



CALIFORNIA HEALTHCARE FOUNDATION



**Better Shop Around:**  
Out-of-Pocket Prescription Drug Costs  
in Covered California Plans

MAY 2015

# Contents

## About the Author

Avalere Health is a strategic advisory company that creates innovative solutions to complex health care problems. Based in Washington, DC, the firm provides business intelligence tools and custom analytics for leaders in health care business and policy.

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## About the Foundation

The California HealthCare Foundation (CHCF) is leading the way to better health care for all Californians, particularly those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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## 3 Introduction

## 4 Background

## 6 Methodology

## 8 Findings

## 14 Policy Considerations

## 17 Glossary

## 19 Appendices

A: Covered California Standard Plans, Select Features, 2014

B: Additional Methodology Notes

## 21 Endnotes

# Introduction

**B**uying health coverage is a complex process. Consumers must compare and evaluate premiums, benefits, drug formularies, and provider networks across a range of insurance products. In choosing the best plan for themselves and their families, consumers must consider their monthly budgets and anticipate their health care needs for the coming year.

Deciding which plan to buy is especially important for those with chronic diseases, as these individuals are likely to encounter out-of-pocket costs for health services, in addition to monthly premiums. Low-income consumers with chronic diseases face particularly challenging trade-offs, as they have little room in their budgets for unexpected out-of-pocket costs on top of their monthly premium payments. Those needing specialty drugs may find it especially difficult to predict out-of-pocket costs because these drugs are typically subject to co-insurance, which requires an enrollee to pay a percentage of the drug cost as opposed to a flat dollar copayment; most consumers do not know the full cost of the drug they are prescribed.

With the 2014 nationwide launch of the Affordable Care Act (ACA) insurance exchanges, including Covered California, large numbers of consumers who were previously unable to purchase health insurance in the individual private insurance market due to cost or pre-existing conditions now have access to more affordable insurance covering vital health services, including necessary prescription medications.

Many of these consumers, however, have little or no previous experience buying health insurance. And many are on tight budgets: Close to two-thirds of 2014 Covered California enrollees had household incomes at or below \$29,175, which is 250% of the 2014 federal poverty level (FPL). For these consumers, understanding the costs associated with different plans is particularly important.

Covered California has taken significant steps to facilitate informed purchasing decisions by the state's residents, including standardizing most elements of plan benefit designs to improve comparison shopping, providing a cost estimator tool on its website to help consumers calculate their potential out-of-pocket costs under various plans, and incorporating early enrollment experience feedback to shape targeted consumer communications

about plan choice and to strengthen benefit transparency requirements.

One goal of some of these education efforts is to raise consumer awareness about possible variation in out-of-pocket costs among plans offered through Covered California. Researchers examining the health plans offered through Covered California in 2014 found that prescription drug coverage was one of the most significant sources of variation among those plans, particularly for drugs treating medication-reliant chronic conditions, such as bipolar affective disorder and rheumatoid arthritis.<sup>1,2</sup>

*Better Shop Around: Out-of-Pocket Prescription Drug Costs in Covered California Plans* describes how plan variation and formulary design choices impacted consumers' out-of-pocket costs in 2014. It highlights the sometimes complex considerations consumers must take into account when choosing a plan. Because the standard benefit designs were virtually unchanged from 2014 to 2015, the findings presented are broadly applicable to the first two years of Covered California's operation.

## Considerations for Consumers

Consumers must account for myriad factors when selecting the plan that is best for them. Some key cost considerations:

- ▶ Select a plan that lists your prescription drugs on formulary and, if you take specialty drugs, try to find a plan that lists these drugs on a lower tier. If you take a drug that is not listed on your plan's formulary, you can apply for an exception.
- ▶ If you have few health needs, a bronze plan might offer the lowest monthly premiums. However, if you have a chronic condition, plans at higher metal levels, such as gold or platinum, may be more cost-effective.
- ▶ Cost-sharing reduction plans generally offer great value to patients, even though bronze plans may have lower or \$0 premiums. Consider a cost-sharing reduction plan if you are eligible.
- ▶ If you have a chronic condition, you are likely to experience high costs at the start of the year as a result of deductibles and high co-insurance for specialty drugs.

This report also notes the steps Covered California is taking for the 2016 benefit year to limit consumers' costs for some prescription drugs. This challenging task requires balancing the need to ensure premium affordability with reducing the financial burden on consumers facing high out-of-pocket costs. The report also identifies additional public education measures to help consumers with chronic conditions understand the out-of-pocket costs associated with different plans.

## Background

The ACA outlines benefit design requirements for participating plans that aim to provide consumers with comprehensive, affordable health insurance coverage. The requirements include:

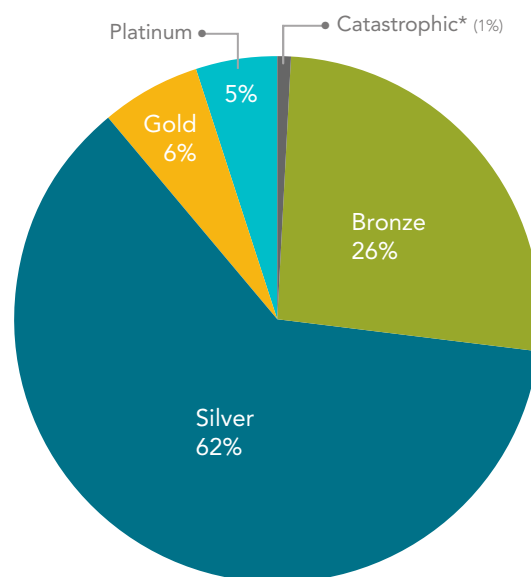
- ▶ Essential health benefits, which specify the scope of covered benefits<sup>3</sup>
- ▶ Actuarial value, which requires plans to match one of four levels of generosity (metal levels) based on the percentage of costs covered by the plan
- ▶ Maximum out-of-pocket limits, which capped total consumer costs (not including premium) at \$6,350 annually for most individual plans in 2014

Bronze and silver plans have lower monthly premiums but require higher consumer cost sharing for health services and drugs, while gold and platinum plans have higher premiums and lower out-of-pocket costs. In 2014, the vast majority of exchange enrollees chose

low metal level, low premium plans. This may reflect the value exchange consumers place on low monthly premium costs. Or it may indicate that these enrollees do not anticipate having significant health care needs throughout the year. Some consumers, especially those with chronic conditions, may have struggled to evaluate premium costs against less-predictable out-of-pocket costs when shopping for plans. State policymakers and Covered California continue to develop and refine transparency requirements and consumer shopping tools that make these trade-offs clearer and help consumers select the best plan for their needs.

The majority of Covered California enrollees (62%) selected a silver plan in 2014 (see Figure 1).<sup>4</sup>

**Figure 1. Percentage of Covered California Enrollment by Metal Level, 2014**



\*Catastrophic coverage is not included in this analysis.

Source: California Health Benefit Exchange, Metal Level by Subsidy Status, [hbex.coveredca.com](http://hbex.coveredca.com).

**Table 1. Levels of Coverage: Metal Levels Explained**

LEVEL	ACTUARIAL VALUE*	PREMIUM
Platinum	90%	Highest ↑ ↓ Lowest
Gold	80%	
Silver	70%	
Bronze	60%	
Catastrophic†	0% until MOOP is met	Lowest

\*Percentage of health care costs covered by plan after premiums.

†Available only to those under age 30 and those who qualify for a hardship exemption.

Note: MOOP is maximum out-of-pocket limit.

Under the ACA, Covered California enrollees can access two forms of financial assistance based on their income level:

- **Sliding-scale tax credits** are available to enrollees with incomes between 100% and 400% of the federal poverty level.<sup>5</sup> These tax credits limit monthly premium payments for enrollees to a percentage of their income. About 88% of enrollees in Covered California in 2014 qualified for tax credits to reduce premiums costs.<sup>6</sup>
- **Cost-sharing reductions** allow individuals and families with incomes between 100% and 250%<sup>7</sup> of the federal poverty level (FPL) to enroll in silver plans with lower cost sharing (see Table 2). In 2014, 13% of those eligible for cost-sharing reduction plans chose bronze plans with higher cost sharing.<sup>8</sup> Additional research is needed to better understand the implications of this choice: Healthy individuals may have decided to forego cost-sharing reductions to lower their monthly premium spending. However, for individuals with greater health care needs, this choice may have resulted in higher out-of-pocket costs.

**Table 2. Cost-Sharing Reduction Plans, Individual, 2014**

HOUSEHOLD INCOME As a percentage of FPL	Amount	MAXIMUM OOP	ACTUARIAL VALUE*
100%-150% FPL	\$11,670-\$17,505	\$2,250	94%
151%-200% FPL	\$17,506-\$23,340	\$2,250	87%
201%-250% FPL	\$23,341-\$29,175	\$5,200	73%

\*These plans have actuarial values set by the ACA that are higher than silver coverage, which is designed to cover 70% of a consumer's expected annual health care costs.

Notes: FPL is federal poverty level. OOP is out-of-pocket limit.

## California Standard Benefit Designs Compared with Exchange Plans Nationwide

California went beyond federal rules by requiring plans offered through Covered California to align with eight standardized benefit designs (see Appendix A for details). Issuers not participating in the exchange are required to offer at least one product with the standard benefit design in each of the four metal levels.<sup>9</sup> Taken

together, these requirements mean a large proportion of enrollees in California's individual market are now in plans with standardized benefits.

California's standard benefit design creates greater uniformity across health plans by adding a fixed deductible and set cost-sharing amounts for medical services and prescription drugs to the ACA's maximum out-of-pocket limit. In fact, plans using California's standard benefit design can only vary based on premium, provider network, and formulary design. As in most insurance markets, in 2014, California plans had the flexibility to decide which drugs would be included on formulary, into which consumer cost category (tier) they would be placed, and which utilization management requirements, such as prior authorization, would apply.

California's standard benefit design differs from that of many plans sold in other states' exchanges. Most notably, California's plans have separate medical and drug deductibles rather than integrated deductibles, which are used in almost half of the plans in the federal exchange (see Table 3). Under an integrated deductible, patients who rely on medications may face more

**Table 3. Comparison of Silver Plans in California vs. the Federally Facilitated Marketplace (FFM), 2014**

	COVERED CA STANDARD SILVER	FFM SILVER PLANS*
Medical Deductible	\$2,000	\$2,932
Drug Deductible	\$250 <sup>†</sup>	\$559
Maximum Out-of-Pocket	\$6,350	\$5,947
Drugs, generics	\$19	\$13
Drugs, preferred brand	\$50	\$48
Drugs, non-preferred brand	\$70	\$87
Drugs, specialty	20%	32%

\*Plan averages include those plans with similar structures to the Covered California standard silver plans. In general, Covered California structures (copayments vs. co-insurance) mirror the most commonly used techniques across FFM plans. This is a sample of unique benefit designs available through the federal exchange, and excludes products where the deductible equals the maximum out-of-pocket or where most service categories are subject to \$0 cost sharing, since these tend to be unique structures that are not comparable to the products in California.

<sup>†</sup>Deductible includes brand drugs only (approaches likely vary for FFM plans).

Source: Avalere Health analysis of benefit designs in the Federally Facilitated Marketplace Landscape File compared to California standard benefits.



up-front, out-of-pocket spending before their plan begins to share in the cost, compared to plans with separate drug deductibles that tend to be much lower than the integrated deductible.

The drug deductible in California was also well below the federally facilitated marketplace average, which enables medication-reliant patients to more quickly fulfill their deductibles and begin plan coverage, thus potentially lowering their costs.

Further, in 2014 Covered California used a 20% co-insurance for specialty drugs in silver plans, which is substantially below the national average of 32%. As a result, Covered California consumers who rely on specialty medicines may have lower costs per refill compared to patients in other states. California also standardized its cost-sharing reduction plans, which further limits consumers' deductibles and copayments for all services, including prescription drugs.

**In 2014 Covered California used a 20% co-insurance for specialty drugs in silver plans, which is substantially below the national average of 32%. California's drug deductible was also below the federally facilitated marketplace average.**

## Methodology

To understand the out-of-pocket cost experience for chronically ill consumers enrolled in plans through Covered California, researchers created profiles of patients with medication-dependent chronic conditions and mapped their use of prescription drugs and health services across the 2014 benefit year. Researchers calculated average annual out-of-pocket costs using a database of 68 Covered California plans with unique formulary-benefit design combinations.<sup>10</sup> The subset of plans used for each finding is specified accordingly.<sup>11</sup>

This analysis examines the experience of consumers with one of five chronic conditions:

1. Bipolar affective disorder
2. Chronic obstructive pulmonary disease (COPD)
3. Diabetes mellitus (Type 2)
4. Human immunodeficiency virus / acquired immune deficiency syndrome (HIV/AIDS)
5. Rheumatoid arthritis (RA)

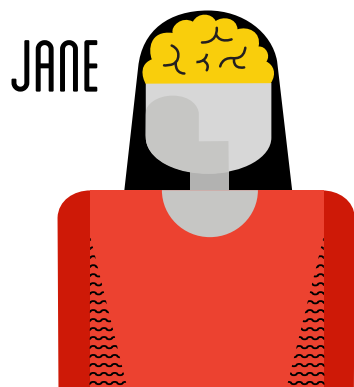
**Key assumptions:** This analysis assumes that patients receive all recommended care from in-network providers. It further assumes that consumers enroll in a plan in which their drugs are on formulary, and that they do not request alternative drugs on lower tiers. Plans that do not cover the specific medications used in each patient profile are excluded from the analysis to maintain a consistent set of drugs and services across plans.

Researchers projected each consumer's expected use and costs of health care services and medications throughout the year, based on 2014 plan designs. Researchers then overlaid these patterns against each of California's standard benefit designs to identify when the patient reached the deductible and out-of-pocket limits. Unless noted, costs displayed represent the after-premium costs. (See Appendix B for additional methodology notes.)

## PATIENT PROFILES

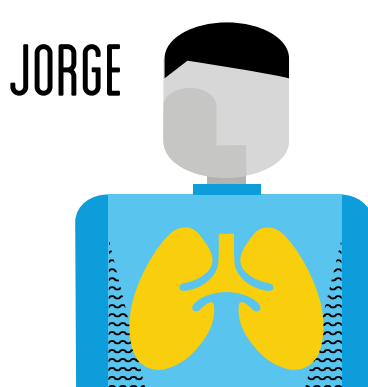
Throughout the paper, the authors refer to five sample patients with chronic diseases to help illustrate the experience of individuals purchasing insurance through Covered California.

These patient profiles were constructed in partnership with clinicians to represent realistic health care needs for moderate-acuity patients with the given condition.



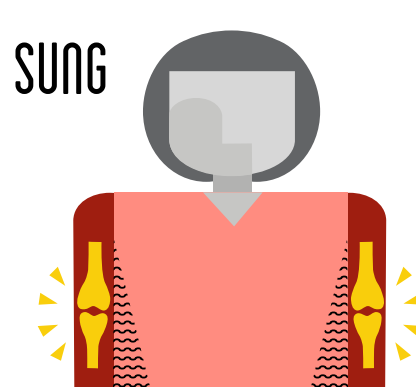
JANE

**Diagnosis:** Bipolar Disorder  
**Age:** 34  
**Income:** \$25,674 (220% FPL)



JORGE

**Diagnosis:** COPD  
**Age:** 47  
**Income:** \$32,092 (275% FPL)



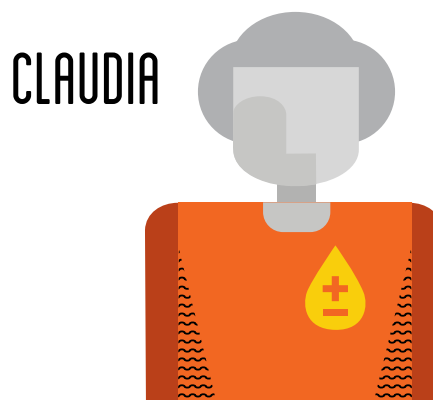
SUNG

**Diagnosis:** RA  
**Age:** 53  
**Income:** \$35,010 (300% FPL)



PAUL

**Diagnosis:** HIV/AIDS  
**Age:** 45  
**Income:** \$58,000 (497% FPL)



CLAUDIA

**Diagnosis:** Diabetes  
**Age:** 61  
**Income:** \$40,845 (350% FPL)

## Findings

*Consumers who rely on specialty drugs experience higher out-of-pocket costs than those who don't use specialty drugs.*

Patients who use medicines that are usually placed on a specialty tier, such as those for HIV/AIDS or RA, are more likely to have increased out-of-pocket spending and to reach their out-of-pocket maximum, based on an analysis of standard, unsubsidized silver plans. In contrast, the patients with bipolar disorder, COPD, and diabetes experience lower overall spending, since the drugs used to treat these conditions are not placed on the specialty tier in any Covered California plans. (See Figure 2.)

In 2014 silver plans, specialty drugs had a 20% co-insurance, compared to a \$70 flat copayment for Tier

3 non-preferred brand drugs. Particularly since many specialty tier drugs are expensive, the co-insurance can result in much higher out-of-pocket costs.

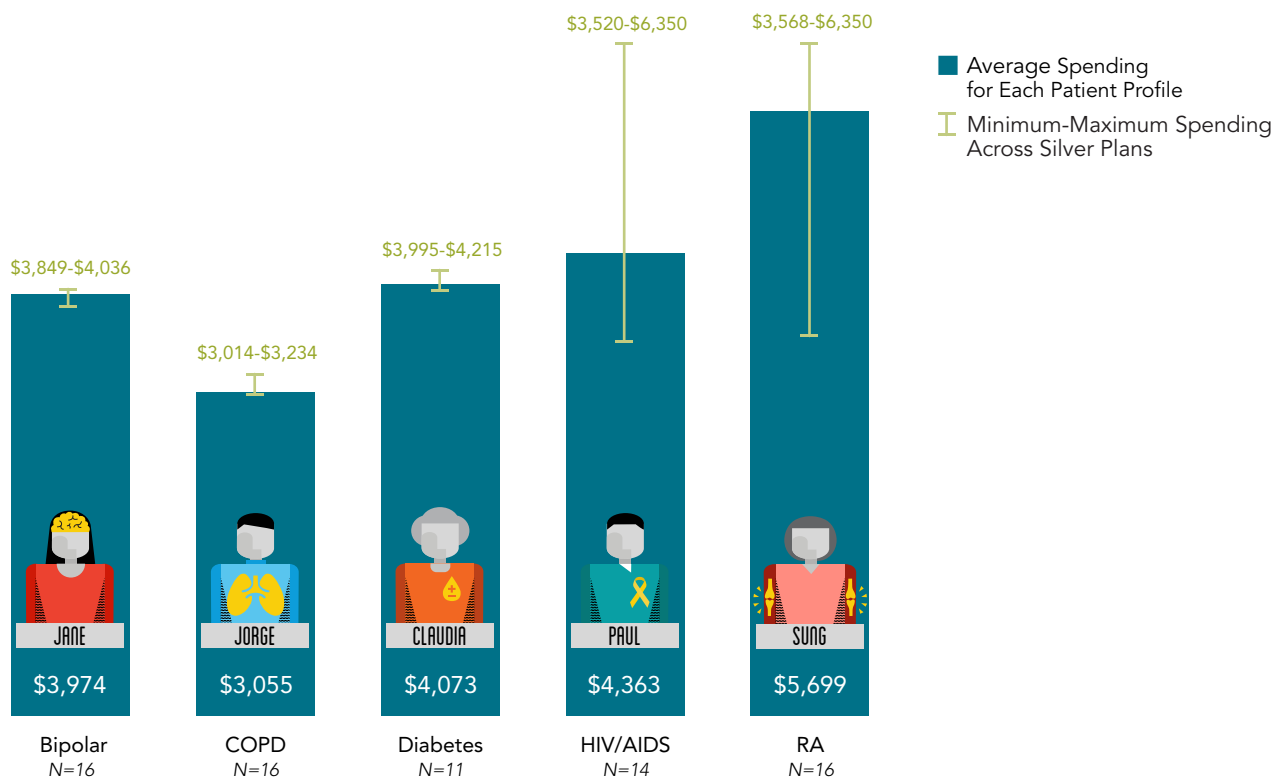
*Because California requires standard benefit designs, prescription drug formulary placement is the primary source of variation in out-of-pocket costs across different plans.*

Cost sharing for medical services is standardized within metal levels and in Covered California. As such, tier placement of medications is the primary driver of plan-to-plan cost variation for consumers who regularly use prescription drugs.



For instance, Paul's annual out-of-pocket costs to treat his HIV/AIDS in an unsubsidized silver plan would range from \$3,520 to \$6,350,

**Figure 2. Range of Out-of-Pocket Spending for Each Patient Profile, by Condition, Standard Silver Plans, 2014**



Notes: Out-of-pocket costs are weighted by distribution of silver plans in the sample. *N* is the number of silver plans included in the spending range for each condition because plans that did not list the branded drug on formulary were excluded from out-of-pocket cost calculations. Costs do not include premiums. *COPD* is chronic obstructive pulmonary disease; *HIV/AIDS* is human immunodeficiency virus infection and acquired immune deficiency syndrome; *RA* is rheumatoid arthritis.

Source: Avalere Health analysis of patient profiles and Covered California plan features, 2014.



depending on which plan he selected. This variation is due to differences between plans in formulary tier placement for these medications. For example, Paul's drug is covered on the preferred brand tier in 57% of plans, the non-preferred brand tier in 14% of plans, and on the specialty tier in 29% of plans.<sup>12</sup> As a result, Paul's monthly cost for a single, branded HIV/AIDS drug ranges from \$50 on the preferred brand tier to \$474 on the specialty tier.<sup>13</sup>



Similarly, Sung's out-of-pocket costs for care associated with her RA would range from \$3,568 in a plan that placed her drug on a preferred brand tier to \$6,350 in a plan that placed the same drug on its specialty tier.

In contrast, average costs for the other consumers' bipolar disorder, COPD, and diabetes drugs range very little, since all plans placed drugs used by these patients on either the preferred or non-preferred brand tier. In standard silver plans, the difference in copayment between the preferred and non-preferred brand tiers is \$20 per prescription.

*While standard benefit designs limit variation across plans, consumer costs will still vary based on an enrollee's unique health needs.*

Even for patients who have the same chronic condition, variations in disease acuity and comorbidities can lead to significant differences in patient costs.



For example, patients with COPD, like Jorge, can have widely different health care needs. A low-acuity patient with limited medication needs could pay as little as \$2,270 out of pocket annually. Meanwhile, a medium-acuity patient who sees

several doctors and takes multiple medications to manage COPD and other comorbidities could pay up to \$3,234 out of pocket annually. Costs for a high-acuity COPD patient who also has to be hospitalized during the year could rise to \$6,305. As a result of different prescription regimens and inpatient care needs, the high-acuity patient spends almost three times as much out of pocket annually as the low-acuity patient. (See Table 4.)

*For consumers with significant health needs, cost-sharing reduction silver plans dramatically reduce expected enrollee costs relative to nonsubsidized alternatives.*

Consumers who earn less than 250% FPL — approximately 66% of 2014 Covered California enrollees — have the option of enrolling in silver plans with lower cost sharing.<sup>14</sup> However, consumers have the option to forego the subsidized policy and instead enroll in a standard bronze plan to minimize their monthly premium. Despite lower premiums in bronze plans, consumers with significant health needs are likely to face greater annual costs after accounting for benefit design.



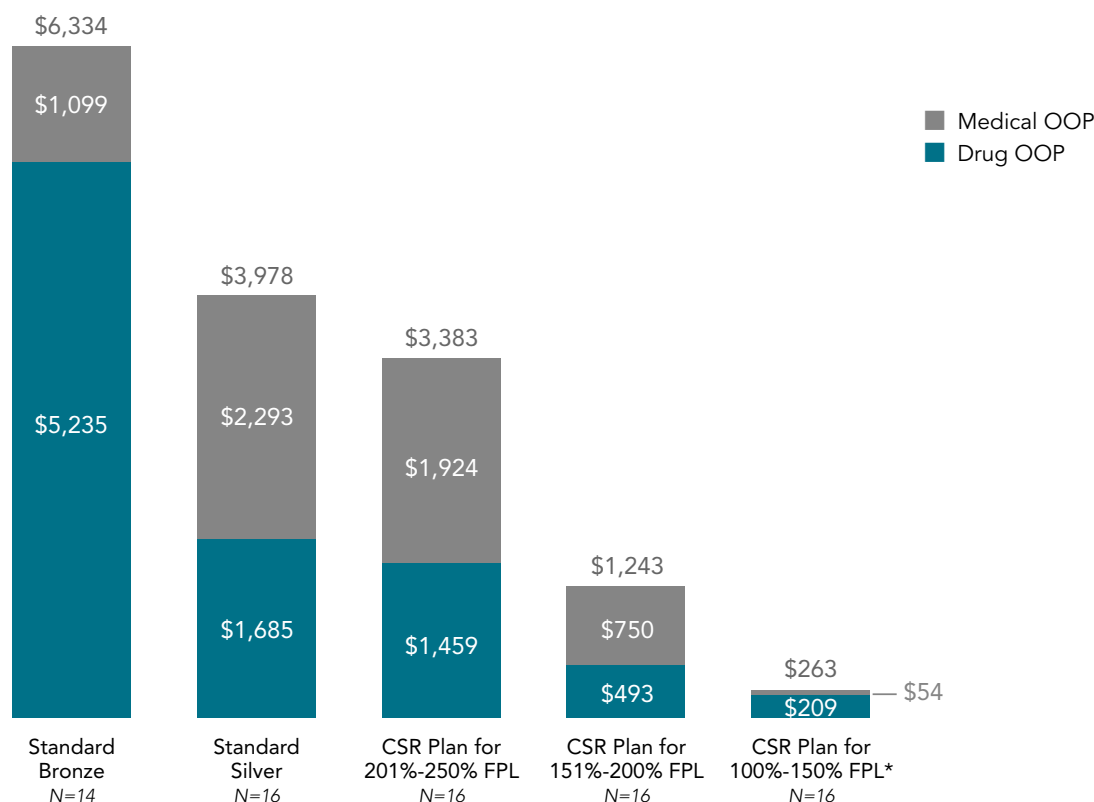
For Jane, who earns 220% of the federal poverty level (\$25,674) and has bipolar disorder, the cost-sharing reduction plan reduces out-of-pocket costs by \$2,951, or 47%, compared to a standard bronze plan (see Figure 3 on page 10). When adjusted for premium subsidies, the silver plan will cost an additional \$936 in annual premiums; however, Jane will still save \$2,000 in total annual health care costs by selecting the cost-sharing reduction plan. Meanwhile, if Jane's income was only 140% of the federal poverty level (\$16,338), she would save \$4,700 (96%) annually in total costs by purchasing a cost-sharing reduction plan rather than buying a standard bronze plan.

**Table 4. Range in Out-of-Pocket Costs in Standard Silver Plans, COPD, 2014**

PATIENT ACUITY	PATIENT DETAILS	ANNUAL OOP (N=16)
Low	Newly diagnosed, manages condition with generic medications and visits to primary care physician and pulmonologist	\$2,270
Medium	History of COPD, several comorbidities, including diabetes, manages conditions with branded generic medicines and visits to several specialists	\$3,104-\$3,234
High	Same set of medicine needs and comorbidities as the medium acuity patient but experiences an acute COPD complication and is hospitalized for two days	\$6,133-\$6,305

Notes: N is the number of silver plans included. COPD is chronic obstructive pulmonary disease; OOP is out-of-pocket cost (does not include premiums). Source: Avalere Health analysis of patient profiles and Covered California plan features, 2014.

**Figure 3. Average Out-of-Pocket Costs for Jane (bipolar patient), Standard Bronze, Standard Silver, and Cost-Sharing Reduction Plans, 2014**



\*Enrollees in this group will have incomes from 138% to 150% FPL, since most individuals earning less than 138% FPL will be eligible for Medi-Cal.

Notes: Average out-of-pocket costs for silver plans weighted by distribution of silver copay and co-insurance plans in sample. This figure does not include premiums. *N* is the number of silver plans included. *FPL* is federal poverty level; *OOP* is out-of-pocket; *CSR* is cost-sharing reduction.

Source: Avalere Health analysis of patient profiles and Covered California plan features, 2014.

**An enrollee with bipolar disorder and income at 140% FPL could expect a savings of \$4,700 annually by choosing a cost-sharing reduction plan instead of a standard bronze plan.**

*Some unsubsidized consumers may benefit from paying higher premiums for a platinum plan to reduce their total annual costs.*

For consumers with high annual health care spending, including on specialty drugs, platinum plans feature a lower maximum out-of-pocket limit (\$4,000 for an individual) that may save consumers money.



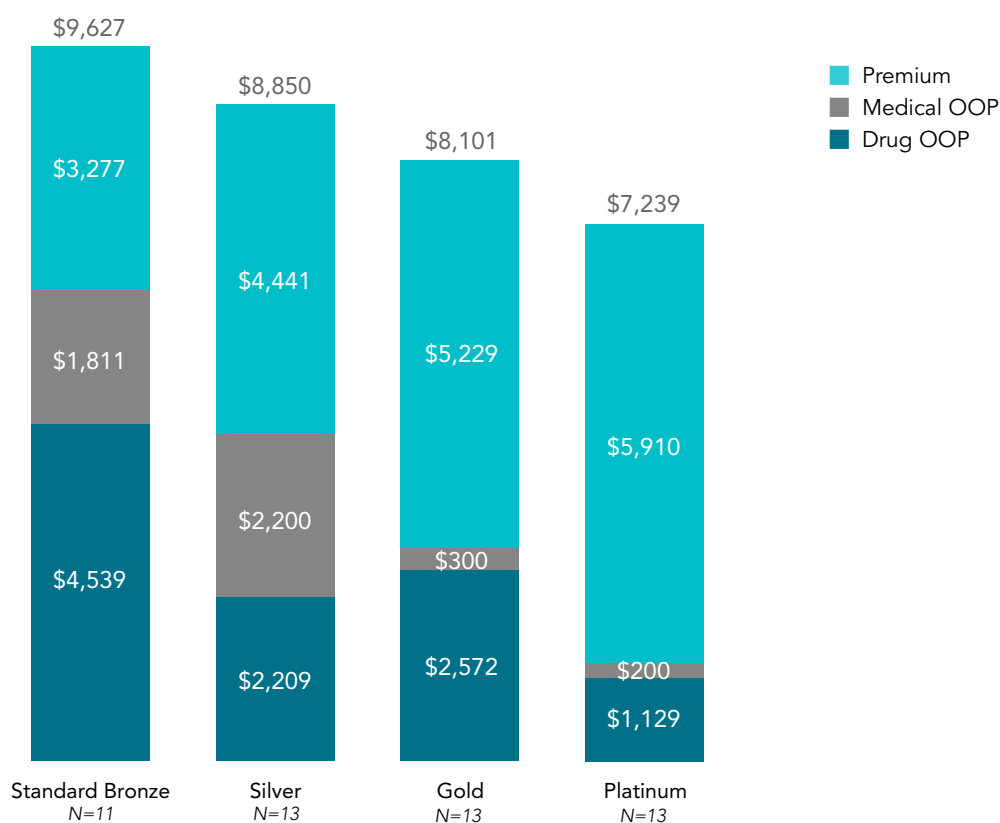
Paul, who has HIV/AIDS and earns \$58,000 annually (497% FPL), spends most of his health care budget on a branded, single-tablet regimen drug and on quarterly lab tests.<sup>15</sup> Cost sharing for these services varies by metal level. For example, although bronze plans have the lowest premiums, the co-insurance for a drug on the specialty tier under that plan is 40%, which would cost almost \$1,000 per fill for

Paul's medication. In contrast, a platinum plan will have a higher premium, but cost sharing on the specialty tier is only 10% co-insurance, and out-of-pocket costs are capped at \$4,000 compared to \$6,350 across other unsubsidized metal levels. After accounting for premiums, Paul's total costs would be lowest if he selects a platinum plan, whereas bronze plans result in the highest total spending (see Figure 4).

The cost-benefit trade-off of paying a higher premium to reduce out-of-pocket costs will vary by age. Notably, for younger enrollees with chronic conditions, the difference across metal levels is even more pronounced because premiums are significantly lower in the younger age groups. For example, a 35-year-old with HIV/AIDS would pay 15% less in premiums than a 45-year-old and would

**A 45-year-old person with HIV who is not eligible for premium and cost-sharing subsidies could save more than \$2,000 by choosing a platinum plan, and paying higher premiums, rather than a bronze plan.**

**Figure 4. Average Total Annual Costs for Paul (45-year-old HIV/AIDS patient, non-ADAP eligible), Including Premium by Unsubsidized Standard Plan Design, 2014**



Notes: Products from Contra Costa Health Plan are excluded because premium data are not available. N is the number of plans included; for silver, gold, and platinum plans, range of out-of-pocket costs weighted by distribution of copay and co-insurance plans in plan sample that listed the HIV/AIDS branded drug on formulary: silver copay (10), silver co-insurance (3); gold copay (4), gold co-insurance (9); platinum copay (4), platinum co-insurance (9). OOP is out-of-pocket cost. ADAP is AIDS Drug Assistance Program.

Source: Avalere Health analysis of patient profiles and Covered California plan features, 2014.

still benefit from the lower maximum out-of-pocket of a platinum plan.

*Regardless of income, medication-reliant consumers face front-loaded spending at the start of the year as a result of deductible requirements and specialty tier costs.*



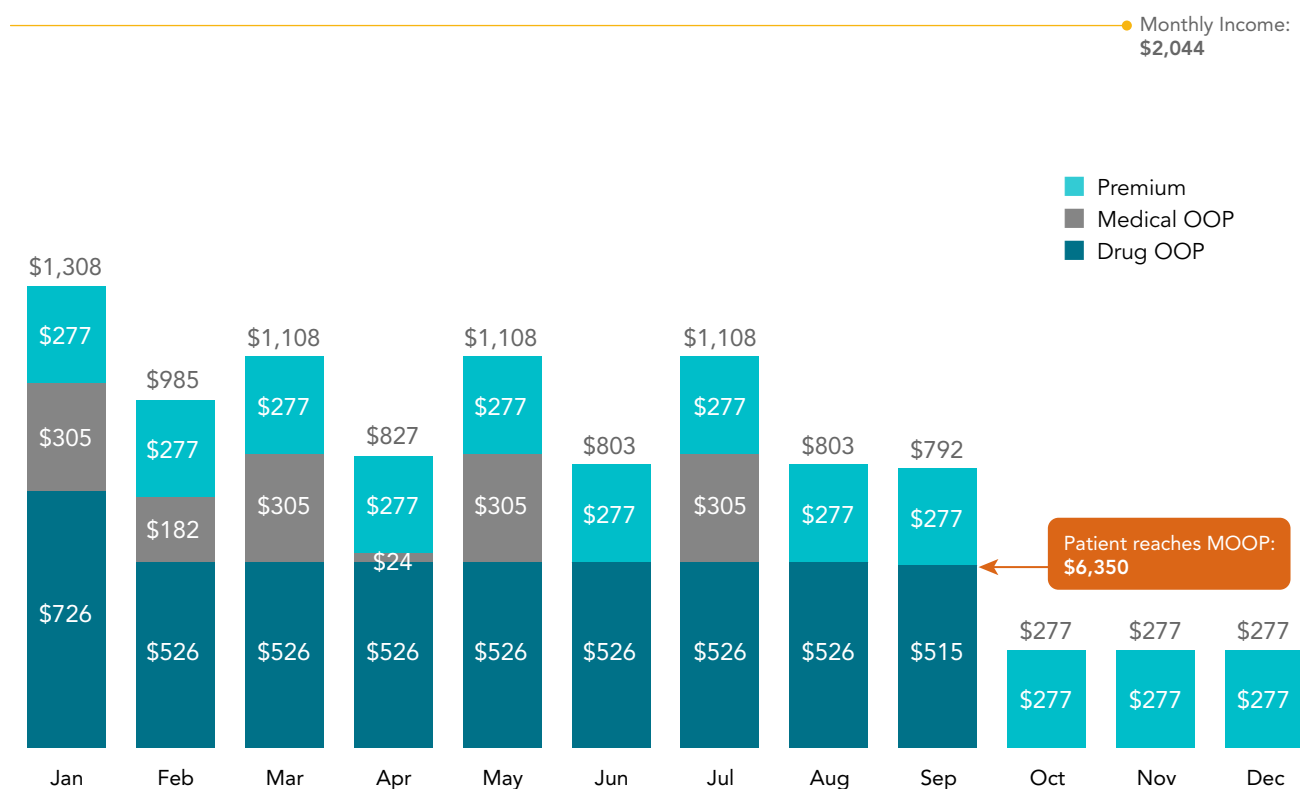
If Sung, who is being treated for RA, selects a plan in which her drug is on the specialty tier, she may face high costs early in the year that are unaffordable, threatening her ability to adhere to her medication regimen. Across the 2014 Covered California plan sample used for this analysis, the branded RA drug used in this case study was placed on the specialty tier 75% of the time. If Sung has an income at 300% of the federal poverty level (\$35,010) and enrolls in a standard silver plan that covers her drug on the specialty tier, her

out-of-pocket costs in January are \$1,031, which is 50% of her monthly take-home pay — on top of premium payments of \$277 monthly (see Figure 5). Sung is expected to reach her annual out-of-pocket limit by September, after which she will be responsible for premium payments and no cost sharing for services or drugs.

**After accounting for premiums and cost sharing, a consumer with RA who earns \$35,010 annually must spend up to 64% of her monthly take-home pay on health care until she reaches her annual out-of-pocket limit in nine months.**

**Figure 5. Average Cost Sharing for Sung (RA patient), Unsubsidized Standard Silver Plan, by Month, 2014**

BASED ON SPECIALTY TIER PLACEMENT, PATIENT WITH INCOME OF 300% FPL (N=12)



Notes: Monthly income is after tax, calculated using the ADP calculator. N is the number of silver plans included. MOOP is maximum out-of-pocket limit.

Source: Avalere Health analysis of patient profiles and Covered California plan features, 2014.

If Sung's income dropped to 170% of the federal poverty level (\$19,800), she would qualify for a cost-sharing reduction plan. Under this plan, her out-of-pocket costs would be \$718 in January — 55% of her monthly after-tax income, on top of premium payments of \$81 monthly. Sung would reach her out-of-pocket maximum of \$2,250 by May (see Figure 6).

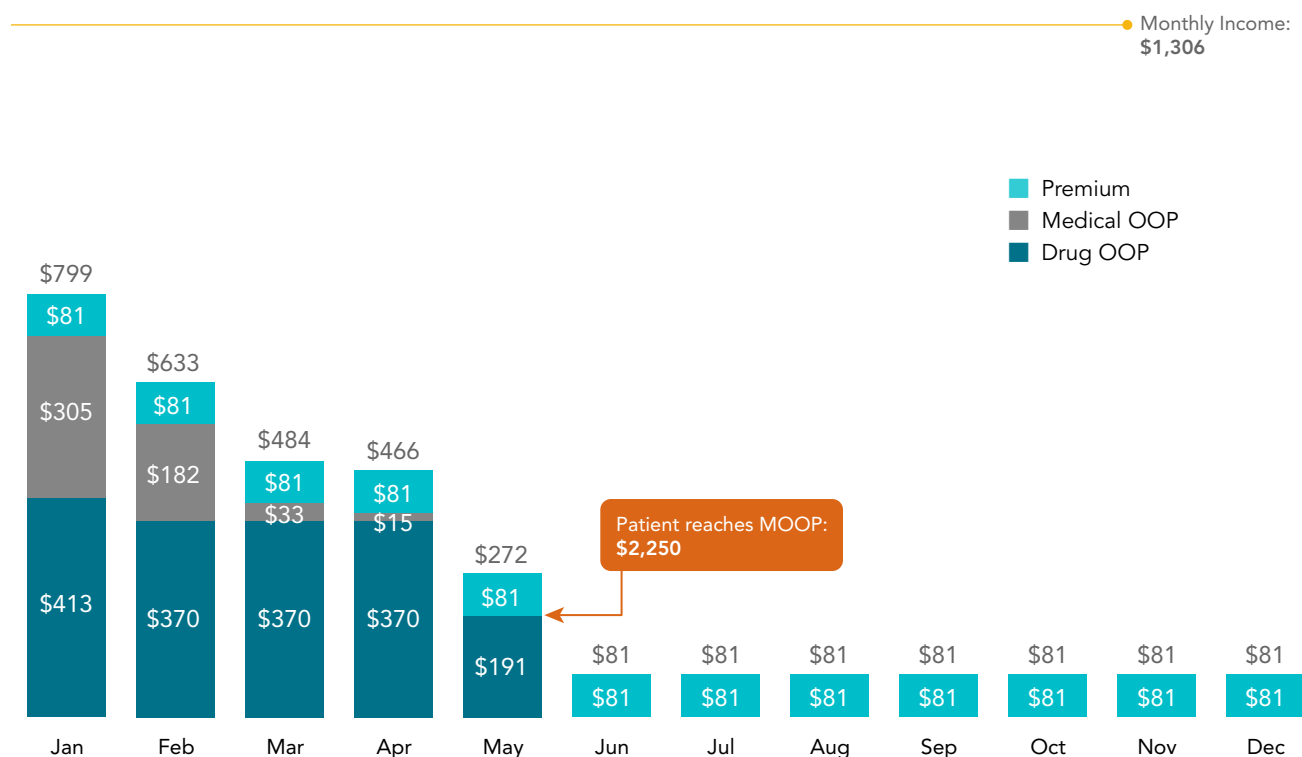
Although consumers who purchase cost-sharing reduction plans face lower up-front out-of-pocket costs than individuals who buy standard silver plans, medication-reliant people at both income levels experience significant up-front spending, reaching their out-of-pocket maximum before the end of the calendar year.

Extensive literature suggests that high out-of-pocket costs can be a barrier to access that reduces medication

adherence, which in turn can lead to negative health outcomes.<sup>16</sup> One study found that when monthly out-of-pocket costs were kept below \$250 for a specialty drug, patients were less likely to abandon their therapies. Conversely, more than half of the patients analyzed in the study who were required to pay more than \$2,000 per month abandoned their medications.<sup>17</sup> Further, in a study examining the abandonment rate of newly initiated specialty cancer therapies, high patient cost sharing correlated with a decrease in medication adherence. Consumer claims with cost sharing over \$500 were four times more likely to be abandoned than claims with cost sharing of \$100 or less.<sup>18</sup> Moreover, consumers that experience high up-front out-of-pocket costs often incur medical debt in an attempt to maintain their treatment regimes.

**Figure 6. Average Cost Sharing for Sung (RA patient), Subsidized 87% Cost-Sharing Reduction Silver Plan, by Month, 2014**

BASED ON SPECIALTY TIER PLACEMENT, PATIENT WITH INCOME OF 170% FPL (N=12)



Notes: Monthly income is after tax, calculated using the ADP calculator. N is the number of silver plans included. MOOP is maximum out-of-pocket limit. Source: Avalere Health analysis of patient profiles and Covered California plan features, 2014.

## Policy Considerations

Although Covered California's standard benefit designs have made it easier for exchange enrollees to compare plan offerings, it remains difficult for some consumers to accurately estimate their out-of-pocket costs when shopping for health insurance. Furthermore, researchers found that for chronically ill patients, out-of-pocket costs may be front-loaded in the year and may constitute a significant portion of consumers' monthly income. Such front-loaded costs may present a wide range of challenges for consumers, from increased medical debt to drug abandonment.<sup>19</sup>

Covered California and California policymakers have already begun considering a range of policy proposals that would improve drug coverage, limit the cost burden to medication-dependent consumers, and improve transparency during the plan shopping process. These proposals and others can help consumers manage their out-of-pocket expenses and improve access to drug benefits. Decisionmakers will need to pay careful attention to the impacts of reducing out-of-pocket costs on premium costs over time.

*As California policymakers refine the state's benefit requirements over time, they will need to balance the goals of affordable premiums with minimizing the burden of front-loaded costs for the chronically ill. Proposals are already under review in California.*

In early 2015, Covered California began considering new benefit design requirements for 2016 that aim to reduce out-of-pocket costs for exchange consumers with specialty medication needs without producing large increases in premiums. One proposal would cap the maximum consumer payment for filling a drug on the specialty tier, thereby limiting the per-prescription out-of-pocket costs for products subject to co-insurance. Implementation of this change could reduce the high monthly costs for specialty drugs that some chronically ill consumers face prior to reaching their out-of-pocket maximum. If specialty drug caps were applicable before consumers reached their deductibles, many medication-dependent patients would be able to avoid the high front-loaded annual costs that they currently experience. Data provided by health plans suggests that the impact on premiums for 2016 would be small; however the impact on premiums in future years may be greater, particularly as more high-cost specialty drugs come to market. (At the time of this

report's publication, the Covered California Board of Directors has not yet acted on this proposal.)

In addition, in 2016, for chronic conditions that have multiple treatments available, Covered California plans will be required to place at least one medication on a non-specialty tier. This change will ensure that patients have access to at least one treatment option at a lower out-of-pocket cost. While not all consumers will be able to switch to the therapy covered on this lower tier — since patients should follow their doctors' assessments of drug efficacy and side effects — the change will prevent plans from uniformly subjecting all drugs for a condition to high cost-sharing.

*All health plan consumers would benefit from more information and better shopping tools to help select the plan that is the best value for their specific health needs.*

In 2014, Covered California was the only exchange website with a cost estimator tool to help consumers calculate their potential out-of-pocket costs under various plans. Covered California's online tool allows individuals to indicate if they have low, medium, or high health care needs, based on the number of times they visit a doctor and how many medicines they take.

This estimator tool may be sufficient for consumers with straightforward health care needs, but patients who rely on multiple non-generic medications and other specific health services need more support than the online tool provides. Because researchers found that formulary placement is a key driver of variation in out-of-pocket prescription costs across plans, consumers would benefit from an enhanced calculator that incorporates tier placement and negotiated drug price information to accurately predict out-of-pocket costs for medication regimens. This is particularly important for specialty drugs, where co-insurance makes it hard for consumers to predict their monthly costs. Such a tool would more accurately help consumers select not just a metal level, but a specific plan that includes the best available coverage for their drug.

As noted in *Disease Matters: Comparing Prescription Drug Benefits in Covered California Plans*, the companion to this report, California enacted SB 1052 in September 2014 to improve the transparency of drug coverage policies.<sup>20</sup> This law requires the Department of Insurance



and the Department of Managed Health Care to jointly develop a standard formulary template for reporting and displaying formulary information, including coverage, tiers, and utilization management information. This legislation represents an important step toward presenting information to consumers in a clear and understandable way.

New federal rules for 2016 will also require health plans to publish comprehensive formularies in machine-readable formats. This will reduce ambiguity about coverage for products not listed on the formulary. Because formularies will be machine-readable, it will make it easier for other stakeholders to build consumer tools that will facilitate informed plan purchasing decisions.

The Covered California board took further action in 2015 to improve transparency to consumers by mandating that plans make drug lists more comprehensive and easier to interpret by 2016. Starting in 2016, qualified health plans are required to:

- ▶ Provide an estimate of the range of costs for specific drugs to help enrolled consumers predict their spending for products subject to co-insurance.
- ▶ Clearly write the exception process on the formulary.
- ▶ Provide an opt-out retail option for mail order, which allows consumers who want or need in-person assistance to get such service at no additional cost.
- ▶ Provide a dedicated pharmacy customer service line for advocates and prospective consumers to call for clarification.

*Across health insurance markets, consumer education is a critical element for appropriate plan selection. As California implements legislation to improve the transparency of prescription drug coverage, Covered California state officials, and other stakeholders, should create and disseminate more tailored information for the chronically ill.*

As officials in California enact SB 1052 to improve the transparency of drug coverage, there is an opportunity to also bolster education and tools to assist people in selecting the most appropriate coverage for their health needs. The formulary template can provide a useful vehicle for consumer education. In addition, Covered California is positioned to take a leadership role in building new resources relevant to consumers inside and outside the exchange market.

Covered California has made considerable investment in consumer education and awareness about plan and financial assistance options. For example, the state's "Getting Covered" web page includes a host of topics, such as coverage levels, prescription drugs, the application process, and financial help.<sup>21</sup> In consultation with Covered California, state officials and entities should consider whether customized materials for specific consumers, such as those with chronic illnesses, might be helpful. Beyond ensuring that consumers have online access to standardized, up-to-date formularies, officials should consider providing information that is tailored to the needs of people with chronic diseases, especially those relying on specialty medicines who are attempting to predict costs associated with co-insurance. Further, as consumer cost tools continue to evolve to account for more specific medical services and drug utilization, California state officials should ensure that consumers are provided with the training to use such tools appropriately.

Navigators, assisters, and brokers play a key role in helping consumers pick the best plan for their needs. In training and certifying agents and brokers, both the California Department of Insurance and Covered California have the opportunity to equip these entities with customized information to help consumers with chronic illnesses in selecting plans. Such training should include efforts to help these counselors collect and use clinical information to help patients understand cost differences across plan options, accounting for the value of premium subsidies and cost-sharing reductions where applicable. Navigators, assisters, and brokers should

also be trained to use any enhanced consumer shopping tools that state entities launch, as such tools will prove critical in ensuring patients are selecting the most cost-effective and comprehensive plan to meet their specific health needs.

State officials will need to balance providing information that is useful to the majority of interested consumers with offering sufficiently tailored information for consumers with specific needs. To supplement the efforts of state officials, consumer- and disease-advocacy groups will continue to play an indispensable role in ensuring that consumers with particular conditions have deep awareness of the factors most critical to their enrollment decision.

## Glossary

**Actuarial value.** Exchange plans must meet standards related to actuarial value, an insurance term that refers to the percentage of health care costs covered by the plan after premiums. Exchange plans fall into one of four categories:

- ▶ **Bronze.** Plan covers 60% to total costs.
- ▶ **Silver.** Plan covers 70% to total costs.
- ▶ **Gold.** Plan covers 80% to total costs.
- ▶ **Platinum.** Plan covers 90% to total costs.

**Advance payment of premium tax credit.** People eligible for advance payments (i.e., those with incomes between 100% and 400% FPL<sup>22</sup>) receive sliding scale tax credits that limit the amount they must pay toward monthly premiums to a percentage of income.

**Brand drug deductible.** The amount an individual must pay in out-of-pocket costs for branded prescription medications before health plan coverage begins for these medicines.

**Co-insurance.** A percentage of the cost of a medical service or prescription drug that a health plan member must pay out-of-pocket.

**Copayment.** A fixed dollar amount that a patient pays for medical services or prescription drugs. The health plan pays the remainder of the claim.

**Cost-sharing reduction.** Cost-sharing reductions allow individuals and families with incomes between 100% and 250% FPL to enroll in silver plans with lower cost sharing.

**Essential health benefits.** Essential health benefit rules set the scope of covered benefits by linking coverage to a benchmark in the state.

**Integrated deductible.** The amount an individual must pay in out-of-pocket costs each year before health plan coverage begins for medical or prescription drug costs.

**Maximum out-of-pocket (MOOP).** An annual limitation on all cost sharing for which consumers are responsible under a health insurance plan. Spending on services accessed out of network or that are not covered by a plan do not typically count toward this cap.

**Medical deductible.** The amount an individual must pay in out-of-pocket costs before health plan coverage begins for medical costs.

**Metal level.** Description of the actuarial value of a health plan. In Covered California, plans are offered at four metal levels: bronze (60% actuarial value), silver (70%), gold (80%), and platinum (90%). Catastrophic coverage with a lower actuarial value is available only to people under age 30 or who obtain a hardship exemption from the exchange.

**Out-of-pocket costs.** Consumer spending on deductibles, copayments, and co-insurance related to the use of health services; does not include premiums.

**Pre-existing condition.** A disease or condition for which an individual had received a diagnosis and/or sought treatment prior to enrolling in a new insurance policy.

**Premium tax credit.** Known officially as an Advanced Premium Tax Credit, financial assistance offered through Covered California that reduces premiums for people earning between 100% and 400% of the federal poverty level (\$11,670 to \$46,680 for an individual and \$23,850 to \$95,400 for a family of four in 2014). (Note that those earning up to 138% FPL may qualify for Medi-Cal.)

**Qualified health plan.** Health plan offered through Covered California that meets standards for actuarial value, covers the EHBs, and meets requirements for deductibles and cost-sharing structure.

**Single-tablet regimens.** HIV/AIDS medications that combine several chemical compounds into a single pill.

**Standardized benefit design.** Covered California created standard plan designs, including deductibles, copayment, and co-insurance amounts for prescription drugs and services, and maximums on out-of-pocket spending.

**Tier placement.** Covered California plans group covered drugs into four tiers. Typically, drugs placed on higher tiers are subject to higher cost sharing.

- ▶ **Generic tier.** The lowest formulary tier (Tier 1), usually reserved for generic drugs and with the lowest cost sharing and fewest limits on access.
- ▶ **Preferred brand tier.** The second formulary tier (Tier 2), for a plan's recommended branded drugs. Preferred drugs are selected based on a combination of price and quality.
- ▶ **Non-preferred brand tier.** The third formulary tier (Tier 3), for branded drugs whose use is discouraged by the plan due to cost or clinical considerations.
- ▶ **Specialty tier.** The highest formulary tier (4 or higher), on which drugs are subject to the highest cost sharing.

**Utilization management.** Procedures required by health plans or pharmacy benefit managers that govern patient access to drugs.

- ▶ **Prior authorization.** Requirement that a health plan reviews requests for certain medicines, on an individual patient basis, before granting coverage.
- ▶ **Step therapy.** Requirement that, before accessing a prescribed drug, patients try and "fail" on at least one alternative drug.

## Appendix A. Covered California Standard Plans, Select Features, 2014

PLAN TYPE*	MEDICAL DEDUCTIBLE	BRAND DEDUCTIBLE	DRUGS, GENERIC	DRUGS, PREFERRED BRAND	DRUGS, NON-PREFERRED BRAND	DRUGS, SPECIALTY	OUT-OF-POCKET LIMIT
Platinum	\$0	\$0	\$5	\$15	\$25	10%	\$4,000
Gold	\$0	\$0	\$19	\$50	\$70	20%	\$6,350
Silver	\$2,000	\$250	\$19	\$50	\$70	20%	\$6,350
Bronze	\$5,000	N/A	\$19	\$50	\$75	30%	\$6,350
Bronze HSA	\$4,500	N/A	40%	40%	40%	40%	\$6,350
Silver CSR 100%-150% FPL	\$0	\$0	\$3	\$5	\$10	10%	\$2,250
Silver CSR 151%-200% FPL	\$500	\$50	\$5	\$15	\$25	15%	\$2,250
Silver CSR 201%-250% FPL	\$1,500	\$250	\$19	\$30	\$50	20%	\$5,200

\*Covered California, Standard Benefit Plan Designs, 2014. The state designed two plans at the platinum, gold, and silver levels, but such plans do not differ on the parameters displayed.

Notes: CSR is cost-sharing reduction; HSA is health savings account.

## Appendix B. Additional Methodology Notes

For the condition case studies, clinicians generated profiles intended to represent hypothetical patients with moderate levels of acuity, which are not representative of the experience of all patients with these conditions. Profiles included details on age, prescription drug regimen, and medical services utilization including physician visits, lab work, and where applicable, emergency department visits and hospitalizations. For the COPD case study, clinicians also generated low- and high-acuity patients to demonstrate how costs can vary within a given chronic condition.

Researchers developed a utilization schedule across a year for health care services and medications, with prescription drug fills designated as the first cost incurred each month, followed by doctor visits, labs, and where applicable, emergency department visits and hospitalizations. To calculate spending, researchers determined prices for prescription drugs and medical services. For prescription drugs, this analysis uses Average Wholesale Price (AWP) with industry average discounts to approximate drug prices that reflect the negotiated price between health plans and pharmacies.<sup>23</sup> For the majority of medical services, including physician office visits, emergency department visits, and hospitalizations, researchers used the Medical Expenditure Panel Survey (MEPS), which is the average negotiated payer rate, based on a national sample of claims.<sup>24</sup> Standard rate assumptions vary by service type but are not adjusted by disease state.<sup>25</sup> Finally, for lab services, researchers used the Healthcare Bluebook prices based on the negotiated payer rate in California.<sup>26</sup>

Using this data, researchers applied benefit designs to patient spending and identified the point at which the patient reached the deductible and out-of-pocket limit. For the service whose cost brought the patient to the deductible, the service is charged at the full pre-deductible cost up to the deductible, plus the copayment for the service. Cost sharing for services is the lesser of the cost sharing or the allowed amount.

To analyze the relationship between plan metal level, out-of-pocket spending, and total spending, researchers obtained premium data information from Covered California's website in June 2014. Researchers captured premiums for a single zip code within each rating region and generated an average premium. Contra Costa premium data were not available at time of analysis, since the plan is not participating in future years. Premium amounts presented throughout the brief represent an average across rating regions for each issuer, and each issuer's premium is weighted equally toward the overall average. This premium amount does not represent the actual premium in any single rating region.



## Endnotes

1. Findings are reported in *Disease Matters: Comparing Prescription Drug Coverage in Covered California Plans*, also published by the California HealthCare Foundation, February 2015, [www.chcf.org](http://www.chcf.org).
2. This analysis includes five conditions: bipolar affective disorder, chronic obstructive pulmonary disease (COPD), diabetes mellitus (Type II), human immunodeficiency virus / acquired immunodeficiency disorder syndrome (HIV/AIDS), and rheumatoid arthritis (RA).
3. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care, [www.healthcare.gov](http://www.healthcare.gov).
4. "Covered California's Historic First Open Enrollment Finishes with Projections Exceeded; Agents, Counselors, Community Organizations and County Workers Credited as Reason for High Enrollment in California," April 17, 2014, [news.coveredca.com](http://news.coveredca.com). Catastrophic coverage is not included in this analysis.
5. Eligible individuals earning up to 138% FPL (i.e., \$16,105 in 2014) may qualify for Medi-Cal. In 2014, an individual at 100% FPL earned \$11,670; 200% FPL, \$23,340; 250% FPL, \$29,175; and 400% FPL, \$46,680.
6. Covered California April 17, 2014 press release, [news.coveredca.com](http://news.coveredca.com).
7. For an individual in 2014, \$29,175.
8. Data from Covered California, 2014.
9. Issuers off the exchange may also offer nonstandardized benefit products.
10. Plan sample used for the analysis includes all unique bronze, silver, gold, and platinum plans offered by issuers in Covered California. All plans are standard benefit designs. Catastrophic and bronze HSA plans are not included.
11. Findings generally use the subset of plans that list in the formulary publicly available at time of research the drug specified in the profile.
12. In this example, Paul's medication is placed on the specialty tier by plans covering a small portion of Covered California enrollment.
13. Monthly cost after the patient has met the \$250 brand drug deductible and before the patient reaches the maximum out-of-pocket.
14. Data from Covered California, 2014.
15. The California AIDS Drug Assistance Program (ADAP) provides financial assistance to individuals with incomes up to \$50,000, which is generally around 450% FPL.
16. Michael Eaddy et al., "How Patient Cost-Sharing Trends Affect Adherence and Outcomes: A Literature Review," *Pharmacy and Therapeutics* 37, no. 1 (January 2012): 45-55.
17. Catherine Starner et al., "Specialty Drug Coupons Lower Out-of-Pocket Costs and May Improve Adherence at the Risk of Increasing Premiums," *Health Affairs* 33, no. 10 (October 2014): 1761-69.
18. Lee Schwartzberg et al., "Abandoning Oral Oncolytic Prescriptions at the Pharmacy: Patient and Health Plan Factors Influencing Adherence," *Community Oncology Alliance*.
19. Eaddy et al., "Patient Cost-Sharing Trends."
20. Senate Bill 1052 (Torres, 2014) approved by the governor on September 25, 2014.
21. "Getting Covered," Covered California, [www.coveredca.com](http://www.coveredca.com).
22. Eligible people earning up to 138% FPL (i.e., \$16,105) may qualify for Medi-Cal. In 2014, a person at 100% FPL earned up to \$11,670; 200% FPL was up to \$23,340; 250% FPL was up to \$29,175; and 400% FPL was up to \$46,680.
23. AWP was selected because it is widely available for all drugs, both brand and generic, unlike other data sources. Discount rates taken from *Prescription Drug Benefit Cost and Plan Design Report, 2013-2014* from the Pharmacy Benefit Management Institute.
24. State-level sample sizes in public files are insufficient to calculate California-specific payments. One study found that in 2010, per capita health care spending averaged \$3,946 in California, lower than the US average of \$4,849. However, some studies note that differences in health care price and spending by region are driven by the underlying socioeconomic characteristics and health needs of the population, not geography alone. 2011 Medical Expenditures Panel Survey (MEPS); Louise Sheiner, "Why the Geographic Variation in Health Care Spending Can't Tell Us Much About the Efficiency or Quality of Our Health Care System," Brookings Institution, Fall 2014, [www.brookings.edu](http://www.brookings.edu).
25. Avalere research finds that adjusting basic rate by disease state does not correlate meaningfully.
26. Includes prices based on the negotiated payer rate in zip code 90001 (Los Angeles). These rates are the same across other California cities, including Anaheim, Fresno, Sacramento, and San Diego, and the Bay Area.