Improving Exchange Coverage in Alaska

Alaska plays the primary role in reviewing health plans, consistent with its role prior to the Affordable Care Act, even though the state has a federally facilitated exchange. Through this role, Alaska has the opportunity to protect its residents through the following actions:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the Alaska Exchange:

Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines. In Alaska, no silver plans have a separate deductible for prescription medicines.

Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Health plans on Alaska’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Alaska’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Alaska’s benchmark plan covers 99% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.
- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.
- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.
- The addition of newly approved medicines to formularies mid-year is not required.

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2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
While states typically play the primary role in reviewing health plans, plans in Alabama are reviewed by the federal government for compliance with the Affordable Care Act. Alabama has the opportunity to take a larger role in reviewing plans and could protect its residents through the following actions:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

**Key Facts about 2014 Health Plans in the Alabama Exchange:**

**Deductibles**

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- Alabama, in contrast to most states, had no silver plans with a combined deductible for both medical and prescription drug costs.

**Cost Sharing**

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Health plans on Alabama’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Alabama’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Alabama’s benchmark plan covers 91% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.
- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.
- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.
- The addition of newly approved medicines to formularies mid-year is not required.

Based on an analysis of actual 2014 exchange plan formulary information in Alabama, the following key findings are of particular importance to Alabama residents:

- An average of 86% of brand medicines are covered across a range of key drug classes in the Alabama exchange. The national average is 69% of brand medicines covered in exchange plans.
- An average of 0% of brand drugs have a coinsurance of 30% or higher in the Alabama exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C: 1 formulary was analyzed in Alabama; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
State oversight can ensure that coverage meets the Affordable Care Act’s standard of providing coverage similar to what is typically offered by employers. Arkansas has chosen to enter into a partnership model with the federal government in which the state reviews health plans that wish to participate in the exchange. Arkansas can protect its residents by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

**Key Facts about 2014 Health Plans in the Arkansas Exchange:**

**Deductibles**

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

**Cost Sharing**

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.

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**Fig. 1: Average Deductibles in Silver Plans: Arkansas Plans Compared to U.S. Average**

<table>
<thead>
<tr>
<th>Average Combined Deductible</th>
<th>AR</th>
<th>U.S.</th>
</tr>
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<tbody>
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</tbody>
</table>

Average Deductible for Workers in Employer-Sponsored Insurance is $1,135

**Fig. 2: Average Cost Sharing in Exchange and Employer Plans**

- **Primary Care Office Visit**
  - Employer: $24
  - U.S.: $37
  - AR: $41
- **Specialist Office Visit**
  - Employer: $38
  - U.S.: $61
  - AR: $75
- **Preferred Brand**
  - Employer: $34
  - U.S.: $52
  - AR: $55
- **Non-preferred Brand**
  - Employer: $64
  - U.S.: $90
  - AR: $95
- **Specialty**
  - Employer: $306
  - U.S.: $362
  - AR: $362

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1. Potential Size of Exchange Market: About 227,000 Arkansas residents.
Health plans on Arkansas’ Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Arkansas’ benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Arkansas’ benchmark plan covers 91% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

1. Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

2. Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.

3. There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.

4. The addition of newly approved medicines to formularies mid-year is not required.

Based on an analysis of actual 2014 exchange plan formulary information in Arkansas, the following key findings are of particular importance to Arkansas residents:

- An average of 57% of brand medicines are covered across a range of key drug classes in the Arkansas exchange. The national average is 69% of brand medicines covered in exchange plans.

- An average of 0% of brand drugs have a coinsurance of 30% or higher in the Arkansas exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighted by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C. 4 formularies were analyzed in Arkansas; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
ARIZONA’S EXCHANGE PLANS

Potential Size of Exchange Market: About 551,000 Arizona residents.

Improving Exchange Coverage in Arizona

Arizona plays the primary role in reviewing health plans, consistent with its role prior to the Affordable Care Act, even though the state has a federally facilitated exchange. Through this role, Arizona has the opportunity to protect its residents through the following actions:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the Arizona Exchange:

Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Health plans on Arizona’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Arizona’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Arizona’s benchmark plan covers 98% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- **Federal standards specific to prescription drug coverage** apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

- **Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules.** These medicines play an important role in patients sticking to and benefiting from the treatments they need.

- **There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.**

- **The addition of newly approved medicines to formularies mid-year is not required.**

Based on an analysis of actual 2014 exchange plan formulary information in Arizona, the following key findings are of particular importance to Arizona residents:7

An average of **71%** of brand medicines are covered across a range of key drug classes in the Arizona exchange. The national average is **69%** of brand medicines covered in exchange plans.

An average of **39%** of brand drugs have a coinsurance of 30% or higher in the Arizona exchange, compared to a national average of **31%** of brand drugs having coinsurance of 30% or higher.

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2 42 U.S.C. § 18022(b)(2).

3 Kaiser/HRET 2013.

4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.

5 Avalere March 2014 analysis of HHS Landscape File.

6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighted by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.

7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C. 6 formularies were analyzed in Arizona; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
California’s state-based exchange is responsible for the operation of all core exchange functions. State regulators are charged with reviewing health insurance plans offered on the state-based exchange to ensure compliance with important consumer protections. Under this broad authority, the exchange should strengthen insurance coverage for enrollees by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Enhancing its website to allow for more meaningful plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

California is among a handful of states that have mandated standardized cost sharing for exchange plans. This means that carriers are required to offer plans with set deductibles and cost sharing.

Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately. In California, all standard Silver plans have a $250 deductible for brand medicines, which may discriminate against patients who need brand medicines for effective treatment.

Prescription drug cost sharing is a recurring expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.

Patients under 250% of the federal poverty level (about $29,000 for an individual) may qualify for cost sharing subsidies that reduce the out-of-pocket costs for Silver plans. California’s standardized cost sharing for the lowest-income subsidy-eligible beneficiaries requires a 10% coinsurance for specialty tier medicines, raising affordability concerns.
Health plans on California’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to California’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, California’s benchmark plan covers 62% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

1. **Federal standards specific to prescription drug coverage** apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.
2. **Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.**
3. **There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.**
4. **The addition of newly approved medicines to formularies mid-year is not required.**

**Based on an analysis of actual 2014 exchange plan formulary information in California, the following key findings are of particular importance to California residents:**

- An average of **64%** of brand medicines are covered across a range of key drug classes in the California exchange. The national average is **69%** of brand medicines covered in exchange plans.
- An average of **13%** of brand drugs have a coinsurance of 30% or higher in the California exchange, compared to a national average of **31%** of brand drugs having coinsurance of 30% or higher.

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2. **42 U.S.C. § 18022(b)(2).**
4. Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5. Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
6. **Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C; 8 formularies were analyzed in California; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.**

Analytics by Avalere Health. Developed by PhRMA.
COLORADO’S EXCHANGE PLANS

Potential Size of Exchange Market: About 501,000 Colorado residents.¹

Improving Exchange Coverage in Colorado

Colorado’s state-based exchange is responsible for the operation of all core exchange functions. State regulators are charged with reviewing health insurance plans offered on the state-based exchange to ensure compliance with important consumer protections. Under this broad authority, the exchange should strengthen insurance coverage for enrollees by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Enhancing its website to allow for more meaningful plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the Colorado Exchange:

Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance²—the vast majority of which covers prescription drugs immediately.³
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.⁵

Fig. 1: Average Deductibles in Silver Plans: Colorado Plans Compared to U.S. Average⁴

Fig. 2: Average Cost Sharing in Exchange and Employer Plans⁶
Health plans on Colorado’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Colorado’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Colorado’s benchmark plan covers 55% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.
- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.
- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.
- The addition of newly approved medicines to formularies mid-year is not required.

Based on an analysis of actual 2014 exchange plan formulary information in Colorado, the following key findings are of particular importance to Colorado residents:7

An average of 63% of brand medicines are covered across a range of key drug classes in the Colorado exchange. The national average is 69% of brand medicines covered in exchange plans.

An average of 26% of brand drugs have a coinsurance of 30% or higher in the Colorado exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 State-specific data is an average of cost sharing for all unique silver plans based on Breakaway Policy Strategies analysis of summary of benefits and coverage documents; average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. State-specific data is an average of cost sharing for all silver plans based on Breakaway Policy Strategies analysis of summary of benefits and coverage documents for unique silver plans. National exchange data is from HHS landscape file and employer data is from 2013 Kaiser/HRET and were analyzed by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C; 6 formularies were analyzed in Colorado; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
Connecticut’s state-based exchange is responsible for the operation of all core exchange functions. State regulators are charged with reviewing health insurance plans offered on the state-based exchange to ensure compliance with important consumer protections. Under this broad authority, the exchange should strengthen insurance coverage for enrollees by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Enhancing its website to allow for more meaningful plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Connecticut is among a handful of states that have mandated standardized cost sharing for exchange plans. This means that carriers are required to offer plans with set deductibles and cost sharing.

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In Connecticut, all standard Silver plans have a separate $400 deductible for medicines.

Prescription drug cost sharing is a recurring expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.

- Connecticut requires 40% coinsurance for specialty tier medicines under its standardized cost sharing design. Some patients may find that this level of cost sharing presents a barrier to access.
- Patients under 250% of the federal poverty level (about $29,000 for an individual) may qualify for cost sharing subsidies that reduce their out-of-pocket costs for Silver plans.
An average of 62% of brand medicines are covered across a range of key drug classes in the Connecticut exchange. The national average is 69% of brand medicines covered in exchange plans.

An average of 58% of brand drugs have a coinsurance of 30% or higher in the Connecticut exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

**Prescription Drug Coverage in Connecticut**

Health plans on Connecticut’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Connecticut’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Connecticut’s benchmark plan covers 99% of available medicines.

Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

Health plans on Connecticut’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Connecticut’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Connecticut’s benchmark plan covers 99% of available medicines.

Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

**State review of exchange plan formularies is important because:**

- **Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.**

- **Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.**

- **There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.**

- **The addition of newly approved medicines to formularies mid-year is not required.**

Based on an analysis of actual 2014 exchange plan formulary information in Connecticut, the following key findings are of particular importance to Connecticut residents:

- An average of 62% of brand medicines are covered across a range of key drug classes in the Connecticut exchange. The national average is 69% of brand medicines covered in exchange plans.

- An average of 58% of brand drugs have a coinsurance of 30% or higher in the Connecticut exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

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4. Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5. Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
6. Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C; 1 formulary was analyzed in Connecticut; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.

Analytics by Avalere Health. Developed by PhRMA.
The District of Columbia's state-based exchange is responsible for the operation of all core exchange functions. State regulators are charged with reviewing health insurance plans offered on the state-based exchange to ensure compliance with important consumer protections. Under this broad authority, the exchange should strengthen insurance coverage for enrollees by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Enhancing its website to allow for more meaningful plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

### Key Facts about 2014 Health Plans in the District of Columbia Exchange:

#### Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.

- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

#### Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.

- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Health plans on the District of Columbia’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to the District of Columbia’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, the District of Columbia’s benchmark plan covers 61% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.
- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.
- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.
- The addition of newly approved medicines to formularies mid-year is not required.

Based on an analysis of actual 2014 exchange plan formulary information in the District of Columbia, the following key findings are of particular importance to the District of Columbia residents:

- An average of 72% of brand medicines are covered across a range of key drug classes in the District of Columbia exchange. The national average is 69% of brand medicines covered in exchange plans.
- An average of 84% of brand drugs have a coinsurance of 30% or higher in the District of Columbia exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 State-specific data is an average of cost sharing for all unique silver plans based on Breakaway Policy Strategies analysis of summary of benefits and coverage documents; average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighted by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. State-specific data is an average of cost sharing for all silver plans based on Breakaway Policy Strategies analysis of summary of benefits and coverage documents for unique silver plans. National exchange data is from HHS landscape file and employer data is from 2013 Kaiser/HRET and were analyzed by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C; 1 formulary was analyzed in the District of Columbia; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
State oversight can ensure that coverage meets the Affordable Care Act’s standard of providing coverage similar to what is typically offered by employers. Delaware has chosen to enter into a partnership model with the federal government in which the state reviews health plans that wish to participate in the exchange. Delaware can protect its residents by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

### Key Facts about 2014 Health Plans in the Delaware Exchange:

#### Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

#### Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.

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**Fig. 1: Average Deductibles in Silver Plans: Delaware Plans Compared to U.S. Average**

<table>
<thead>
<tr>
<th>Type</th>
<th>Delaware</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Combined Deductible</td>
<td>$3,000</td>
<td>$2,276</td>
</tr>
<tr>
<td>Average Rx-Only Deductible</td>
<td>$1,000</td>
<td>$735</td>
</tr>
</tbody>
</table>

Average Deductible for Workers in Employer-Sponsored Insurance is $1,335

**Fig. 2: Average Cost Sharing in Exchange and Employer Plans**

<table>
<thead>
<tr>
<th>Type</th>
<th>Delaware</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Office Visit</td>
<td>$24</td>
<td>$37</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>$38</td>
<td>$61</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$34</td>
<td>$52</td>
</tr>
<tr>
<td>Non-preferred Brand</td>
<td>$64</td>
<td>$90</td>
</tr>
<tr>
<td>Specialty</td>
<td>$269</td>
<td>$362</td>
</tr>
</tbody>
</table>

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1. Potential Size of Exchange Market: About 48,000 Delaware residents.
2. Exchange plan coverage is supposed to be consistent with employer-sponsored insurance.
3. The vast majority of which covers prescription drugs immediately.
4. Average Deductible for Workers in Employer-Sponsored Insurance is $1,335.
5. Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.

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Health plans on Delaware’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Delaware’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Delaware’s benchmark plan covers 99% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

1. Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

2. Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.

3. There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.

4. The addition of newly approved medicines to formularies mid-year is not required.
Florida plays the primary role in reviewing health plans, consistent with its role prior to the Affordable Care Act, even though the state has a federally facilitated exchange. Through this role, Florida has the opportunity to protect its residents through the following actions:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the Florida Exchange:

Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Health plans on Florida’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Florida’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Florida’s benchmark plan covers 86% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

**State review of exchange plan formularies is important because:**

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.
- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.
- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.
- The addition of newly approved medicines to formularies mid-year is not required.

**Based on an analysis of actual 2014 exchange plan formulary information in Florida, the following key findings are of particular importance to Florida residents:**

An average of 67% of brand medicines are covered across a range of key drug classes in the Florida exchange. The national average is 69% of brand medicines covered in exchange plans.

An average of 34% of brand drugs have a coinsurance of 30% or higher in the Florida exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

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2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C; 9 formularies were analyzed in Florida; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
Improving Exchange Coverage in Georgia

Georgia plays the primary role in reviewing health plans, consistent with its role prior to the Affordable Care Act, even though the state has a federally facilitated exchange. Through this role, Georgia has the opportunity to protect its residents through the following actions:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the Georgia Exchange:

**Deductibles**

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

**Cost Sharing**

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Health plans on Georgia’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Georgia’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Georgia’s benchmark plan covers 87% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

**State review of exchange plan formularies is important because:**

- **Federal standards specific to prescription drug coverage** apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

- **Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules.** These medicines play an important role in patients sticking to and benefiting from the treatments they need.

- **There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit.**—these medicines often treat serious conditions such as cancer and neurologic diseases.

- **The addition of newly approved medicines to formularies mid-year is not required.**

Based on an analysis of actual 2014 exchange plan formulary information in Georgia, the following key findings are of particular importance to Georgia residents:

- An average of 46% of brand medicines are covered across a range of key drug classes in the Georgia exchange. The national average is 69% of brand medicines covered in exchange plans.

- An average of 27% of brand drugs have a coinsurance of 30% or higher in the Georgia exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

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2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C. 5 formularies were analyzed in Georgia; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
HAWAII’S EXCHANGE PLANS

Potential Size of Exchange Market: About 58,000 Hawaii residents.

Improving Exchange Coverage in Hawaii

Hawaii’s state-based exchange is responsible for the operation of all core exchange functions. State regulators are charged with reviewing health insurance plans offered on the state-based exchange to ensure compliance with important consumer protections. Under this broad authority, the exchange should strengthen insurance coverage for enrollees by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Enhancing its website to allow for more meaningful plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the Hawaii Exchange:

Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately. In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.

Fig. 1: Average Deductibles in Silver Plans: Hawaii Plans Compared to U.S. Average

Fig. 2: Average Cost Sharing in Exchange and Employer Plans

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1. Source: KFF analysis.  
2. Source: Centers for Medicare & Medicaid Services.  
4. Source: KFF analysis.  
5. Source: KFF analysis.  
Health plans on Hawaii’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Hawaii’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Hawaii’s benchmark plan covers 85% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.

- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.

- The addition of newly approved medicines to formularies mid-year is not required.

2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 State-specific data is an average of cost sharing for all unique silver plans based on Breakaway Policy Strategies analysis of summary of benefits and coverage documents; average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. State-specific data is an average of cost sharing for all silver plans based on Breakaway Policy Strategies analysis of summary of benefits and coverage documents for unique silver plans. National exchange data is from HHS landscape file and employer data is from 2013 Kaiser/HRET and were analyzed by Avalere.
Improving Exchange Coverage in Iowa

State oversight can ensure that coverage meets the Affordable Care Act’s standard of providing coverage similar to what is typically offered by employers. Iowa has chosen to enter into a partnership model with the federal government in which the state reviews health plans that wish to participate in the exchange. Iowa can protect its residents by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the Iowa Exchange:

**Deductibles**

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

**Cost Sharing**

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.

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**Fig. 1: Average Deductibles in Silver Plans: Iowa Plans Compared to U.S. Average**

**Fig. 2: Average Cost Sharing in Exchange and Employer Plans**
Health plans on Iowa’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Iowa’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Iowa’s benchmark plan covers 79% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

**State review of exchange plan formularies is important because:**

- **Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing.** Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

- **Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules.** These medicines play an important role in patients sticking to and benefiting from the treatments they need.

- **There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.**

- **The addition of newly approved medicines to formularies mid-year is not required.**

**Based on an analysis of actual 2014 exchange plan formulary information in Iowa, the following key findings are of particular importance to Iowa residents:**

- An average of **58%** of brand medicines are covered across a range of key drug classes in the Iowa exchange. The national average is **69%** of brand medicines covered in exchange plans.

- An average of **0%** of brand drugs have a coinsurance of 30% or higher in the Iowa exchange, compared to a national average of **31%** of brand drugs having coinsurance of 30% or higher.

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4. Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5. Avalere March 2014 analysis of HHS Landscape File.
6. Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighted by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
7. Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C. 1 formulary was analyzed in Iowa; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
State oversight can ensure that coverage meets the Affordable Care Act’s standard of providing coverage similar to what is typically offered by employers. Idaho is a state-based exchange using healthcare.gov for enrollment in 2014. In 2014, the state initiated contracts with vendors to develop and implement the state’s own eligibility and enrollment website. The state is currently responsible for administering many core exchange functions, and its quasi-governmental exchange board reviews health plans that wish to participate in the exchange. The Idaho Exchange Board can protect Idahoans by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Developing a website that allows for meaningful plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

**Key Facts about 2014 Health Plans in the Idaho Exchange:**

### Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

### Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Health plans on Idaho’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Idaho’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Idaho’s benchmark plan covers 99% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

**State review of exchange plan formularies is important because:**

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.
- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.
- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.
- The addition of newly approved medicines to formularies mid-year is not required.

Based on an analysis of actual 2014 exchange plan formulary information in Idaho, the following key findings are of particular importance to Idaho residents: 7

- An average of 57% of brand medicines are covered across a range of key drug classes in the Idaho exchange. The national average is 69% of brand medicines covered in exchange plans.
- An average of 10% of brand drugs have a coinsurance of 30% or higher in the Idaho exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

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2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C. 2 formularies were analyzed in Idaho; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
State oversight can ensure that coverage meets the Affordable Care Act’s standard of providing coverage similar to what is typically offered by employers. Illinois has chosen to enter into a partnership model with the federal government in which the state reviews health plans that wish to participate in the exchange. Illinois can protect its residents by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

**Key Facts about 2014 Health Plans in the Illinois Exchange:**

**Deductibles**

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately. In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

**Cost Sharing**

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.

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**Fig. 1: Average Deductibles in Silver Plans: Illinois Plans Compared to U.S. Average**

<table>
<thead>
<tr>
<th>Deductible Type</th>
<th>Illinois</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Combined Deductible</td>
<td>$3,175</td>
<td>$2,276</td>
</tr>
<tr>
<td>Average Rx-Only Deductible</td>
<td>$964</td>
<td>$735</td>
</tr>
</tbody>
</table>

Average Deductible for Workers in Employer-Sponsored Insurance is $1,135

**Fig. 2: Average Cost Sharing in Exchange and Employer Plans**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Employer</th>
<th>U.S.</th>
<th>IL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Office Visit</td>
<td>$24</td>
<td>$37</td>
<td>$33</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>$38</td>
<td>$61</td>
<td>$61</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$34</td>
<td>$52</td>
<td>$43</td>
</tr>
<tr>
<td>Non-preferred Brand</td>
<td>$64</td>
<td>$90</td>
<td>$88</td>
</tr>
<tr>
<td>Specialty</td>
<td>$306</td>
<td>$362</td>
<td>$374</td>
</tr>
</tbody>
</table>

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2. Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
3. In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.
4. Average Deductible for Workers in Employer-Sponsored Insurance is $1,135.
5. Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
6. Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Health plans on Illinois’ Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Illinois’ benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Illinois’ benchmark plan covers 88% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

**State review of exchange plan formularies is important because:**

- **Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing.** Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.
- **Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules.** These medicines play an important role in patients sticking to and benefiting from the treatments they need.
- **There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.**
- **The addition of newly approved medicines to formularies mid-year is not required.**

Based on an analysis of actual 2014 exchange plan formulary information in Illinois, the following key findings are of particular importance to Illinois residents:

- An average of **68%** of brand medicines are covered across a range of key drug classes in the Illinois exchange. The national average is **69%** of brand medicines covered in exchange plans.
- An average of **48%** of brand drugs have a coinsurance of 30% or higher in the Illinois exchange, compared to a national average of **31%** of brand drugs having coinsurance of 30% or higher.

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2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C. 6 formularies were analyzed in Illinois; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.

Analytics by Avalere Health. Developed by PhRMA.
Indiana plays the primary role in reviewing health plans, consistent with its role prior to the Affordable Care Act, even though the state has a federally facilitated exchange. Through this role, Indiana has the opportunity to protect its residents through the following actions:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the Indiana Exchange:

**Deductibles**

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

**Cost Sharing**

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Health plans on Indiana’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Indiana’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Indiana’s benchmark plan covers 97% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.

- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.

- The addition of newly approved medicines to formularies mid-year is not required.

Based on an analysis of actual 2014 exchange plan formulary information in Indiana, the following key findings are of particular importance to Indiana residents:

- An average of 67% of brand medicines are covered across a range of key drug classes in the Indiana exchange. The national average is 69% of brand medicines covered in exchange plans.

- An average of 31% of brand drugs have a coinsurance of 30% or higher in the Indiana exchange. This is the same as the national average.
Improving Exchange Coverage in Kansas

State oversight can ensure that coverage meets the Affordable Care Act’s standard of providing coverage similar to what is typically offered by employers. Kansas will operate a federally facilitated exchange, though as a marketplace plan management state, the state will conduct plan management activities to support certification of qualified health plans. Kansas can protect its residents by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the Kansas Exchange:

Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.

Fig. 1: Average Deductibles in Silver Plans: Kansas Plans Compared to U.S. Average

Fig. 2: Average Cost Sharing in Exchange and Employer Plans
Prescription Drug Coverage in Kansas

Health plans on Kansas’ Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Kansas’ benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Kansas’ benchmark plan covers 98% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.

- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.

- The addition of newly approved medicines to formularies mid-year is not required.

Based on an analysis of actual 2014 exchange plan formulary information in Kansas, the following key findings are of particular importance to Kansas residents:

- An average of 67% of brand medicines are covered across a range of key drug classes in the Kansas exchange. The national average is 69% of brand medicines covered in exchange plans.

- An average of 56% of brand drugs have a coinsurance of 30% or higher in the Kansas exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C; 1 formulary was analyzed in Kansas; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
Kentucky’s state-based exchange is responsible for the operation of all core exchange functions. State regulators are charged with reviewing health insurance plans offered on the state-based exchange to ensure compliance with important consumer protections. Under this broad authority, the exchange should strengthen insurance coverage for enrollees by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Enhancing its website to allow for more meaningful plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

### Key Facts about 2014 Health Plans in the Kentucky Exchange:

#### Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.

- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

### Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.

- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Health plans on Kentucky’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Kentucky’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Kentucky’s benchmark plan covers 97% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.
- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.
- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.
- The addition of newly approved medicines to formularies mid-year is not required.

Based on an analysis of actual 2014 exchange plan formulary information in Kentucky, the following key findings are of particular importance to Kentucky residents:

- An average of 49% of brand medicines are covered across a range of key drug classes in the Kentucky exchange. The national average is 69% of brand medicines covered in exchange plans.
- An average of 79% of brand drugs have a coinsurance of 30% or higher in the Kentucky exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

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2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 State-specific data is an average of cost sharing for all unique silver plans based on Breakaway Policy Strategies analysis of summary of benefits and coverage documents; average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighted by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. State specific data is an average of cost sharing for all silver plans based on Breakaway Policy Strategies analysis of summary of benefits and coverage documents for unique silver plans. National exchange data is from HHS landscape file and employer data is from 2013 Kaiser/HRET and were analyzed by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C; 2 formularies were analyzed in Kentucky; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.

Developed by PhRMA
LOUISIANA’S EXCHANGE PLANS

Potential Size of Exchange Market:  About 489,000 Louisiana residents. 1

Improving Exchange Coverage in Louisiana

Louisiana plays the primary role in reviewing health plans, consistent with its role prior to the Affordable Care Act, even though the state has a federally facilitated exchange. Through this role, Louisiana has the opportunity to protect its residents through the following actions:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the Louisiana Exchange:

Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance— the vast majority of which covers prescription drugs immediately. 2
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers. 3

Fig. 1: Average Deductibles in Silver Plans: Louisiana Plans Compared to U.S. Average

Fig. 2: Average Cost Sharing in Exchange and Employer Plans
Prescription Drug Coverage in Louisiana

Health plans on Louisiana’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Louisiana’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Louisiana’s benchmark plan covers 92% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.
- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.
- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.
- The addition of newly approved medicines to formularies mid-year is not required.

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2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
Improving Exchange Coverage in Massachusetts

Massachusetts’ state-based exchange is responsible for the operation of all core exchange functions. State regulators are charged with reviewing health insurance plans offered on the state-based exchange to ensure compliance with important consumer protections. Under this broad authority, the exchange should strengthen insurance coverage for enrollees by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Enhancing its website to allow for more meaningful plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the Massachusetts Exchange:

Deductibles

- Massachusetts is among a handful of states that have mandated standardized cost sharing for exchange plans. This means that carriers are required to offer plans with set deductibles and cost sharing.
- In Massachusetts, all standard Silver plans have a $2,000 medical-only deductible. This means that standard Silver plans provide first-dollar coverage for all prescription medicines. A medical-only deductible is consistent with the vast majority of employer-sponsored plans that do not subject medicines to a deductible.²

Cost Sharing

- Recognizing the important role that medicines play in health care and the potential for specialty tiers to lead to discriminatory formularies, the Massachusetts exchange does not have a specialty tier and requires copayments instead of coinsurance for all formulary tiers in the Silver plan.
- Patients under 250% of the federal poverty level (about $29,000 for an individual) may qualify for cost sharing subsidies that reduce their out-of-pocket costs for Silver plans.
Health plans on Massachusetts’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Massachusetts’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Massachusetts’s benchmark plan covers 89% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.
- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.
- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.
- The addition of newly approved medicines to formularies mid-year is not required.

Based on an analysis of actual 2014 exchange plan formulary information in Massachusetts, the following key findings are of particular importance to Massachusetts residents:\(^5\)

An average of 71% of brand medicines are covered across a range of key drug classes in the Massachusetts exchange. The national average is 69% of brand medicines covered in exchange plans.

An average of 0% of brand drugs have a coinsurance of 30% or higher in the Massachusetts exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

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3. Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
4. Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighted by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
5. Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C; 1 formulary was analyzed in Massachusetts; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.

Analytics by Avalere Health. Developed by PhRMA.
Maryland’s state-based exchange is responsible for the operation of all core exchange functions. State regulators are charged with reviewing health insurance plans offered on the state-based exchange to ensure compliance with important consumer protections. Under this broad authority, the exchange should strengthen insurance coverage for enrollees by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Enhancing its website to allow for more meaningful plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Maryland’s state-based exchange is responsible for the operation of all core exchange functions. State regulators are charged with reviewing health insurance plans offered on the state-based exchange to ensure compliance with important consumer protections. Under this broad authority, the exchange should strengthen insurance coverage for enrollees by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Enhancing its website to allow for more meaningful plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the Maryland Exchange:

Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.

Fig. 1: Average Deductibles in Silver Plans: Maryland Plans Compared to U.S. Average

Fig. 2: Average Cost Sharing in Exchange and Employer Plans
Health plans on Maryland’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Maryland’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Maryland’s benchmark plan covers 61% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

Based on an analysis of actual 2014 exchange plan formulary information in Maryland, the following key findings are of particular importance to Maryland residents:

1. Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

2. Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.

3. There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.

4. The addition of newly approved medicines to formularies mid-year is not required.

An average of 71% of brand medicines are covered across a range of key drug classes in the Maryland exchange. The national average is 69% of brand medicines covered in exchange plans.

An average of 86% of brand drugs have a coinsurance of 30% or higher in the Maryland exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 State-specific data is an average of cost sharing for all unique silver plans based on Breakaway Policy Strategies analysis of summary of benefits and coverage documents; average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. State-specific data is an average of cost sharing for all silver plans based on Breakaway Policy Strategies analysis of summary of benefits and coverage documents for unique silver plans. National exchange data is from HHS landscape file and employer data is from 2013 Kaiser/HRET and were analyzed by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C; 3 formularies were analyzed in Maryland; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
Improving Exchange Coverage in Maine

State oversight can ensure that coverage meets the Affordable Care Act’s standard of providing coverage similar to what is typically offered by employers. Maine will operate a federally facilitated exchange, though as a marketplace plan management state, the state will conduct plan management activities to support certification of qualified health plans. Maine can protect its residents by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the Maine Exchange:

Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines. In Maine, no silver plans have a separate deductible for prescription medicines.

Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.

Fig. 1: Average Deductibles in Silver Plans: Maine Plans Compared to U.S. Average

Fig. 2: Average Cost Sharing in Exchange and Employer Plans
Health plans on Maine’s Health Insurance Exchange are required to cover "Essential Health Benefits" established by federal regulation. Prescription drug benefits are evaluated in comparison to Maine’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Maine’s benchmark plan covers 98% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for "counting" prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.
- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.
- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.
- The addition of newly approved medicines to formularies mid-year is not required.

Based on an analysis of actual 2014 exchange plan formulary information in Maine, the following key findings are of particular importance to Maine residents:

- An average of 69% of brand medicines are covered across a range of key drug classes in the Maine exchange. This is the same as the national average.
- An average of 100% of brand drugs have a coinsurance of 30% or higher in the Maine exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C. 1 formulary was analyzed in Maine; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
Michigan plays the primary role in reviewing health plans, consistent with its role prior to the Affordable Care Act, even though the state has a federally facilitated exchange. Through this role, Michigan has the opportunity to protect its residents through the following actions:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

### Key Facts about 2014 Health Plans in the Michigan Exchange:

#### Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

#### Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Prescription Drug Coverage in Michigan

Health plans on Michigan's Health Insurance Exchange are required to cover "Essential Health Benefits" established by federal regulation. Prescription drug benefits are evaluated in comparison to Michigan's benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Michigan's benchmark plan covers 80% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state's benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for "counting" prescription drug coverage may allow plans to effectively cover fewer drugs than a state's benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.
- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.
- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.
- The addition of newly approved medicines to formularies mid-year is not required.

Based on an analysis of actual 2014 exchange plan formulary information in Michigan, the following key findings are of particular importance to Michigan residents:7

- An average of 58% of brand medicines are covered across a range of key drug classes in the Michigan exchange. The national average is 69% of brand medicines covered in exchange plans.
- An average of 30% of brand drugs have a coinsurance of 30% or higher in the Michigan exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighted by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C; 8 formularies were analyzed in Michigan; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.

Analytics by Avalere Health. Developed by PhRMA.
Improving Exchange Coverage in Minnesota

Minnesota’s state-based exchange is responsible for the operation of all core exchange functions. State regulators are charged with reviewing health insurance plans offered on the state-based exchange to ensure compliance with important consumer protections. Under this broad authority, the exchange should strengthen insurance coverage for enrollees by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Enhancing its website to allow for more meaningful plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the Minnesota Exchange:

Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.³
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines. In Minnesota, no silver plans have a separate deductible for prescription medicines.

Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.⁵
Health plans on Minnesota’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Minnesota’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Minnesota’s benchmark plan covers 58% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.
- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.
- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.
- The addition of newly approved medicines to formularies mid-year is not required.

2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 State-specific data is an average of cost sharing for all unique silver plans based on Breakaway Policy Strategies analysis of summary of benefits and coverage documents; average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. State-specific data is an average of cost sharing for all silver plans based on Breakaway Policy Strategies analysis of summary of benefits and coverage documents for unique silver plans. National exchange data is from HHS landscape file and employer data is from 2013 Kaiser/HRET and were analyzed by Avalere.
MISSOURI’S
EXCHANGE PLANS

Potential Size of Exchange Market:  About 657,000 Missouri residents.

Improving Exchange Coverage in Missouri

While states typically play the primary role in reviewing health plans, plans in Missouri are reviewed by the federal government for compliance with the Affordable Care Act. Missouri has the opportunity to take a larger role in reviewing plans and could protect its residents through the following actions:

• Enforcing non-discrimination requirements, which apply to benefit design and provider networks;

• Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and

• Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the Missouri Exchange:

Deductibles

• Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.

• In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

Cost Sharing

• Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.

• Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Prescription Drug Coverage in Missouri

Health plans on Missouri’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Missouri’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Missouri’s benchmark plan covers 97% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

Based on an analysis of actual 2014 exchange plan formulary information in Missouri, the following key findings are of particular importance to Missouri residents:

- An average of 68% of brand medicines are covered across a range of key drug classes in the Missouri exchange. The national average is 69% of brand medicines covered in exchange plans.

- An average of 10% of brand drugs have a coinsurance of 30% or higher in the Missouri exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.

- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.

- The addition of newly approved medicines to formularies mid-year is not required.


2 42 U.S.C. § 18022(b)(2).

3 Kaiser/HRET 2013.

4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.

5 Avalere March 2014 analysis of HHS Landscape File.

6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.

7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C. 6 formularies were analyzed in Missouri; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
MISSISSIPPI’S EXCHANGE PLANS

Potential Size of Exchange Market: About 298,000 Mississippi residents.

Improving Exchange Coverage in Mississippi

Mississippi plays the primary role in reviewing health plans, consistent with its role prior to the Affordable Care Act, even though the state has a federally facilitated individual exchange. Through this role, Mississippi has the opportunity to protect its residents through the following actions:

• Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
• Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
• Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the Mississippi Exchange:

Deductibles

• Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.

• Mississippi, in contrast to most states, had no silver plans with a combined deductible for both medical and prescription drug costs.

Cost Sharing

• Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.

• Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.

Fig. 1: Average Deductibles in Silver Plans: Mississippi Plans Compared to U.S. Average

Fig. 2: Average Cost Sharing in Exchange and Employer Plans
Health plans on Mississippi’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Mississippi’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Mississippi’s benchmark plan covers 95% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.

There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.

The addition of newly approved medicines to formularies mid-year is not required.

**Based on an analysis of actual 2014 exchange plan formulary information in Mississippi, the following key findings are of particular importance to Mississippi residents:**

- An average of 65% of brand medicines are covered across a range of key drug classes in the Mississippi exchange. The national average is 69% of brand medicines covered in exchange plans.
- An average of 0% of brand drugs have a coinsurance of 30% or higher in the Mississippi exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

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2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
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6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighted by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C. 1 formulary was analyzed in Mississippi; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
Improving Exchange Coverage in Montana

State oversight can ensure that coverage meets the Affordable Care Act’s standard of providing coverage similar to what is typically offered by employers. Montana will operate a federally facilitated exchange, though as a marketplace plan management state, the state will conduct plan management activities to support certification of qualified health plans. Montana can protect its residents by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the Montana Exchange:

Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines. In Montana, no silver plans have a separate deductible for prescription medicines.

Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Health plans on Montana’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Montana’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Montana’s benchmark plan covers 95% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.
- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.
- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.
- The addition of newly approved medicines to formularies mid-year is not required.

Based on an analysis of actual 2014 exchange plan formulary information in Montana, the following key findings are of particular importance to Montana residents:

An average of 77% of brand medicines are covered across a range of key drug classes in the Montana exchange. The national average is 69% of brand medicines covered in exchange plans.

An average of 0% of brand drugs have a coinsurance of 30% or higher in the Montana exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C. 1 formulary was analyzed in Montana; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
North Carolina plays the primary role in reviewing health plans, consistent with its role prior to the Affordable Care Act, even though the state has a federally facilitated exchange. Through this role, North Carolina has the opportunity to protect its residents through the following actions:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the North Carolina Exchange:

**Deductibles**

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.

- North Carolina, in contrast to most states, had no silver plans with a combined deductible for both medical and prescription drug costs.

**Cost Sharing**

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.

- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Health plans on North Carolina’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to North Carolina’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, North Carolina’s benchmark plan covers 87% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- **Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing.** Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

- **Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules.** These medicines play an important role in patients sticking to and benefiting from the treatments they need.

- **There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.**

- **The addition of newly approved medicines to formularies mid-year is not required.**

Based on an analysis of actual 2014 exchange plan formulary information in North Carolina, the following key findings are of particular importance to North Carolina residents:

- An average of **87%** of brand medicines are covered across a range of key drug classes in the North Carolina exchange. The national average is **69%** of brand medicines covered in exchange plans.

- An average of **16%** of brand drugs have a coinsurance of 30% or higher in the North Carolina exchange, compared to a national average of **31%** of brand drugs having coinsurance of 30% or higher.

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2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C; 3 formularies were analyzed in North Carolina; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
North Dakota plays the primary role in reviewing health plans, consistent with its role prior to the Affordable Care Act, even though the state has a federally facilitated exchange. Through this role, North Dakota has the opportunity to protect its residents through the following actions:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

### Key Facts about 2014 Health Plans in the North Dakota Exchange:

#### Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines. In North Dakota, no silver plans have a separate deductible for prescription medicines.

#### Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.

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1. Potential Size of Exchange Market: About 77,000 North Dakota residents.

2. Exchange plan coverage is supposed to be consistent with employer-sponsored insurance, the vast majority of which covers prescription drugs immediately.

3. In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines. In North Dakota, no silver plans have a separate deductible for prescription medicines.

4. Average Deductible for Workers in Employer-Sponsored Insurance is $1,135

5. Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.

6. Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Health plans on North Dakota’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to North Dakota’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, North Dakota’s benchmark plan covers 81% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.

- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.

- The addition of newly approved medicines to formularies mid-year is not required.

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2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighted by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
State oversight can ensure that coverage meets the Affordable Care Act’s standard of providing coverage similar to what is typically offered by employers. Nebraska will operate a federally facilitated exchange, though as a marketplace plan management state, the state will conduct plan management activities to support certification of qualified health plans. Nebraska can protect its residents by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

**Key Facts about 2014 Health Plans in the Nebraska Exchange:**

**Deductibles**

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance\(^2\)—the vast majority of which covers prescription drugs immediately.\(^3\)
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

**Cost Sharing**

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.\(^5\)

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**Fig. 1: Average Deductibles in Silver Plans:** Nebraska Plans Compared to U.S. Average\(^4\)

**Fig. 2: Average Cost Sharing in Exchange and Employer Plans**
Health plans on Nebraska’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Nebraska’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Nebraska’s benchmark plan covers 97% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.
- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.
- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.
- The addition of newly approved medicines to formularies to formularies mid-year is not required.

Based on an analysis of actual 2014 exchange plan formulary information in Nebraska, the following key findings are of particular importance to Nebraska residents:

An average of 80% of brand medicines are covered across a range of key drug classes in the Nebraska exchange. The national average is 69% of brand medicines covered in exchange plans.

An average of 53% of brand drugs have a coinsurance of 30% or higher in the Nebraska exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.
State oversight can ensure that coverage meets the Affordable Care Act’s standard of providing coverage similar to what is typically offered by employers. New Hampshire has chosen to enter into a partnership model with the federal government in which the state reviews health plans that wish to participate in the exchange. New Hampshire can protect its residents by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

**Key Facts about 2014 Health Plans in the New Hampshire Exchange:**

**Deductibles**

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines. In New Hampshire, no silver plans have a separate deductible for prescription medicines.

**Cost Sharing**

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Health plans on New Hampshire’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to New Hampshire’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, New Hampshire’s benchmark plan covers 98% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.

- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.

- The addition of newly approved medicines to formularies mid-year is not required.

Based on an analysis of actual 2014 exchange plan formulary information in New Hampshire, the following key findings are of particular importance to New Hampshire residents:

- An average of 62% of brand medicines are covered across a range of key drug classes in the New Hampshire exchange. The national average is 69% of brand medicines covered in exchange plans.

- An average of 85% of brand drugs have a coinsurance of 30% or higher in the New Hampshire exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

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2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C. 1 formulary was analyzed in New Hampshire; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
New Jersey plays the primary role in reviewing health plans, consistent with its role prior to the Affordable Care Act, even though the state has a federally facilitated exchange. Through this role, New Jersey has the opportunity to protect its residents through the following actions:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

### Key Facts about 2014 Health Plans in the New Jersey Exchange:

#### Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.³
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines. In New Jersey, no silver plans have a separate deductible for prescription medicines.

#### Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.⁵

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### Potential Size of Exchange Market

About 628,000 New Jersey residents.

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### Average Deductibles in Silver Plans: New Jersey Plans Compared to U.S. Average

![Fig. 1](chart)

**Fig. 1:** Average Deductibles in Silver Plans: New Jersey Plans Compared to U.S. Average

<table>
<thead>
<tr>
<th>Category</th>
<th>New Jersey</th>
<th>U.S. Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Combined Deductible</td>
<td>$1,894</td>
<td>$2,276</td>
</tr>
<tr>
<td>Average Rx-Only Deductible</td>
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<td>$735</td>
</tr>
</tbody>
</table>

Average Deductible for Workers in Employer-Sponsored Insurance is $1,135

### Average Cost Sharing in Exchange and Employer Plans

![Fig. 2](chart)

**Fig. 2:** Average Cost Sharing in Exchange and Employer Plans

- **Primary Care Office Visit:**
  - Employer: $24
  - U.S.: $37
  - New Jersey: $38
- **Specialist Office Visit:**
  - Employer: $38
  - U.S.: $61
  - New Jersey: $65
- **Preferred Brand:**
  - Employer: $34
  - U.S.: $52
  - New Jersey: $79
- **Non-preferred Brand:**
  - Employer: $64
  - U.S.: $90
  - New Jersey: $109
- **Specialty:**
  - Employer: $306
  - U.S.: $362
  - New Jersey: $620
Prescription Drug Coverage in New Jersey

Health plans on New Jersey’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to New Jersey’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, New Jersey’s benchmark plan covers 87% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- **Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing.** Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

- **Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules.** These medicines play an important role in patients sticking to and benefiting from the treatments they need.

- **There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.**

- **The addition of newly approved medicines to formularies mid-year is not required.**

**Based on an analysis of actual 2014 exchange plan formulary information in New Jersey, the following key findings are of particular importance to New Jersey residents:**

An average of **89%** of brand medicines are covered across a range of key drug classes in the New Jersey exchange. The national average is **69%** of brand medicines covered in exchange plans.

An average of **84%** of brand drugs have a coinsurance of 30% or higher in the New Jersey exchange, compared to a national average of **31%** of brand drugs having coinsurance of 30% or higher.

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2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C; 4 formularies were analyzed in New Jersey; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
New Mexico plays an important role in reviewing plans as the state transitions to a state-based exchange. Through this role, New Mexico should take the following actions to protect its residents:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Developing a website that allows for meaningful plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

**Improving Exchange Coverage in New Mexico**

New Mexico plays an important role in reviewing plans as the state transitions to a state-based exchange. Through this role, New Mexico should take the following actions to protect its residents:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Developing a website that allows for meaningful plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

**Key Facts about 2014 Health Plans in the New Mexico Exchange:**

**Deductibles**

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

**Cost Sharing**

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Prescription Drug Coverage in New Mexico

Health plans on New Mexico’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to New Mexico’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, New Mexico’s benchmark plan covers 67% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.
- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.
- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.
- The addition of newly approved medicines to formularies mid-year is not required.

Based on an analysis of actual 2014 exchange plan formulary information in New Mexico, the following key findings are of particular importance to New Mexico residents:7

An average of 100% of brand medicines are covered across a range of key drug classes in the New Mexico exchange. The national average is 69% of brand medicines covered in exchange plans.

An average of 0% of brand drugs have a coinsurance of 30% or higher in the New Mexico exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C. 1 formulary was analyzed in New Mexico; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
NEVADA’S EXCHANGE PLANS

Potential Size of Exchange Market: About 249,000 Nevada residents.¹

Improving Exchange Coverage in Nevada

Nevada’s state-based exchange is responsible for the operation of all core exchange functions. State regulators are charged with reviewing health insurance plans offered on the state-based exchange to ensure compliance with important consumer protections. Under this broad authority, the exchange should strengthen insurance coverage for enrollees by:

• Enforcing non-discrimination requirements, which apply to benefit design and provider networks; and
• Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend.

Key Facts about 2014 Health Plans in the Nevada Exchange:

Deductibles

• Exchange plan coverage is supposed to be consistent with employer-sponsored insurance²—the vast majority of which covers prescription drugs immediately.³

• In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines. In Nevada, no silver plans have a separate deductible for prescription medicines.

Cost Sharing

• Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.

• Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.⁵

Potential Size of Exchange Market: About 249,000 Nevada residents.¹

Fig. 1: Average Deductibles in Silver Plans: Nevada Plans Compared to U.S. Average⁴

Fig. 2: Average Cost Sharing in Exchange and Employer Plans⁶
Health plans on Nevada’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Nevada’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Nevada’s benchmark plan covers 96% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

Based on an analysis of actual 2014 exchange plan formulary information in Nevada, the following key findings are of particular importance to Nevada residents:

- An average of **67%** of brand medicines are covered across a range of key drug classes in the Nevada exchange. The national average is **69%** of brand medicines covered in exchange plans.

- An average of **21%** of brand drugs have a coinsurance of 30% or higher in the Nevada exchange, compared to a national average of **31%** of brand drugs having coinsurance of 30% or higher.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.

- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.

- The addition of newly approved medicines to formularies mid-year is not required.

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2 42 U.S.C. § 18022(b)(2).

3 Kaiser/HRET 2013.

4 State-specific data is an average of cost sharing for all unique silver plans based on Breakaway Policy Strategies analysis of summary of benefits and coverage documents; average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.

5 Avalere March 2014 analysis of HHS Landscape File.

6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. State-specific data is an average of cost sharing for all silver plans based on Breakaway Policy Strategies analysis of summary of benefits and coverage documents for unique silver plans. National exchange data is from HHS landscape file and employer data is from 2013 Kaiser/HRET and were analyzed by Avalere.

7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C. 3 formularies were analyzed in Nevada; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.

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Developed by PhRMA.
New York’s state-based exchange is responsible for the operation of all core exchange functions. State regulators are charged with reviewing health insurance plans offered on the state-based exchange to ensure compliance with important consumer protections. Under this broad authority, the exchange should strengthen insurance coverage for enrollees by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Enhancing its website to allow for more meaningful plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Improving Exchange Coverage in New York

New York is among a handful of states that have mandated standardized cost sharing for exchange plans. This means that carriers are required to offer plans with set deductibles and cost sharing.

In New York, all standard Silver plans have a $2,000 medical-only deductible. This means that standard Silver plans provide first-dollar coverage for all prescription medicines. A medical-only deductible is consistent with the vast majority of employer-sponsored plans that do not subject medicines to a deductible.2

Fig. 1: Deductibles in Silver Plans: New York Standard Plan Compared to U.S. Average3

![Deductibles Graph]

Key Facts about 2014 Health Plans in the New York Exchange:

**Deductibles**

- New York is among a handful of states that have mandated standardized cost sharing for exchange plans. This means that carriers are required to offer plans with set deductibles and cost sharing.
- In New York, all standard Silver plans have a $2,000 medical-only deductible. This means that standard Silver plans provide first-dollar coverage for all prescription medicines. A medical-only deductible is consistent with the vast majority of employer-sponsored plans that do not subject medicines to a deductible.2

**Cost Sharing**

- Recognizing the important role that medicines play in health care and the potential for specialty tiers to lead to discriminatory formularies, the New York exchange does not have a specialty tier and requires copayments instead of coinsurance for all formulary tiers in the Silver plan.
- Patients under 250% of the federal poverty level (about $29,000 for an individual) may qualify for cost sharing subsidies that reduce their out-of-pocket costs for Silver plans.

Fig. 2: Cost Sharing in Exchange and Employer Plans: New York Standard Plan Compared to U.S. and Employer Averages4

![Cost Sharing Graph]
Health plans on New York’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to New York’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, New York’s benchmark plan covers 85% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.
- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.
- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.
- The addition of newly approved medicines to formularies mid-year is not required.

Based on an analysis of actual 2014 exchange plan formulary information in New York, the following key findings are of particular importance to New York residents:

- An average of 58% of brand medicines are covered across a range of key drug classes in the New York exchange. The national average is 69% of brand medicines covered in exchange plans.
- An average of 0% of brand drugs have a coinsurance of 30% or higher in the New York exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

2 Kaiser/HRET 2013.
3 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
4 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighted by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
5 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C; 6 formularies were analyzed in New York; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
State oversight can ensure that coverage meets the Affordable Care Act’s standard of providing coverage similar to what is typically offered by employers. Ohio will operate a federally facilitated exchange, though as a marketplace plan management state, the state will conduct plan management activities to support certification of qualified health plans. Ohio can protect its residents by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

### Key Facts about 2014 Health Plans in the Ohio Exchange:

#### Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.

- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

#### Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.

- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.

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1. Potential Size of Exchange Market: About 812,000 Ohio residents.

2. Exchange plan coverage is supposed to be consistent with employer-sponsored insurance, the vast majority of which covers prescription drugs immediately.

3. In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

4. Average Deductible for Workers in Employer-Sponsored Insurance is $1,135.

5. Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.

6. Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Health plans on Ohio’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Ohio’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Ohio’s benchmark plan covers 97% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.
- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.
- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.
- The addition of newly approved medicines to formularies mid-year is not required.

Based on an analysis of actual 2014 exchange plan formulary information in Ohio, the following key findings are of particular importance to Ohio residents:

An average of 63% of brand medicines are covered across a range of key drug classes in the Ohio exchange. The national average is 69% of brand medicines covered in exchange plans.

An average of 32% of brand drugs have a coinsurance of 30% or higher in the Ohio exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C. 6 formularies were analyzed in Ohio; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
While states typically play the primary role in reviewing health plans, plans in Oklahoma are reviewed by the federal government for compliance with the Affordable Care Act. Oklahoma has the opportunity to take a larger role in reviewing plans and could protect its residents through the following actions:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

### OKLAHOMA’S EXCHANGE PLANS

#### Potential Size of Exchange Market:

**About 446,000 Oklahoma residents.**

### Improving Exchange Coverage in Oklahoma

#### Key Facts about 2014 Health Plans in the Oklahoma Exchange:

#### Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.

- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

#### Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.

- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.

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**Fig. 1: Average Deductibles in Silver Plans: Oklahoma Plans Compared to U.S. Average**

**Fig. 2: Average Cost Sharing in Exchange and Employer Plans**

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Health plans on Oklahoma's Health Insurance Exchange are required to cover “Essential Health Benefits" established by federal regulation. Prescription drug benefits are evaluated in comparison to Oklahoma's benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Oklahoma's benchmark plan covers 88% of available medicines. The regulations allow health plans significant leeway in designing formularies to meet a state's benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for "counting" prescription drug coverage may allow plans to effectively cover fewer drugs than a state's benchmark and typical employer plans.

State review of exchange plan formularies is important because:

1. Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

2. Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.

3. There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.

4. The addition of newly approved medicines to formularies mid-year is not required.

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2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.

Analytics by Avalere Health. Developed by PhRMA.
OREGON’S EXCHANGE PLANS

Potential Size of Exchange Market:  About 337,000 Oregon residents. 1

Improving Exchange Coverage in Oregon

Oregon’s state-based exchange is responsible for the operation of all core exchange functions. State regulators are charged with reviewing health insurance plans offered on the state-based exchange to ensure compliance with important consumer protections. Under this broad authority, the exchange should strengthen insurance coverage for enrollees by:

• Enforcing non-discrimination requirements, which apply to benefit design and provider networks; and
• Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend.

Key Facts about 2014 Health Plans in the Oregon Exchange:

Deductibles

• Oregon is among a handful of states that have mandated standardized cost sharing for exchange plans. This means that carriers are required to offer plans with set deductibles and cost sharing.

• In Oregon, all standard Silver plans have a $2,500 medical-only deductible. This means that standard Silver plans provide first-dollar coverage for all prescription medicines. A medical-only deductible is consistent with the vast majority of employer-sponsored plans that do not subject medicines to a deductible. 2

Cost Sharing

• Oregon requires 50% coinsurance for non-preferred brand and specialty medicines. This cost sharing penalizes patients who need innovative medicines that have been placed on a high cost sharing tier. This cost sharing is also substantially higher than all other states with standardized exchange cost sharing.

• Patients under 250% of the federal poverty level (about $29,000 for an individual) may qualify for cost sharing subsidies that reduce their out-of-pocket costs for Silver plans.
Prescription Drug Coverage in Oregon

Health plans on Oregon’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Oregon’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Oregon’s benchmark plan covers 98% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

**State review of exchange plan formularies is important because:**

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.
- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.
- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.
- The addition of newly approved medicines to formularies mid-year is not required.

Based on an analysis of actual 2014 exchange plan formulary information in Oregon, the following key findings are of particular importance to Oregon residents:

1. An average of 63% of brand medicines are covered across a range of key drug classes in the Oregon exchange. The national average is 69% of brand medicines covered in exchange plans.
2. An average of 87% of brand drugs have a coinsurance of 30% or higher in the Oregon exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

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3. Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
4. Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighted by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
5. Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C; 2 formularies were analyzed in Oregon; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
Improving Exchange Coverage in Pennsylvania

Pennsylvania plays the primary role in reviewing health plans, consistent with its role prior to the Affordable Care Act, even though the state has a federally facilitated exchange. Through this role, Pennsylvania has the opportunity to protect its residents through the following actions:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the Pennsylvania Exchange:

### Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

### Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Health plans on Pennsylvania’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Pennsylvania’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Pennsylvania’s benchmark plan covers 93% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.
- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.
- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.
- The addition of newly approved medicines to formularies mid-year is not required.

Based on an analysis of actual 2014 exchange plan formulary information in Pennsylvania, the following key findings are of particular importance to Pennsylvania residents:

- An average of 81% of brand medicines are covered across a range of key drug classes in the Pennsylvania exchange. The national average is 69% of brand medicines covered in exchange plans.
- An average of 42% of brand drugs have a coinsurance of 30% or higher in the Pennsylvania exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

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2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C; 5 formularies were analyzed in Pennsylvania; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
Rhode Island’s state-based exchange is responsible for the operation of all core exchange functions. State regulators are charged with reviewing health insurance plans offered on the state-based exchange to ensure compliance with important consumer protections. Under this broad authority, the exchange should strengthen insurance coverage for enrollees by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Enhancing its website to allow for more meaningful plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

**Key Facts about 2014 Health Plans in the Rhode Island Exchange:**

**Deductibles**

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately. In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines. In Rhode Island, no silver plans have a separate deductible for prescription medicines.

**Cost Sharing**

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.

- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Health plans on Rhode Island’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Rhode Island’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Rhode Island’s benchmark plan covers 95% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

### State review of exchange plan formularies is important because:

- **Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing.** Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

- **Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules.** These medicines play an important role in patients sticking to and benefiting from the treatments they need.

- **There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.**

- **The addition of newly approved medicines to formularies mid-year is not required.**

### Based on an analysis of actual 2014 exchange plan formulary information in Rhode Island, the following key findings are of particular importance to Rhode Island residents:

1. An average of **78%** of brand medicines are covered across a range of key drug classes in the Rhode Island exchange. The national average is **69%** of brand medicines covered in exchange plans.

2. An average of **0%** of brand drugs have a coinsurance of 30% or higher in the Rhode Island exchange, compared to a national average of **31%** of brand drugs having coinsurance of 30% or higher.

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4. State-specific data is an average of cost sharing for all unique silver plans based on Breakaway Policy Strategies analysis of summary of benefits and coverage documents; average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5. Avalere March 2014 analysis of HHS Landscape File.
6. Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighted by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. State-specific data is an average of cost sharing for all silver plans based on Breakaway Policy Strategies analysis of summary of benefits and coverage documents for unique silver plans. National exchange data is from HHS landscape file and employer data is from 2013 Kaiser/HRET and were analyzed by Avalere.
7. Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C; 1 formulary was analyzed in Rhode Island; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.

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Developed by PhRMA
South Carolina plays the primary role in reviewing health plans, consistent with its role prior to the Affordable Care Act, even though the state has a federally facilitated exchange. Through this role, South Carolina has the opportunity to protect its residents through the following actions:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the South Carolina Exchange:

Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Health plans on South Carolina’s Health Insurance Exchange are required to cover "Essential Health Benefits" established by federal regulation. Prescription drug benefits are evaluated in comparison to South Carolina’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, South Carolina’s benchmark plan covers 97% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for "counting" prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

**State review of exchange plan formularies is important because:**

- **Federal standards specific to prescription drug coverage** apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

- **Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules.** These medicines play an important role in patients sticking to and benefiting from the treatments they need.

- **There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit**—these medicines often treat serious conditions such as cancer and neurologic diseases.

- **The addition of newly approved medicines to formularies mid-year is not required.**

Based on an analysis of actual 2014 exchange plan formulary information in South Carolina, the following key findings are of particular importance to South Carolina residents:7

An average of 86% of brand medicines are covered across a range of key drug classes in the South Carolina exchange. The national average is 69% of brand medicines covered in exchange plans.

An average of 31% of brand drugs have a coinsurance of 30% or higher in the South Carolina exchange. This is the same as the national average.

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2 42 U.S.C. § 18022(b)(2).

3 Kaiser/HRET 2013.

4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.

5 Avalere March 2014 analysis of HHS Landscape File.

6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.

7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C. 1 formulary was analyzed in South Carolina; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.

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Analytics by Avalere Health. Developed by PhRMA.
Improving Exchange Coverage in South Dakota

State oversight can ensure that coverage meets the Affordable Care Act’s standard of providing coverage similar to what is typically offered by employers. South Dakota will operate a federally facilitated exchange, though as a marketplace plan management state, the state will conduct plan management activities to support certification of qualified health plans. South Dakota can protect its residents by:

• Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
• Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
• Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the South Dakota Exchange:

Deductibles

• Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
• In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines. In South Dakota, no silver plans have a separate deductible for prescription medicines.

Cost Sharing

• Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
• Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Health plans on South Dakota’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to South Dakota’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, South Dakota’s benchmark plan covers 79% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for "counting" prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.

- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.

- The addition of newly approved medicines to formularies mid-year is not required.

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2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
TENNESSEE’S EXCHANGE PLANS

Potential Size of Exchange Market: About 645,000 Tennessee residents.

Improving Exchange Coverage in Tennessee

Tennessee plays the primary role in reviewing health plans, consistent with its role prior to the Affordable Care Act, even though the state has a federally facilitated exchange. Through this role, Tennessee has the opportunity to protect its residents through the following actions:

• Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
• Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
• Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the Tennessee Exchange:

Deductibles

• Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
• In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

Cost Sharing

• Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
• Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Health plans on Tennessee’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Tennessee’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Tennessee’s benchmark plan covers 84% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

**State review of exchange plan formularies is important because:**

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.

- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.

- The addition of newly approved medicines to formularies mid-year is not required.

**Based on an analysis of actual 2014 exchange plan formulary information in Tennessee, the following key findings are of particular importance to Tennessee residents:**

- An average of 51% of brand medicines are covered across a range of key drug classes in the Tennessee exchange. The national average is 69% of brand medicines covered in exchange plans.

- An average of 0% of brand drugs have a coinsurance of 30% or higher in the Tennessee exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

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2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C. 1 formulary was analyzed in Tennessee; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.

Analytics by Avalere Health. Developed by PhRMA
While states typically play the primary role in reviewing health plans, plans in Texas are reviewed by the federal government for compliance with the Affordable Care Act. Texas has the opportunity to take a larger role in reviewing plans and could protect its residents through the following actions:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

### Key Facts about 2014 Health Plans in the Texas Exchange:

#### Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

#### Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Health plans on Texas’ Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Texas’ benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Texas’ benchmark plan covers 87% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.
- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.
- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.
- The addition of newly approved medicines to formularies mid-year is not required.

Based on an analysis of actual 2014 exchange plan formulary information in Texas, the following key findings are of particular importance to Texas residents:

- An average of 75% of brand medicines are covered across a range of key drug classes in the Texas exchange. The national average is 69% of brand medicines covered in exchange plans.
- An average of 33% of brand drugs have a coinsurance of 30% or higher in the Texas exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C. 8 formularies were analyzed in Texas; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.

Analytics by Avalere Health. Developed by PhRMA.
Improving Exchange Coverage in Utah

Utah plays the primary role in reviewing health plans, consistent with its role prior to the Affordable Care Act, even though the state has a federally facilitated individual exchange. Through this role, Utah has the opportunity to protect its residents through the following actions:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the Utah Exchange:

Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Health plans on Utah’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Utah’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Utah’s benchmark plan covers 55% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.

- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.

- The addition of newly approved medicines to formularies mid-year is not required.

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2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
Improving Exchange Coverage in Virginia

State oversight can ensure that coverage meets the Affordable Care Act’s standard of providing coverage similar to what is typically offered by employers. Virginia will operate a federally facilitated exchange, though as a marketplace plan management state, the state will conduct plan management activities to support certification of qualified health plans. Virginia can protect its residents by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the Virginia Exchange:

**Deductibles**

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.

- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

**Cost Sharing**

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.

- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.

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*Fig. 1: Average Deductibles in Silver Plans: Virginia Plans Compared to U.S. Average*

*Fig. 2: Average Cost Sharing in Exchange and Employer Plans*
Health plans on Virginia’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Virginia’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Virginia’s benchmark plan covers 98% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

**State review of exchange plan formularies is important because:**

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.

- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.

- The addition of newly approved medicines to formularies mid-year is not required.

Based on an analysis of actual 2014 exchange plan formulary information in Virginia, the following key findings are of particular importance to Virginia residents:

- An average of 66% of brand medicines are covered across a range of key drug classes in the Virginia exchange. The national average is 69% of brand medicines covered in exchange plans.

- An average of 38% of brand drugs have a coinsurance of 30% or higher in the Virginia exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

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2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C. 4 formularies were analyzed in Virginia; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
Improving Exchange Coverage in Vermont

Vermont’s state-based exchange is responsible for the operation of all core exchange functions. State regulators are charged with reviewing health insurance plans offered on the state-based exchange to ensure compliance with important consumer protections. Under this broad authority, the exchange should strengthen insurance coverage for enrollees by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Enhancing its website to allow for more meaningful plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the Vermont Exchange:

Deductibles

- Vermont is among a handful of states that have mandated standardized cost sharing for exchange plans. This means that carriers are required to offer plans with set deductibles and cost sharing.
- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In Vermont, all standard Silver plans have a $100 deductible for brand medicines.

Cost Sharing

- Vermont requires patients to pay 50% coinsurance for specialty medicines. Such high cost sharing could present an affordability barrier for some patients and may be discriminatory.
- Vermont has a separate out-of-pocket cap for medicines of $1,250 that provides additional protection against high out-of-pocket costs.
- Patients under 250% of the federal poverty level (about $29,000 for an individual) typically qualify for cost sharing subsidies that reduce their out-of-pocket costs for Silver plans.
Prescription Drug Coverage in Vermont

Health plans on Vermont’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Vermont’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Vermont’s benchmark plan covers 98% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.

- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.

- The addition of newly approved medicines to formularies mid-year is not required.

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4. Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5. Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET, Analysis by Avalere.
Improving Exchange Coverage in Washington

Washington’s state-based exchange is responsible for the operation of all core exchange functions. State regulators are charged with reviewing health insurance plans offered on the state-based exchange to ensure compliance with important consumer protections. Under this broad authority, the exchange should strengthen insurance coverage for enrollees by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Enhancing its website to allow for more meaningful plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the Washington Exchange:

Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Health plans on Washington’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Washington’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Washington’s benchmark plan covers 87% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.
- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.
- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.
- The addition of newly approved medicines to formularies mid-year is not required.

Based on an analysis of actual 2014 exchange plan formulary information in Washington, the following key findings are of particular importance to Washington residents:

- An average of 62% of brand medicines are covered across a range of key drug classes in the Washington exchange. The national average is 69% of brand medicines covered in exchange plans.
- An average of 47% of brand drugs have a coinsurance of 30% or higher in the Washington exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 State-specific data is an average of cost sharing for all unique silver plans based on Breakaway Policy Strategies analysis of summary of benefits and coverage documents; average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. State-specific data is an average of cost sharing for all silver plans based on Breakaway Policy Strategies analysis of summary of benefits and coverage documents for unique silver plans. National exchange data is from HHS landscape file and employer data is from 2013 Kaiser/HRET and were analyzed by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C; 5 formularies were analyzed in Washington; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
Wisconsin plays the primary role in reviewing health plans, consistent with its role prior to the Affordable Care Act, even though the state has a federally facilitated exchange. Through this role, Wisconsin has the opportunity to protect its residents through the following actions:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

### Key Facts about 2014 Health Plans in the Wisconsin Exchange:

#### Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines.

#### Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Health plans on Wisconsin's Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Wisconsin’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Wisconsin’s benchmark plan covers 71% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.
- Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules. These medicines play an important role in patients sticking to and benefiting from the treatments they need.
- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.
- The addition of newly approved medicines to formularies mid-year is not required.

Based on an analysis of actual 2014 exchange plan formulary information in Wisconsin, the following key findings are of particular importance to Wisconsin residents:

- An average of 59% of brand medicines are covered across a range of key drug classes in the Wisconsin exchange. The national average is 69% of brand medicines covered in exchange plans.
- An average of 9% of brand drugs have a coinsurance of 30% or higher in the Wisconsin exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C: 5 formularies were analyzed in Wisconsin; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
Improving Exchange Coverage in West Virginia

State oversight can ensure that coverage meets the Affordable Care Act’s standard of providing coverage similar to what is typically offered by employers. West Virginia has chosen to enter into a partnership model with the federal government in which the state reviews health plans that wish to participate in the exchange. West Virginia can protect its residents by:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the West Virginia Exchange:

**Deductibles**

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines. In West Virginia, no silver plans have a separate deductible for prescription medicines.

**Cost Sharing**

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.

Fig. 1: Average Deductibles in Silver Plans: West Virginia Plans Compared to U.S. Average

Fig. 2: Average Cost Sharing in Exchange and Employer Plans
Health plans on West Virginia’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to West Virginia’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, West Virginia’s benchmark plan covers 99% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

### State review of exchange plan formularies is important because:

- **Federal standards specific to prescription drug coverage apply to the number of medicines in a formulary—not the cost sharing.** Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

- **Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules.** These medicines play an important role in patients sticking to and benefiting from the treatments they need.

- **There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.**

- **The addition of newly approved medicines to formularies mid-year is not required.**

### Based on an analysis of actual 2014 exchange plan formulary information in West Virginia, the following key findings are of particular importance to West Virginia residents:

- An average of 58% of brand medicines are covered across a range of key drug classes in the West Virginia exchange. The national average is 69% of brand medicines covered in exchange plans.

- An average of 0% of brand drugs have a coinsurance of 30% or higher in the West Virginia exchange, compared to a national average of 31% of brand drugs having coinsurance of 30% or higher.

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2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2013.
4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.
5 Avalere March 2014 analysis of HHS Landscape File.
6 Average cost sharing is the weighted average of exchange plan copayments and coinsurances, weighed by the frequency with which plans use each type of cost sharing. For plans using coinsurance, average drug costs were determined using the National Average Retail Prices of Prescription (NARP) Drugs Reference file. Average physician visit costs were determined using the Medical Expenditure Panel Survey (MEPS). Plans with no cost sharing after the deductible were excluded from analysis. Exchange data from HHS landscape file and employer data from 2013 Kaiser/HRET; Analysis by Avalere.
7 Analysis by Avalere of single-source brand medicines (medicines without a generic alternative on the market) across 21 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C. 1 formulary was analyzed in West Virginia; formularies are generally consistent across different plans and metal tiers offered by a single issuer within a state and therefore a single formulary typically represents multiple plans offered in each state.
While states typically play the primary role in reviewing health plans, plans in Wyoming are reviewed by the federal government for compliance with the Affordable Care Act. Wyoming has the opportunity to take a larger role in reviewing plans and could protect its residents through the following actions:

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks;
- Establishing stronger rules regarding exceptions and appeals processes, which help enrollees get the medicines and care their doctors recommend; and
- Advocating for a healthcare.gov website that allows for easier plan comparisons, including searchable formularies and estimates of total out-of-pocket costs.

Key Facts about 2014 Health Plans in the Wyoming Exchange:

**Deductibles**

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance—the vast majority of which covers prescription drugs immediately.
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines. In Wyoming, no silver plans have a separate deductible for prescription medicines.

**Fig. 1: Average Deductibles in Silver Plans: Wyoming Plans Compared to U.S. Average**

[Graph showing average combined and Rx-only deductibles for Wyoming and the U.S.]

**Fig. 2: Average Cost Sharing in Exchange and Employer Plans**

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**Cost Sharing**

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Patients under 250% of poverty (about $29,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.
Prescription Drug Coverage in Wyoming

Health plans on Wyoming’s Health Insurance Exchange are required to cover “Essential Health Benefits” established by federal regulation. Prescription drug benefits are evaluated in comparison to Wyoming’s benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Wyoming’s benchmark plan covers 91% of available medicines.

The regulations allow health plans significant leeway in designing formularies to meet a state’s benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because the federal rules for “counting” prescription drug coverage may allow plans to effectively cover fewer drugs than a state’s benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- **Federal standards specific to prescription drug coverage** apply to the number of medicines in a formulary—not the cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.

- **Plans have no incentive to cover combination therapies and extended release medicines under the federal counting rules.** These medicines play an important role in patients sticking to and benefiting from the treatments they need.

- **There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit**—these medicines often treat serious conditions such as cancer and neurologic diseases.

- **The addition of newly approved medicines to formularies mid-year is not required.**

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2 42 U.S.C. § 18022(b)(2).

3 Kaiser/HRET 2013.

4 Exchange data is based on Avalere analysis of the HHS landscape file silver plans; Average for U.S. is based on Avalere analysis of Idaho, New Mexico, and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2013.

5 Avalere March 2014 analysis of HHS Landscape File.

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