ACCESS TO ONCOLOGY MEDICINES IN EXCHANGE PLANS

Chemotherapy and other medicines are central to the treatment of nearly all forms of cancer. Chemotherapy has evolved tremendously as researchers have come to better understand the genetic underpinnings of cancer. New, targeted therapies attack aspects of cancer cells that distinguish them from normal, healthy cells and are often designed to treat a handful of specific cancer types. Targeted therapies cause less damage to non-cancer cells; thus these medicines often produce less severe side effects than other kinds of chemotherapy. Access to a broad array of medicines in these classes ensures that individuals with cancer are not discouraged from enrolling on the basis of their health needs. The results presented below provide insights into how plans in the new health insurance exchanges cover key classes of oncology medicines.[1] Key findings are primarily based on an analysis of 84 plans in the 15 states with the highest expected exchange enrollment for 2014.[2]

COVERAGE & ACCESS FOR ONCOLOGY MEDICINES

Oncology medicines are subject to high cost-sharing in exchange plans as well as tight utilization management, both of which could be barriers to access for many patients.

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

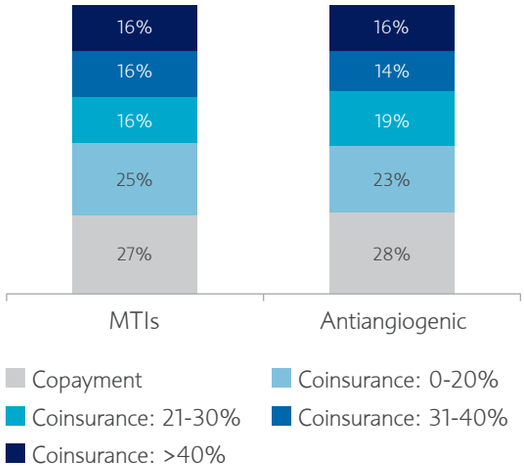
- Across six classes of oncology medicines, including targeted therapies, exchange plans cover about (59%) of single-source (defined as medicines for which a generic equivalent is not available) medicines on the market.
- This is similar to the share of these medicines covered by a sample of employer plans (58%).[3]
- Note that several classes of oncology medicines include therapies that may be covered through the medical benefit but not listed on the plan formulary; this information may be difficult to find for consumers shopping for exchange coverage.

Cost-Sharing: Medicines to treat oncology are often subject to high coinsurance.

Several classes of cancer medicines are subject to exceptionally high cost-sharing.

- Targeted therapies—both molecular target inhibitors and antiangiogenic agents—are subject to coinsurance greater than 40% in silver exchange plans 16% of the time.
- At a 40% coinsurance, a patient's monthly cost for a targeted therapy[4] could range from $375 to more than $6,000. For patients with high deductibles, filling even a single prescription could be a significant financial burden.
- Unlike most employer plans,[5] many silver and bronze-level exchange plans apply a global deductible for both medicines and other services. Deductibles average about $2,500 in silver plans and $4,300 in bronze plans;[6] these amounts must be spent out-of-pocket before any coverage for medicines is offered.
- 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.[7]

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

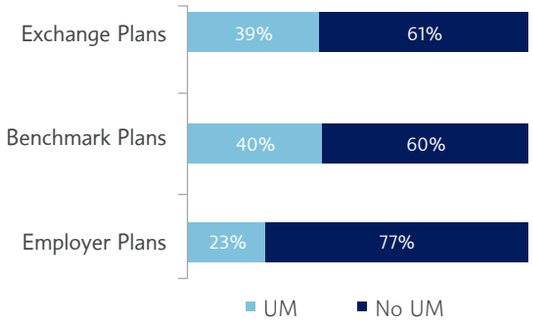


Analytics by Avalere Health. Developed by PhRMA.

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

- Utilization management (UM) occurs much more frequently in exchange offerings than in employer plans. Prior authorization, step therapy, or both occur 39% of the time for single-source oncology medicines in exchange plans, compared to 23% of the time in employer plans.
- An analysis of 2014 version of essential health benefit benchmark formularies in 12 states found that these benchmark formularies require UM about 40% of the time for oncology medicines. However, exchange plans require utilization management more often for some kinds of oncology medicines. For example, exchange plans require UM for antiangiogenic agents 84% of the time compared to benchmark plans which require UM 76% of the time. Employer plans require UM for these medicines 64% of the time.

Frequency of Utilization Management of Single-Source Oncology Medicines



Patients transitioning to exchange plans are not guaranteed access to oncology medicines they are currently taking.

VARIATION ACROSS STATES

- 13 of the top 15 states by expected exchange enrollment cover less than 60% of the single-source oncology medicines on the market.
  - Plans in Arkansas, Georgia, Illinois, Michigan, New York, and Wisconsin have the least generous coverage (less than 50% of medicines covered).
  - New Jersey is the most generous of the top 15 states, covering 77% of single-source medicines on the market.
- Many oncology medicines may be covered under an exchange plan's medical benefit. Transparency into medical benefit coverage is limited, and it may be difficult for consumers shopping for an exchange plan to access information about coverage and cost-sharing for these medicines.

[1] Includes medicines from the following 6 USP classes: Antiangiogenic agents, Alkylating agents, Emetogenic therapy adjunts, Metabolic bone disease agents, Molecular target inhibitors, Selective estrogen receptor modifying agents.
[2] Silver plans in AR, CA, FL, GA, IL, IN, MI, NC, NJ, NY, OH, PA, TX, VA, WI.
[3] 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.
[4] Single-source antiangiogenic agent or molecular target inhibitor covered under the pharmacy benefit.
[5] Kaiser/HRET Survey of Employer Sponsored Health Benefits 2013.
[6] Avalere Health PlanScape,™ a proprietary analysis of exchange plan features. Data as of October 31, 2013.
[7] Avalere March 2014 analysis of HHS Landscape File.