ACCESS TO ASTHMA MEDICINES IN EXCHANGE PLANS

Asthma is a common, chronic lung disease that inflames and narrows the airways. Asthma causes recurring periods of wheezing, chest tightness, shortness of breath, and coughing. Asthma affects people of all ages, but it most often starts during childhood. In the United States, more than 25 million people are known to have asthma, including about 7 million children.[1] Goals of asthma treatment are reduced impairment from symptoms; minimized risk of asthma attacks and other adverse outcomes, such as hospitalizations and loss of lung function; and minimized side effects of asthma medicines. Treatment with medicines is the key to successfully managing asthma for most patients.[2] One recent study found that children with low adherence to certain asthma medicines experience a higher risk of emergency department visit and hospital admissions compared to children with better adherence.[3] This fact sheet offers insight into access to the most commonly-used asthma medicines[4] covered in the new health insurance exchanges. Key findings are primarily based on an analysis of 84 plans in the 15 states with the highest expected exchange enrollment for 2014.[5]

COVERAGE AND ACCESS FOR ASTHMA MEDICINES

Cost-sharing for asthma medicines regularly exceeds 30% coinsurance.

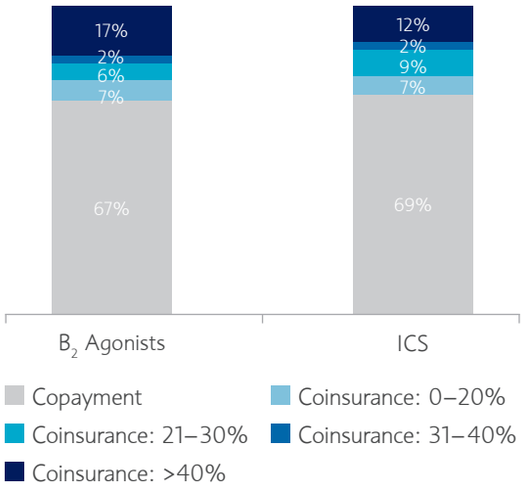
Formulary Coverage: Certain types of medicines are often excluded from the formulary.

- Exchange plans cover only 68% of single-source (defined as medicines for which a generic equivalent is not available) asthma medicines. Coverage of asthma medicines is less generous than coverage of medicines for other chronic conditions, such as diabetes.
- This level of coverage may be adequate for patients taking a single asthma medicine; however, patients often take two to three asthma medicines and may have difficulty accessing all of the medicines prescribed to manage their condition.

Cost-Sharing: Medicines to treat asthma are sometimes subject to high coinsurance in exchange plans.

- In about 17% of cases, asthma medicines are subject to coinsurance of 30% or more. The out-of-pocket cost for a one-month fill of a single asthma medicine at a 30% coinsurance level ranges from $25 to $115 monthly, amounting to $300 to $1,380 annually. For patients with high deductibles, filling a single asthma prescription over the course of the year might mean paying fully out-of-pocket each month because these patients may never reach their deductible.
- Also, unlike most employer plans,[6] many silver and bronze plans in exchanges subject prescription medicines to a single global deductible for both medicines and other services. Those deductibles average about $2,500 in silver plans and $4,300 in bronze plans.[7]
- These cost-sharing details do not reflect subsidies for enrollees with incomes below 250% of poverty; however plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.[8]

Frequency of Copayment vs. Coinsurance by Amount for Asthma Medicines in Silver Plans

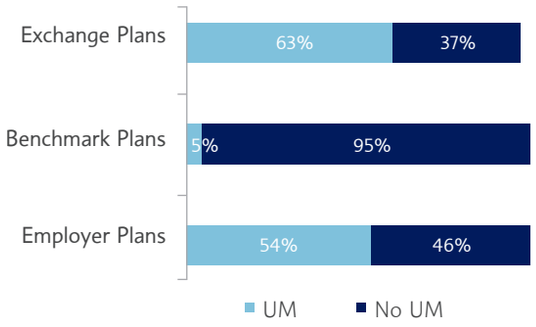


Analytics by Avalere Health. Developed by PhRMA.

Access Limits: Medicines are more likely to be subject to step therapy or prior authorization in exchange plans than in employer or benchmark plans.

- An analysis of the 2014 version of essential health benefit benchmark formularies in 12 states found that these benchmark formularies require utilization management for asthma medicines less often compared to exchange plans (5% compared to 63% for single-source asthma medicines, when listed).
- Asthma medicines are subject to utilization management 63% of the time in exchange plans and 54% of the time in employer[9] plans, when listed.

Utilization Management of Single-Source Asthma Medicines



VARIATION ACROSS STATES

Several states appear to have plans that do not meet the essential health benefit benchmark requirements for asthma medicines.

In several states, at least one plan does not cover as many medicines as the state's standard. Though these plans appear non-compliant with benchmarks, publically-available formularies may not be inclusive of all covered medicines. Either situation raises concerns about how patients can make informed enrollment decisions.

- 2 of 9 plans in Michigan appear not to meet the benchmark for one class of asthma medicines, sympathomimetic bronchodilators. In addition, at least 1 plan in four states—Florida, Illinois, Ohio, and Texas—appears to be non-compliant with the state benchmark.
- Across all 15 states, 11 of 84 plans examined cover no more than 10 of the 37 bronchodilators on the market.[10]

[1] National Heart, Lung, and Blood Institute http://www.nhlbi.nih.gov/health/health-topics/topics/asthma/.
[2] Fanta CH. Asthma. N Engl J Med 2009; 360:1002.
[3] Inhaled corticosteroid adherence and emergency department utilization among Medicaid-enrolled children with asthma. Rust G. Zhang S. Reynolds J. Journal of Asthma. 50(7):769-75, 2013 Sep.
[4] Includes single-source medicines in the following USP classes: sympathomimetic bronchodilators and inhaled corticosteroids.
[5] Silver plans in AR, CA, FL, GA, IL, IN, MI, NC, NJ, NY, OH, PA, TX, VA, WI.
[6] Kaiser/HRET Survey of Employer Sponsored Health Benefits 2013.
[7] Avalere Health PlanScape,™ a proprietary analysis of exchange plan features. Data as of October 31, 2013.
[8] Avalere March 2014 analysis of HHS Landscape File.
[9] Employer-sponsored insurance (ESI) data based on 2013 formularies from the following plans: the largest federal employee health plan (FEHBP); a large public, non-governmental, self-insured employer plan; a large, self-insured employer plan; a national carrier plan sponsored by a large employer; and a national carrier plan sponsored by a mid-size employer.
[10] Includes single-source, brands, and generic medicines.