HIV Health Care Access Working Group

October 18, 2013

The Honorable Kathleen Sebelius
Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Dear Secretary Sebelius:

On behalf of the HIV Health Care Access Working Group (HHCAWG), thank you for your ongoing leadership and commitment to the successful implementation of the Patient Protection and Affordable Care Act (ACA). HHCAWG strongly supports the ACA as an unprecedented opportunity to expand access to critical health care and treatment for people with HIV/AIDS.

We are writing to alert you to concerns regarding poor access to essential HIV care and treatment information, and to preliminary findings that some critical HIV medications are absent from drug formularies. Both issues demand immediate attention as we work to facilitate enrollment of people with HIV/AIDS into the Marketplace Qualified Health Plans (QHPs).

Access to formulary, provider network and benefit design information is critical to the QHP selection process and should not be impeded by requiring individuals and those assisting them to initiate the enrollment process. This is particularly important for many people with HIV whose health outcomes will depend on continuity of care as they transition from Ryan White-funded care and treatment to QHP coverage.

The success of the ACA for people with HIV/AIDS also will be determined by whether they have access to the latest treatment advances as recommended by the Department of Health and Human Services Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents (DHHS guidelines). One of these important advances has been the availability of combination antiretroviral medications. Based on our review of plans in several states, some of the most commonly prescribed combination medications appear to be absent from many drug formularies, and when they are covered they are placed on high cost sharing tiers. This is true even when the co-formulated product costs no more than its components.

We hope the concerns that are outlined below can be resolved expeditiously to ensure people with HIV/AIDS are able to enroll in QHPs with coverage sufficient to meet their medical needs and so that they can avoid dangerous treatment disruptions in January 2014.

1) Information on antiretroviral coverage and in-network HIV providers is critical to effective QHP selection, yet is currently extremely difficult to obtain. Details on QHP antiretroviral coverage and provider networks are not available in an accessible and transparent manner. In some cases, basic information such as which antiretrovirals are covered and their associated out-patient costs is not available without calling the plans and even then may not be provided, e.g., one plan in Florida would only provide formulary details after enrollment.

Cost sharing for medications can vary dramatically by plan and is a critical component of the plan selection process. Details on estimated monetary amounts also are important to
have for cost-sharing designs calculated as a percentage of the retail cost of the drug. Information about how to access clinically appropriate drugs not covered by the plan also is not readily available (See 45 CFR 156.122(c)). Without access to this information along with drug coverage and provider network details, people with HIV/AIDS are ill equipped to select a QHP.

In order for state AIDS Drug Assistance Programs (ADAP) to offer premium and cost sharing assistance, they must be able to evaluate QHP coverage to ensure that the formulary is equivalent to the ADAP formulary and that providing premium and cost sharing assistance is cost effective. ADAPs have been severely hampered in conducting the necessary analysis by challenges accessing drug coverage and cost-sharing data.

Meanwhile, many people with HIV/AIDS are enrolling in QHPs without knowing whether the plan they select will be eligible for premium assistance from their state ADAP or if it will meet their medical needs. In addition, we are concerned that a lack of plan formulary and provider information may discourage people with HIV/AIDS and others with higher cost medical needs from enrolling in certain plans.

We strongly urge the following:

- Ensure that details on the QHP drug formularies, particularly the antiretrovirals, as well as details on provider networks, are made readily available on www.healthcare.gov.
- Revise www.healthcare.gov to make detailed plan information available without requiring the initiation of an application for enrollment, so that those assisting with plan assessment, but not applying for coverage, can view plan details. Consider using the Medicare Part D Drug Plan Finder website as a model for ongoing development.
- Police plans to ensure websites summaries are available that include benefits and coverage details, specific formularies and current networks for marketplace plans. Require all plans to provide summaries of HIV medication coverage in their marketplace plans, similar to the one Aetna provides.
- Require QHPs to clearly describe any non-traditional plan designs and provide details on how such designs may affect access. For example, the Florida Blue Plan, BlueCare Plan 1490 has two different strata for tier one and tier two drugs. Under each tier cost-sharing differs for “condition care” prescription drugs and “all other” drugs, yet no information is provided to indicate which drugs are considered “condition care.” These details are essential as individuals and ADAPs assess potential out-of-pocket costs.

2) In a preliminary review of plans where information was available, it appears that many are not covering combination medications, and when they are covered they are often placed on high cost sharing tiers. HIV treatment has undergone a revolution since antiretroviral medications proved effective at suppressing the virus in the mid-1990s. Initially, effective HIV treatment consisted of a complex regimen of drugs that required individuals to take multiple medications several times a day. Today some of the preferred HIV treatment regimens recommended in the DHHS guidelines are available as combination medications that reduce daily pill burden and cost sharing by limiting monthly copayments. These medications better support the strict adherence required for
suppression of HIV, which can reduce hospitalization associated costs and overall medical costs. Most of the co-formulated products are no more expensive than their component parts and can be of greater value when the benefit to treatment adherence is considered.

We are concerned that the Center for Consumer Information and Insurance Oversight (CCIIO) signaled to QHPs that coverage of these medications was not necessary by not including the combination medications in the benchmark drug counts unless they included a unique active ingredient. This is despite the fact that many of the plans selected as the state benchmarks cover these medications. The U.S. Pharmacopeia (USP) includes nearly all of the combination medications in its proposed updated drug formulary and classification system (version 6.0). We strongly urge you to quickly issue guidance to QHPs urging coverage for these medications and educating them on the DHHS guidelines. We also recommend that you correct the drug counts in 2015 by including combination medications as reflected in the proposed revised USP model formulary guidelines and urge adoption of the USP Model Guidelines v6.0 beginning in plan year 2015.

We remain strongly committed to the ACA and the health insurance coverage that it will provide to thousands of people with HIV/AIDS for the first time. We welcome the opportunity to meet with you to address these issues and to secure the promise of the ACA for people with HIV/AIDS. Please request that your staff contact Andrea Weddle with the HIV Medicine Association (aweddle@hivma.org), Amy Killelea with the National Alliance of State & Territorial AIDS Directors (akillelea@nastad.org) or Robert Greenwald with the Treatment Access Expansion Project (rgreenwa@law.harvard.edu) to arrange a meeting.

Respectfully Submitted by the Steering Committee of the HIV Health Care Access Working Group,


CC:

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Gary Cohen, CCIIO, Deputy Administrator and Director
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Melissa Harris, CMS Disabled & Elderly Health Programs Group, Director, Division of Benefits & Coverage
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Interscience Conference on Anti-Microbial Agents and Chemotherapy