# HIV Health Care Access Working Group

January 17, 2016

Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201
Submitted via email to: FFEcomments@cms.hhs.gov

To Whom It May Concern:

The HIV Health Care Access Working Group (HHCAWG) appreciates the opportunity to comment on the 2017 letter to issuers in the federally facilitated marketplaces.

In conjunction with responding to the draft *2017 Letter to Issuers*, we thought it was important to **reiterate the need for CMS to enforce the strong patient non-discrimination provisions contained in the Patient Protection and Affordable Care Act.** Based on plans reviews conducted over the past three years, it appears that several issuers consistently discriminate against people with HIV, hepatitis, and other conditions through their plan design. We are extremely supportive of the statements included in the draft *2017 Letter to Issuers* regarding plan design and what constitutes discriminatory practices. Yet, to date, there has been little enforcement. We also are concerned that the Office of Civil Rights has not finalized its Section 1557 nondiscrimination rule and that the proposed rule did not provide specific examples of what constitutes discrimination in plan design.

Our comments regarding the draft *2017 Letter to Issuers* are brief in light of the extensive comments we submitted in response to the *HHS Notice of Benefit and Payment Parameters for 2017.* Our comments and recommendations below are organized by the letter section as requested.

**Section 3 – Network Adequacy**

**V. Network Transparency**

We strongly support the proposal to label the provider networks according to the breadth of providers relative to other QHPs provider networks to help enrollees identify plans that will best meet their medical needs. We urge CMS to expand the classification to other specialists, including HIV and infectious diseases specialists and would consider including behavioral health providers in the initial year.

**Section 4. Essential Community Providers**

We are concerned that some QHPs continue to avoid contracting with Ryan White providers and likely other Essential Community Providers. We strongly urge requiring QHPs to identify the Essential Community Providers by ECP provider type in their online directories. In addition, we urge CMS to publish ECP reviews and the justifications submitted by QHPs. At a minimum reviews should be available for plans not meeting the minimum ECP coverage requirements.

We appreciate the need to collect and make available accurate and complete data regarding eligible Essential Community Providers (ECPs) through the ECP petition process. Given the tight timeline for educating ECPs and compiling petition data, we strongly support the flexibility that is being granted to

not remove ECPs from the ECP list until Plan Year 2018. We also support keeping the petition process open to allow for ECPs to submit petitions throughout the year to build the database for Plan Year 2018 and beyond. We urge ongoing review and monitoring of the ECP petition process to ensure eligible ECPs receive consistent and complete information regarding the ECP designation and have sufficient time to respond to information requests.

**Section 9. Discriminatory Benefit Design**

i. EHB Discriminatory Benefit Design

We are concerned that contrary to last year's guidance, QHPs may justify excluding coverage for a single tablet regimen based on cost. Single tablet regimens play an important role in simplifying HIV treatment regimens and improving adherence to treatment – which is critical to successful treatment of HIV. In addition, the cost to enrollees is often greater when they are required to take multiple medications with multiple copayments instead of a single tablet regimen with a single co-payment. High cost sharing presents a significant barrier to accessing treatment for many people with HIV. Access to single tablet regimens should be based on the recommendation of a clinician consistent with the federal HIV treatment guidelines.

ii. QHP Discriminatory Benefit Design

We strongly support the CMS proposal to conduct a review of each QHP with regard to estimated out-of-pocket-costs for standard treatment protocols for certain chronic, high cost conditions, including bipolar disease, diabetes, HIV, rheumatoid arthritis and schizophrenia. We urge CMS to add hepatitis C to the list of conditions for which cost sharing will be compared and evaluated across QHPs.

We appreciate the CMS recognition that an outlier approach will not identify discriminatory benefit designs if a majority of QHPs are employing benefit designs that provide poor or inadequate coverage for certain higher cost patient populations. We urge CMS not to rely on the outlier test for identifying discriminatory benefit designs for conditions when it is documented QHPs have employed discriminatory benefit practices, such as HIV and hepatitis C.

We support the inclusion of a review of QHP complaint data in the compliance review process and urge CMS to ensure that consumers understand the complaint process.

**Section 10. Prescription Drugs**

ii. Clinical Guideline-Based Review of Prescription Drug Coverage

We strongly support the review of QHP coverage of, and the associated costing sharing for, drugs recommended in nationally-recognized clinical guidelines for the expanded list of conditions that now includes hepatitis C and HIV. The Department of Health and Human Services Guidelines for the Use of Antiretroviral Therapy in Adults and Adolescents and for Pediatric HIV Infection are widely recognized as setting the standard of care for HIV treatment in the U.S.[1]

iii. Review of Tier Placement of Prescription Drugs Recommended for Treatment of Specific Medical Conditions

[1] AIDSinfo.org. Clinical Guidelines Portal. Online at: https://aidsinfo.nih.gov/guidelines.

We also strongly support the review of cost sharing tier placement for a class or classes of drugs used to treat a certain condition. Some QHPs continue to place all or most of the antiretroviral drugs on the top cost sharing tiers. We urge CMS to monitor closely for adverse tiering and to require corrective action when adverse tiering is identified.

A recent analysis conducted by Avalere of Silver plans found that while many plans (51 percent) cover HIV drugs on lower-cost tiers, 30 percent of the plans placed all of the most common 10 treatment regimens on the highest formulary tier.[2]

In addition to monitoring for tier placement, we urge CMS to review for plans that apply utilization management, such as prior authorization, to all of the medications used to treat a certain condition. This is another discriminatory practice employed by some QHPs that unfairly restricts access to HIV treatment. Step therapy – or requiring individuals to try and fail on a lower cost treatment before coverage of a higher cost therapy - is never appropriate for HIV and should not be allowed.

**Section 12. Supporting Informed Consumer Choice/Meaningful Difference**

We support CMS applying a more standardized approach to evaluating meaningful difference among an issuer's QHP products. Taking steps to ensuring meaningful differences among QHP options is important to improve consumer options, reduce confusion among enrollees and streamline the enrollment process.

Thank you again for the opportunity to comment on the draft letter to issuers. We appreciate the ongoing responsiveness to the challenges experienced by QHP enrollees with HIV and others and hope to soon see stronger enforcement of these policies. We look forward to continuing to work with HHS to ensure the ACA works as intended for people with HIV and others with serious chronic conditions. Please contact the HHCAWG co-chairs Andrea Weddle with the HIV Medicine Association (aweddle@hivma.org), Amy Killelea with the National Alliance of State & Territorial AIDS Directors (akillelea@nastad.org), or Robert Greenwald with the Treatment Access Expansion Project (rgreenwa@law.harvard.edu) if we can be of assistance.

Submitted on behalf of the HHCAWG Steering Committee,

AIDS Action Baltimore | AIDS Action Committee of MA | AIDS Alliance for Women, Infants, Children, Youth & Families | AIDS Foundation of Chicago | The AIDS Institute | AIDS Project Los Angeles | AIDS Treatment Data Network | AIDS United | American Academy of HIV Medicine | Association of Nurses in AIDS Care | Community Access National Network | Communities Advocating Emergency AIDS Relief (CAEAR) Coalition | Gay Men's Health Crisis | Georgia AIDS Coalition | Harlem United | Health and Disability Advocates | HealthHIV | HIVictorious, Inc. | HIV Medicine Association | HIV Prevention Justice Alliance | Housing Works | Los Angeles LGBT Center | Moveable Feast | National Alliance of State and Territorial AIDS Directors | National Minority AIDS Council | The National Working Positive Coalition| Project Inform | San Francisco AIDS Foundation | South Carolina Campaign to End AIDS| Treatment Access Expansion Project | Treatment Action Group | VillageCare

[2] Avalere. Patient Access to HIV Drugs in the Exchange Plans Is Limited Compared to Other Sources of Coverage. November 2015. Online at: http://avalere-health-production.s3.amazonaws.com/uploads/pdfs/1447260444_20151111_HIV_Rx_Access_Release.pdf