Operation of the AIDS Drug Assistance Program

Health Insurance Premium Assistance Program

Session Law 2016-94, Section 12E.1.(b)

Report to the

House Appropriations Committee on Health and Human Services

and

Senate Appropriations Committee on Health and Human Services

and

Fiscal Research Division

By

North Carolina Department of Health and Human Services

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Legislative Reporting Requirement

Session Law (SL) 2016-94, Section 12E.1.(a) directed the Department of Health and Human Services' Division of Public Health to create within the North Carolina AIDS Drug Assistance Program (ADAP) a health insurance premium assistance program that utilized federal funds from Part B of the Ryan While HIV/AIDS Program and ADAP funds to provide eligible beneficiaries with premium and cost-sharing assistance for the purchase or maintenance of private health insurance coverage, including premiums, co-payments, and deductibles. In creating this program, the Department was directed to ensure full compliance with federal Health Resources and Services Administration (HRSA) guidance, including the methodology used to do all of the following:

1. Assess and compare the cost of providing prescription drugs to eligible beneficiaries through the health insurance premium assistance program created versus the existing ADAP program.
2. Ensure that insurance premium assistance program funds are used solely to pay for premium and cost-sharing assistance for the purchase or maintenance of private health insurance coverage that provides, at a minimum, prescription coverage equivalent to the formulary available under Part B of the Ryan White HIV/AIDS Program.
3. Limit the total annual amount of funds expended for the health insurance premium assistance program authorized to no more than the total annual cost of maintaining the same individuals on the existing ADAP Program.

Session Law 2016-94, Section 12E.1. (b) further required the Department of Health and Human Services' Division of Public Health to submit a report to the House Appropriations Committee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division on the operation of the program, including any obstacles to implementation.

Executive Summary

The North Carolina AIDS Drug Assistance Program (ADAP) assists people living with HIV who lack adequate financial resources and are ineligible for Medicaid or any other assistance. North Carolina's commitment to ADAP has resulted in improved health outcomes for people living with HIV, decreased healthcare costs, and reduced HIV transmission. The antiretroviral medication regimens that ADAP provides make it possible for people living with HIV to achieve viral suppression (an undetectable amount of HIV in their blood), which prevents the transmission of HIV. Currently, 82% of all ADAP enrollees are virally suppressed.

In 2016, the North Carolina General Assembly passed legislation that gave the NC ADAP the authority to create a health insurance premium assistance program. DHHS immediately started collaborating with contracted vendors to make that possible.

The first of two steps necessary to implement ADAP premium assistance is to amend the agency's existing Pharmacy Benefits Manager contract. The contracted Pharmacy Benefits Manager has provided information necessary to create an implementation plan and has indicated they will accept the terms of a contract amendment to make ADAP insurance premium

assistance possible, if DHHS determines this program will be cost neutral, as required by the legislation.

The second of two steps necessary to implement ADAP premium assistance is to confirm cost neutrality with the agency's contracted Actuarial Service. A preliminary analysis, completed in February 2016, determined that cost neutrality was possible but indicated that cost neutrality may not be sustainable: (1) if health insurance premiums increased; and/or (2) medication rebates generated by copay assistance decreased.

Since the 2016 legislation was passed, both have occurred.

- Health insurance premiums continue to rise at substantial rates. For example, Blue Cross Blue Shield of North Carolina increased its marketplace plan premiums by 24.3% in 2016 for its 2017 plans (applicable to rates before applying any applicable federal subsidy - http://blog.bcbsnc.com/2016/10/2017-rate-announcement/).
- Recent changes to ADAP pricing agreements will lead to significant decreases to ADAP medication rebates over the next two years.

DHHS is committed to implementing ADAP premium assistance in a way that is sustainably cost neutral and is currently working with its contracted Actuarial Service to identify subsets of ADAP enrollees who are eligible for low cost premiums. **If DHHS is able to identify a subset of ADAP enrollees who can be served at a cost that is lower than the current cost of the traditional ADAP model by June 2017, health insurance premium assistance will be implemented before January 2018.**

Background

HIV in North Carolina

There are an estimated 36,800 people in North Carolina who are HIV positive; of those, approximately 3,400 are unaware of their infection. The Communicable Disease Branch of the Department of Health and Human Services' (DHHS) Division of Public Health (DPH) has active 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 prevents the transmission of HIV. People living with HIV who adhere to an antiretroviral medication regimen and achieve durable viral suppression (an undetectable amount of HIV in their blood) are unable to transmit the virus to others. Providing antiretroviral medication regimens to people living with HIV is the most effective 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 their prescribed antiretroviral medications daily in order to achieve and maintain viral suppression. As a result, they 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 and transmissible disease. The North Carolina State Center for Health Statistics reported 235 HIV-related deaths in 2015 (2.3

per 100,000 population). HIV was among the leading causes of death for those aged 25 to 44 in North Carolina in 2015.

A significant health disparity exists in rates of HIV infection in North Carolina. In 2015, the rate of HIV diagnoses among Black/African Americans was eight and a half times greater than the rate of HIV diagnoses among White/Caucasians. In 2015, young Black/African American males ages 13-24 years represented approximately 19% of new cases.

The AIDS Drug Assistance Program (ADAP)
Established in 1994, North Carolina's ADAP uses a combination of Federal Ryan White Part B funds, state appropriations, and medication rebates to provide HIV positive residents of North Carolina (with income at or below 300 percent of the federal poverty guidelines) with essential medications for the treatment of HIV, opportunistic infections, and related conditions. As of September 30, 2016, the end of the most recent complete enrollment cycle, there were 7,949 clients enrolled in ADAP. This represents a 5% increase from the previous year.

Providing antiretroviral medication regimens to people living with HIV is the most effective method of reducing the spread of HIV. The primary goal of ADAP is to assure that all enrollees adhere to their antiretroviral medication regimen and achieve viral suppression. Currently, 82% of all ADAP enrollees are virally suppressed. **ADAP currently provides medication to clients under three models: APP, ICAP, and SPAP.**

- The **ADAP Pharmacy Program (APP)** serves uninsured ADAP clients. Approximately 76% of ADAP clients are served through APP. The program purchases medications from a contracted wholesaler (Cardinal Health) and distributes medications directly to clients through a contracted dispensing pharmacy (Walgreens); this is the traditional ADAP model. APP has utilized this purchasing and distribution model since 2005.

- The **Insurance Copayment Assistance Program (ICAP)** serves ADAP clients who are enrolled in a Qualified Health Plan purchased through the federal health insurance marketplace. Approximately 3% of ADAP clients are served through ICAP. 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 (Ramsell Corporation). ICAP was implemented in February 2015.

- 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% of ADAP clients are served through SPAP. Clients served through SPAP are required to pay their monthly Medicare Prescription Drug Plan premiums. SPAP pays medication cost-sharing (deductibles, copayments, coinsurance) through a contracted Pharmacy Benefits Manager (Ramsell Corporation). SPAP was piloted between 2009 and 2010 and permanently implemented in 2011.

ICAP and SPAP were implemented to comply with federal expectations to lower program costs through insurance coordination. The Health Resources and Services Administration (HRSA),

which oversees the federal Ryan White grant, expects grantees to reduce program costs and increase access to care by covering medication cost-sharing (deductibles, copayments, and coinsurance) and premiums for clients, if doing so is cost neutral at the aggregate level. North Carolina's ICAP and SPAP currently achieve this expectation:

- In calendar year 2016, the cost of ICAP copayments was 23% lower than the cost of dispensing the same medications through the traditional ADAP model at the current ADAP prices.
- In calendar year 2016, the cost of SPAP copayments was 61% lower than the cost of dispensing the same medications through the traditional ADAP model at the current ADAP prices.

Implementation of the ADAP Health Insurance Premium Assistance Program

In 2016, the North Carolina General Assembly passed legislation that gave the NC ADAP the authority to create a health insurance premium assistance program. This 2016 legislation and the existing federal ADAP policies limit the total amount of insurance expenditures (premiums and cost sharing) to no more than the cost of an existing ADAP client served through APP (the traditional ADAP program that purchases medications only), at the aggregate level.

Before implementing an ADAP health insurance premium assistance program, DHHS must first amend the contract with its existing contracted Pharmacy Benefits Manager (Ramsell Corporation) and confirm cost neutrality with its existing contracted Actuarial Service (Mercer).

DHHS initiated conversations with the contracted Pharmacy Benefits Manager (Ramsell) and contracted Actuarial Service (Mercer) in July 2016 to add premium assistance to ICAP and/or SPAP. The scope of work in the current contract with the Pharmacy Benefits Manager already includes an option to implement premium assistance. DHHS has met with Ramsell Corporation about implementing this option several times since the legislation was passed. Ramsell Corporation has confirmed they are willing and able to implement premium assistance and has participated in preliminary discussions about the addition of premium assistance for both ICAP and SPAP. Ramsell Corporation has also indicated they will accept the terms of a contract amendment to initiate premium assistance once DHHS has determined that doing so would be cost neutral. **The existing DHHS Pharmacy Benefits Manager contract will not be amended until DHHS has confirmed cost neutrality and is ready to implement ADAP premium assistance.**

In February 2016, the contracted Actuarial Service worked with the DHHS to analyze the cost and feasibility of adding premium assistance to ICAP and SPAP. This preliminary analysis, completed before the 2016 legislation was passed, determined that cost neutrality was possible but indicated that cost neutrality may not be sustainable: (1) if health insurance premiums increased; and/or (2) medication rebates generated by copay assistance decreased.

Since the 2017 health insurance premium rates became available in November 2016, DHHS and the contracted Actuarial Service have spent significant time determining a method to implement premium assistance for ICAP and/or SPAP that will ensure sustainable cost neutrality. The recent annual increases in insurance premiums make it difficult to ensure the amount of funds

expended on insurance premiums and cost sharing remains lower than the cost of serving a client through the traditional ADAP model.

In addition, recent changes in the ADAP pricing agreements, negotiated between the National ADAP Task Force and the companies that manufacture antiretroviral medications, will lead to decreases in rebates to states which are generated by copayment expenditures starting in State Fiscal Year (SFY) 2017-2018. These decreased rebates will also make it difficult to ensure the combined funds expended on insurance premiums and cost sharing remain lower than the cost of serving a client through the traditional ADAP model.

Other major changes, such as the significant decrease in competition in the North Carolina Insurance Marketplace and the Office of Pharmacy Affairs' (OPA) recent withdrawal of proposed federal guidance on the 340B drug pricing (and ADAP rebates), have added new levels of complexity to the ever changing landscape within which ADAP operates. Although the cost savings generated by paying medication cost-sharing (deductibles, copayments, coinsurance) through both ICAP and SPAP will likely remain unchanged, the addition of premium assistance benefits does not appear to be sustainably cost neutral.

DHHS continues to collaborate with Mercer to identify subsets of ADAP enrollees who are eligible for low cost premiums and who might be served through insurance premium assistance program while remaining cost neutral. Mercer is currently examining:

- The different federal subsidy levels, based on income, to determine which levels could be cost neutral.
- The difference in premiums between tobacco users and non-tobacco users to determine if limiting premium assistance to non-tobacco users could be cost neutral.
- The cost across health insurance metal level plans (bronze, silver, gold, and platinum) to determine if one plan might be more likely than the others to remain cost neutral with implementation of a premium assistance program.

DHHS anticipates receiving a report and recommendations on implementing the insurance premium assistance program in a cost neutral manner from Mercer the end of April, 2017.

DHHS expects to make a decision about implementing an ADAP premium assistance program by the end of the current SFY 2016-2017. DHHS plans to implement an ADAP premium assistance program before the end of calendar year 2017, if doing so is determined through actuarial analysis to be sustainably cost neutral.