Implementation of a Cost Neutral Premium Assistance Program Within the North Carolina HIV Medication Assistance Program (HMAP)

Session Law 2017-57, Section 11E.8

Report to the

Joint Legislative Oversight Committee on Health and Human Services

And

Fiscal Research Division

By

North Carolina Department of Health and Human Services

March 1, 2018

Reporting Requirement

Session Law 2017-57 Section 11E.8 directs the Department of Health and Human Services' (DHHS) Division of Public Health (DPH) to continue to implement within the North Carolina AIDS Drug Assistance Program (ADAP) a health insurance premium assistance program that is cost neutral or achieves savings; utilizes federal funds from Part B of the Ryan White HIV/AIDS Program and ADAP funds to provide individual ADAP participants or subsets of ADAP participants with premium and cost-sharing assistance for the purchase or maintenance of private health insurance coverage, including premiums, co-payments, and deductibles; and meets the requirements of Section 12E.1 of Session Law 2016-94.

Session Law 2017-57 further requires the Department to submit a report by March 1, 2018 to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on implementation of the health insurance premium assistance program and include at least all of the following components:

(1) A detailed explanation of the program design.
(2) A demonstration of cost neutrality, which shall include a comparison of the cost of providing prescription drugs to eligible beneficiaries through the health insurance premium program and the cost of providing prescription drugs to eligible beneficiaries through the existing ADAP program.
(3) Information on health outcomes of program participants.
(4) Any obstacles to program implementation.

Executive Summary

DHHS is dedicated to the overall health of people living with HIV while assuring financial stability and cost effectiveness in its health programs. The North Carolina AIDS Drug Assistance Program (ADAP) assists people living with HIV who lack adequate financial resources, have incomes at or below 300% federal poverty level (FPL) and are ineligible for Medicaid or other health coverage. North Carolina's commitment to ADAP has resulted in improved health outcomes for people living with HIV, decreased healthcare costs, and reduced HIV transmission.

The antiretroviral medication regimens ADAP provides its recipients allow people living with HIV to achieve viral suppression (an undetectable amount of HIV in their blood), which prevents the transmission of HIV. Currently, 85% of all ADAP enrollees are virally suppressed compared to 62% of all people living with HIV statewide and 58% nationally.

In 2016, the North Carolina General Assembly passed legislation to give NC ADAP the authority to create a health insurance premium assistance program. DHHS immediately took the following actions:

- Working with its contracted actuarial service (Mercer), DHHS determined eligibility criteria that would achieve cost neutrality. In April 2017, the actuarial service finalized a report that determined that by limiting premium assistance to eligible clients at or above 100% of the FPL guidelines, the program would be sustainably cost neutral. The actuarial service also estimated that premium assistance could be offered to clients on Medicare

Part D or a Medicare Advantage plan with partial or no Low-Income Subsidy while remaining cost neutral.

- Based on the actuarial report, DHHS moved forward to amend the agency's existing Pharmacy Benefits Manager contract to include services related to premium assistance.
- The Premium and Copay Assistance Program (PCAP) was implemented in December 2017.
- As of February 22, 2018, 242 clients have been enrolled in PCAP. While it is premature to assess health outcomes of program participants, a preliminary report shows 95% of participants were virally suppressed (an undetectable amount of HIV in their blood) upon enrollment in PCAP, based on data from their previous enrollment in ADAP.

HIV in North Carolina

There are an estimated 36,700 people in North Carolina who are living with HIV. Approximately 2,500 of these citizens are unaware of their infection. The Communicable Disease Branch of the Department of Health and Human Services' (DHHS) Division of Public Health (DPH) has active strategies to identify all cases of HIV infection, to link those individuals to appropriate medical care, and to support their ability to stay in care and on antiretroviral medication regimens.

Recent research has proven that people living with HIV who adhere to an antiretroviral medication regimen and achieve durable viral suppression (an undetectable amount of HIV in their blood) are unable to transmit the virus to others. Providing antiretroviral medication regimens to people living with HIV is the most effective method of reducing the spread of HIV. The cornerstone of North Carolina's strategy to end the HIV epidemic is to identify all people who are HIV positive and assure they are in appropriate medical care. People living with HIV need to take their prescribed antiretroviral medications daily to achieve and maintain viral suppression. As a result, they will live much longer and healthier lives and be able to work, raise families, and contribute to society in a way that had previously been very difficult, as well as being unable to transmit the virus to others.

Without proper care and treatment, HIV is still a transmissible and fatal disease. The North Carolina State Center for Health Statistics reported 209 HIV-related deaths in 2016 (2.1 per 100,000 population). Additionally, a significant health disparity exists in rates of HIV infection and viral suppression in North Carolina. In 2016, Latina and Latino residents in our state had lower viral suppression rates than other race or ethnicity groups.

Program History and Design

Established in 1994, North Carolina's ADAP uses a combination of Federal Ryan White Part B funds, state appropriations, and medication rebates to provide HIV positive residents of North Carolina (with income at or below 300% of the FPL guidelines) with essential medications for the treatment of HIV, opportunistic infections, and related conditions.

In October 2017, the North Carolina AIDS Drug Assistance Program modified its name to the North Carolina HIV Medication Assistance Program (HMAP). This name change reflects a

focus on promoting the accessibility, adherence and advancement of HIV treatment and is consistent with a national shift away from the term "AIDS".

When people living with HIV have health insurance and access to HIV medical care, including antiretroviral medication, the rates of viral suppression are improved. Providing antiretroviral medication regimens to people living with HIV is the most effective method of reducing the spread of HIV. The primary goal of HMAP (formerly ADAP) is to assure all enrollees adhere to their antiretroviral medication regimen and achieve viral suppression. Currently, 85% of all HMAP enrollees are virally suppressed. As of September 28, 2017, the end of the most recent complete enrollment cycle, there were 8,495 clients enrolled in HMAP. This represents a 6% increase from the previous year.

HMAP currently provides medication to clients under four models described below.

- The **Uninsured/Underinsured Medication Assistance Program (UMAP)** serves uninsured and underinsured HMAP clients.
    - Approximately 74% of HMAP clients are served through UMAP.
    - The program purchases medications from a contracted wholesaler (Cardinal Health) and distributes medications directly to clients through a contracted dispensing pharmacy (Walgreens).
    - This is the traditional HMAP model. UMAP has utilized this purchasing and distribution model since 2005.
    - These clients are not eligible for any of the other sub-programs.

Two additional models were implemented prior to the premium assistance program to comply with expectations from the Health Resources and Services Administration (HRSA), which oversees the federal Ryan White grant. HRSA requires that grantees should reduce program costs and increase access to care by covering medication cost-sharing (deductibles, copayments, and coinsurance) and premiums for clients, if doing so is cost neutral at the aggregate level. These two models are:

- The **HIV-specific State Pharmaceutical Assistance Program (SPAP)** serves HMAP clients who are enrolled in a Medicare Prescription Drug Plan (Medicare Part D).
    - Approximately 21% of HMAP clients are served through SPAP.
    - Clients served through SPAP are required to pay their monthly Medicare Prescription Drug Plan premiums. SPAP pays medication cost-sharing (deductibles, copayments, and coinsurance) through a contracted Pharmacy Benefits Manager (Ramsell Corporation).
    - SPAP was piloted between 2009 and 2010 and permanently implemented in 2011.
    - In calendar year 2016, the cost of SPAP copayments was 61% lower than the cost of dispensing the same medications through the traditional HMAP model at the current HMAP prices.

- The **Insurance Copayment Assistance Program (ICAP)** serves HMAP clients who are enrolled in a Qualified Health Plan purchased through the federal health insurance marketplace and are below 100% FPL.

- Approximately 2% of HMAP clients are served through ICAP.
- Clients served through ICAP are required to pay their own monthly Qualified Health Plan premiums. ICAP pays medication cost-sharing (deductibles, copayments, and coinsurance) through a contracted Pharmacy Benefits Manager (Ramsell Corporation).
- ICAP was implemented in February 2015.
- In calendar year 2016, the cost of ICAP copayments was 23% lower than the cost of dispensing the same medications through the traditional HMAP model at the current HMAP prices.
- These clients are not eligible for the new Premium and Copay Assistance Program (PCAP; see below description) because they are not eligible for federal subsidies for their monthly premium costs, which would result in a failure of PCAP to be cost-neutral in the aggregate.

In 2016, the North Carolina General Assembly passed legislation to give NC HMAP the authority to create a health insurance premium assistance program. This 2016 legislation and the existing federal ADAP policies limit the total amount of insurance expenditures (premiums and cost sharing) to no more than the cost of an existing HMAP client served through UMAP (the traditional program that purchases medications only) at the aggregate level.

- The **Premium and Copay Assistance Program (PCAP)** serves clients enrolled in an individual Qualified Health Plan purchased through the federal health insurance marketplace, utilized their full Advanced Premium Tax Credit, and are between 100-300% FPL.
    - PCAP pays the clients' monthly Qualified Health Plan premiums and medication cost-sharing (deductibles, copayments, and coinsurance) through a contracted Pharmacy Benefits Manager (Ramsell Corporation).
    - While implementation of PCAP began in 2016, PCAP effectively launched in December 2017 with the opening of the federal Marketplace enrollment period.

Implementation of the New Premium and Copay Assistance Program (PCAP)

Multiple steps were required prior to implementation of a new insurance premium and copay assistance program. DHHS completed the following actions to implement the PCAP:

- Confirmed cost neutrality with the agency's contracted Actuarial Service (Mercer).
    - In February 2016, Mercer worked with DHHS to analyze the cost and feasibility of adding premium assistance to ICAP and SPAP, in preparation for possible implementation.
    - This preliminary analysis determined that cost neutrality was possible but indicated that cost neutrality may not be sustainable if (1) health insurance premiums increased, and/or (2) medication rebates generated by copay assistance decreased.
    - A final analysis completed by Mercer in April 2017 determined that limiting premium assistance to ICAP clients at or above 100% FPL would allow the

program to be sustainably cost neutral. The Mercer report also estimated that premium assistance can be offered to SPAP clients with partial or no Low-Income Subsidy without violating the cost neutrality as defined by legislation (without exceeding current UMAP cost per client).

- Based on these actuarial findings, DHHS began the Pharmacy Benefits Manager (Ramsell Corporation) contract amendment in August 2017. The scope of work in the existing contract with the Pharmacy Benefits Manager already included an option to implement premium assistance. The amendment expanded the Pharmacy Benefits Manager optional services to coordinate payment of Medicare Part D premiums and payment of premiums for Public Insurance (Qualified Health Plans from the Health Insurance Marketplace). The existing DHHS Pharmacy Benefits Manager contract was executed on November 14th, 2017, and the Ramsell Corporation optional services began January 1, 2018.

DHHS initiated general PCAP implementation in August 2017, including the following actions:

- DHHS completed business and technology requirements to add PCAP client information into the nightly data transfer to the Ramsell Corporation. For this transfer of data to be accomplished, the creation of a new database screen including new data fields was designed in the existing Purchase of Medical Care Services (POMCS) database. Several reports generated by the POMCS database had to be updated to incorporate PCAP. These enhancements were tested in November and finalized on December 22, 2017. On January 3, 2018, HMAP began collecting PCAP client information in the POMCS database. DHHS, in coordination with the Ramsell Corporation, tracks the successful transfer of the nightly eligibility file.
- DHHS created PCAP policies and procedures, incorporating guidance from HRSA and other state ADAPs. DHHS shared these policies and procedures with community stakeholders in preparation for several program related trainings. Trainings were conducted in November and December 2017 to coincide with the Affordable Care Act (ACA) Marketplace open enrollment period, which ended on December 15, 2017.
- DHHS took steps to coordinate the payment of the initial fees (known as “binder fees”) associated with enrollment into a qualified health plan for eligible PCAP clients. This was done after DHHS identified the initial payments as a possible barrier to client enrollment. Initial payments began on December 13, 2017 to Blue Cross Blue Shield and Cigna, the only providers of Marketplace coverage in the state.

As of February 22, 2018, 242 clients have been enrolled in PCAP. DHHS anticipates the number of clients enrolled in PCAP will continue to increase until March 31, 2018, the end of the current enrollment cycle.

Demonstration of Cost Neutrality

DHHS, in collaboration with the agency’s contracted Actuarial Service (Mercer), identified a subset of HMAP (formally ADAP) enrollees who are eligible for low cost premiums and who could be served through insurance premium assistance program (PCAP) while remaining cost neutral. Mercer conducted two separate studies in April and December of 2017. In these two reports, Mercer examined three issues:

- **Issue 1:** Mercer examined the different federal subsidy levels, based on income, to determine which levels could be cost neutral.
    - Mercer concluded that if the premium assistance was restricted to clients at or above 100% FPL, the new cost may drop below the current UMAP cost by as much as 28%. The savings for clients at or above 100% FPL could be maximized by enrolling these clients in Silver plans, which are eligible for both premium tax credits and cost sharing subsidies.
    - However, Mercer further concluded the maximum savings generated by clients at or above 100% FPL (approximately 40% of UMAP population) would not be sufficient to cover the increase in cost that would be generated by clients <u>below</u> 100% FPL (approximately 60% of UMAP population).
    - ***Therefore, Mercer recommended limiting premium assistance to clients at or <u>above</u> 100% FPL. Mercer recommended this would be the most effective strategy for DHHS to achieve and sustain cost neutrality while remaining as inclusive as possible for enrolling clients.***
    - Mercer further estimated, by adding premium assistance to SPAP, the estimated new cost per SPAP client ($2,230, as of January 12, 2018 expenditures) would remain below the UMAP cost per client served ($7,959, as of January 12, 2018 expenditures).
        - Mercer estimated that premium assistance could be offered to SPAP clients with partial or no Low-Income Subsidy without violating the cost neutrality as defined by the legislature (without exceeding current UMAP cost per client). However, adding premium assistance to SPAP would result in an increase in total program costs but would still be below UMAP costs and thus cost neutral.

- **Issue 2:** Mercer examined the difference in premiums between tobacco users and non-tobacco users to determine if limiting premium assistance to non-tobacco users could be cost neutral.
    - Mercer estimated approximately 30% to 40% of the UMAP enrollees were tobacco users based on the demographics provided by DPH for the Pre-Existing Condition Insurance Program, a similar population. Mercer also assumed a tobacco surcharge percentage between 20% and 30%, since insurers often charge less than the maximum amount (50%) allowed under the law.
    - Simply limiting premium assistance to only non-tobacco users was not determined by Mercer to be sufficient to ensure cost neutrality.

- **Issue 3:** Mercer examined the cost across health insurance metal level plans (bronze, silver, gold, and platinum) to determine if one plan might be more likely than the others to remain cost neutral with implementation of a premium assistance program.
    - Mercer found that although savings are relatively higher for Silver plans (due to the availability of both premium tax credits and cost sharing subsidies), the savings are not high enough to cover the cost for clients who are not eligible for subsidies (clients at or below 100% FPL, or approximately 60% of UMAP population).

Mercer determined that cost neutrality was possible but indicated that cost neutrality may not be sustainable (1) if health insurance premiums increased, and/or (2) medication rebates generated by copay assistance decreased.

- In 2017, Blue Cross Blue Shield of North Carolina increased its marketplace plan premiums by 14.1 percent.
- Recent changes to federal ADAP pricing agreements are expected to lead to decreases to federal ADAP medication SPAP rebates over the next two years. DHHS will be carefully monitoring income and expenditures for the program.

Other major changes, such as the significant decrease in competition in the North Carolina Insurance Marketplace and the federal Office of Pharmacy Affairs' recent withdrawal of proposed federal guidance on the 340B drug pricing (and ADAP rebates), have added new levels of complexity to the ever-changing landscape within which HMAP operates. Although the cost savings generated by paying medication cost-sharing (deductibles, copayments, and coinsurance) through both ICAP and SPAP will likely remain unchanged, the addition of premium assistance benefits could eventually increase the cost of the program beyond cost-neutrality, depending on market factors such as premium costs and changes to the Affordable Care Act in the future. However, cost neutrality is assured for calendar year 2018 since the annual premium costs are already known.

Health Outcomes

The North Carolina HIV Medication Assistance Program (formerly ADAP) tracks viral suppression rates across all programs. The overall program has a viral suppression rate of 85%, higher than the state (62%) and national (58%) averages.

- When HMAP is broken into the sub-programs, UMAP clients or those who are uninsured have the lowest viral suppression rate (83%).
- There is a significant increase in viral suppression rates in the sub-programs with insured clients.
    - SPAP, the sub-program for those insured through a Medicare Part D or Medicare Advantage Plan, has a viral suppression rate of 93%.
    - ICAP, the sub-program for clients enrolled in a qualified health plan through the federal Marketplace, also has a viral suppression rate of 95%.
    - While it is premature to assess health outcomes of the premium and copay assistance program (PCAP), preliminary data suggests that 95% of clients are virally suppressed. DDHHS expects this number to change as more clients are enrolled in PCAP.

In summary, though in a limited population, preliminary information indicates existing HMAP clients with HIV who are insured and receive ongoing medical care and HIV medications appear to be more virally suppressed than their counterparts who receive only HIV medications and do not receive ongoing medical care. Providing insurance coverage, through Medicaid expansion or other avenues, might improve viral suppression rates in this population and assist in controlling the HIV epidemic in North Carolina. Approximately 70% of the over 8,400 total HMAP clients are at or below 138% FPL.

Obstacles to Program Implementation

While a few obstacles arose during the implementation of the Premium and Copy Assistance Program (PCAP), these were primarily programmatic and were overcome without compromising the program. DHHS' identification of a process for paying initial payments (sometimes called 'binder fees") removed significant barriers to both HIV care and client enrollment in this new program. These initial payments stood as a significant burden to low income clients who often do not have a mechanism for payment (such as credit cards).

Due to the ever-changing environment of health insurance in which HMAP operates, staff will continue to monitor issues that include:

- Uncertainty of the status of the federal health insurance marketplace
- Possible continued annual increase of premiums
- Maintenance of cost-neutrality from year to year