

AFFORDABLE

HEALTHCARE

For individuals with chronic illness who are treated with expensive medications, ensuring the marketplace plan they pick is the most affordable can be complicated.

By Ronale Tucker Rhodes, MS



FOR THE CHRONICALLY ill, the Affordable Care Act (ACA) represents guaranteed access to care, coverage for essential health benefits, caps on out-of-pocket expenses, elimination of lifetime caps, expanded access to Medicaid and standardization of the appeals process. But, the ACA's title — indicating its main

under age 30 or to those who have a hardship exemption (situations that keep one from getting insurance). Each of these plans offers a variety of plan types (e.g., PPOs and HMOs). In addition, all plans have a set of minimum benefits that includes hospitalizations, prescription drugs and maternity care.

How to Navigate the ACA Marketplace Plans

purpose: to ensure that all Americans have access to “affordable” healthcare — is a misnomer for many patients who rely on expensive medications such as immune globulin (IG) when purchasing insurance on the healthcare exchanges (aka marketplaces).

Figuring out which marketplace plan will result in the lowest cost for patients is no easy task due to price variables and individual needs. Furthermore, these plans use specialty tiers, and expensive biologic medications like IG are placed in the highest tier with the highest level of cost-sharing. Consequently, patients who rely on these lifesaving medications could find that high out-of-pocket expenses put their therapy out of reach. In essence, the ACA may have resulted in more chronically ill patients being insured, but many continue to be underinsured. Fortunately, states are taking steps to make their exchanges more patient-friendly, and laws are being passed that may help to lower cost-sharing.

The Marketplace Plans

While healthcare exchanges have been in existence in the private sector for some time, with the passage of the ACA in 2010, the new federal- and state-run health exchanges “provide a set of government-regulated and standardized health care plans from which individuals may purchase health insurance policies eligible for federal subsidies.” Marketplaces are not insurers, but they do determine which insurance companies participate in them.¹ This year, 11.7 million people are estimated to have enrolled in the marketplaces during the open enrollment period from November 2014 to February 2015, which includes 4.5 million from 2014 who re-enrolled.²

Consumers can choose from four metal plans — bronze, silver, gold and platinum — that are available to all individuals, as well as a catastrophic plan that is available only to individuals

However, premiums (the amount a person pays per month, quarter or year for a plan) vary widely based on the cost of healthcare where a person lives (even in the same state), age, family size and tobacco use, and that difference in price for the same plan can range in the thousands of dollars. Importantly, though, prices cannot be based on medical history, and patients with a preexisting condition can't be turned away.³

Catastrophic plans have the lowest premiums, followed by bronze, silver, gold and platinum. But, each plan differs in financial protection. Generally, the lower premiums mean higher out-of-pocket costs. For instance, catastrophic plans

**THE ACA MAY HAVE RESULTED
IN MORE CHRONICALLY ILL
PATIENTS BEING INSURED,
BUT MANY CONTINUE TO
BE UNDERINSURED.**

cover less than 60 percent of expected costs, bronze covers 60 percent, silver covers 70 percent, gold covers 80 percent and platinum covers 90 percent. It's important to note that catastrophic plans are intended for worst-case scenarios, like serious accidents or diseases. They require individuals to pay all of their medical costs until the deductible is reached, usually several thousand dollars. Once the deductible is reached, costs for essential health benefits are generally paid.⁴

The ACA's tax credits to help with premiums are keyed to a benchmark silver plan, the standard for most consumers, in each geographical area. Gold plans are the closest to employer-provided coverage. For those with chronic illness, gold and platinum plans are likely a better option because they reduce out-of-pocket expenses.^{5,6}

Federal subsidies are available to those whose income is between 100 percent (\$11,490 for an individual) and 400 percent (\$45,960) of the federal poverty level. In addition, a family of four can get a subsidy, although just a small one, with income up to \$94,200. To qualify for subsidies for deductibles and co-pays, income has to be less than 2.5 times the poverty level (\$28,725 for an individual or \$58,875 for a family of four). However, out-of-pocket subsidies are available only to people who have a silver plan. Subsidy amounts are calculated based on modified adjusted gross income.⁷

A NUMBER OF LAWS ARE BEING PROPOSED IN VARIOUS STATES TO CAP CO-PAYS, AND SOME HAVE ALREADY PASSED.

Out-of-Pocket Expenses

Out-of-pocket costs include annual deductibles, co-insurance, co-pays and out-of-pocket maximums. A deductible is the amount patients pay for covered services before the insurance starts to pay.⁸ More than 70 percent of marketplace plans have deductibles under \$3,000.⁹ After the deductible is reached, some services might be covered at 100 percent, while others might require a co-insurance to be paid. Co-insurance is a share of the costs of a healthcare service, which is typically a fixed percentage. A co-pay is a fixed dollar amount that is paid for certain healthcare services such as doctor office or emergency room visits. In most cases, co-pays do not count toward the deductible. A plan's out-of-pocket maximum is the most patients have to pay during a policy period (typically a year) before the plan starts to pay 100 percent of the allowed amount.⁸

Depending on the plan, deductibles, co-payments and/or co-insurance may apply toward the out-of-pocket maximum. But, premiums and non-covered healthcare (e.g., elective surgery) do not. The various healthcare plans have different out-of-pocket maximums. In 2015, under the ACA, the limits

are \$6,600 for an individual plan and \$13,200 for a family plan. Once the deductibles, co-payments and co-insurance reach these limits, the insurance company pays 100 percent of the costs for covered care under all plans.^{9,10}

Interestingly, an analysis by Avalere Health, a consulting firm, shows that out-of-pocket spending caps in 2015 for 71 percent of bronze, 74 percent of silver, 94 percent of gold and 98 percent of platinum plans are below the allowed limits. These include an average of \$6,381 for bronze, \$5,853 for silver, \$4,458 for gold and \$2,145 for platinum. However, the trade-off is higher deductibles, with the average deductible for a silver plan having increased 7 percent in 2015 to \$2,658.¹¹

Specialty Tiers

Understanding what out-of-pocket expenses are is one thing. Understanding what they will cost, especially when specialty medications are involved, is yet another. Most of the marketplace plans use a specialty tier structure that includes four tiers. Tier one includes low-cost generic drugs that require a modest co-pay such as \$15, while the highest tier (tier four) includes the most expensive medications such as IG or other cell-derived biologic medications, cancer medicines and drugs for chronic or rare diseases that are disproportionately higher. Tier four also has the highest level of cost-sharing, a co-insurance rate that is a percent of the drug's cost.¹² According to a study by Avalere Health, these co-insurance rates are often 30 percent to 40 percent of the cost of the drug.¹³

What's worse is that when choosing marketplace plans, Avalere Health reported that "HealthCare.gov may not accurately reflect these specialty tiers' out-of-pocket obligations for some patients."¹² For instance, HealthCare.gov fails to report cost-sharing information for many of the specialty tier structures, which leaves patients in the dark about their cost-sharing requirements.¹³ And, the analysis by Avalere Health suggests a cost-sharing discrepancy for patients with chronic or serious illnesses. In seven of the drug classes it studied, one-fifth of silver plans had a patient co-insurance requirement of 40 percent or higher.¹⁴

The four-tier structure is being called discriminatory, with more than 300 patient groups having sent a letter to Health and Human Services Secretary Sylvia Mathews Burwell to complain.¹³ Specialty tiers apply a totally different benefit structure to certain medications, most of which are used by those living with specific conditions such as cancer, multiple sclerosis, hemophilia, primary immune deficiencies and certain neuropathies.

Fortunately, a number of laws are being proposed in various states to cap co-pays, and some have already passed. For instance,

in California, the Neuropathy Action Foundation and 30 other patient and provider groups asked the state's insurance commissioner to investigate whether specialty tier cost structures violate federal and California law. In Oregon, two bills are pending that would cap co-pays at \$100 per 30-day supply of standard drugs and \$200 for specialty medications. In Maryland and Louisiana, bills that limit co-pays or co-insurance to \$150 per specialty drug up to a 30-day supply were signed into law May 5, 2014, and June 14, 2014, respectively. And, in Virginia, a law passed that requires insurers to provide affected enrollees 30 days' notice of a modification to a formulary that moves a prescription drug to a tier with higher cost-sharing requirements.

Calculating Costs

Few state exchange websites offer cost-calculating tools that allow consumers to figure out how much they would owe under various plan options. But, one is offered by the National Health Council, which has an initiative titled Putting Patients First that strives to ensure that the voices of individuals living with a chronic disease or disability and their family caregivers are heard. On its website (www.puttingpatientsfirst.net), a healthcare calculator titled Estimate My Costs allows individuals to enter personal information such as the state in which they reside, annual income, estimated doctor and hospital visits and medications they are prescribed. The site then calculates both the estimated premiums and out-of-pocket costs for the low and high of each metal plan.

An out-of-pocket cost estimator is currently under development for the federally facilitated marketplace for the 2016 enrollment period, and at the end of June, 103 patient, provider and consumer organizations sent a letter to the Center for Consumer Information and Insurance Oversight to encourage the Centers for Medicare and Medicaid to include accurate drug-specific out-of-pocket costs in that estimator. Specifically, they requested that the calculator 1) reflect real formularies with coverage and tier placement information, 2) allow patients to enter their medicines and 3) use approximate negotiated prices of these drugs.¹⁵

Access Today, Affordability Tomorrow

According to a National Health Council report, all 50 states, plus the District of Columbia, have taken steps to enhance their health insurance exchanges to make them more patient-friendly. But, it adds that much more needs to be done to ensure the marketplaces meet the needs of people with chronic diseases and disabilities. The report identified five key principles of concern to the patient community: non-discrimination, transparency, state oversight, uniformity and continuity of care.¹⁶

While passage of the ACA has greatly improved access to care, there are many aspects of the law that still need improvement to make the marketplaces more navigable and affordable for patients with chronic illness. Fortunately, many organizations are "putting patients first," and it is likely only a matter of time before cost-sharing under specialty tiers becomes more

AN OUT-OF-POCKET COST ESTIMATOR IS CURRENTLY UNDER DEVELOPMENT FOR THE FEDERALLY FACILITATED MARKETPLACE FOR THE 2016 ENROLLMENT PERIOD.

equitable. "If the question is, will some people find that coverage and care remain unaffordable, the answer is yes," said Ron Pollack, executive director of Families USA. "There will be some people who feel that way. [But,] the overwhelming majority will be far better off, even if what they have is not perfect." ■

RONALE TUCKER RHODES, MS, is the editor of *IG Living* magazine.

References

1. Wikipedia, Health Insurance Marketplace. Accessed at en.wikipedia.org/wiki/Health_insurance_marketplace.
2. Obamacare Facts. Obamacare Enrollment Numbers. Accessed at obamacarefacts.com/sign-ups/obamacare-enrollment-numbers.
3. Young, J. Obamacare Premiums Will Vary Widely by State and City: Report. *The Huffington Post*, Sept. 26, 2013. Accessed at www.huffingtonpost.com/2013/09/05/obamacare-premiums_n_3869782.html.
4. Healthcare.gov. Catastrophic Health Insurance Plans. Accessed at www.healthcare.gov/choose-a-plan/catastrophic-plans.
5. Associated Press. Under Obamacare, Out-of-Pocket Costs Leave Some 'Underinsured.' *PBS Newshour*, Jan. 3, 2014. Accessed at www.pbs.org/newshour/rundown/under-obamacare-out-of-pocket-costs-leave-some-underinsured.
6. Healthcare.gov. Marketplace Insurance Categories. Accessed at www.healthcare.gov/choose-a-plan/plans-categories.
7. FAQ: All About Health Insurance Exchanges And How to Shop for Coverage. NPR, Oct. 11, 2013. Accessed at www.npr.org/2013/10/11/230916150/faq-all-about-health-insurance-exchanges-and-how-to-shop-for-coverage.
8. Folger, G. How to Choose Between Bronze, Silver, Gold and Platinum Health Insurance Plans. *Investopedia*, Jan. 16, 2014. Accessed at www.investopedia.com/articles/personal-finance/092413/how-choose-between-bronze-silver-gold-and-platinum-health-insurance-plans.asp.
9. Healthcare.gov. 6 Things to Know about Deductibles in the Health Insurance Marketplace. Accessed at www.healthcare.gov/blog/6-things-to-know-about-deductibles-in-the-health-insurance-marketplace.
10. Healthcare.gov. Out-of-Pocket Costs. Accessed at www.healthcare.gov/choose-a-plan/out-of-pocket-costs.
11. Andrews, M. Many Obamacare Plans Set Out-of-Pocket Spending Limits Below the Cap. *Kaiser Health News*, Dec. 12, 2014. Accessed at khn.org/news/many-obamacare-plans-set-out-of-pocket-spending-limits-below-the-cap.
12. Conshafier, A. Exchange Plans' Cost-Sharing Confuses, Burdens Patients. *Institute for Patient Access*, Feb. 4, 2015. Accessed at allianceforpatientaccess.org/exchange-plans-cost-sharing-confuses-burdens-patients.
13. Conshafier, A. Exchange Open Enrollment Ends, But Rx Access Concerns Linger. *Institute for Patient Access*, Feb. 16, 2015. Accessed at allianceforpatientaccess.org/exchange-open-enrollment-ends-rx-access-concerns-linger.
14. Charles, D, and Conshafier, A. Technology Fixes Don't Solve ObamaCare's Access Problem. *Institute for Patient Access*, Oct. 21, 2014. Accessed at allianceforpatientaccess.org/technology-fixes-dont-solve-obamacares-access-problem.
15. Letter for the Center for Consumer Information and Insurance Oversight. Accessed at www.nationalhealthcouncil.org/sites/default/files/OOPC-Comment-Letter.pdf.
16. National Health Council. Post ACA-Decision: Which States Are Enhancing Their Exchanges? Accessed at www.nationalhealthcouncil.org/post-aca-decision-which-states-are-enhancing-their-exchanges.