other drugs to treat the same conditions."[11]

- Balanced Care 2 and Balanced Care 3 cover the cost of Tier 2 medications before the deductibles are met. The required co-payment for Tier 2 drugs is $50 in both plans.

[9] The *Mississippi 2018 Plan Analysis: Qualified Health Plans* report uses a list of medications created in consultation with HIV specialists. The list of medications includes the component drugs of recommended frontline regimens for treatment-naïve patients. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV, U.S. Department of Health and Human Services (March 2018), https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/11/what-to-start.

[10] 2018 Prescription Drug List, Ambetter from Magnolia Health (2018), archived at https://www.chlpi.org/wp-content/uploads/2013/12/2018_ms_formulary.pdf.

[11] *Id.*

The third tier, Tier 3, includes "higher cost brand name drugs."[12] This tier has the same cost sharing properties as the specialty tier (Tier 4).

- Balanced Care 2 does not cover the cost of Tier 3 medications until the deductible is met ($7,050 for an individual or $14,100 for a family). Because the deductible and the out-of-pocket maximum are the same in this plan, once the deductible is met, Ambetter will pay the entire cost of covered Tier 3 medications.
- Balanced Care 3 does not cover the cost of Tier 3 medications until the deductible is met ($2,350 for an individual or $4,700 for a family). Once the deductible is met, members are responsible for paying 30% of the cost of covered specialty medications. Members will pay up to the out-of-pocket maximum ($6,500 for an individual or $13,000 for a family) before Ambetter pays for the entire cost of covered care.

Having HIV medications on three different tiers adds variety to the affordability of HIV medications. Medications on Tier 1 and Tier 2 are particularly helpful to consumers who have a restricted cash flow, since they require a set co-payment and are not subject to a deductible before coverage. This cost sharing structure allows members to adequately plan out their health care budget for the year.

Ambetter covers all component drugs used in the recommended initial regimens for treatment-naïve people living with HIV. Component drugs are either listed on Tier 2 or Tier 3. Below is a chart of a member's cost sharing responsibilities under each plan:

Recommended Regimen	**Ambetter Balanced Care 2**	**Ambetter Balanced Care 3**
Triumeq*	0%*	30%*
Tivicay* + Truvada	0%* + $50	30%* + $50
Tivicay* + Descovy	0%* + $50	30%* + $50
Genvoya*	0%*	30%*
Isentress + Truvada	$50 + $50	$50 + $50
Isentress + Descovy	$50 + $50	$50 + $50

* Each drug with an asterisk is on Tier 3; consumers must cover the entire cost of these drugs until the plan deductible is met.

[12] *Id.*

As seen in the chart, two regimens (Isentress + Truvada and Isentress + Descovy) only include medications that are not subject to a plan deductible being met. Consumers who take these regimens will not shoulder the full cost of drugs before their plan's deductible is met and can easily plan out the future costs of medication. The other four recommended regimens, however, include Tier 3 medications that are not covered until the plan deductible is met. This cost sharing structure introduces a degree of unpredictability as negotiated drug prices are inaccessible to the public. Consumers cannot easily determine how much their medications will cost and whether it will be too expensive for their budgets.

STATE ANALYSIS & TRENDS: CANCER

Cancer is the second-leading cause of death in Mississippi and can be one of the most expensive conditions to treat.[13] For this analysis, we reviewed select recommended medications for prostate cancer (the most common cancer among Mississippi men) and breast cancer (the most common cancer among Mississippi women).[14] The selected medications represent only a fraction of available treatments for these cancers and do not include all brand name drugs for available generics.[15]

Ambetter's two silver-level QHPs use the same formulary and thus provide identical coverage of cancer medications. The coverage is relatively good as the formulary includes 15 of the 20 assessed hormone therapy medications used to treat prostate cancer and all assessed chemotherapy drugs used to treat early-stage breast cancer.

Ambetter's formulary, however, places 11 of the 15 covered hormone therapy medications on the specialty tier, subjecting them to the highest cost sharing in both plans.

- Balanced Care 2 does not cover the cost of specialty medications until the deductible is met ($7,050 for an individual or $14,100 for a family). Because the deductible and the out-of-pocket maximum are the same in this plan, once the deductible is met, Ambetter will pay the entire cost of covered specialty medications.
- Balanced Care 3 does not cover the cost of specialty medications until the deductible is met ($2,350 for an individual or $4,700 for a family). Once the deductible is met, members are responsible for paying 30% of the cost of covered specialty medications. Members will pay up to the out-of-pocket maximum ($6,500 for an individual or $13,000 for a family) before Ambetter pays for the entire cost of covered care.

The formulary places four of the covered hormone therapy medications on Tier 1, where the drugs are not subject to a deductible being met, and have the plans' lowest co-payment ($15 for Balanced Care 2 and $25 for Balanced Care 3).

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[13] *Burden of Cancer - Mississippi*, Mississippi State Department of Health, https://msdh.ms.gov/msdhsite/_static/resources/6191.pdf.
[14] *Id*. at 2.
[15] Selected medications were taken from the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines for Patients. For purposes of this analysis, we selected medications used in chemotherapy to treat early-stage breast cancer (preferred and other regimens listed on pp. 50-53) and medications used in hormone therapy to treat certain cases of prostate cancer (treatments listed on pp. 39, 41). *NCCN Guidelines for Patients*, National Comprehensive Cancer Network (2016), https://www.nccn.org/patients/guidelines/cancers.aspx.

The Ambetter formulary unfortunately places all but one assessed chemotherapy medication for breast cancer on the specialty tier. The single medication not on the specialty tier (methotrexate) is placed on Tier 1 where it is subject to the lowest co-payment in both plans. Methotrexate, however, is used in combination with other chemotherapy drugs, leaving all early-stage breast cancer chemotherapy treatment options subject to the highest cost sharing. [16]

Costs associated with the specialty tier are identical to that described above for Tier 3. Members in both plans must meet their plan deductibles before medications are covered. Once the deductibles are met, members of Balanced Care 2 have the entire cost of the medications covered, whereas members of Balanced Care 3 have to pay a 30% co-insurance on their specialty medications until their out-of-pocket costs are met.

Ambetter's coverage of recommended treatment options for breast cancer and prostate cancer only partially make treatment accessible. While the recommended drugs are mostly covered, the majority of covered drugs are listed on the highest cost sharing tier. Cancer treatment is a long and arduous process itself and requires additional regular services, including mammograms, blood tests, specialist visits, and sometimes surgeries. Placing these drugs on the highest tier makes life-saving medications unaffordable and unfairly punishes patients who do not have the financial flexibility to pay the full cost of medication before the deductible or out-of-pocket maximums are met.

[16] Methotrexate is used in combination with other top-tier component drugs when administered as a chemotherapy regimen.

STATE ANALYSIS & TRENDS: HEART FAILURE

Heart failure is a common chronic condition in the United States. Unfortunately, Mississippi (along with other southern states) has one of the highest heart failure death rates in the country.[17] For this analysis, we reviewed commonly used angiotensin-converting enzyme (ACE) inhibitors for heart failure with reduced ejection fraction (Stage C).[18] ACE inhibitors are also used to treat high blood pressure, strokes, heart attacks, diabetes, and kidney problems.[19]

Ambetter's two silver-level QHPs use the same formulary and thus provide identical coverage of common ACE inhibitors. The coverage is excellent, as all eight commonly-used medications are covered. The cost of the medications is also low as all eight of the commonly-used medications are placed on the lowest tier. The lowest tier, Tier 1, includes prescription drugs that Ambetter has deemed "the greatest value compared to other drugs used to treat similar conditions."[20] This tier includes some over-the-counter, generic, and brand name medications.

- Balanced Care 2 covers the cost of Tier 1 medications before the deductible is met. The required co-payment for Tier 1 drugs is $15.
- Balanced Care 3 covers the cost of Tier 1 medications before the deductible is met. The required co-payment for Tier 1 drugs is $25.

Drug coverage that is not subject to meeting a deductible and that uses flat co-payment cost sharing is ideal for people who rely on medications to manage their chronic conditions. This type of cost sharing is ideal for members who have a restricted cash flow, and must budget ahead for their medical costs. Chronic conditions, including heart failure, are rarely treated with a single prescription medication though, and could require additional medication that is listed on the specialty tier. This underlies the importance for insurers to monitor disease-specific drug affordability trends within their plans.

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[17] *Heart Failure Fact Sheet*, Centers for Disease Control and Prevention (June 16, 2016), https://www.cdc.gov/DHDSP/data_statistics/fact_sheets/fs_heart_failure.htm.
[18] 2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure, 70 J. AMER. C. CARDIOLOGY 1, 788 (Aug. 2017).
[19] *ACE Inhibitors*, MedlinePlus (Aug. 2, 2016), https://medlineplus.gov/ency/patientinstructions/000087.htm.
[20] 2018 Prescription Drug List, Ambetter from Magnolia Health (2018), archived at https://www.chlpi.org/wp-content/uploads/2013/12/2018_ms_formulary.pdf.

FUTURE STEPS

The information assessed in the *Mississippi 2018 Plan Analysis: Qualified Health Plans* report exposes many obstacles to accessing needed care and treatment at a reasonable cost for people living with chronic health conditions. Reviewing the plans is not an easy assignment and, in fact, while not spelled out in this report, we identified several places where plan documents could include more transparent and easily accessible coverage and cost information to consumers. People living with chronic conditions often require a particular medication regimen that is tailored to their medical profile. The inability to readily locate plan information can be dangerous to their medical health and financial stability.

Additionally, while coverage was often strong in the Mississippi silver-level QHPs, the insurer often requires members to pay a co-insurance amount for recommended HIV, HCV, and cancer medications that raises serious concerns. Co-insurance often results in significant costs to consumers as compared to co-payments. In addition, since negotiated prices are inaccessible to the public, having to pay a percentage of the negotiated price through co-insurance leaves consumers with inadequate information to assess the cost-effectiveness of the coverage or predict their out-of-pocket costs.

As the Center for Health Law and Policy Innovation and the Mississippi Center for Justice proceed to assess QHPs, we will increasingly identify the trends in the coverage and cost barriers consumers face when selecting an insurance plan on the Mississippi Marketplace. We will continue to use the analyses of plan benefit designs to educate and inform the chronic illness community, as well as to mobilize support for advocacy with state and federal officials to hold insurers accountable for the accuracy, affordability, and legality of Marketplace QHP health insurance coverage.

Ambetter of Magnolia Inc.
Ambetter Balanced Care 2 (2018)
2018 Marketplace

Overall Plan Information	
Issuer Name	Ambetter of Magnolia Inc.
Plan Name	Ambetter Balanced Care 2 (2018)
Plan ID	90714MS0010003
Link to Summary of Benefits	https://api.centene.com/SBC/2018/90714MS0010003-01.pdf
Coverage Area (counties)	Adams, Alcorn, Amite, Attala, Benton, Bolivar, Calhoun, Carroll, Chickasaw, Choctaw, Claiborne, Clarke, Clay, Coahoma, Copiah, Covington, DeSoto, Forrest, Franklin, George, Greene, Grenada, Hancock, Harrison, Hinds, Holmes, Humphreys, Issaquena, Itawamba, Jackson, Jasper, Jefferson, Jefferson Davis, Jones, Kemper, Lafayette, Lamar, Lauderdale, Lawrence, Leake, Lee, Leflore, Lincoln, Lowndes, Madison, Marion, Marshall, Monroe, Montgomery, Neshoba, Newton, Noxubee, Oktibbeha, Panola, Pearl River, Perry, Pike, Pontotoc, Prentiss, Quitman, Rankin, Scott, Sharkey, Simpson, Smith, Stone, Sunflower, Tallahatchie, Tate, Tippah, Tishomingo, Tunica, Union, Walthall, Warren, Washington, Wayne, Webster, Wilkinson, Winston, Yalobusha, and Yazoo

Cost Information			
Premium (per month in Hinds County)	Individual: $451	Family: $1,406	
Deductible	Individual: $7,050	Family: $14,100	
Prescription-specific Deductible	Individual: N/A	Family: N/A	
Does the deductible need to be met before prescription drugs are covered?	Yes, for non-preferred and specialty drugs.	Individual Out-of-pocket Limit: $7,050	Family Out-of-pocket Limit: $14,100
Referral required for specialists?	No		
Primary Care Visit	Co-Payments: $30	Co-Insurance: N/A	
Specialist Visit	Co-Payments: $60	Co-Insurance: N/A	

Cost Information			
Diagnostic Test	Co-Payments: N/A	Co-Insurance: 0% after deductible	
Hospital Stay – Physician Fee	Co-Payments: N/A	Co-Insurance: 0% after deductible	
Hospital Stay – Facility Fee	Co-Payments: N/A	Co-Insurance: 0% after deductible	
Emergency Room	Co-Payments: N/A	Co-Insurance: 0% after deductible	
Mental/Behavioral Health Outpatient Services	Prior Approval? Yes	Co-Payments: $30	Co-Insurance: N/A
Substance Use Disorder Outpatient Services	Prior Approval? Yes	Co-Payments: $30	Co-Insurance: N/A

Tier Information			
Tier A	Name: Tier 1	Co-Payments: $15	Co-Insurance: N/A
Tier B	Name: Tier 2	Co-Payments: $50	Co-Insurance: N/A
Tier C	Name: Tier 3	Co-Payments: N/A	Co-Insurance: 0% after deductible
Tier D	Name: Tier 4	Co-Payments: N/A	Co-Insurance: 0% after deductible
Notes on Tiers		While the Summary of Benefits indicates that prior authorization is required for Tier 2, Tier 3, and Tier 4, some drugs classified on those tiers are listed without prior authorization requirements in the Formulary.	

Formulary Information	
Formulary Name	Ambetter from Magnolia Health
Link to Formulary	https://www.chlpi.org/MS18
Insurance Customer Service Contact Number	877-687-1187
Notes on Formulary	Some drugs were listed in the Formulary as not covered, but are subject to restrictions (such as quantity limits). This table does not reflect additional restrictions on drugs that are not covered.

Medications

HCV	Covered?	Tier	Prior Auth.	Quantity Limit	Step Therapy
Epclusa (sofosbuvir/velpatasvir)	Yes	D	Yes	Yes	No
Harvoni (ledipasvir/sofosbuvir)	Yes	D	Yes	Yes	No
Olysio (simeprevir)	No	N/A	N/A	N/A	N/A
Sovaldi (sofosbuvir)	Yes	D	Yes	Yes	No
Viekira Pak (ombitasvir/paritaprevir/ ritonavir/dasabuvir)	No	N/A	N/A	N/A	N/A
Zepatier (elbasvir/grazoprevir)	No	N/A	N/A	N/A	N/A
Mavyret (glecaprevir/pibrentasvir)	Yes	D	Yes	Yes	No
Daklinza (daclatasvir)	Yes	D	Yes	Yes	No

Medications

HIV	Covered?	Tier	Prior Auth.	Quantity Limit	Step Therapy
Atripla (efavirenz/emtricitabine/tenofovir DF)	Yes	C	No	Yes	No
Combivir (lamivudine/zidovudine)	No	N/A	N/A	N/A	N/A
zidovudine/lamivudine	Yes	A	No	Yes	No
Complera (emtricitabine/rilpivirine/tenofovir DF)	Yes	C	No	Yes	No
Descovy (emtricitabine/tenofovir AF)	Yes	B	No	Yes	No
Edurant (rilpivirine)	Yes	B	No	Yes	No
Epzicom (abacavir/lamivudine)	Yes	B	No	Yes	No
abacavir/lamivudine	Yes	A	No	Yes	No
Evotaz (atazanavir/cobicistat)	No	N/A	N/A	N/A	N/A
Isentress (raltegravir)	Yes	B	No	Yes	No

Medications					
HIV	**Covered?**	**Tier**	**Prior Auth.**	**Quantity Limit**	**Step Therapy**
Isentress HD (raltegravir)	No	N/A	N/A	N/A	N/A
Genvoya (elvitegravir/cobicistat/ emtricitabine/tenofovir AF)	Yes	C	No	Yes	No
Epivir (lamivudine)	Yes	C	No	Yes	No
lamivudine	Yes	A	No	Yes	No
Norvir (ritonavir)	Yes	B	No	Yes	No
Ritonavir	No	N/A	N/A	N/A	N/A
Odefsey (emtricitabine/rilpivirine/tenofovir AF)	Yes	C	No	Yes	No
Prezcobix (darunavir/cobicistat)	No	N/A	N/A	N/A	N/A
Prezista (darunavir)	Yes	B	No	Yes	No
Reyataz (atazanavir)	Yes	B	No	Yes	No
Stribild (cobicistat/elvitegravir/ emtricitabine/tenofovir DF)	Yes	C	No	Yes	No
Tivicay (dolutegravir)	Yes	C	No	No	No
Triumeq (abacavir/dolutegravir/lamivudine)	Yes	C	No	Yes	No
Abacavir	Yes	A	No	Yes	No
Truvada (emtricitabine/tenofovir DF)	Yes	B	Yes	Yes	No
Viramune (nevirapine)	No	N/A	N/A	N/A	N/A
nevirapine	Yes	A	No	Yes	No
Retrovir (zidovudine)	No	N/A	N/A	N/A	N/A
zidovudine	Yes	A	No	Yes	No
Ziagen (abacavir sulfate)	No	N/A	N/A	N/A	N/A

Medications

Prostate Cancer	Covered?	Tier	Prior Auth.	Quantity Limit	Step Therapy
Zytiga (abiraterone acetate)	Yes	D	Yes	Yes	No
Casodex (bicalutamide)	Yes	D	Yes	Yes	No
bicalutamide	Yes	D	Yes	Yes	No
Firmagon (degarelix)	Yes	D	Yes	Yes	No
diethylstilbestrol	No	N/A	N/A	N/A	N/A
Xtandi (enzalutamide)	Yes	D	Yes	Yes	No
flutamide	Yes	D	Yes	Yes	No
Zoladex (goserelin acetate)	Yes	D	Yes	Yes	No
Vantas (histrelin acetate)	No	N/A	N/A	N/A	N/A
Cortef (hydrocortisone)	No	N/A	N/A	N/A	N/A
hydrocortisone	Yes	A	No	No	No
Nizoral (ketoconazole)	No	N/A	N/A	N/A	N/A
ketoconazole	Yes	A	No	No	No
Eligard (leuprolide acetate)	Yes	D	Yes	No	No
Lupron Depot (leuprolide acetate)	Yes	D	Yes	Yes	No
leuprolide acetate	Yes	D	Yes	No	No
Nilandron (nilutamide)	No	N/A	N/A	N/A	N/A
nilutamide	Yes	A	No	Yes	No
prednisone	Yes	A	No	No	No
Trelstar (triptorelin pamoate)	Yes	D	Yes	No	No

Medications

Breast Cancer	Covered?	Tier	Prior Auth.	Quantity Limit	Step Therapy
doxorubicin	Yes	D	Yes	No	No
cyclophosphamide	Yes	D	Yes	No	No
paclitaxel	Yes	D	Yes	No	No
docetaxel	Yes	D	Yes	No	No
Herceptin (trastuzumab)	Yes	D	Yes	No	No
Perjeta (pertuzumab)	Yes	D	Yes	No	No
carboplatin	Yes	D	Yes	No	No
methotrexate	Yes	A	No	No	No
5 fluorouracil	Yes	D	Yes	No	No
epirubicin	Yes	D	Yes	No	No

Medications

Heart Failure	Covered?	Tier	Prior Auth.	Quantity Limit	Step Therapy
captopril	Yes	A	No	No	No
enalapril	Yes	A	No	No	No
fosinopril	Yes	A	No	No	No
lisinopril	Yes	A	No	No	No
perindopril	Yes	A	No	No	No
quinapril	Yes	A	No	No	No
ramipril	Yes	A	No	No	No
trandolapril	Yes	A	No	No	No

Ambetter of Magnolia Inc.
Ambetter Balanced Care 3 (2018)

2018 Marketplace

Overall Plan Information	
Issuer Name	Ambetter of Magnolia Inc.
Plan Name	Ambetter Balanced Care 3 (2018)
Plan ID	90714MS0010008
Link to Summary of Benefits	https://api.centene.com/SBC/2018/90714MS0010008-01.pdf
Coverage Area (counties)	Adams, Alcorn, Amite, Attala, Benton, Bolivar, Calhoun, Carroll, Chickasaw, Choctaw, Claiborne, Clarke, Clay, Coahoma, Copiah, Covington, DeSoto, Forrest, Franklin, George, Greene, Grenada, Hancock, Harrison, Hinds, Holmes, Humphreys, Issaquena, Itawamba, Jackson, Jasper, Jefferson, Jefferson Davis, Jones, Kemper, Lafayette, Lamar, Lauderdale, Lawrence, Leake, Lee, Leflore, Lincoln, Lowndes, Madison, Marion, Marshall, Monroe, Montgomery, Neshoba, Newton, Noxubee, Oktibbeha, Panola, Pearl River, Perry, Pike, Pontotoc, Prentiss, Quitman, Rankin, Scott, Sharkey, Simpson, Smith, Stone, Sunflower, Tallahatchie, Tate, Tippah, Tishomingo, Tunica, Union, Walthall, Warren, Washington, Wayne, Webster, Wilkinson, Winston, Yalobusha, and Yazoo

Cost Information			
Premium (per month in Hinds County)	Individual: $489	Family: $1,526	
Deductible	Individual: $2,350	Family: $4,700	
Prescription-specific Deductible	Individual: N/A	Family: N/A	
Does the deductible need to be met before prescription drugs are covered?	Yes, for non-preferred and specialty drugs.	Individual Out-of-pocket Limit: $6,500	Family Out-of-pocket Limit: $13,000
Referral required for specialists?	No		
Primary Care Visit	Co-Payments: $30	Co-Insurance: N/A	
Specialist Visit	Co-Payments: $60	Co-Insurance: N/A	

Cost Information			
Diagnostic Test	Co-Payments: N/A	Co-Insurance: 30%	
Hospital Stay – Physician Fee	Co-Payments: N/A	Co-Insurance: 30%	
Hospital Stay – Facility Fee	Co-Payments: $750 per day (prior to deductible)	Co-Insurance: 30% (after deductible)	
Emergency Room	Co-Payments: $600 (prior to deductible)	Co-Insurance: 30% (after deductible)	
Mental/Behavioral Health Outpatient Services	Prior Approval? Yes	Co-Payments: $30	Co-Insurance: N/A
Substance Use Disorder Outpatient Services	Prior Approval? Yes	Co-Payments: $30	Co-Insurance: N/A

Tier Information			
Tier A	Name: Tier 1	Co-Payments: $25	Co-Insurance: N/A
Tier B	Name: Tier 2	Co-Payments: $50	Co-Insurance: N/A
Tier C	Name: Tier 3	Co-Payments: N/A	Co-Insurance: 30%
Tier D	Name: Tier 4	Co-Payments: N/A	Co-Insurance: 30%
Notes on Tiers	While the Summary of Benefits indicates that prior authorization is required for Tier 2, Tier 3, and Tier 4, some drugs classified on those tiers are listed without prior authorization requirements in the Formulary.		

Formulary Information	
Formulary Name	Ambetter from Magnolia Health
Link to Formulary	https://www.chlpi.org/MS18
Insurance Customer Service Contact Number	877-687-1187
Notes on Formulary	Some drugs were listed in the Formulary as not covered, but are subject to restrictions (such as quantity limits). This table does not reflect additional restrictions on drugs that are not covered.

Medications					
HCV	**Covered?**	**Tier**	**Prior Auth.**	**Quantity Limit**	**Step Therapy**
Epclusa (sofosbuvir/velpatasvir)	Yes	D	Yes	Yes	No
Harvoni (ledipasvir/sofosbuvir)	Yes	D	Yes	Yes	No
Olysio (simeprevir)	No	N/A	N/A	N/A	N/A
Sovaldi (sofosbuvir)	Yes	D	Yes	Yes	No
Viekira Pak (ombitasvir/paritaprevir/ ritonavir/dasabuvir)	No	N/A	N/A	N/A	N/A
Zepatier (elbasvir/grazoprevir)	No	N/A	N/A	N/A	N/A
Mavyret (glecaprevir/pibrentasvir)	Yes	D	Yes	Yes	No
Daklinza (daclatasvir)	Yes	D	Yes	Yes	No

Medications					
HIV	**Covered?**	**Tier**	**Prior Auth.**	**Quantity Limit**	**Step Therapy**
Atripla (efavirenz/emtricitabine/tenofovir DF)	Yes	C	No	Yes	No
Combivir (lamivudine/zidovudine)	No	N/A	N/A	N/A	N/A
zidovudine/lamivudine	Yes	A	No	Yes	No
Complera (emtricitabine/rilpivirine/tenofovir DF)	Yes	C	No	Yes	No
Descovy (emtricitabine/tenofovir AF)	Yes	B	No	Yes	No
Edurant (rilpivirine)	Yes	B	No	Yes	No
Epzicom (abacavir/lamivudine)	Yes	B	No	Yes	No
abacavir/lamivudine	Yes	A	No	Yes	No
Evotaz (atazanavir/cobicistat)	No	N/A	N/A	N/A	N/A
Isentress (raltegravir)	Yes	B	No	Yes	No

Medications

HIV	Covered?	Tier	Prior Auth.	Quantity Limit	Step Therapy
Isentress HD (raltegravir)	No	N/A	N/A	N/A	N/A
Genvoya (elvitegravir/cobicistat/ emtricitabine/tenofovir AF)	Yes	C	No	Yes	No
Epivir (lamivudine)	Yes	C	No	Yes	No
lamivudine	Yes	A	No	Yes	No
Norvir (ritonavir)	Yes	B	No	Yes	No
ritonavir	No	N/A	N/A	N/A	N/A
Odefsey (emtricitabine/rilpivirine/tenofovir AF)	Yes	C	No	Yes	No
Prezcobix (darunavir/cobicistat)	No	N/A	N/A	N/A	N/A
Prezista (darunavir)	Yes	B	No	Yes	No
Reyataz (atazanavir)	Yes	B	No	Yes	No
Stribild (cobicistat/elvitegravir/ emtricitabine/tenofovir DF)	Yes	C	No	Yes	No
Tivicay (dolutegravir)	Yes	C	No	No	No
Triumeq (abacavir/dolutegravir/lamivudine)	Yes	C	No	Yes	No
abacavir	Yes	A	No	Yes	No
Truvada (emtricitabine/tenofovir DF)	Yes	B	Yes	Yes	No
Viramune (nevirapine)	No	N/A	N/A	N/A	N/A
nevirapine	Yes	A	No	Yes	No
Retrovir (zidovudine)	No	N/A	N/A	N/A	N/A
zidovudine	Yes	A	No	Yes	No
Ziagen (abacavir sulfate)	No	N/A	N/A	N/A	N/A

Medications

Prostate Cancer	Covered?	Tier	Prior Auth.	Quantity Limit	Step Therapy
Zytiga (abiraterone acetate)	Yes	D	Yes	Yes	No
Casodex (bicalutamide)	Yes	D	Yes	Yes	No
bicalutamide	Yes	D	Yes	Yes	No
Firmagon (degarelix)	Yes	D	Yes	Yes	No
diethylstilbestrol	No	N/A	N/A	N/A	N/A
Xtandi (enzalutamide)	Yes	D	Yes	Yes	No
flutamide	Yes	D	Yes	Yes	No
Zoladex (goserelin acetate)	Yes	D	Yes	Yes	No
Vantas (histrelin acetate)	No	N/A	N/A	N/A	N/A
Cortef (hydrocortisone)	No	N/A	N/A	N/A	N/A
hydrocortisone	Yes	A	No	No	No
Nizoral (ketoconazole)	No	N/A	N/A	N/A	N/A
ketoconazole	Yes	A	No	No	No
Eligard (leuprolide acetate)	Yes	D	Yes	No	No
Lupron Depot (leuprolide acetate)	Yes	D	Yes	Yes	No
leuprolide acetate	Yes	D	Yes	No	No
Nilandron (nilutamide)	No	N/A	N/A	N/A	N/A
nilutamide	Yes	A	No	Yes	No
prednisone	Yes	A	No	No	No
Trelstar (triptorelin pamoate)	Yes	D	Yes	No	No

Medications

Breast Cancer	Covered?	Tier	Prior Auth.	Quantity Limit	Step Therapy
doxorubicin	Yes	D	Yes	No	No
cyclophosphamide	Yes	D	Yes	No	No
paclitaxel	Yes	D	Yes	No	No
docetaxel	Yes	D	Yes	No	No
Herceptin (trastuzumab)	Yes	D	Yes	No	No
Perjeta (pertuzumab)	Yes	D	Yes	No	No
carboplatin	Yes	D	Yes	No	No
methotrexate	Yes	A	No	No	No
5 fluorouracil	Yes	D	Yes	No	No
epirubicin	Yes	D	Yes	No	No

Medications

Heart Failure	Covered?	Tier	Prior Auth.	Quantity Limit	Step Therapy
captopril	Yes	A	No	No	No
enalapril	Yes	A	No	No	No
fosinopril	Yes	A	No	No	No
lisinopril	Yes	A	No	No	No
perindopril	Yes	A	No	No	No
quinapril	Yes	A	No	No	No
ramipril	Yes	A	No	No	No
trandolapril	Yes	A	No	No	No

APPENDIX A

Financial Assistance on the Marketplace

The costs included in this report reflect what a consumer would pay if she did not qualify for financial assistance. About 94% of people in Mississippi who enrolled into a silver-level QHP in 2018 are able to use advan premium tax credits (APTC) to lower the monthly cost of their health insurance. [21] This support brings the average premium amount down to $90. Additionally, approximately 88% of people in Mississippi who enrolled into a silver-level QHP in 2018 are able to receive cost sharing reductions (CSRs). These subsidies provide upfront discounts on the costs of health care and treatment services.

APTCs and CSRs can greatly alter the costs associated with silver-level plans on the Marketplace. For example, a non-smoking 30 year-old in Hinds County making $30,000 a year is eligible to receive both an APTC and CSRs on the Marketplace. This financial support will lower the plan cost information as follows:

QHP Name	Premium	Premium with APTC	Deductible	Deductible with CSRs	Out-of-pocket Maximum	Out-of-pocket Maximum with CSRs
Balanced Care 2	$451	$163	$7,050	$5,000	$7,050	$5,000
Balanced Care 3	$489	$201	$2,350	$1,950	$6,500	$5,850

APTCs and CSRs are essential for low- and moderate-income individuals and families. They provide sliding-scale support that makes health care more affordable. Consumers looking to purchase a QHP on the Marketplace should consult a navigator to determine if they are eligible for APTCs and CSRs, as well as to more accurately estimate the actual costs of these plans based upon each consumer's specific income level.

[21] Statistics in this paragraph are derived from the 2018 OEP State-Level Public Use File. 2018 OEP State-Level Public Use File, Centers for Medicare and Medicaid Services (April 2018), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html.

Methodology

The Center for Health Law and Policy Innovation and the Mississippi Center for Justice used the summary of benefits and formularies available at the beginning of open enrollment on the health insurance Marketplace to assess the 2018 silver-level QHPs. When the summary of benefits and formulary did not provide information needed to assess the QHP, or provided inconsistent or unclear information, assessors called the insurer using the general contact number and identified themselves as an individual seeking plan information for that particular QHP.

The *Mississippi 2018 Plan Analysis: Qualified Health Plans* report should be considered a snapshot of the insurance market during the open enrollment period. Information may have changed or been updated since. Individuals looking to select a plan should go to their local health insurance Marketplace or contact a licensed navigator to obtain the most up to date information on available QHPs.

Notes Regarding Plan Assessment Charts

Plans Listed: Plans offered by the same insurer are sometimes distinguished (either by name or plan ID) based on their network, coverage area, and premiums, but do not differ in cost sharing and coverage of services and medications. In order to avoid duplication, each unique benefit design was analyzed once and can be considered a composite of the related plans. This report does not include plans with vision or dental services that otherwise were duplicates of other plans offered.

Premiums: Premium payments differ based on age, smoking status, and geographic location of the applicant. Insurers may include small variations in pricing based on age (up to a 3:1 ratio for adults), but must follow a Mississippi-specific age curve variation.[22] Insurers are also permitted to charge smokers more than non-smokers for health insurance coverage (up to a 1.5:1 ratio) and can vary premiums based on six pre-determined rating areas in Mississippi.[23]

[22] 2018 State Specific Age Curve Variations, Centers for Medicare and Medicaid Services (May 2017), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/StateSpecAgeCrv053117.pdf.
[23] Mississippi Geographic Rating Areas: Including State Specific Geographic Divisions, Centers for Medicare and Medicaid Services (April 2018), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/ms-gra.html.

Additionally, applicants with low to moderate incomes may qualify for financial assistance that lowers the cost of health insurance. For this report, premiums were calculated for a 30 year-old non-smoking individual and a non-smoking family of four, consisting of two 30 year-old adults and two 12 year-old children. To reflect a county that encompasses a large metropolitan region of the state, premiums were calculated with the applicants based in Hinds County making an income that would not qualify for financial assistance. The premiums cited in this report should be used to understand the cost of available QHPs rather than considered a guaranteed premium for any particular individual.

Generics and Branded Medication: All branded medications are listed by their commercial name with the first letter of the name capitalized. Generics are referred to by their chemical name and are not capitalized.

Tiering: Ambetter's formulary lists five different tiers: Tier 0, Tier 1, Tier 2, Tier 3, and Tier 4. Tier 0 only includes preventive and ACA-mandated medications that are covered without co-pay. To assist our upcoming multi-year analyses where we compare coverage between insurers who use different tier-naming conventions, we disregarded Ambetter's no co-pay tier in plan assessments.

Multiple Formulations: This report generally reflects the cost sharing tier for the more commonly-used formulation of a drug, as indicated by certain medical providers. If one formulation of a medication was covered, but others were not, the plan assessments reflect the cost sharing tier for the covered formulation.

The Center for Health Law and Policy Innovation of Harvard Law School and the Mississippi Center for Justice note that they are not licensed navigators or insurance brokers and that they do not purport to recommend specific plans for individuals. Formulary coverage of medications is subject to change throughout the plan year. Individuals should review the information themselves and discuss their health needs with a navigator or certified application counselor. For more information, visit www.healthcare.gov.