2017 Plan Analysis for Qualified Health Plans:

ALABAMA

Produced in collaboration with AIDS Alabama

Center for Health Law & Policy Innovation
Harvard Law School

AIDSAlabama

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2017 Plan Analysis for Qualified Health Plans: Alabama released December 2016

Introduction:

People living with HIV and HCV have historically faced discrimination throughout the health care system. The Affordable Care Act (ACA) was in part intended to dramatically increase access to care for those previously excluded from our health care system, requiring coverage for preexisting conditions, and prohibiting discrimination against people with disabilities. To this end, the ACA created the health insurance Marketplaces in each state and prohibits insurers from discriminating against or denying benefits to individuals with disabilities. Despite these regulations, the Marketplaces are facing two major challenges: the changing political landscape and insurers' efforts to discriminate against high cost enrollees.

Although the future of the ACA and its component initiatives is uncertain in the changing political landscape, it is unlikely that the Marketplaces will be significantly modified or terminated before the end of 2017 at the earliest. This means that individuals can still obtain coverage through the Marketplaces for at least a year by enrolling in the 2017 Qualified Health Plans (QHPs). Furthermore, one of the best protections for a government initiative is a large number of people utilizing that program successfully. A robust and successful open enrollment for the 2017 QHPs is vital for preserving the Marketplaces and the protections afforded to people living with HIV and HCV by the ACA.

The other challenge facing the Marketplaces is the increasing adoption of discriminatory plan benefit design by participating insurers. Insurance companies are consistently utilizing discriminatory plan benefit designs to avoid meeting the needs of expensive-to-insure individuals, such as those living with HIV and HCV. Insurers' failure to meet the needs of consumers living with HIV and HCV means that these individuals are prevented from realizing the promises of the ACA. Documenting these practices is key to generating advocacy to prevent insurers from normalizing these practices and regulators from approving discriminatory plans.

Introduction:

In the face of increasingly restrictive and discriminatory health insurance plans within the Marketplaces and mindful of the importance of a healthy 2017 open enrollment period, the Center for Health Law and Policy Innovation of Harvard Law School (CHLPI) has developed the QHP Assessment Project to evaluate QHPs on key Marketplaces and assess their coverage and cost-sharing requirements for HIV and HCV medications. The QHP Assessment Project has two major goals: 1) to provide specific, detailed information on the QHPs offerings to allow individuals to select the correct QHP for their health needs; and 2) to utilize the information generated to inform the advocacy and litigation efforts of CHLPI and its partners. The ACA promises equal and affordable coverage for all persons, regardless of pre-existing conditions or disability, and this project is an important step in enforcing the health care rights of people living with HIV and HCV.

For further questions and inquiries please contact Carmel Shachar at cshachar@law.harvard.edu. To learn more about CHLPI's litigation initiative, please contact Kevin Costello at kcostello@law.harvard.edu.

Overview:

The purpose of the QHP Assessment Project is to present all the information relating to a plan's benefit design that would lead an individual living with HIV and/or HCV to choose one QHP over another. Therefore the assessments of each QHP include a variety of information, including premiums, cost sharing for provider services, and deductibles. CHLPI has also identified discriminatory plan benefit design trends in the coverage and cost of key HIV and HCV medications. Correspondingly, CHLPI's 2017 QHP Assessment Project has a special focus on these metrics.

The lack of coverage for common and newer HIV and HCV regimens is cause for significant concern. HIV and HCV treatment regimens are not interchangeable and should be driven by clinical considerations, treatment guidelines, and patient and provider choice. Beginning with the most cost-effective treatment and then escalating to newer, more expensive treatments is contrary to federal guidelines for HIV, which recommend that the "[s]election of a regimen should be individualized."[1] The newer HCV medications are such an improvement over the older treatment regimens that to use an older treatment would mean failing to meet a basic standard of care. Additionally, some of the newer HCV medications are not appropriate for all genotypes or for individuals co-infected with HIV, so individuals must be able to access all newer treatments. QHPs should provide access to the full range of commonly prescribed medications in keeping with federal guidelines and best standards of care. Insurers' failure to cover critical medications is discriminatory in that it discourages enrollment by individuals living with these conditions.

1 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

Overview:

Coverage of medications is not the only criteria for assessing meaningful health care access. Insurers must also make HIV and HCV medications affordable to their plan beneficiaries by keeping out of pocket costs reasonable. Often, insurers will place all HIV and HCV medications on the highest cost sharing tier of their formulary, in a discriminatory practice commonly referred to as adverse tiering. Adverse tiering forces individuals living with HIV and/or HCV to shoulder a much higher percentage of their health care costs than other enrollees in the same plans. It also can prevent individuals from affording critical medications, despite paying premiums for health care coverage. Adverse tiering is often used by insurers to deter "undesirable" consumers from selecting their plans.

Further exacerbating cost-related concerns, CHLPI has seen a trend to use co-insurance rather than co-payments for cost sharing. As CHLPI and others have noted, co-insurance tends to quickly increase cost to consumers for expensive medications, especially as compared to co-payments. Additionally, co-insurance is a transparency concern because it is hard for consumers with co-insurance to calculate the actual cost sharing owed before attempting to purchase their prescriptions. Co-insurance 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 and HCV with unreasonable cost sharing.

How to Use This Tool:

CHLPI will produce a series of reports and analyses of the state of the 2017 Silver QHP offerings based on the data from the 2017 QHP Assessment Project. This document is one of the initial reports, evaluating all 2017 silver-level QHPs in this state as well as a high level analysis of cost and coverage trends in this Marketplace, including some basic recommendations for appropriate QHPs for individuals living with HIV and/or HCV.

This report is intended to be used by advocates, navigators, and consumers to help them determine which silver-level QHPs best serve the needs of individuals living with HIV and/or HCV. As such, CHLPI, in collaboration with its state partner, has gathered information on each silver-level QHP in this Marketplace on:

- **Overall Plan Information:** Including coverage area, plan type, and premium amounts.
- **Cost Sharing Information:** Including deductibles, co-payment and co-insurance amounts for medical services, as well as out of pocket cost sharing requirements for the different tiers of drugs in the QHP's formulary.
- **Formulary Information:** Provides name of formulary, link to formulary and notes regarding deductible or coverage issues.
- **HCV Medication Cost and Coverage:** Examining which newer HCV medications are listed on the formulary linked to by the Marketplace, covered by the QHP, and the cost sharing requirements for accessing each medication.
- **HIV Medication Cost and Coverage:** Examining which standard of care HIV medications are listed on the formulary, covered by the QHP, and the cost sharing requirements for accessing each medication.

CHLPI notes that it is not a licensed navigator or insurance broker and that it does not purport to recommend specific plans for individuals. Individuals should review the information themselves and discuss their health needs with a navigator or certified application counselor.

Legend NC/NL= Not Covered/Not Listed QL= Quantity Limit SP= Specialty Pharmacy ST= Step Therapy

Methodology:

The Center for Health Law and Policy Innovation (CHLPI) collaborated with state based partner organizations in key states across the country to gather information on the 2017 Silver Qualified Health Plans (QHPs). CHLPI staff trained community advocates to analyze the 2017 silver-level QHPs. CHLPI then utilized the assessments generated by the advocates to provide an analysis of coverage and cost sharing trends in the QHPs. Assessors and CHLPI used materials available on the applicable health insurance Marketplace, specifically plan summary of benefits and drug formularies, to assess the plans and generate an analysis of key trends.

Notes Regarding Sources

CHLPI staff and assessors used the summary of benefits and formularies available at the beginning of open enrollment on the health insurance Marketplaces to assess the 2017 silver-level QHPs. When the summary of benefits and formularies did not provide information needed to assess the QHP, or provided inconsistent or unclear information, CHLPI staff and asessors called the relevant insurer using the general contact number and identified themselves as an individual considering enrollment in that QHP. The reports generated by the 2017 QHP Assessment Project, including this one, should be considered snapshots of the insurance markets at the beginning of the 2017 open enrollment period. Information may have changed or been updated since the assessment was completed and report released. Individuals looking to select a plan should go to their local health insurance exchange to obtain the most up to date information on available QHPs.

Methodology:

Notes Regarding Plan Assessment Charts

Plans Listed: In some states, plans offered by the same insurer were distinguished (either by name or plan ID) based on their network, coverage area, and premiums but did not differ for cost sharing and coverage of services and medications. Because of the focus on benefit design in this project and to avoid duplication, in this situation, the plan benefit design was analyzed once and the coverage listed is a composite of the coverage area for the related plans. This project did not include plans with vision or dental services that otherwise were duplicates of other plans offered.

Premiums: Premium payments cited in these reports were generally for the county that encompasses a large metropolitan region in the state, unless noted otherwise. Sometimes, a QHP was not offered in that county, in which case, another county was selected. Premiums vary depending on age, smoking status, and location of the applicant. The premiums cited in this report should be used to compare the cost of available QHPs rather than considered a guaranteed premium for any particular individual.

Selected Formularies and Covered Medications: In an effort to capture transparency issues, the plan assessments evaluate whether a QHP not only covers a medication but if it lists that medication on the formulary available on its health insurance exchange. Despite regulatory prohibitions against this practice, some insurers cover specific medication under a QHP but do not list that medication on the formulary posted to the Marketplace. These incomplete formularies are referred to as 'select' formularies. Complete formularies that list all covered medication are referred to as 'non-select' formularies. In cases where there was confusion or concern about the coverage, or lack thereof, of a particular medication, CHLPI staff and assessors called the insurer or obtained a more comprehensive formulary from the insurer's website. Medications were given one of the following designations in our assessment, depending on their coverage status and appearance on formulary.

Methodology:

- ***'Covered':*** A drug is listed on the formulary available on the applicable health insurance exchange and is covered by the insurer under that particular QHP.
- ***'Not, but covered:'*** The drug is not listed on the formulary provided on the applicable health insurance exchange but is covered under the particular QHP. Often, this information was obtained by calling the insurance company's customer service and speaking with a representative who provided additional information not listed on the formulary.
- ***'No, not covered':*** A drug is not listed on any formulary and is not covered by the insurer under that particular QHP.

Generics and Branded Medication: All branded medications are listed by their commercial name and that name is capitalized. Generics are referred to by their chemical name and are not capitalized.

Tiering: In some cases, an insurer may place one formulation of a medication on a lower tier than a different formulation. The plan assessments reflect the lower cost sharing tier for that medication. CHLPI staff consulted medical providers to determine which formulation was more commonly used. If medical providers agreed that the higher cost formulation was more important, CHLPI changed the designation of the medication to the higher cost sharing tier. Similarly, if one formulation of a medication was covered, but others were not, the plan assessments reflected the cost sharing tier for the covered formulation.

Methodology:

Notes Regarding Overall Analysis and Trends

For each state, CHLPI staff analyzed the QHP assessment raw data for trends relating to coverage and cost sharing of HIV and HCV medications. CHLPI staff then completed a summary, drawing attention to the trends as well as discussing outlier QHPs that advocates and individuals living with HIV and/or HCV should be aware of. These reports are meant for educational, policy, and advocacy purposes and should not be considered navigation services or enrollment recommendations for individuals.

Coverage: CHLPI mapped coverage concerns by creating graphs that illustrated the percentage of QHPs that covered all, some or none of the approved new generation HCV medications. Medications include Sovaldi, Harvoni, Epclusa, Olysio, Zepatier, and Viekira Pak. CHLPI also developed coverage graphs for 27 HIV medications most likely to be prescribed, using the *Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents*, developed by the Department of Health and Human Services, as well as consultation from medical providers specializing in HIV care. For the coverage graphs of HIV medications, CHLPI used the following categories: 0-6 medications covered, 7-12 medications covered, 13-18 medications covered, and 19-27 medications covered. Trends in which medications were not covered, such as when newer, more expensive single tablet regimens were excluded, are generally noted in the summary.

Cost Sharing: CHLPI also mapped cost sharing concerns by creating charts that separated out trends for co-payment and co-insurance requirements. Because CHLPI is interested in identifying discriminatory tiering patterns, or when insurers place HIV and HCV medications on the highest cost-sharing tiers compared to the rest of their formularies, we did not categorize QHPs by absolute cost to the consumer.

Methodology:

For example, if QHP A categorized all of its HIV medications on its highest formulary tier, resulting in a 20% co-insurance, and QHP B placed all of its HIV medications on a middle formulary tier, resulting in a 30% co-insurance, QHP A would be categorized as highest tier and QHP B would be categorized as middle tier, despite QHP A actually being lower cost to the consumer than QHP B. CHLPI did note which QHPs would be more expensive to consumers in the narrative summary, however.

QHPs were sorted into highest, middle, and lowest cost sharing catagories in the cost sharing charts based on the placement of the majority of the medications. For example, if a QHP placed 17 HIV medications on its middle tier and 10 medications on its highest tier, it would be categorized into the middle cost sharing category. In the event of a tie, preference was given to the newer medications that are components of recommended treatment regimens in the *Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents*. Some high deductible QHPs tiered covered medications but did not impose any cost sharing after the deductible is met. Those QHPs were still placed into highest, middle, and lowest cost sharing catagories in the cost sharing charts but were not included in the co-payment or co-insurance subcatgories.

Unless noted otherwise, plans in which HIV and HCV medications were categorized as preferred drugs (usually tier 1 or tier 2) were classified as lowest formulary. Plans in which HIV and HCV medications were categorized as non-preferred but were not on the highest cost sharing tier or a specialty medication tier were classified as middle formulary. Plans in which HIV and HCV medications were categorized as the highest cost sharing tier or the specialty medication tier (usually tier 4 or tier 5) were classified as highest formulary. Advocates and individuals living with HIV and HCV interested in understanding which QHPs would result in the lowest cost sharing burden for medications should review the summary and the QHP assessment charts.

State Findings | HCV:

As was the case in 2016, residents of Alabama enrolled in the 2017 Silver Qualified Health Plans (QHPs) have relatively good access to Hepatitis C (HCV) medications, compared to individuals living in neighboring states. The only two silver level QHPs available on the 2017 Alabama marketplace are both offered by Blue Cross Blue Shield of Alabama (BCBS of AL), whose 2017 formulary offers five out of six of the currently approved new generation HCV medications. Epclusa, recently approved by the FDA in June of 2016, is the only HCV medication not offered on either of BCBS's Silver QHPs.[1]

Cost, on the other hand, continues to be a challenge in the 2017 silver QHPs, although it has improved somewhat. The 2017 BCBS formulary focuses on co-payments, not co-insurance, for some HCV medications. The use of co-payments in the BCBS formularies is particularly helpful for consumers because co-payments tend to be lower and more predictable than co-insurance. Located on Tier 5 (described as "preferred specialty"), Sovaldi or Harvoni would cost an enrollee $250 for a 30-day supply. While enrollees must pay one flat monthly co-payment for HCV medications on Tier 5, such is not the case for Viekira Pack, Olysio, and Zepatier. These three medications are located on Tier 6 (the "non preferred" specialty tier), requiring consumers to pay at least $300 for their monthly prescription. Medications on Tier 6 will cost an enrollee the greater of either a $300 co-payment or 30% co-insurance. Without knowing the actual cost of the medication, consumers cannot easily determine whether 30% co-insurance would amount to a much greater out-of-pocket cost than a $300 co-payment. Because the negotiated prices of medications are inaccessible to the public, consumers cannot easily or accurately compare the costs of plans prior to enrollment. It is likely that all HCV medications on Tier 6 will cost significantly more than $300 per month, however. For example, a conservative estimate of Olysio's wholesale acquisition cost is $16,063.60 per month, which would cost consumers almost $5,000 per month in cost-sharing.

[1] *See* "U.S. Food and Drug Administration Approves Gilead's Epclusa® (Sofosbuvir/Velpatasvir) for the Treatment of All Genotypes of Chronic Hepatitis C" *available at* http://www.gilead.com/news/press-releases/2016/6/us-food-and-drug-administration-approves-gileads-epclusa-sofosbuvirvelpatasvir-for-the-treatment-of-all-genotypes-of-chronic-hepatitis-c Last visited Nov. 12, 2016.

State Findings | HCV:

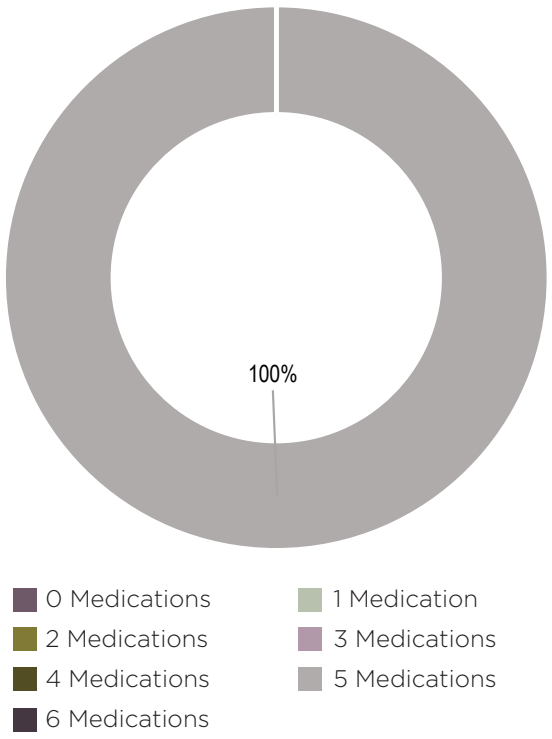
Furthermore, BCBS buries the Tiers 4 and 6 co-insurance requirements in the "Limitations & Exceptions" column of its plans' Summary of Benefits chart, rather than the Costs column. Enrollees might not read through the fine print of either plan, and simply assume that their Tier 6 HCV medications cost a flat rate of $300 a month.

BCBS of AL has reduced the cost-sharing requirements for Sovaldi and Harvoni in its 2017 formulary, however. In 2016, the same HCV medications would have cost a Blue Cross Blue Shield enrollee $425 per month on the Blue Value Saver and Blue Saver Silver plans or 20% of the cost of the medication on the Blue Select Silver plan. As the wholesale acquisition cost of a course of treatment of Sovaldi is estimated at $84,000, the 20% co-insurance would have been a significant burden to those enrolled in Blue Cross Blue Shield Blue Saver Silver. In contrast, these two medications cost $250 for a 30 day supply on the 2017 BCBS Silver QHP plans—a significant reduction in out-of-pocket costs from last year's co-payment and co-insurance requirements.

With several high profile withdrawals from the 2017 Alabama marketplace, including UnitedHealthcare, however, there are no plans that offer any new generation HCV medications at truly affordable prices. In 2016, UnitedHealthcare plans had covered Sovaldi and Harvoni on Tier 2 of its formulary, amounting to a monthly co-payment of $40. Mostly because of United's offerings, 43% of the 2016 Silver QHPs in Alabama offered at least some HCV medications at a lower cost sharing tier than the often costly specialty tiers. After UnitedHealthcare's exit, not a single Silver QHP remaining on the 2017 marketplace provides HCV medications at such reasonable costs.

State Findings | HCV:

PLAN COVERAGE



COST SHARING

Lowest Tier Formulary[1]	Number	Percent
Plans using lowest tier formulary	0	0%
Plans using lowest tier formulary and co-pay	0	0%
Plans using lowest tier formulary and coinsurance	0	0%
Middle Tier Formulary[2]		
Plans using middle tier formulary	0	0%
Plans using middle tier formulary and co-pay	0	0%
Plans using middle tier formulary and coinsurance	0	0%
Highest Tier Formulary[3]		
Plans using highest tier formulary	0	0%
Plans using highest tier formulary and co-pay	2	100%
Plans using highest tier formulary and coinsurance	0	0%

[1] Plans were categorized in the lowest tier if they placed the majority of medications in that tier.
[2] Plans were categorized in the middle tier if they placed the majority of medications in that tier.
[3] Plans were categorized in the highest tier if they placed the majority of medications in that tier.

State Findings | HIV:

The Silver Qualified Health Plans (QHPs) offered in 2017 for Alabama residents covered all but one of the HIV medications researched in the plan assessment initiative. Though ritonavir is not covered on either marketplace plan, it is available to enrollees in its more costly brand name form (Norvir). Comprehensive coverage of HIV antiretrovirals is important because HIV, unlike some other conditions, requires that physicians and patients be able to pick the most appropriate treatment for that individual's needs.

Of the 27 HIV medications offered on BCBS's formulary, 13 are offered on Tier 3. Tier 3 requires a $75 monthly co-payment, which is a $10 to $20 dollar increase compared to last year's cost-sharing requirements. There are 7 HIV medications offered on Tier 4, however, which requires enrollees to pay the greater amount of $125 or 50% co-insurance. Though enrollees are aware that they must pay at least $125 a month for these seven HIV medications, it is unclear whether 50% of the actual cost of the medication would require them to pay significantly more than $125 per month for their medications. Odefsey, for example, has an estimated wholesale acquisition cost of $1421.53 a month, which would translate to $710.77 in monthly out-of-pocket costs for enrollees. Similarly, Genvoya costs an estimated $1528.52, which would cost enrollees $764.26 per month in co-insurance. Without clear warning on behalf of the insurer, consumers will undoubtedly be alarmed by a nearly sixfold increase in anticipated monthly out-of-pocket costs for these HIV medications. Furthermore, BCBS buries the Tiers 4 and 6 co-insurance requirements in the "Limitations & Exceptions" column of its plans' Summary of Benefits chart, rather than the Costs column. Enrollees might not read through the fine print of either plan, and simply assume that their Tier 4 HIV medications cost a flat rate of $125 a month.

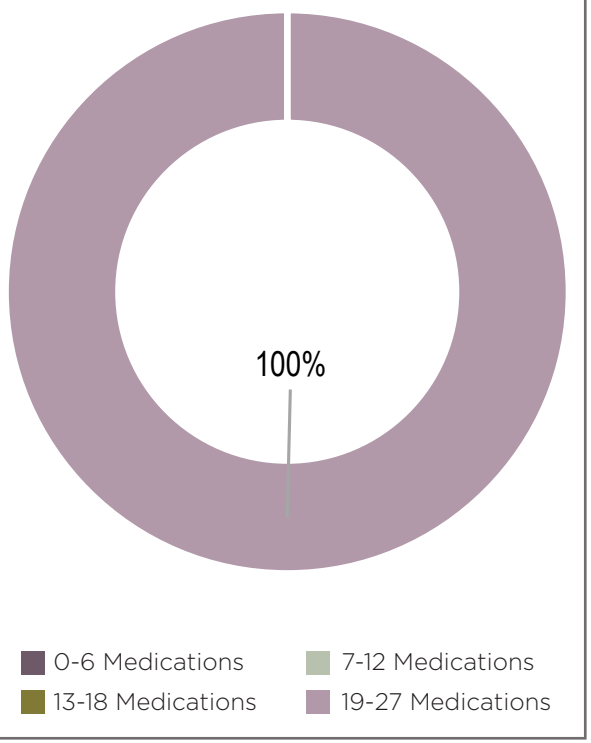
State Findings | HIV:

In 2016, the BCBS and UnitedHealthcare plans placed the majority of their HIV medications on non-specialty tiers. For example, BCBS placed virtually all HIV medication on Tier 2 for its plans, and no medications above Tier 3. For the enrollees of BCBS Blue Saver Silver this translated to a $55 co-payment for a 30-day supply. By contrast, Humana offered the most costly 2016 options for enrollees seeking coverage for their HIV treatment regimens. Virtually all HIV medications were placed on the specialty tier, requiring enrollees to pay 50% of the cost of these medications every month. By placing nearly all commonly prescribed HIV medications on their highest cost-sharing tier, Humana discouraged people living with HIV and AIDS from enrolling in its health plans—a practice which unlawfully discriminates on the basis of disability.

In September of 2016, CHLPI and AIDS Alabama filed a complaint with the Office of Civil Rights requesting an investigation into Humana's discriminatory benefit designs. In our complaint to OCR, we had predicted that Humana's business practices would lead other insurers to raise premiums or alter their marketplace products to mirror Humana's benefit designs. Although BCBS remains the only insurer on the Alabama marketplace for 2017, this prediction still holds. Without any competition, BCBS runs a dangerous monopoly over the Alabama marketplace. BCBS places some HIV medications on the higher-level tiers of its 2017 drug formulary, requiring consumers to shoulder half the costs of these expensive medications. Without state regulations, vigilant plan reviews, and inspection from the Alabama Department of Insurance, any of BCBS's monopolistic practices may continue to go unchallenged.

State Findings | HIV:

PLAN COVERAGE



COST SHARING

Lowest Tier Formulary[1]	Number	Percent
Plans using lowest tier formulary	0	0%
Plans using lowest tier formulary and co-pay	0	0%
Plans using lowest tier formulary and coinsurance	0	0%
Middle Tier Formulary[2]		
Plans using middle tier formulary	0	0%
Plans using middle tier formulary and co-pay	2	100%
Plans using middle tier formulary and coinsurance	0	0%
Highest Tier Formulary[3]		
Plans using highest tier formulary	0	0%
Plans using highest tier formulary and co-pay	0	0%
Plans using highest tier formulary and coinsurance	0	0%

[1] Plans were categorized in the lowest tier if they placed the majority of medications in that tier.
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[3] Plans were categorized in the highest tier if they placed the majority of medications in that tier.

Blue Cross Blue Shield of Alabama
Blue Cross Select Silver, A Multi-State Plan
2017 Marketplace

Overall Plan Information			
Issuer Name	Blue Cross and Blue Shield of Alabama		
Plan Name	Blue Cross Select Silver, A Multi-State Plan	Simple Choice Plan: No	
Plan ID	46944AL0630001		
Plan Type	PPO		
Coverage Area (counties)	All Counties		
Link to Summary of Benefits	https://www.bcbsal.org/sb/2017sms.pdf?frm=alabamablue.com		
Individual Deductibles	Medical: $2800	Prescription: $0	Out of Pocket Cap: $6850
Family Deductibles	Medical: $5600	Prescription: $0	Out of Pocket Cap: $13700
Does Deductible Need to be Met Before Prescription Drugs are Covered?	No		
Is there a Prescription Drug Deductible?	No		
Premiums (per month)	Individual: $406	Family: $1267	

Cost Sharing Information			
Tier One	Name of Tier: Tier 1	Co-Payments: $20	Co-Insurance: %
Tier Two	Name of Tier: Tier 2	Co-Payments: $30	Co-Insurance: %
Tier Three	Name of Tier: Tier 3	Co-Payments: $75	Co-Insurance: %
Tier Four	Name of Tier: Tier 4	Co-Payments: $125	Co-Insurance: 50%
Tier Five/Specialty	Name of Tier: Tier 5 (Preferred Specialty)	Co-Payments: $250	Co-Insurance: %
Tier Other	Name of Tier: Tier 6 (Non-preferred specialty)	Co-Payments: $300	Co-Insurance: 30%
Primary Care Providers	Co-Payments: $40	Co-Insurance: %	
Specialists	Co-Payments: $65	Co-Insurance: %	Referral required for specialists? Yes

Hospital Stay – Physician Fee	Co-Payments: $	Co-Insurance: 0%	
Hospital Stay – Facility Fee	Co-Payments: $350	Co-Insurance: 20%	
Emergency Room	Co-Payments: $350	Co-Insurance: %	
Mental/Behavioral Health Outpatient Health Services	Co-Payments: $65	Co-Insurance: %	Prior Approval? Yes
Substance Use Disorder Outpatient Services	Co-Payments: $65	Co-Insurance: %	Prior Approval? Yes
Laboratory Services	Co-Payments: $0	Co-Insurance: %	

Formulary Information	
Name of formulary used	Blue Cross and Blue Shield of Alabama Source+Rx 1.0 Prescription Drug List
Selected or non-selected formulary?	Non-selected
Link to formulary	https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/IVL/2017/2017_AL_6T_Source+Rx_1.0.pdf
Contact number	1-855-350-7437
Notes re: deductible or coverage	The Blue Cross prescription benefit is multi-tiered, placing prescription drugs into one of six tier levels. Tier 1 primarily contains preferred (lowest cost) generic drugs (but may include low cost brands), Tier 2 primarily contains non-preferred generic drugs (higher in cost but covered for efficacy or uniqueness purposes) . Similar to Tier 1, based on cost consideration, there may be brands placed into this tier on occasion as well. Tier 3 primarily contains preferred (based on efficiacy, uniqueness, safety advantages, and/or cost considerations) brands. Tier 4 primarily contains non-preferred (less preferred compared to alternatives available based on efficiacy, uniqueness, safety, and cost) brands. Tier 5 primarily contains preferred specialty drugs, and Tier 6 contains primarily non-preferred specialty drugs. All tiers may contain drugs otherwise categorized as generic, brand, or specialty. Preferred drugs may offer a clinical or cost advantage over non-preferred drugs within the same therapeutic category. Coverage and copayment/co-insurance levels vary depending on the plan. Drugs that require Prior Authorization, Step Therapy, or that have Dispensing Limits or are considered Limited Distribution are noted in the Prescription Drug List. Tier 1 - primarily preferred generics Tier 2 - primarily non-preferred generics Tier 3 - primarily preferred brands Tier 4 - primarily non-preferred brands Tier 5 - primarily preferred specialty Tier 6 - primarily non-preferred specialty.

Medications					
HCV	**On Formulary**	**Tier**	**PA**	**QL**	**ST**
Epclusa (sofosbuvir/velpatasvir)	No	None	None	None	None
Harvoni (ledipasvir, sofosbuvir)	Yes	5	Yes	No	No
Olysio (simeprevir)	Yes	Other	Yes	No	No
Sovaldi (sofosbuvir)	Yes	5	Yes	No	No
Viekira Pak (ombitasvir, paritaprevir, ritonavir)	Yes	Other	Yes	No	No
Zepatier (elbasvir and grazoprevir)	Yes	Other	Yes	No	No
HIV	**On Formulary**	**Tier**	**PA**	**QL**	**ST**
Atripla (efavirenz/emtricitabine/tenofovir)	Yes	3	No	Yes	No
Combivir (lamivudine/zidovudine)	Yes	2	No	Yes	No
Complera (emtricitabine/rilpivirine/tenofovir)	Yes	3	No	Yes	Yes
Descovy (Emtricitabine/Tenofovir/Alafenamide)	Yes	4	No	Yes	No
Edurant (rilpivirine)	Yes	4	No	Yes	No
Epizicom (abacavir/lamivudine)	Yes	3	No	Yes	No
abacavir	Yes	2	No	Yes	No
Evotaz (atazanavir/cobicistat)	Yes	3	No	Yes	No
Isentress (raltegravir)	Yes	3	No	Yes	No
Genvoya (Elvitegravir/ Cobicistat/Emtricitabine/Tenofovir Alafenamide)	Yes	4	No	Yes	No
Epivir (lamivudine)	Yes	2	No	Yes	No
lamivudine	Yes	2	No	Yes	No
Zidovudine/lamivudine	Yes	2	No	Yes	No
Norvir (ritonavir)	Yes	4	No	Yes	No
ritonavir	Yes	3	No	Yes	No
Odefsey (Emtricitabine/Rilpivirine/Tenofovir/Alafenamid)	Yes	4	No	Yes	No
Prezcobix (darunavir/cobicistat)	Yes	3	No	Yes	No
Prezista (darunavir)	Yes	3	No	Yes	No
Reyataz (atazanavir)	Yes	3	No	Yes	No
Stribild (cobicistat/elvitegravir/emtricitabine/tenofovir)	Yes	3	No	Yes	No
Tivicay (dolutegravir)	Yes	3	No	Yes	No
Triumeq (abacavir/dolutegravir/lamivudine)	Yes	3	No	Yes	No

HIV	On Formulary	Tier	PA	QL	ST
Truvada (emtricitabine/tenofovir)	Yes	3	No	Yes	No
Viramune (nevirapine)	Yes	3	No	Yes	No
nevirapine	Yes	4	No	Yes	No
Retrovir (zidovudine)	Yes	2	No	Yes	No
zidovudine	Yes	2	No	Yes	No

Blue Cross Blue Shield of Alabama
Blue Value Silver
2017 Marketplace

Overall Plan Information			
Issuer Name	Blue Cross Blue Shield of Alabama		
Plan Name	Blue Value Silver	Simple Choice Plan: No	
Plan ID	46944AL0410001		
Plan Type	PPO		
Coverage Area (counties)	All Counties		
Link to Summary of Benefits	https://www.bcbsal.org/sb/2017vsi.pdf?frm=alabamablue.com		
Individual Deductibles	Medical: $2600	Prescription: $	Out of Pocket Cap: $6850
Family Deductibles	Medical: $5200	Prescription: $	Out of Pocket Cap: $13700
Does Deductible Need to be Met Before Prescription Drugs are Covered?	No		
Is there a Prescription Drug Deductible?	No		
Premiums (per month)	Individual: $438	Family: $1364	

Cost Sharing Information			
Tier One	Name of Tier: Tier 1	Co-Payments: $20	Co-Insurance: %
Tier Two	Name of Tier: Tier 2	Co-Payments: $30	Co-Insurance: %
Tier Three	Name of Tier: Tier 3	Co-Payments: $75	Co-Insurance: %
Tier Four	Name of Tier: Tier 4	Co-Payments: $125	Co-Insurance: 50%
Tier Five/Specialty	Name of Tier: Preferred Specialty	Co-Payments: $250	Co-Insurance: %
Tier Other	Name of Tier: Non-preferred Specialty	Co-Payments: $300	Co-Insurance: 30%
Primary Care Providers	Co-Payments: $40	Co-Insurance: %	
Specialists	Co-Payments: $55	Co-Insurance: %	Referral required for specialists? No
Hospital Stay – Physician Fee	Co-Payments: $	Co-Insurance: 0%	

Hospital Stay – Facility Fee	Co-Payments: $350	Co-Insurance: 20%	
Emergency Room	Co-Payments: $350	Co-Insurance: %	
Mental/Behavioral Health Outpatient Health Services	Co-Payments: $55	Co-Insurance: %	Prior Approval? Yes
Substance Use Disorder Outpatient Services	Co-Payments: $55	Co-Insurance: %	Prior Approval? Yes
Laboratory Services	Co-Payments: $350	Co-Insurance: %	

Formulary Information	
Name of formulary used	Blue Cross and Blue Shield of Alabama Source+Rx 1.0 Prescription Drug List
Selected or non-selected formulary?	Non-selected
Link to formulary	https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/IVL/2017/2017_AL_6T_Source+Rx_1.0.pdf
Contact number	1-855-350-7437
Notes re: deductible or coverage	An "NA" displayed in the drug tier field indicates the drug may only be covered if a member meets criteria for $0 preventative coverage under the Affordable Care Act (ACA). If a member does not meet ACA coverage criteria, these drugs are not covered under the plan but may be available over the counter without a prescription. Coverage is limited to prescription drugs approved by the Food and Drug Administration (FDA) as evidenced by a New Drug Application (NDA), Abbreviated New Drug Application (ANDA), or Biologics License Application (BLA) on file. Any legal requirements or group specific benefits for coverage will supersede this (e.g. preventive drugs per the Affordable Care Act). Newly marketed prescription drugs will not be covered until the P&T Committee has had an opportunity to review the drug, to determine whether the drug will be covered and if so, which tier will apply based on safety, efficiacy, and the availability of other products within that class of drugs. If your physician feels that a new drug is medically necessary prior to P&T Committee evaluation, a non-formulary exception request for coverage may be submitted. Most prescription drug benefit plans provide coverage for up to a 30-day supply of medication, with some exceptions. Your plan may also provide coverage for up to a 90-day supply of maintenance drugs. Maintenance drugs are those drugs you may take on an ongoing basis for chronic conditions such as high blood pressure, diabetes or high cholesterol.You should refer to your benefit plan booklet for details about your particular benefits.

Medications					
HCV	**On Formulary**	**Tier**	**PA**	**QL**	**ST**
Epclusa (sofosbuvir/velpatasvir)	No	None	None	None	None
Harvoni (ledipasvir, sofosbuvir)	Yes	5	Yes	No	No
Olysio (simeprevir)	Yes	Other	Yes	No	No
Sovaldi (sofosbuvir)	Yes	5	Yes	No	No
Viekira Pak (ombitasvir, paritaprevir, ritonavir)	Yes	Other	Yes	No	No
Zepatier (elbasvir and grazoprevir)	Yes	Other	Yes	No	No
HIV	**On Formulary**	**Tier**	**PA**	**QL**	**ST**
Atripla (efavirenz/emtricitabine/tenofovir)	Yes	3	No	Yes	No
Combivir (lamivudine/zidovudine)	Yes	2	No	Yes	No
Complera (emtricitabine/rilpivirine/tenofovir)	Yes	3	No	Yes	Yes
Descovy (Emtricitabine/Tenofovir/Alafenamide)	Yes	4	No	Yes	No
Edurant (rilpivirine)	Yes	4	No	Yes	No
Epizicom (abacavir/lamivudine)	Yes	3	No	Yes	No
abacavir	Yes	2	No	Yes	No
Evotaz (atazanavir/cobicistat)	Yes	3	No	Yes	No
Isentress (raltegravir)	Yes	3	No	Yes	No
Genvoya (Elvitegravir/ Cobicistat/Emtricitabine/Tenofovir Alafenamide)	Yes	4	No	Yes	No
Epivir (lamivudine)	Yes	4	No	No	No
lamivudine	Yes	2	No	Yes	No
Zidovudine/lamivudine	Yes	2	No	Yes	No
Norvir (ritonavir)	Yes	4	No	Yes	No
ritonavir	Yes	4	No	Yes	No
Odefsey (Emtricitabine/Rilpivirine/Tenofovir/Alafenamid)	Yes	4	No	Yes	No
Prezcobix (darunavir/cobicistat)	Yes	3	No	Yes	No
Prezista (darunavir)	Yes	3	No	Yes	No
Reyataz (atazanavir)	Yes	3	No	Yes	No
Stribild (cobicistat/elvitegravir/emtricitabine/tenofovir)	Yes	3	No	Yes	No
Tivicay (dolutegravir)	Yes	3	No	Yes	No
Triumeq (abacavir/dolutegravir/lamivudine)	Yes	3	No	Yes	No

HIV	On Formulary	Tier	PA	QL	ST
Truvada (emtricitabine/tenofovir)	Yes	3	No	Yes	No
Viramune (nevirapine)	Yes	3	No	Yes	No
nevirapine	Yes	4	No	Yes	No
Retrovir (zidovudine)	Yes	2	No	Yes	No
zidovudine	Yes	2	No	Yes	No