NEW YORK'S 2016 EXCHANGE PLANS

Improving Exchange Coverage in New York

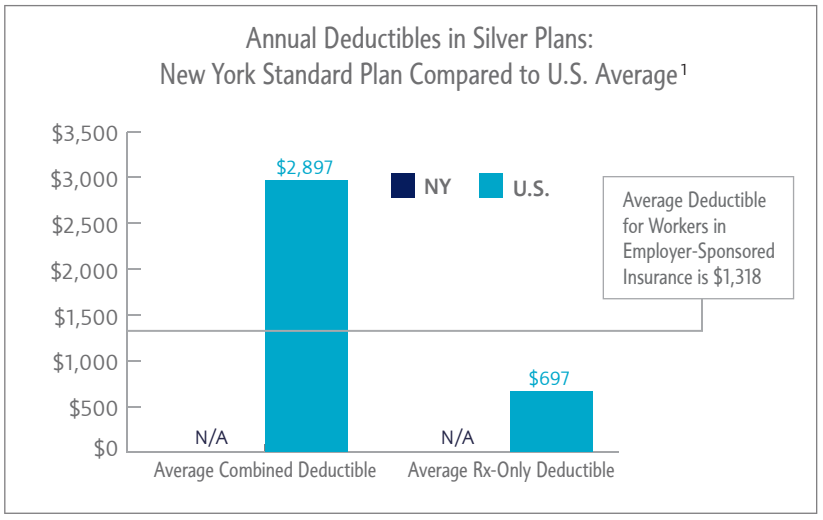
New York's state-based exchange is responsible for the operation of all core exchange functions. State regulators are charged with reviewing health insurance plans offered on the state-based exchange to ensure compliance with important consumer protections. Under this broad authority, the exchange should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

- Enforcing non-discrimination requirements, which apply to benefit design and provider networks; 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 2016 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.
- In New York, all standard silver plans require copays for preferred brand drugs and those copays are $35.[3]
- Patients under 250% of the federal poverty level (about $30,000 for an individual) may qualify for cost sharing subsidies that reduce their out-of-pocket costs for Silver plans.

Prescription Drug Coverage in New York 2016

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 governing 2016 plans covers 85% of medicines that were available when the benchmarks were originally selected. Starting in 2017, plans will have to meet a new benchmark that covers 93% of drugs that were available when these benchmarks were selected.[4] 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 current 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 count-based standards related to the number of medicines a plan must cover do not extend to 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.
- Federal counting rules do not provide an incentive to cover combination therapies and extended release medicines.[5] 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.

Based on an analysis of actual 2016 exchange plan formulary information in New York, the following key findings are of particular importance to New York residents:[6]

An average of **78%** of brand medicines are covered across a range of key drug classes in the New York exchange. The national average is **82%** of brand medicines covered in exchange plans.

An average of **0%** of plans in the New York exchange placed all of their drugs in at least one class on the specialty tier. The national average is **80%**. The conditions most likely to be subject to this type of formulary design are cancer, MS and HIV/AIDS.

An average of **12%** of brand drugs have a coinsurance of 30% or higher in the New York exchange, compared to a national average of **27%** of brand drugs having coinsurance of 30% or higher.

1 Analysis by Avalere of silver plans included in the HHS landscape file and collected from all state based exchanges; Average for U.S. is based on Avalere analysis of California, Nevada, New Mexico, New York, Oregon, Hawaii 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, 2015.
2 Kaiser/HRET 2015.
3 Analysis by Avalere of benefit designs for standard silver plans in the state.
4 Analysis by Avalere of total chemical entity submission counts by USP class covered by 2017 Essential Health Benefits (EHB) Benchmark Plans, https://www.cms.gov/cciio/resources/data-resources/ehb.html.
5 P&T requirement starting in 2017 could add additional protections for patients taking these drugs.
6 Analysis by Avalere Health of single-source brand medicines (medicines without a generic alternative on the market) across 22 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C; based on data collected by Managed Markets Insight & Technology, LLC.

Analytics by Avalere Health. Developed by PhRMA.