# Legislative Report on Alternative Options for Serving Eligible AIDS Drug Assistance Program (ADAP) Clients

Session Law 2013-360, Section 12E.5

State of North Carolina

Department of Health and Human Services

April 1, 2015

## ***Legislative Reporting Requirement***

Session Law 2013-360, Section 12E.5 requires the Department of Health and Human Services (DHHS), Division of Public Health (DPH) to submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division. The report is to include alternative options for serving individuals diagnosed with HIV/AIDS who are eligible to receive services under the AIDS Drug Assistance Program (ADAP), including options related to the State Medicaid program and the federally facilitated Health Benefit Exchange.

## ***Executive Summary***

North Carolina's ADAP continues to assist people living with HIV who lack adequate financial resources and are not eligible for Medicaid or any other assistance. ADAP provides medications to these individuals to manage an otherwise costly and fatal communicable disease. The antiretroviral medication regimens that ADAP provides make it possible for these individuals to achieve viral suppression (an undetectable amount of HIV in their blood). HIV transmission becomes unlikely when people living with HIV become virally suppressed. As of February 28, 2015, 78% of ADAP clients were virally suppressed; this represents a 2% increase from the previous year.

In March 2010, Congress passed the Patient Protection and Affordable Care Act, commonly referred to as the ACA. The ACA provides an opportunity for uninsured ADAP clients to purchase health insurance through the Federal Health Insurance Marketplace, previously known as the federally-facilitated health benefit exchange.

In accordance with the legislative mandate, DPH explored alternative options for serving people living with HIV who are eligible to receive services from ADAP.

The Division explored and ultimately implemented the Insurance Copayment Assistance Program (ICAP) which provides cost-sharing assistance (deductibles, copayments, and coinsurance) to ADAP clients who enroll in a Qualified Health Plan through the Federal Health Insurance Marketplace. The Division used the assistance of a professional actuary to project that ICAP will generate savings for ADAP and contribute to improved client health outcomes. The number of clients who will be served by ICAP is estimated to remain low because most ADAP clients cannot afford the monthly premiums for Qualified Health Plans without assistance of federal subsidies.

ADAP also examined the possibility of providing premium assistance in addition to cost-sharing assistance. Using the assistance of a professional actuary, DPH compared the costs associated with providing premium assistance in addition to cost-sharing assistance to the cost of purchasing medication. This was deemed a non-viable long-term option due to the potential increases to insurance costs in coming years. A variety of complex factors contribute to the overall cost of providing premium assistance; future premiums and cost-sharing limits are unknown at this time but will impact the overall cost of providing premium assistance.

DHHS will continue to explore alternative options for serving people living with HIV who are eligible to receive services under ADAP, including serving these clients through Medicaid and the Federal Health Insurance Marketplace.

## ***Background***

### HIV in North Carolina

There are an estimated 36,300 people in North Carolina who are HIV positive; of those, approximately 6,500 are unaware of their infection. The HIV/STD Care and Prevention Unit within the Department of Health and Human Services' (DHHS) Division of Public Health (DPH) has active and engaging strategies to identify all cases of HIV infection, to link those individuals to appropriate medical care, and to support their ability to stay in care and on antiretroviral medication regimens.

Recent research has proven that the use of antiretroviral medication regimens reliably prevent the transmission of HIV. People living with HIV who adhere to an antiretroviral medication regimen will achieve viral suppression (an undetectable amount of HIV in their blood) which will make them unable to transmit the virus to others. Providing antiretroviral medication regimens to people living with HIV is the most productive method of reducing the spread of HIV.

The cornerstone of North Carolina's strategy to end the HIV/AIDS epidemic is to identify all people who are HIV positive and assure that they are in appropriate medical care. People living with HIV need to take a prescribed antiretroviral medication regimen in order to achieve and maintain viral suppression. They then will live much longer and healthier lives and be able to work, raise families and contribute to society in a way that had previously been very difficult. Without proper care and treatment, HIV is still a fatal infectious disease.

HIV infection represents a significant health disparity in North Carolina. In 2013, the rate of HIV diagnoses among Black/African Americans was eight times greater than white/Caucasians. Roughly 20% of all newly diagnosed cases of HIV were among males 13-24 years of age of all races. In 2013, young Black/African American males (ages 13-24 years) represented 16.3% of new cases; 21.8 % of all newly diagnosed cases of HIV infection were among adolescents age 13-24 years. HIV was also the eighth leading cause of death in Black/African American women ages 25-44 and the seventh for Black/African American men of the same age.

### The AIDS Drug Assistance Program (ADAP)

Established in 1994, North Carolina's ADAP uses a combination of federal funds, state appropriations and medication rebates to provide HIV positive residents of North Carolina (who have incomes at or below 300 percent of the federal poverty guidelines) with essential medications for the treatment of HIV, opportunistic infections, and related conditions. From 2009 to 2014, enrollment has increased by 23%.

As of March 26, 2015, there were 7,510 individuals enrolled in ADAP. The ultimate goal of ADAP is to assure that all clients adhere to their antiretroviral medication regimen, thereby achieving viral suppression and remaining virally suppressed. As of February 28, 2015, 78% of ADAP clients were virally suppressed; this represents a 2% increase from the previous year.

ADAP provides medication to clients under three models:

- The **ADAP Pharmacy Program (APP)** serves uninsured ADAP clients; approximately 79% (5,789) of clients are served through APP. The program purchases medications from a contracted wholesaler and distributes medications directly to clients through a contracted dispensing pharmacy. APP has utilized this purchasing and distribution model since 2005. In calendar year 2014, the average annual cost per enrollee for APP was $8,616; this represents an increase of approximately 6% from calendar year 2013.

- The **HIV specific State Pharmaceutical Assistance Program (SPAP)** serves ADAP clients who are enrolled in a Medicare Prescription Drug Plan (Medicare Part D); approximately 21% (1,496) of clients are served through SPAP. Clients served through SPAP are required to pay their monthly Medicare Prescription Drug Plan premiums. The program pays medication cost-sharing (deductibles, copayments, coinsurance) through a contracted Pharmacy Benefits Manager. In calendar year 2014, the average annual cost per enrollee for SPAP was $2,232; this represents an increase of approximately 8% from calendar year 2013.

  SPAP was piloted between March 2009 and February 2010. During the pilot, over 700 clients were served. The pilot recognized significant savings when cost-sharing expenditures were compared to the cost of the medications provided. SPAP is a proven model that reduces costs and contributes to improved health outcomes. Since its permanent implementation in March 2011, SPAP has generated approximately $19M in savings (approximately 70% savings compared to medication costs) and generated approximately $27M in medication rebates that have been directed back to ADAP. In addition to the financial benefits of SPAP, there is a greater percent of virally suppressed clients (75% for APP and 89% for SPAP) because it is easier for clients to access services covered by their insurance when the Program coordinates with their insurance. It is likely that the comprehensive insurance provided by Medicare contributes significantly to the better health and greater rate of viral suppression of SPAP clients.

- The **Insurance Copayment Assistance Program (ICAP)** serves ADAP clients who are enrolled in a Qualified Health Plan purchased through the federal health insurance marketplace, previously known as the federally facilitated Health Benefit Exchange. As with SPAP, clients served through ICAP are required to pay their monthly Qualified Health Plan premiums and ICAP pays medication cost-sharing (deductibles, copayments, and coinsurance) through a contracted Pharmacy Benefits Manager. ICAP was implemented on February 1, 2015. As of March 26, 2015, eighty three (83) individuals were enrolled in ICAP.

  ICAP was implemented to comply with federal expectations and to lower program costs. The Federal Health Resources and Services Administration (HRSA), which oversees the federal Ryan White funding for ADAP, expects grantees to reduce program costs and increase access to care by covering medication cost-sharing (deductibles, copayments, and coinsurance) for clients, if doing so is cost neutral at the aggregate level. DPH's contracted Actuary estimated savings between 39% and 73% for ICAP plus the generation of additional medication rebates (the exact amount of rebates will depend on ICAP enrollment and

antiretroviral medication utilization). ICAP can be modified or terminated at any point if unexpected costs or problems arise, and clients would be transitioned back to APP in that event. As with APP and SPAP, DPH and the contracted Actuary are monitoring ICAP enrollment, utilization, costs/savings and health outcomes.

**The Affordable Care Act (ACA)**

The ACA includes a number of provisions that take effect between 2010 and 2020. Beginning in 2014, the ACA requires many people without insurance to become insured or pay a penalty, unless eligible for an exemption. The ACA established the Federal Health Insurance Marketplace, an online resource for identifying and purchasing health insurance. Under the ACA, the health insurance industry is more regulated than previously. Insurance companies are not allowed to deny coverage based on pre-existing conditions such as HIV, and plans must include designated essential health benefits such as prescription drug coverage. Additionally, insurance carriers participating in the Federal Health Insurance Marketplace are required to offer Qualified Health Plans (QHPs). All QHPs offer the same essential health benefits coverage, but are differentiated based on their amount of cost sharing or "actuarial value". QHPs also include a cost-sharing (deductible, copayment, and coinsurance) limit on maximum out of pocket costs.

The actuarial value refers to the average amount of insurance expenses that would be paid for by the insurance plan. QHPs are categorized by metal levels. Metal levels do not indicate the quality of the plan or the amount of care that is provided by the plan. Bronze plans cover 60% of the actuarial value; these plans typically have the lowest monthly premiums and the highest out of pocket costs. Silver plans cover 70% of the actuarial value; federal cost-sharing subsidies are only available with silver plans. Gold plans cover 80% of the actuarial value. Platinum plans cover 90% of the actuarial value. Gold and Platinum plans typically have the highest monthly premiums and the lowest out of pocket costs. Catastrophic plans are also available and require consumers to pay all medical costs up to a certain threshold before full coverage begins. These plans generally have lower monthly premiums but they are only available to individuals under 30 years old or with hardship exemptions.

The cost of monthly QHP premiums is dependent on age, county of residence (there are 16 pricing regions in North Carolina, with rural regions experiencing higher premiums), tobacco use (users pay higher premiums), and family size. Monthly QHP premiums costs also vary depending on insurance carrier (there are three carriers in North Carolina), metal level and the specific plan selected. QHP premiums increased significantly from 2014 to 2015. According to DPH's contracted Actuary, Blue Cross Blue Shield North Carolina reports that their premiums increased 13% from 2014 to 2015. The limit on maximum out of pocket costs is set at $6,600 for 2015, up 4% from $6,350 in 2014. Future increases to premiums and the limit on maximum out of pocket costs are likely, but the amount of change is unknown.

The ACA provides federal subsidies for premiums and cost-sharing (deductibles, copayments, and coinsurance). Premium subsidies are available for individuals with incomes between 100 and 400 percent of the federal poverty guidelines in the form of tax credits or up-front discounts in the form of reduced premiums. Cost-sharing subsidies are available for individuals with incomes between 100 and 250 percent of the federal poverty guidelines, under the condition that

they enroll in a Silver plan. Cost-sharing subsidies are provided in the form of a reduced limit on the maximum out of pocket cost.

**Federal Funds Supporting ADAP in North Carolina**

The Federal Health Resources and Services Administration (HRSA) oversees the Ryan White funds provided to states to pay for core medical services, including ADAP, and other support services to low income people living with HIV who have no other resources. HRSA expects grantees to reduce program costs and increase access to care by paying for medication cost-sharing (deductibles, copayments, and coinsurance) associated with insurance and/or insurance premiums for clients, if doing so is cost neutral on the aggregate level when compared to the cost of purchasing medication. HRSA expects coordination with insurance coverage to ensure increased access to care and improved health outcomes. Coordination with insurance coverage enables clients to receive a wider range of services at a lower cost because the cost-sharing (deductibles, copayments, and coinsurance) associated with insurance and insurance premiums is often less costly than paying for medication. The successful implementation of SPAP within North Carolina's ADAP is an example of insurance coordination, in this case with Medicare, which reduces state expenditures and improves client health outcomes.

## ***Alternative Options for Serving ADAP Clients***

**Medicaid**

ADAP is administered through the Federal Ryan White Program, which is a payer of last resort. Applicants who are enrolled in Medicaid are not eligible for ADAP. ADAP applicants are required to apply for Medicaid before they can be determined eligible for ADAP.

DPH currently verifies client Medicaid eligibility during federally-required ADAP eligibility renewals, twice annually. If an ADAP client becomes eligible for Medicaid or other insurance (with medication coverage) between renewal periods, the client should be removed from ADAP immediately. If the contracted vendors (dispensing pharmacy or pharmacy benefits manager) identify through their payer source identification systems that a client has another payment source, the contracted vendor notifies ADAP and the client's eligibility status is reviewed. If another payer source is confirmed, the client's ADAP coverage is terminated. DPH also performs eligibility reviews on a random sample of clients on a quarterly basis.

**Qualified Health Plans (QHPs)**

Anyone who enrolled in a QHP is responsible for two expenses; the monthly premiums and the cost-sharing (deductibles, copayments, and coinsurance) associated with using the QHP to access covered services such as visiting a doctor or filling a prescription. Unfortunately for people living with HIV, most QHPs require high cost-sharing in the form of copayments and coinsurance for antiretroviral medications. Many people living with HIV have found the combination of premiums and medication cost-sharing unaffordable. This creates a significant barrier to reaching the goals of adhering to an antiretroviral medication regimen, achieving viral suppression and reducing HIV transmission. Federal subsidies are available to assist with premiums and cost sharing but they are limited.

As of January 1, 2015, a majority of APP enrollees were not eligible for federal premium or cost-sharing subsidies to assist with QHP enrollment. However, ADAP eligible clients who are unable to enroll in a QHP continue to be served by the APP and continue to receive life-saving medications.

The newly-implemented ICAP is providing cost-sharing assistance to ADAP clients who do enroll in a QHP through the Federal Health Insurance Marketplace. This program is estimated to generate savings for ADAP and improve client health outcomes by enabling them to utilize the coverage provided by their QHP. ICAP enrollment is low and is estimated to remain low due to the high cost of QHP premiums. As previously noted, as of March 26, 2015, eighty three (83) individuals were enrolled in ICAP. ICAP enrollment would likely increase if ADAP clients were able to access QHP premium assistance.

HRSA expects state ADAPs to assist with medication cost-sharing and insurance premiums, provided that doing so is cost neutral on the aggregate level compared to the cost of purchasing medication. ICAP already provides cost-sharing assistance. DPH evaluated the cost neutrality of also providing premium assistance. DPH's contracted Actuary estimated savings between 0% and 32% on the aggregate level compared to the cost of purchasing medication. However, the contracted Actuary noted that providing premium assistance in addition to cost-sharing assistance would likely be a non-viable long-term option due to the potential increases to insurance costs (premiums and the limit on the maximum out of pocket cost) in coming years. The estimated savings are based on 2015 plan structures and pricing, which will likely increase before such a program could be implemented (January 2016).

There are several complex factors that can impact the costs associated with providing premium assistance in addition to cost-sharing assistance and therefore the ability for such assistance to remain cost neutral. Age, county of residence, tobacco use, family size, insurance carrier, plan metal level, specific plan choice and client income all contribute to the overall cost of providing premium assistance in addition to cost-sharing assistance. A large proportion of the ADAP population is ineligible for subsidies which is one of the factors that contribute to the low projected savings. Another factor is the estimated number of clients who would be enrolled for less than a complete calendar year.

The contracted Actuary created two additional models to determine if limiting the premium assistance to a subset of clients would be cost neutral or better. The first model focused on providing premium assistance in addition to cost-sharing assistance to only individuals eligible for a subsidy. The second model focused on providing premium assistance in addition to cost-sharing assistance to only individuals whose coverage starts in January. Both models yielded increases to potential savings but the cost of premiums and the limit on the maximum out of pocket costs remains unknown. The contracted Actuary was unable to estimate savings in future years due to the current trend of escalating insurance costs in addition to the relatively low growth in ADAP costs.

Another factor that can impact the cost neutrality of providing premium assistance to ADAP clients, in addition to cost-sharing assistance, is the ability to generate medication rebates. Medication rebates are generated when cost-sharing is paid for an antiretroviral medication with

a specially negotiated ADAP price. The agreements that make these rebates possible are voluntary and the calculations used by medication manufacturers to determine the rebate amounts are proprietary and kept confidential. HRSA has indicated that rules about rebate collection could change in the future. One of the successes of SPAP is the significant amount of medication rebate funds that have been generated and directed back to ADAP. Implementation of ICAP should increase the amount of rebates generated as more cost-sharing for antiretroviral medications will be paid. However, ICAP enrollment is still low and medication utilization is unknown at this time. Medication rebates are voluntary and unpredictable so they were not included by the Actuary in the cost neutrality calculation. Future analyses should consider any changes to the medication rebate rules, explore the growth and sustainability of medication rebates and evaluate their potential impact on the cost neutrality of premium assistance in addition to cost-sharing assistance.