CENTER FOR HEALTH LAW
& POLICY INNOVATION
Harvard Law School

THE AFFORDABLE CARE ACT & PRIVATE HEALTH INSURANCE:

WHAT HAS BEEN ACCOMPLISHED AND NEXT STEPS

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The Good News:
ACA Significantly Reforms Private Health Insurance

Reforms to All Private Health Insurance Plans

- Cannot be denied insurance because of pre-existing conditions
- Cannot drop people from coverage when they get sick, and no annual or lifetime limits on coverage
- Young adults can stay on parents health plan until age 26

Additional Reforms through Federal and State Marketplaces

- Marketplaces to ensure all consumer friendly requirements are met and to support patient-centered navigation programs and comparative shopping opportunities
- Plans can't charge higher premium based on health status (or gender)
- Plans include Essential Health Benefits
- Plans include essential community providers, including Ryan White providers
- Plans provide subsidies to those with income between 100-400% FPL

The Bad News:
Lack of Transparency in Marketplace Health Insurance Plans

- ACA Marketplaces fail to provide consumers with the ability to review plans, compare them and make informed decisions
- Several trends undermine transparency objectives:
  - Inadequate drug coverage or essential provider information
  - Failure to include adequate information as to cost of covered services and medications
  - Lack of standardization of plan formulary information
  - Inconsistencies between Marketplace and insurer websites
  - Changing plan design and cost-sharing subsequent to enrollment
  - Hidden requirements such as mail order pharmacy only

Progress to Date and Next Step for Addressing Transparency

Administrative/Regulatory Progress

- In general, HHS cautions insurers to avoid discouraging enrollment of people with chronic conditions
  - All formulary drug lists must be up-to-date and accurately list all covered drugs
  - Formulary link must be accessible to the general public through a clearly identified link or tab on the plan website
  - Discourages plans from mid-year formulary changes, while recognizing that changes related to availability may be necessary

Next Steps: Federal/State Administrative and Regulatory Advocacy

- Monitor and enforce new Marketplace transparency rules
- Stricter limits on ability of plans to change formularies after close of open enrollment period OR allow beneficiaries to change plans under "qualifying event" provisions if substantive change

Inadequate Coverage in Private Health Insurance Plans

- In 2014, 28% of all HIV drugs and 19% of STRs not covered
- In 2015, only 46% included the ten most commonly prescribed HIV regimens on their formularies
  - 12% covered six or fewer top ten regimens
  - Recently approved treatments have lowest rates of coverage (i.e., Triumeq, approved in 2014, covered only 50%)
  - Comparing 2014 and 15 data shows some plans moving in the wrong direction
- Increased utilization management (prior authorization and step therapy) also reduce access

Avalere Health, "Coverage of Top HIV Regimens in 2015 Exchange Plans," November 11, 2015; Avalere Health, "Review of Formulary Coverage, Cost Sharing and Access in Top Exchange Plans," March 2014.

Progress to Date and Next Step for Addressing Coverage

Administrative/Regulatory Progress

- CMS will review to identify outlier plans that are excluding large number of treatments or subjecting them to prior authorization or step therapy
    - CMS recently acknowledged outlier approach won't work if majority of plans employ discriminatory plan design, but has not yet identified an alternative monitoring and enforcement approach
    - CMS also acknowledged that insurers who refuse to cover STR might effectively discourage enrollment and as such discriminate
- New rules require plans to create a standardized 72 hour exceptions process, with an independent external review for denials

Next Steps: Federal/State Administrative and Regulatory Advocacy

- Amend EHB rule to require coverage of drugs (where no generic alternative exists) accepted in treatment guidelines or best practices
- Promulgate regulations to clearly define discriminatory plan design

Lack of Affordability

- Many plans are placing all HIV medications on formulary tiers with very high levels of cost-sharing
- In 2015, 30% of plans placed all10 of the most commonly prescribed treatment regimens on the highest formulary tier
- 50% of HIV/AIDS drugs covered are subject to an average of 36% co-insurance
- Some plans are placing all HIV and HCV medications on 50% co-insurance
  - Individuals living with HIV enrolled in a plan with HIV-based adverse tiering spend $3,000 more per year
  - This practice isn't just happening to people living with HIV, but is widely utilized in the context of HIV

Progress to Date and Next Step for Addressing Affordability

Administrative/Regulatory Progress

- CMS has said that insurers who place all drugs that treat a particular condition on higher-cost tier may discriminate against enrollees
- Individual right of action under §1157 – ACA anti-discrimination law

Next Steps: Federal/State Legislative or Regulatory Advocacy

- HHS should amend the EHB rule to prohibit excessive coinsurance for specialty drugs (where no generic) accepted in treatment guidelines
- States should enact laws that limit cost-sharing for specialty drugs
  - Current state laws limit copayment for specialty tier drugs at $150 for 30 days; require appeals process; and prohibit placement of all drugs of a class on specialty tier
- Congress should also enact legislation to limit cost-sharing

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