



Formulary Access for Patients with  
HIV/AIDS

# Background on Avalere's PlanScape® and Methodology for Formulary Analysis

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## PlanScape® Methodology

- This analysis reviews formulary coverage in the exchanges, with comparisons to 2014, 2015, and other markets, including employer coverage.
- For each year, Avalere analyzed formularies for silver plans participating in all 50 states and the District of Columbia
- Analysis for each year uses the same 2016 drug list, but products launched after October 2014 are only included in calculations after they appear in the dataset
- Formulary data is collected by Managed Markets Insight & Technology, LLC.
- Data is weighted according to unique silver benefit designs by state.
- Analysis excludes plans in which the deductible is equal to the annual out-of-pocket maximum and plans for which there is no cost sharing across service categories.

# HIV/AIDS: Drug Coverage Has Expanded, and Across Markets Plans Use Open Access at Least 88% Of The Time

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## Classes Included:

- Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs), Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTIs), Protease Inhibitors (PIs), and HIV-Other

## Coverage for Key HIV Classes:

- In high-enrollment states, the average exchange plan covers at least 43 of 51 HIV/AIDS medications
- Single-source products in the therapeutic area appear on formulary at least 65% of the time in all states other than Utah, which has coverage 25% of the time

## Utilization Management for HIV Classes:

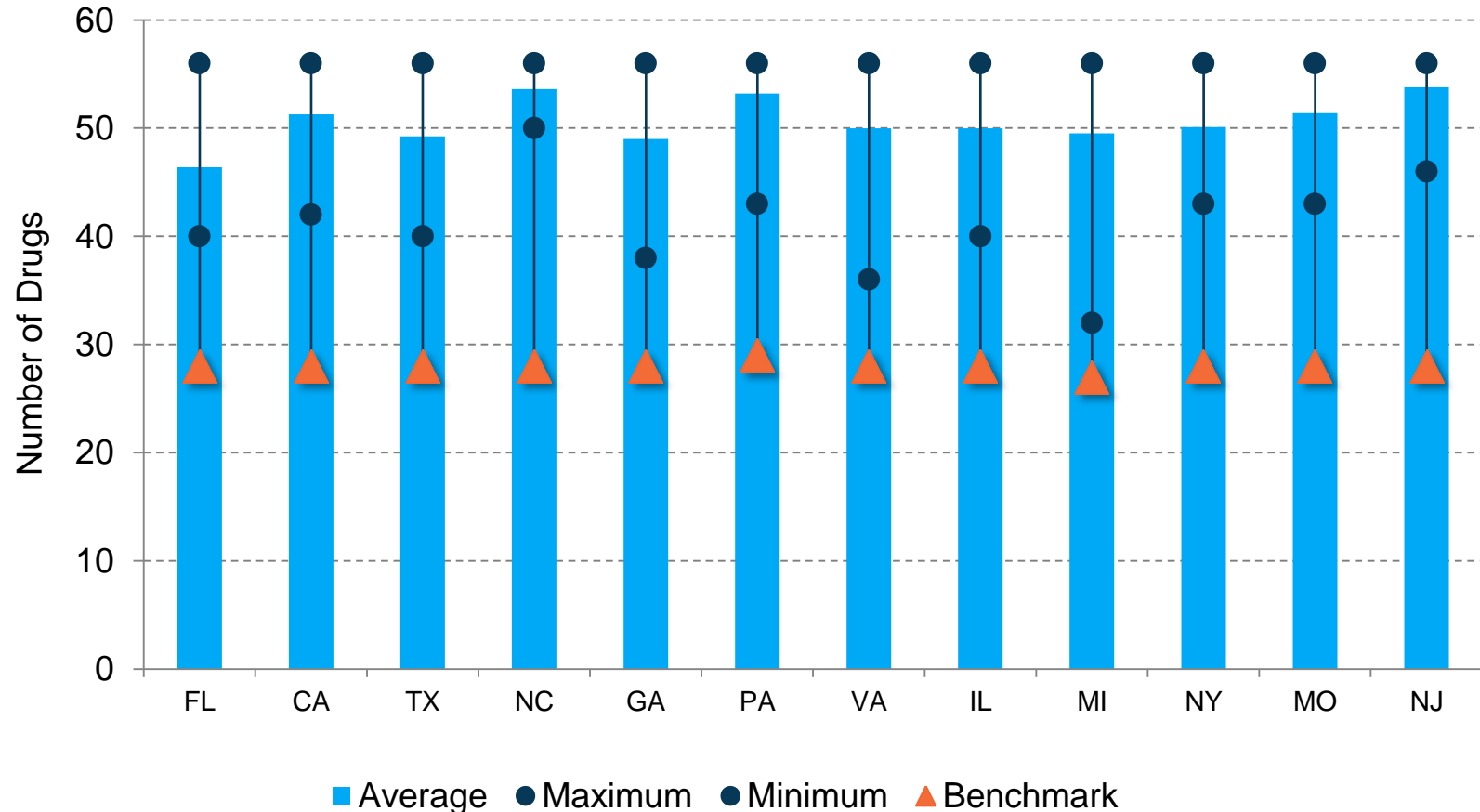
- Exchange plans have continued to reduce their use of UM for HIV/AIDS medications. Now, exchange plans use UM less frequently than employer plans for these medicines

## Tiering and Cost Sharing for Key HIV Classes:

- Preferred placement has increased for HIV/AIDS medications in 2016 exchange plans, though employer plans still use the specialty tier far less often than exchange plans do. And, a portion of plans continue to place all HIV drugs on the specialty tier
- Copays are common across HIV classes, with an average copayment of \$66. When used, coinsurance is 35% on average

# In States with High Exchange Enrollment, Average Plans Cover at Least 43 of 51 Drugs

NUMBER OF COVERED HIV/AIDS MEDICINES,  
SILVER EXCHANGE PLANS, 2016



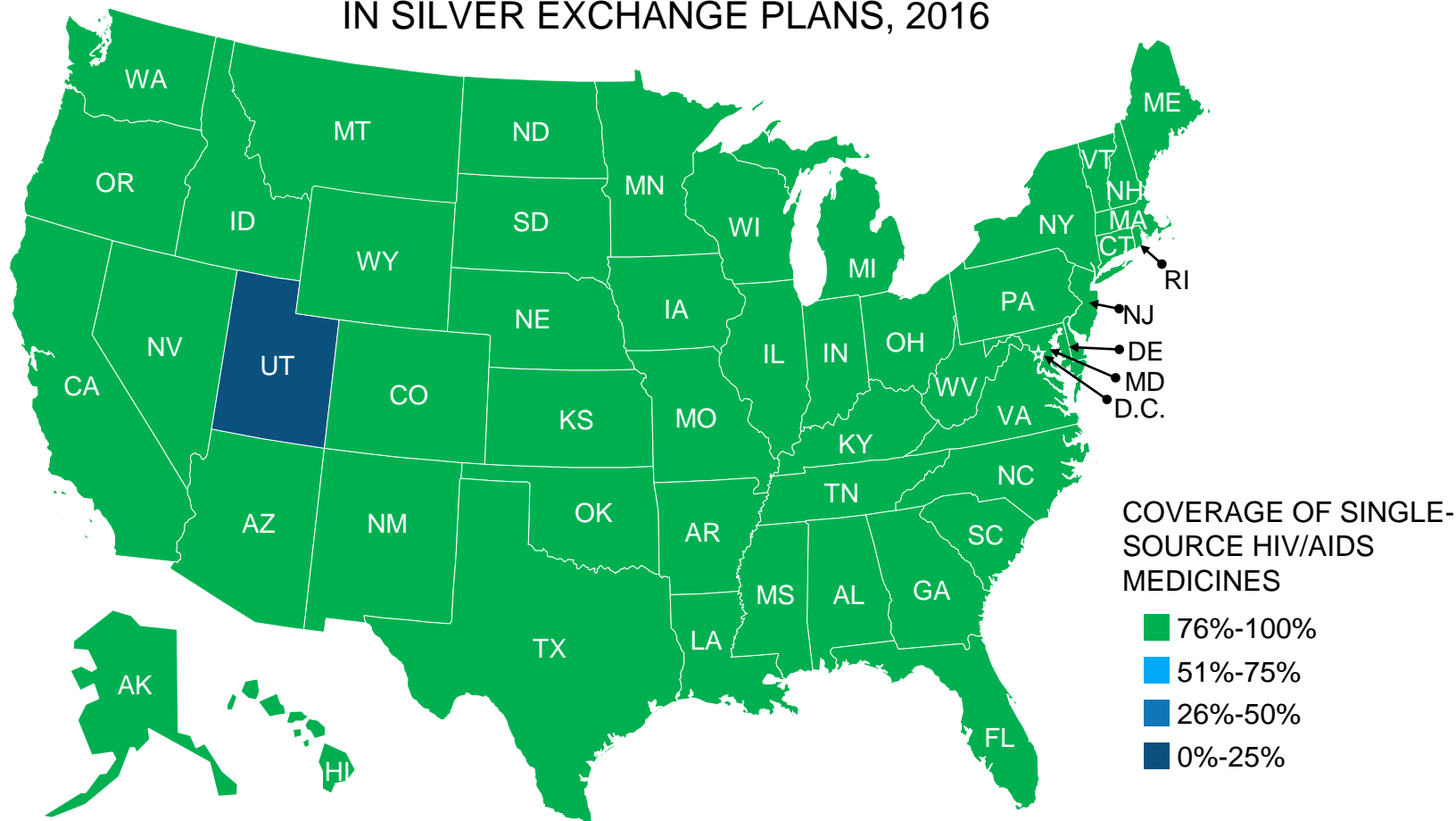
Note: Coverage is weighted according to unique plan-state combinations. Sample includes all silver plans offered in 50 states and the District of Columbia. Medical benefit drugs are included in drug counts. Benchmark counts are based on unique chemical entities, while other coverage data counts each brand or generic drug individually.

Source: Avalere Health PlanScape®, a proprietary analysis of exchange plan features, April 2016. This analysis is based on data collected by Managed Markets Insight & Technology, LLC.



# Across Classes, Plans Cover HIV/AIDS Innovators at Least 76% of the Time, Except UT, an Outlier

## FORMULARY COVERAGE FOR SINGLE-SOURCE HIV/AIDS MEDICINES IN SILVER EXCHANGE PLANS, 2016



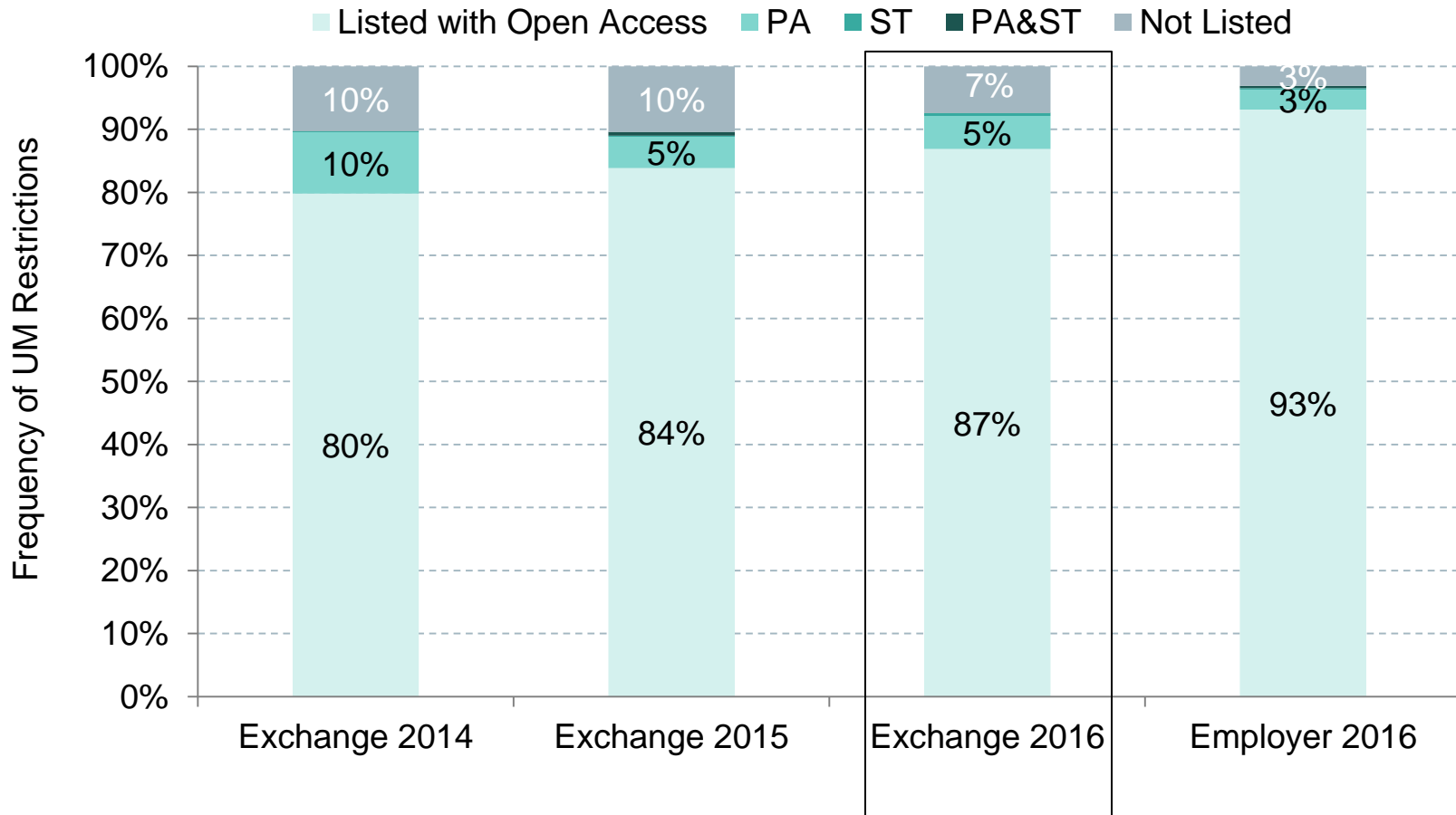
Note: Coverage is weighted according to unique plan-state combinations. Sample includes all silver plans offered in 50 states and the District of Columbia. MMIT uses universal tier status rather than "raw" tier numbers to facilitate comparisons across plans and markets. Avalere uses universal tier status for tiering analyses and raw tier status for cost-sharing analyses. For the purpose of this analysis, "coverage" means formulary inclusion. Avalere excluded physician-administered drugs from this analysis, except when comparing to state benchmark minimums.

Source: Avalere Health PlanScape®, a proprietary analysis of exchange plan features, April 2016. This analysis is based on data collected by Managed Markets Insight & Technology, LLC.



# In 2016, Exchange Plans Use PA for HIV Meds Less Often than Before, But Still More than Employer Plans

## UTILIZATION MANAGEMENT TECHNIQUES FOR SINGLE-SOURCE HIV/AIDS MEDICINES



Includes Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs), Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTIs), Protease Inhibitors (PIs), and HIV-Other

Note: Coverage is weighted according to unique plan-state combinations. Sample includes all silver plans offered in 50 states and the District of Columbia. For the purpose of this analysis, "coverage" means formulary inclusion. Avalere excluded physician-administered drugs from this analysis, except when comparing to state benchmark minimums.

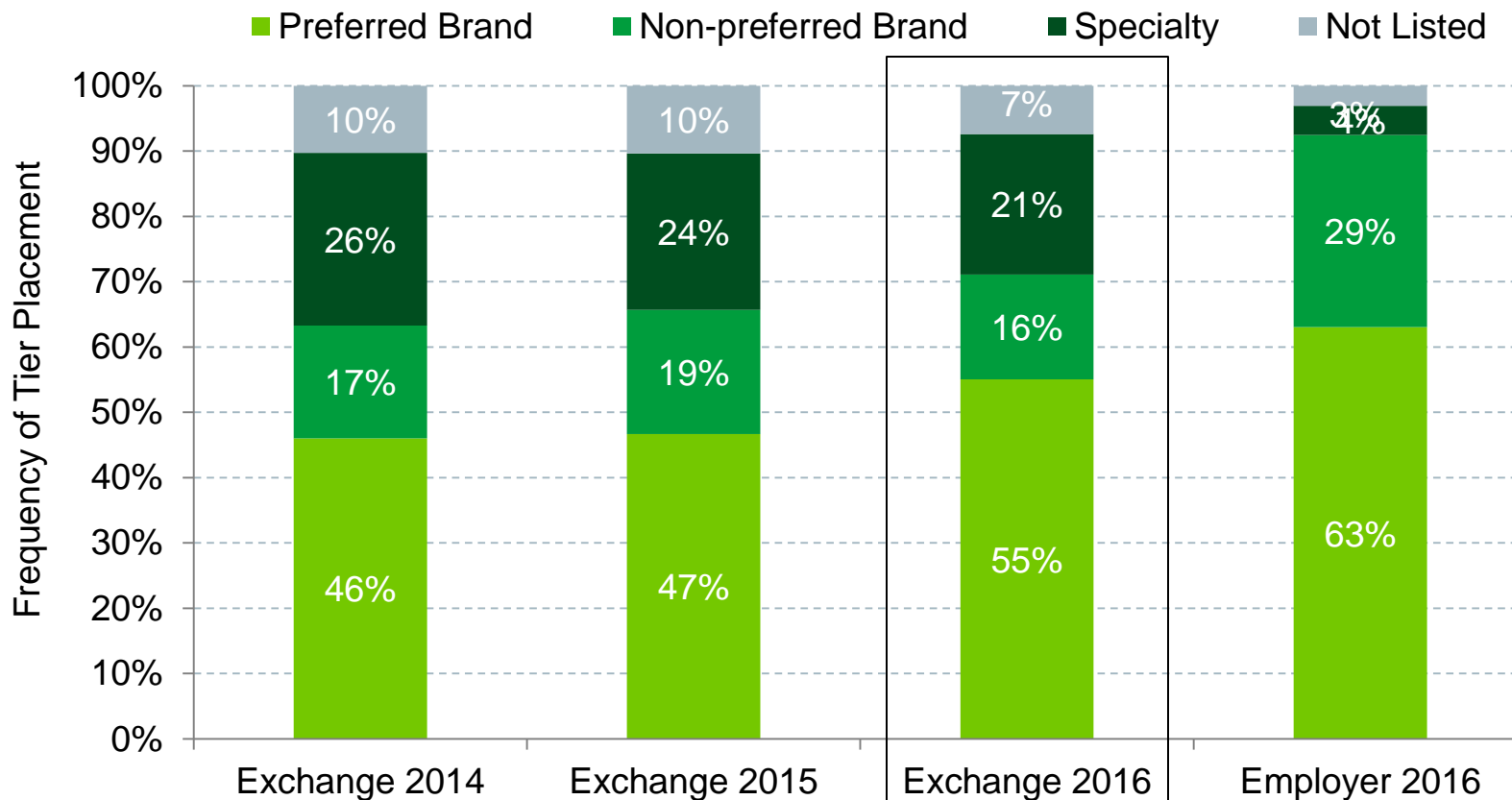
Source: Avalere Health PlanScape®, a proprietary analysis of exchange plan features, April 2016. This analysis is based on data collected by Managed Markets Insight & Technology, LLC.

PA = Prior Authorization; ST = Step Therapy



# Exchange Plans' Placement of HIV/AIDS Drugs on the Preferred Tier Rises to More than Half of the Time in 2016

## TIER PLACEMENT FOR SINGLE-SOURCE HIV/AIDS MEDICINES IN SILVER EXCHANGE PLANS



Includes Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs), Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTIs), Protease Inhibitors (PIs), and HIV-Other

Note: Coverage is weighted according to unique plan-state combinations. Sample includes all silver plans offered in 50 states and the District of Columbia. MMIT uses universal tier status rather than "raw" tier numbers to facilitate comparisons across plans and markets.

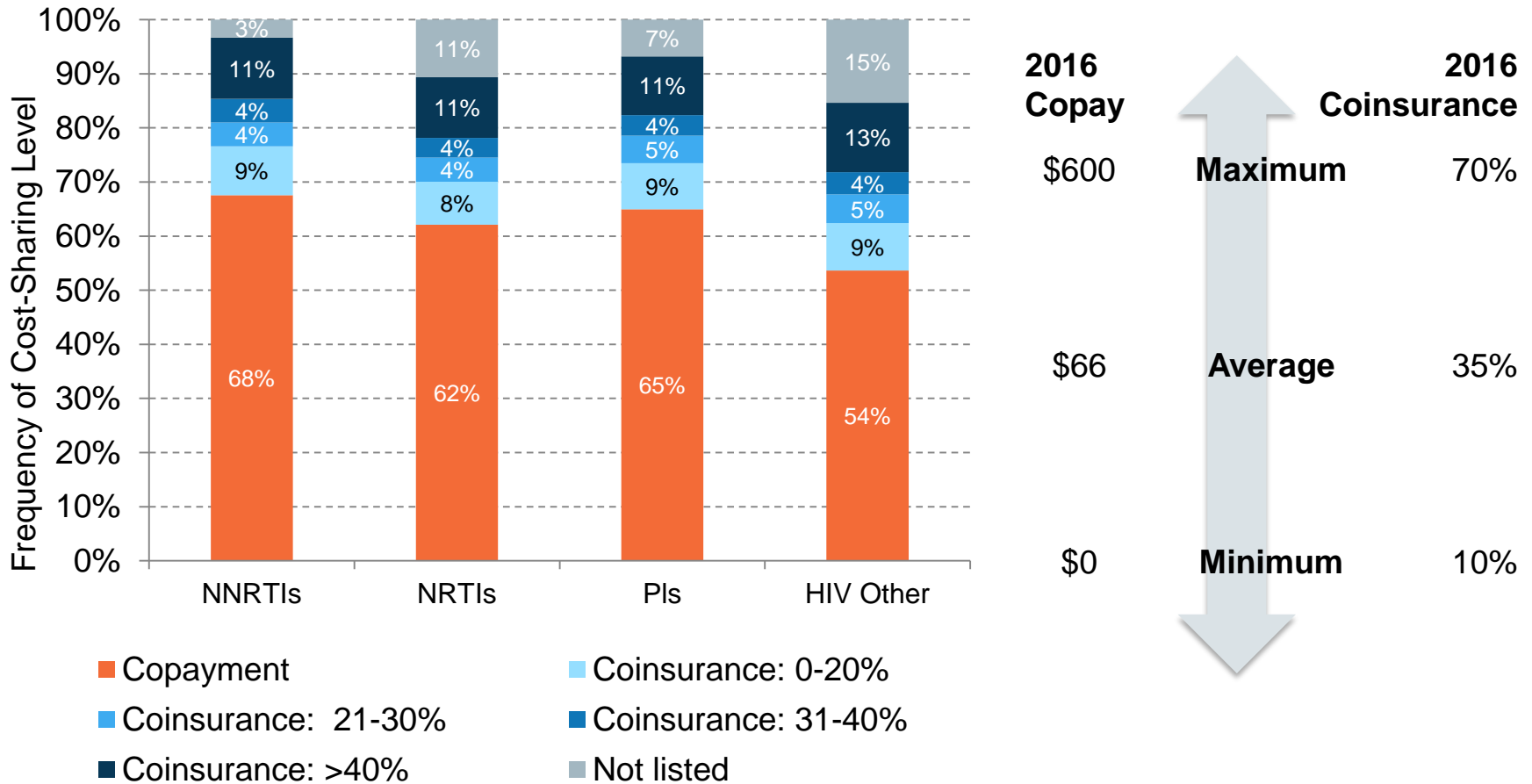
Avalere uses universal tier status for tiering analyses and raw tier status for cost-sharing analyses. For the purpose of this analysis, "coverage" means formulary inclusion. Avalere excluded physician-administered drugs from this analysis, except when comparing to state benchmark minimums.

Source: Avalere Health PlanScape®, a proprietary analysis of exchange plan features, April 2016. This analysis is based on data collected by Managed Markets Insight & Technology, LLC.



# Copays Are More Common than Coinsurance, Though When Used, Coinsurance Averages 35%

## COST-SHARING LEVELS FOR SINGLE-SOURCE HIV/AIDS MEDICINES, SILVER EXCHANGE PLANS



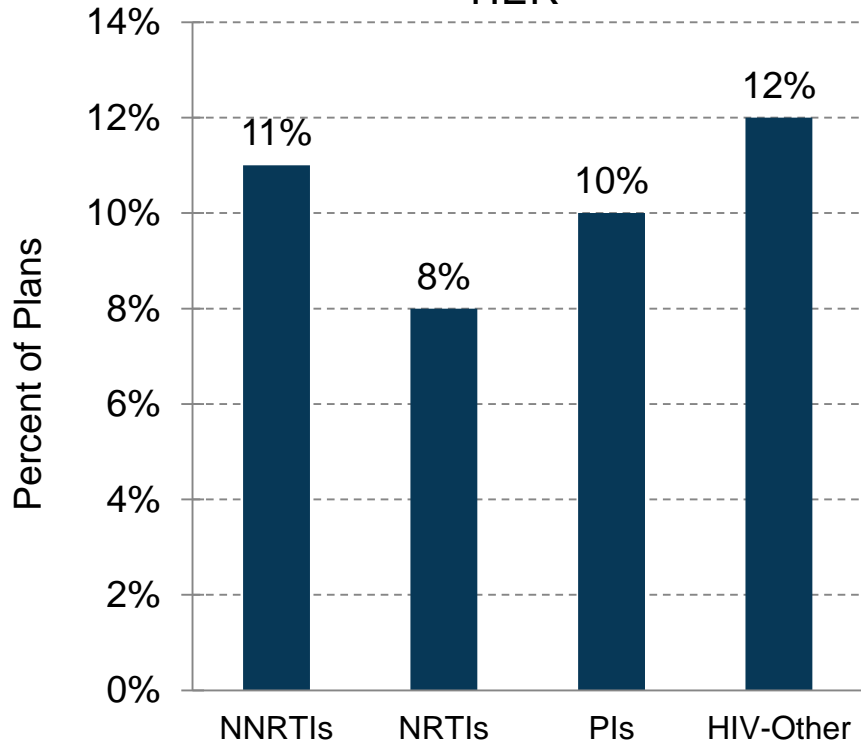
Note: Coverage is weighted according to unique plan-state combinations. Sample includes all silver plans offered in 50 states and the District of Columbia. For the purpose of this analysis, "coverage" means formulary inclusion. Avalere excluded physician-administered drugs from this analysis, except when comparing to state benchmark minimums.

Source: Avalere Health PlanScape®, a proprietary analysis of exchange plan features, April 2016. This analysis is based on data collected by Managed Markets Insight & Technology, LLC. Excludes instances where cost-sharing amount is unknown.

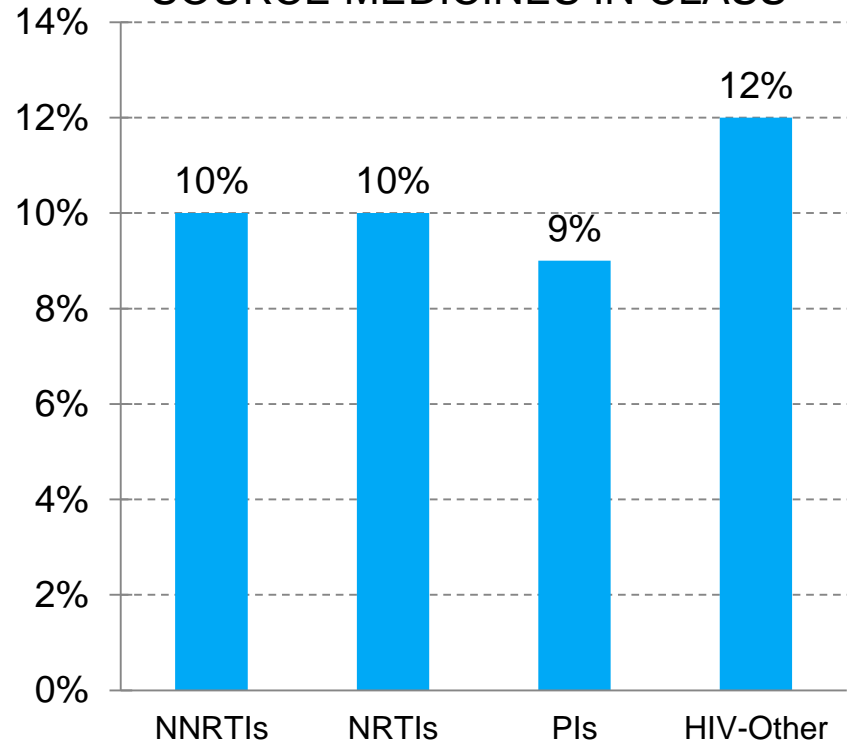


# Around 10% of Plans Use High Tier Placement or Coinsurance for All HIV Innovators

## PLANS PLACING ALL SINGLE-SOURCE MEDICINES IN CLASS ON SPECIALTY TIER



## PLANS REQUIRING OVER 30% COINSURANCE FOR ALL SINGLE-SOURCE MEDICINES IN CLASS



Note: Coverage is weighted according to unique plan-state combinations. Sample includes all silver plans offered in 50 states and the District of Columbia. MMIT uses universal tier status rather than “raw” tier numbers to facilitate comparisons across plans and markets. Avalere uses universal tier status for tiering analyses and raw tier status for cost-sharing analyses. For the purpose of this analysis, “coverage” means formulary inclusion. Avalere excluded physician-administered drugs from this analysis, except when comparing to state benchmark minimums.

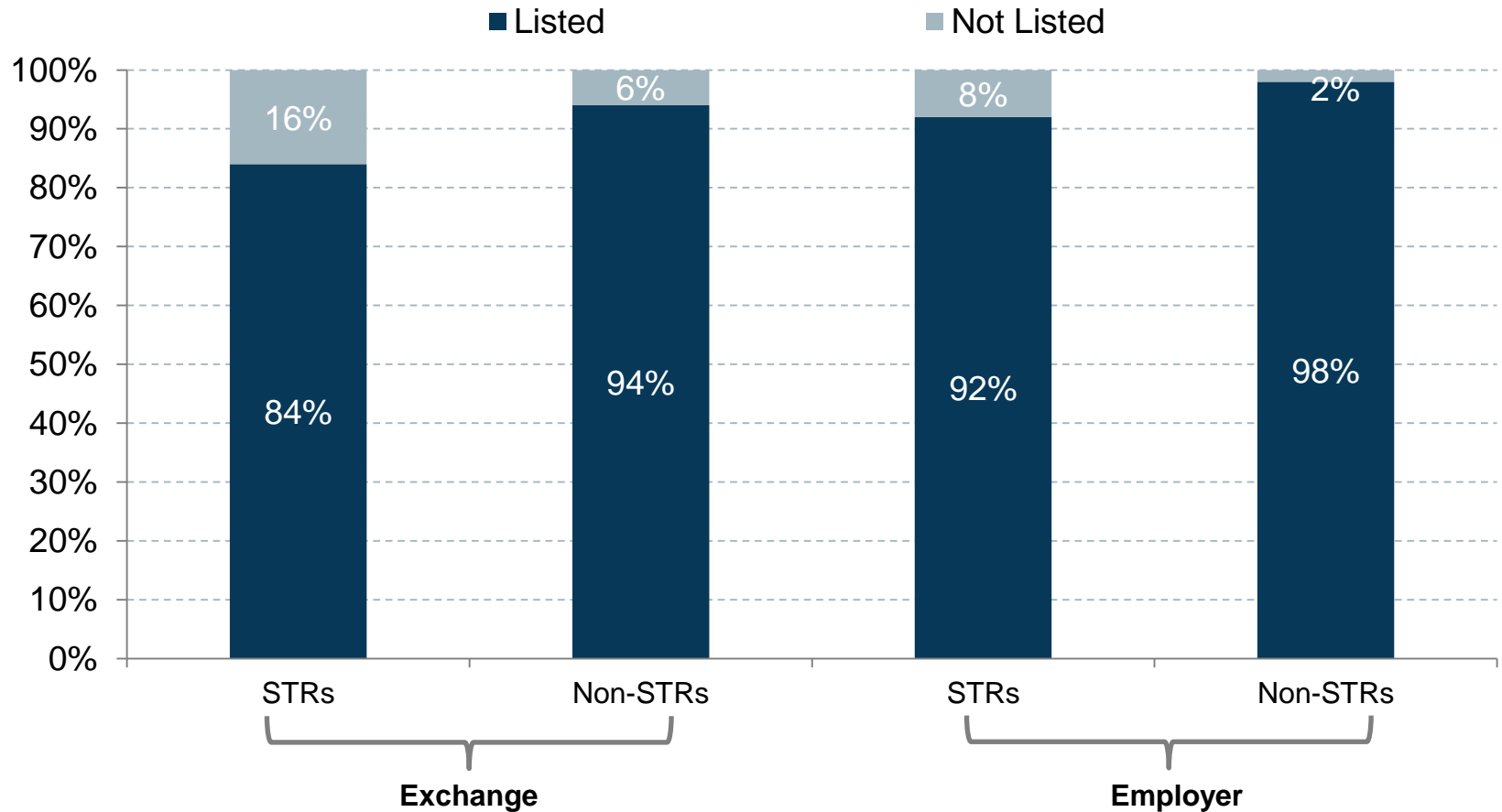
Source: Avalere Health PlanScape®, a proprietary analysis of exchange plan features, April 2016. This analysis is based on data collected by Managed Markets Insight & Technology, LLC.

NNRTIs = Non-Nucleoside Reverse Transcriptase Inhibitors; NRTIs = Nucleoside and Nucleotide Reverse Transcriptase Inhibitors; PIs = Protease Inhibitors



# Exchanges Have Lower Coverage for STRs than for Other Single-Source NTRIs

COVERAGE OF SINGLE-SOURCE NRTIS,  
SINGLE-TABLET REGIMENS AND NON-STRs, 2016



Note: Coverage is weighted according to unique plan-state combinations. Sample includes all silver plans offered in 50 states and the District of Columbia.

Source: Avalere Health PlanScape®, a proprietary analysis of exchange plan features, April 2016. This analysis is based on data collected by Managed Markets Insight & Technology, LLC. For the purpose of this analysis, "coverage" means formulary inclusion. Avalere excluded physician-administered drugs from this analysis, except when comparing to state benchmark minimums.

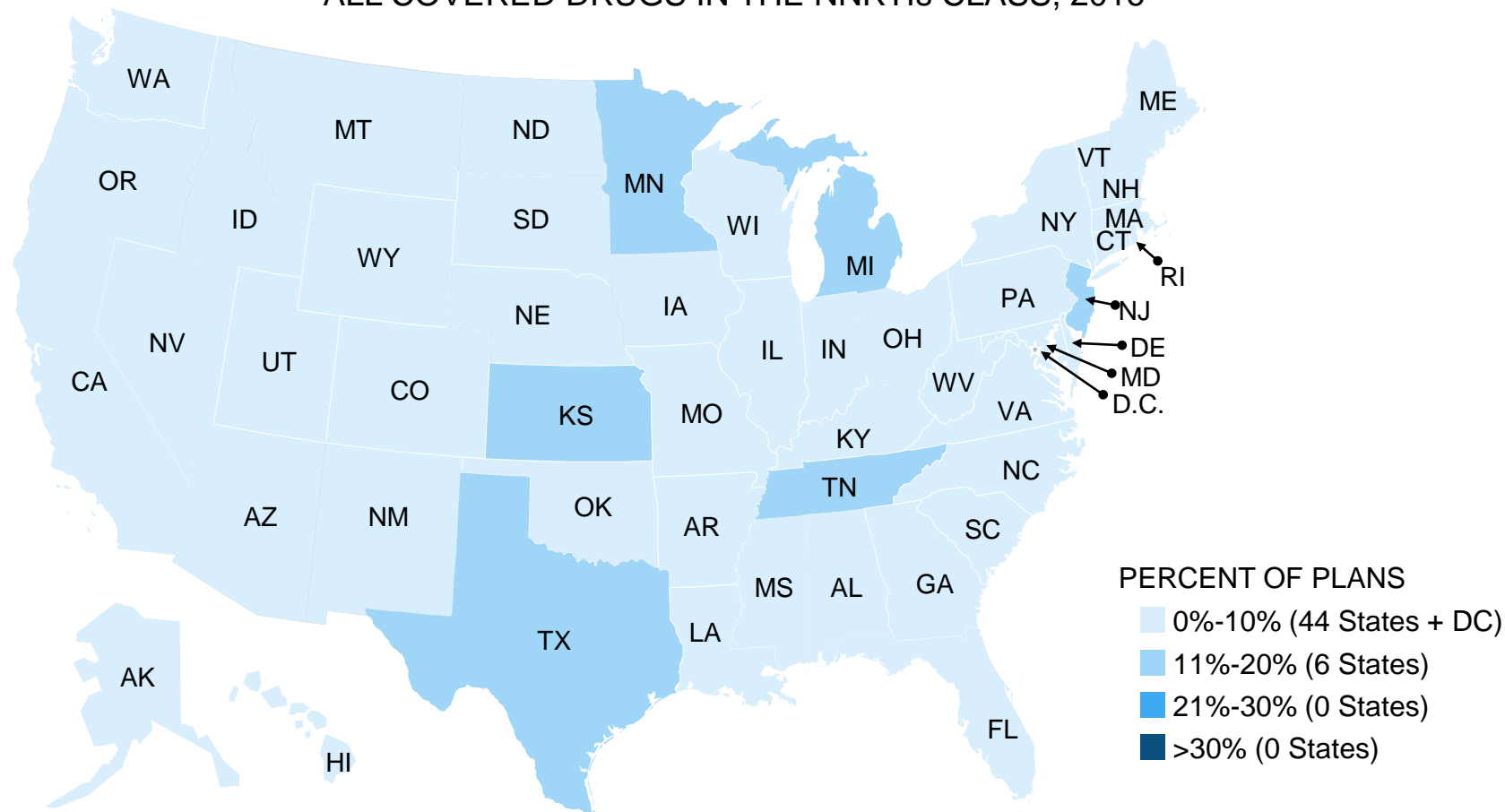
STRs include Atripa, Complera, Stribild and Triumeq. Non-STRs include Emtriva, Epzicom, Truvada and Viread.

STR = Single Tablet Regimen



# 10% or Fewer Plans in 44 States and DC Require Coinsurance Above 30% for All Covered NNRTIs

SILVER EXCHANGE PLANS REQUIRING COINSURANCE HIGHER THAN 30% FOR ALL COVERED DRUGS IN THE NNRTIs CLASS, 2016



Note: Coverage is weighted according to unique plan-state combinations. Sample includes all silver plans offered in 50 states and the District of Columbia. MMIT uses universal tier status rather than "raw" tier numbers to facilitate comparisons across plans and markets. Avalere uses universal tier status for tiering analyses and raw tier status for cost-sharing analyses. For the purpose of this analysis, "coverage" means formulary inclusion. Avalere excluded physician-administered drugs from this analysis, except when comparing to state benchmark minimums.

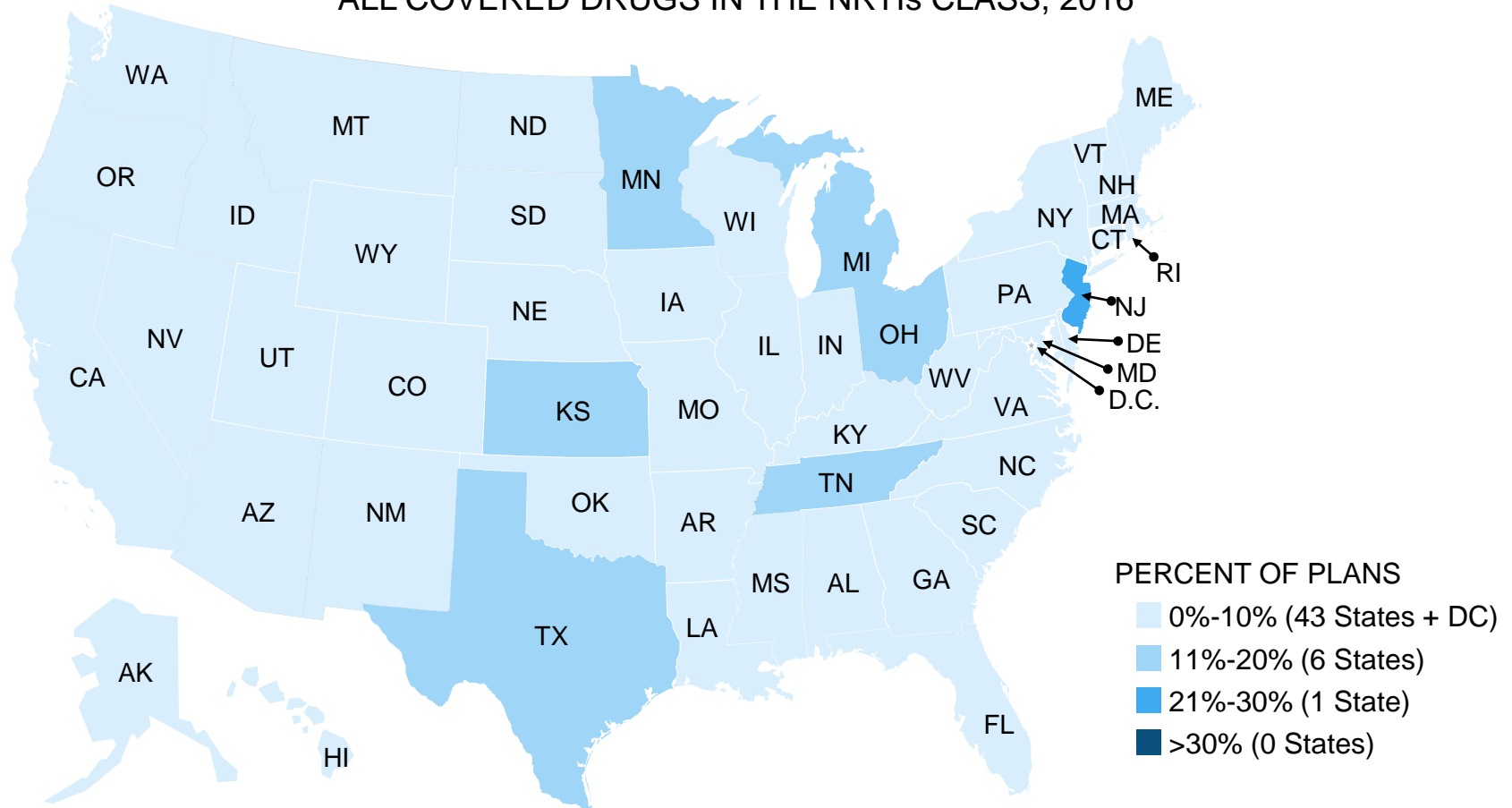
Source: Avalere Health PlanScape®, a proprietary analysis of exchange plan features, April 2016. This analysis is based on data collected by Managed Markets Insight & Technology, LLC.

NNRTIs = Non-Nucleoside Reverse Transcriptase Inhibitors



# New Jersey Has the Highest Proportion of Plans Requiring Coinsurance of 30% or More for All Covered NRTIs

SILVER EXCHANGE PLANS REQUIRING COINSURANCE HIGHER THAN 30% FOR ALL COVERED DRUGS IN THE NRTIs CLASS, 2016



Note: Coverage is weighted according to unique plan-state combinations. Sample includes all silver plans offered in 50 states and the District of Columbia. MMIT uses universal tier status rather than "raw" tier numbers to facilitate comparisons across plans and markets. Avalere uses universal tier status for tiering analyses and raw tier status for cost-sharing analyses. For the purpose of this analysis, "coverage" means formulary inclusion. Avalere excluded physician-administered drugs from this analysis, except when comparing to state benchmark minimums.

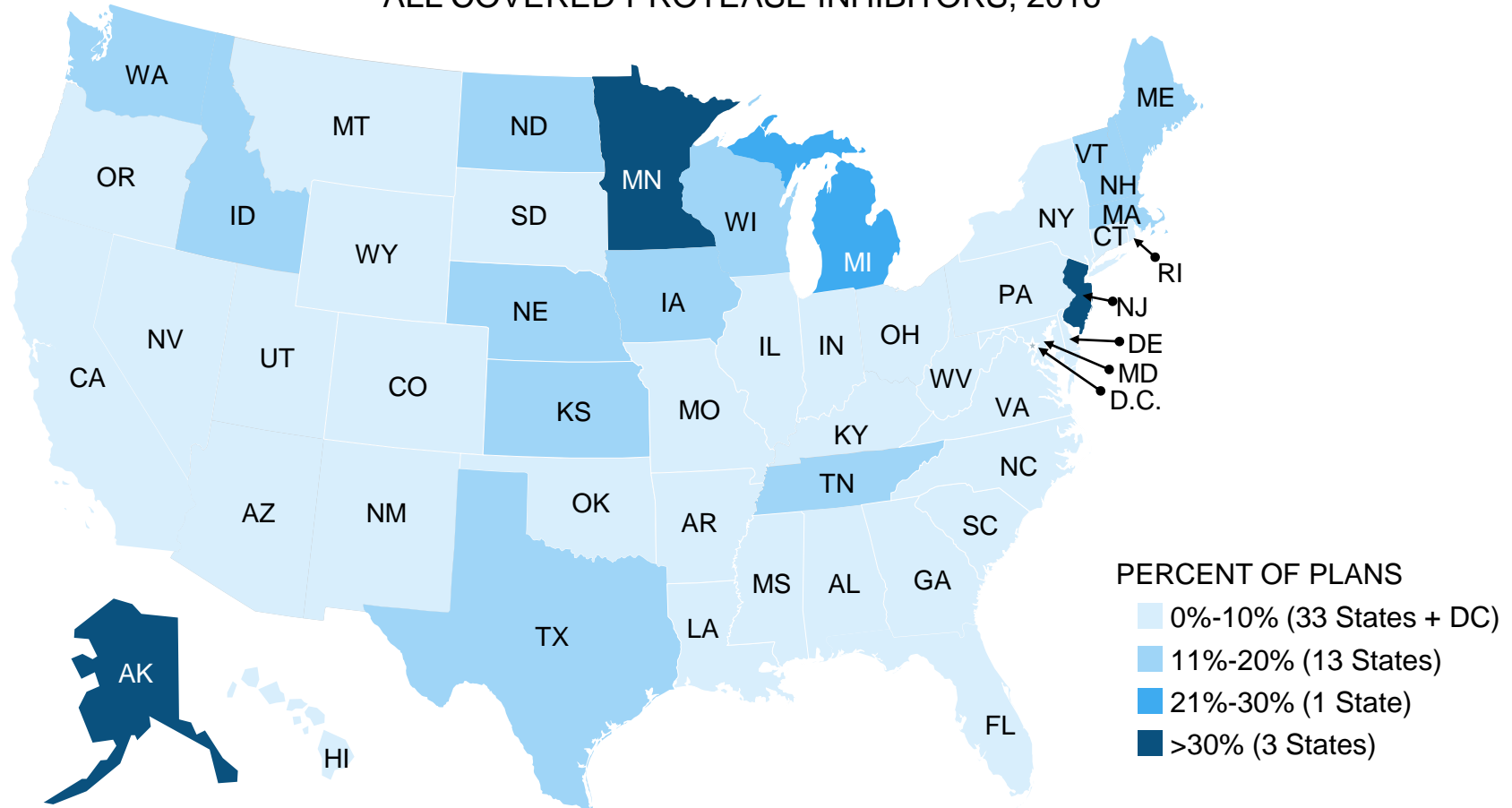
Source: Avalere Health PlanScape®, a proprietary analysis of exchange plan features, April 2016. This analysis is based on data collected by Managed Markets Insight & Technology, LLC.

NNRTIs = Non-Nucleoside Reverse Transcriptase Inhibitors



# AK, MN, and NJ Have the Highest Percentage of Plans Requiring Coinsurance Above 30% for All Protease Inhibitors

SILVER EXCHANGE PLANS REQUIRING COINSURANCE HIGHER THAN 30% FOR ALL COVERED PROTEASE INHIBITORS, 2016



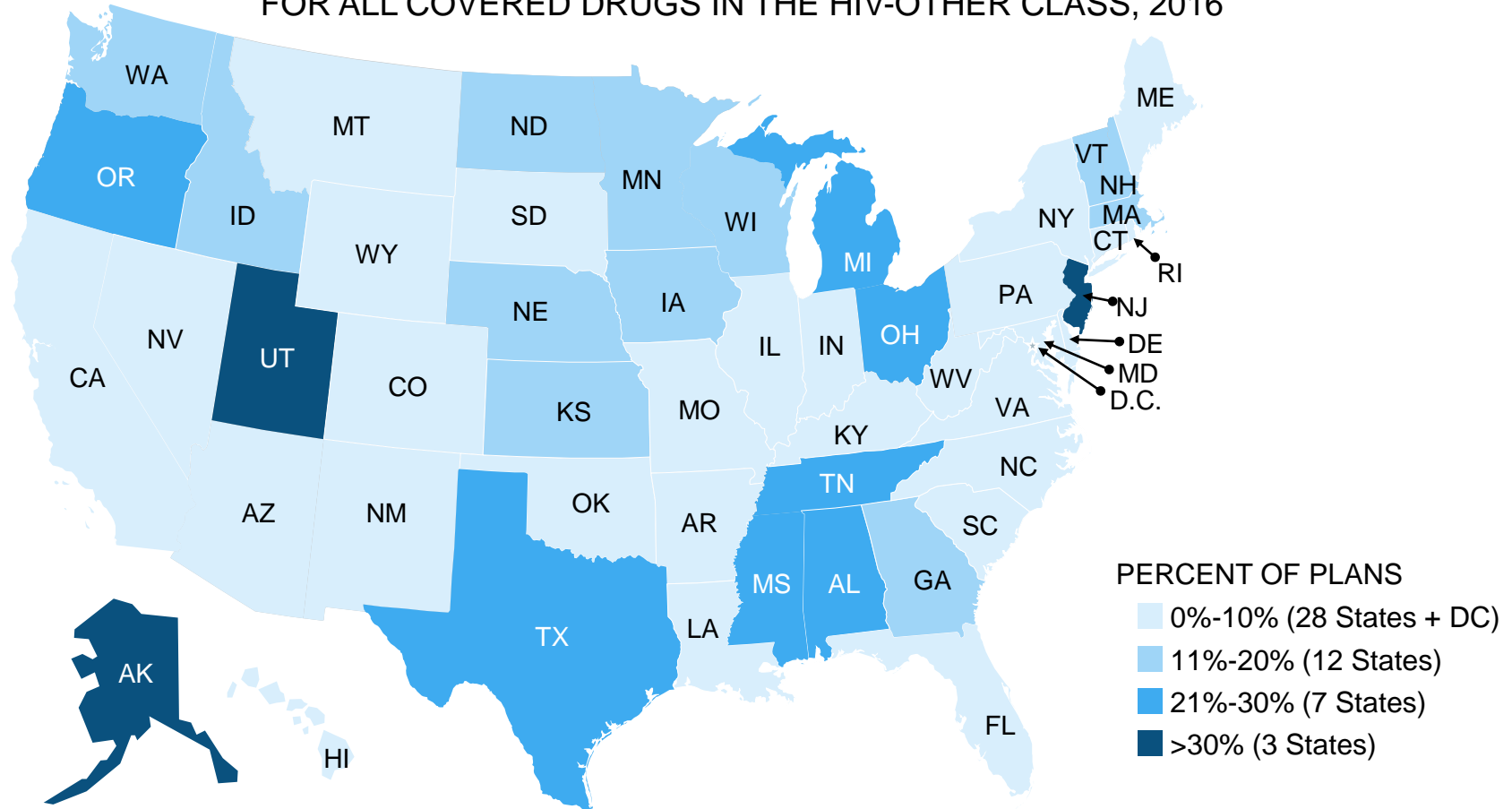
Note: Coverage is weighted according to unique plan-state combinations. Sample includes all silver plans offered in 50 states and the District of Columbia. MMIT uses universal tier status rather than "raw" tier numbers to facilitate comparisons across plans and markets. Avalere uses universal tier status for tiering analyses and raw tier status for cost-sharing analyses. For the purpose of this analysis, "coverage" means formulary inclusion. Avalere excluded physician-administered drugs from this analysis, except when comparing to state benchmark minimums.

Source: Avalere Health PlanScape®, a proprietary analysis of exchange plan features, April 2016. This analysis is based on data collected by Managed Markets Insight & Technology, LLC.



# Coinsurance Above 30% for All Covered Therapies in HIV-Other Class Is Most Common Among Plans in AK, NJ, UT

SILVER EXCHANGE PLANS REQUIRING COINSURANCE OF HIGHER THAN 30% FOR ALL COVERED DRUGS IN THE HIV-OTHER CLASS, 2016



Note: Coverage is weighted according to unique plan-state combinations. Sample includes all silver plans offered in 50 states and the District of Columbia. MMIT uses universal tier status rather than "raw" tier numbers to facilitate comparisons across plans and markets. Avalere uses universal tier status for tiering analyses and raw tier status for cost-sharing analyses. For the purpose of this analysis, "coverage" means formulary inclusion. Avalere excluded physician-administered drugs from this analysis, except when comparing to state benchmark minimums.

Source: Avalere Health PlanScape®, a proprietary analysis of exchange plan features, April 2016. This analysis is based on data collected by Managed Markets Insight & Technology, LLC.





## Methods Appendix

# PlanScape® Methodology: MMIT Data

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## FORMULARY DATA SOURCES

- Formulary data is from Managed Markets Insight & Technology, LLC, an Avalere partner that maintains comprehensive formulary data across a range of payer channels, including the exchanges and employer markets
- Formulary coverage is based on a drug's listing on the plan's published formulary in MMIT's database
  - MMIT gathers data directly from health plans and pharmacy benefit managers, ensuring the accuracy and validity of the formulary data. MMIT's pharmacists and clinicians interpret and standardize formularies
  - In addition, MMIT researchers engage with issuers to understand formulary characteristics, including processes around open and closed formularies, and to understand how plans make coverage decisions so that data reflects accurate consumer experiences for obtaining medications
- Formulary data is based on coverage in all 50 states and DC as of October 2014, October 2015, and April 2016; note that formularies may change throughout the year
- Due to data limitations, 2014 exchange data excludes United Healthcare in NY; 2015 exchange data excludes Health Alliance One in GA; and 2016 exchange data excludes SelectHealth in ID; Health New England in MA; Colorado Choice Health Plans in CO; Minuteman Health in NH; Health Choice in AZ; and Oscar in TX.



# PlanScope® Methodology: Benefit Design Dataset

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## STATES OF FOCUS AND DATA COLLECTION

- For plan benefit designs, Avalere analyzed the FFE landscape file and collected information directly from SBE websites. For 2014 and 2015, Avalere supplemented our SBE data collection with benefit design information from the Robert Wood Johnson Foundation's ACA Silver Plan Dataset
- For SBEs, Avalere collected information for one ZIP code for each rating region<sup>1</sup>
- Avalere made revisions to the FFE landscape file to ensure that only unique plan designs were included in the analysis. That is, duplicate offerings of individual plans were removed prior to analysis when plans shared all benefit design characteristics except premium, county, and region

<sup>1</sup> The data for SBEs may not include all plans available since as Avalere only collected information for one ZIP code in each rating region. The same ZIP codes were used in each year for the plan searches.

# PlanScape® Methodology: Drug List Creation and Cross-Walking Process

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## DRUG LIST CREATION

- To develop the list of drugs per class, Avalere consulted the United States Pharmacopeia (USP) Medicare Model Guidelines v5.0 to obtain a listing of the USP Category, USP Class, and Example Drugs
- Additional drugs were identified based on the USP Model v6.0 guidelines, Medi-Span®, and CenterWatch drug databases and internal clinical assessment to reflect updates not reflected in USP v 5.0
- Avalere collaborated with MMIT clinicians and data experts to finalize drug lists according to client-selected USP classes

## CROSS-WALKING PROCESS

- Oftentimes, carriers will use the same formulary for all of the exchange plans it offers in a state, but occasionally, issuers will have different formularies if they have more than one exchange plan in the state
- Avalere conducted a manual cross-walking process to align formularies with exchange products using plan documents and other publicly-available plan information
- As a result of this process, exchange plans in the analysis are weighted according to unique silver plans in the market

# PlanScape® Methodology: Coverage Statistics and Tiering Data

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## COVERAGE AND UM

- Although some drugs are covered under a plan's medical benefit, Avalere only includes pharmacy-benefit statistics in this analysis, with the exception of where we compare data to benchmarks
- For drugs available in multiple dosages, MMIT's database utilizes the most commonly utilized dosage
- Coverage and UM statistics are weighted by unique plan-state combinations
- Utilization management data captured includes prior authorization and step therapy, but does not reflect quantity limits

## TIERING

- MMIT captures raw status (tier number) and assigns a "universal" tier status, which standardizes formularies into four tiers: generic, preferred brand, non-preferred brand, and specialty
- For the purpose of reporting tiering statistics in this analysis, Avalere used MMIT's universal indicator, as formulary structure varies across plans and universal status allows for easy analysis of drugs within the market
- In contrast, for cost-sharing data, Avalere uses raw tiering information. Avalere excludes cases where raw tiering information is unavailable
- Tiering statistics are weighted by unique plan-state combinations

# PlanScape® Methodology: Cost Sharing Methodology

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## COST-SHARING DATA AND APPROACH

- Because the MMIT dataset does not include cost sharing, Avalere cross-walked MMIT formulary data to its benefit design dataset. The benefit design dataset excludes plans in which the deductible is equal to the annual out-of-pocket maximum, and plans for which there is no cost sharing across service categories
- Summary of Benefits and Coverage documents may relay multiple cost-sharing amounts for a particular formulary tier. Our analysis reflects the highest cost-sharing amount reported for that tier for a 30-day supply purchased at a retail pharmacy
  - Where cost sharing varies based on choice of pharmacy, we selected cost-sharing amounts that apply to preferred pharmacies within a plan's network
- Avalere utilized after-deductible amounts when analyzing cost-sharing categories (e.g., if coinsurance is 10% after meeting a \$1,000 deductible, when analyzing costs for the service, Avalere used the 10% coinsurance amount)
- For drugs or services noting cost sharing as the lesser or greater of a copayment or coinsurance amount, Avalere consistently used the coinsurance amount (e.g., \$100 or 20% whichever is greater). For drugs or services with coinsurance amounts up to a copayment cap (e.g., 25% coinsurance up to \$300), Avalere used the coinsurance amounts

# PlanScape® Methodology: Comparison Markets

## PLAN AND FORMULARY COUNTS

- Exchange data is presented at the plan level, representing each carrier's unique benefit designs offered in a state
  - Carriers often use the same formulary for multiple plans (i.e., cost sharing varies by plan, but coverage, tiering, and UM do not)
  - Therefore, each individual exchange formulary may be counted more than once, based on the number of unique plans (i.e., cost-sharing designs) relying on that formulary
- In contrast, employer data is reported at the formulary level; each formulary counts once in the dataset regardless of the number of cost-sharing designs using that formulary

Market	Plans	Formularies	States
Exchange	1,571	249	51
Employer	9,079	569	51

Note: **Orange** numbers indicate counts used in analysis.