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“The President’s Health Care Law Does Not Equal Health Care Access”

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Americans who sign up for insurance under the Affordable Care Act are finding many of these plans offer very narrow options when it comes to their choice of doctors and drugs.

Some observers argue the insurance business tactics resulting in these narrow benefits are not unique to the ACA plans. But this isn't entirely true.

The rules embedded in the ACA made these very restrictive drug formularies and narrow provider networks almost inevitable, and certainly far more prevalent. It popularized these approaches, and made them politically acceptable. I want to briefly highlight some of the reasons why I believe these outcomes were made inescapable by the way that the rules were crafted under the ACA. I want to briefly describe how these restrictive drug plans and provider networks are taking shape and affecting patients. Finally, I want to make some recommendations on how we can reform the ACA and unwind some of these challenges.

Why did many of the health plans end up with very restrictive networks of doctors, and narrow drug formularies that leave patients exposed to significant out of pocket costs? Simply put, the health plans had to offer full coverage for what were – in many cases -- new and costly mandated benefits, like mental health parity and first-dollar coverage for preventive benefits recommended by the United States Preventive Services Task Force. I don't want to debate the merits of these benefits. There are clearly patients who will benefit substantially from access to these mandated services. But these federally mandated benefits – on top of all of the state insurance mandates that were grandfathered into the exchange-based health plans -- come at a big economic cost. In many cases, that cost was compensated for by skimping when it came to the design of provider networks and the drug formularies.

That's because the mandated benefits were coupled with rules that barred insurers from using many of the traditional tools they employ as a way to manage costs. For example, the health plans couldn't price the coverage to risk, or make full use of co-pays as a way to manage utilization. The major contours of the benefit design were largely established by federal regulation. Premium increases are also tightly controlled. But the health plans were given wide latitude to narrow their provider networks and drug formularies as a way to manage cost and utilization. So the plans made aggressive use of this one allowable tool. It's worth noting that proponents of the ACA who were close to the drafting of the regulations, publicly anticipated that plans would use narrow networks as a way to control costs.

While narrow networks aren't unique to the Affordable Care Act (in 2007, 15% of employer plans had narrow networks) these constructs are far more prevalent in the ACA. The frequency, and indeed, acceptance of these narrow provider networks and restrictive drug formularies matters not only for plans sold in the exchanges, but also health plans offered in other markets. In many respects, the political concessions that were made inside the Affordable Care Act -- to exchange broader access to doctors and drugs in favor of other mandated benefits -- will enable these same constructs to take hold in non-ACA insurance markets. The last time that the commercial insurance industry tried to popularize these restrictive provider networks and closed drug formularies, was in the 1990s with the advent of closed HMOs. It led to a backlash that ultimately culminated in the introduction of the Patients Bill of Rights.¹ Not this time. Narrow networks and drug formularies have been rendered politically acceptable as a result of the concessions made in the ACA. As a result, we will start to see these same approaches become far more prevalent in the commercial

insurance market, and even Medicare. Once established in the ACA, insurers will start to use the same formularies and networks to service many of their other lines of business.

Making Narrow Networks Fashionable

That is the lesson from other government programs, where approaches taken as a cost-saving compromise inside one federal health program were eventually adopted market-wide. For example, prior to the creation of the Medicare Part D drug benefit, in 2000, no drug plans had a “specialty” tier for higher-cost, specialty drugs. In 2004, the year Part D was implemented, 3% of private health plans had a specialty tier. The Part D regulations issued by the Centers for Medicare and Medicaid Services adopted this construct. The rules allowed Medicare drug plans to use this fourth drug tier as a way to control their drug spending. Once Part D made this then-novel construct politically acceptable, commercial drug plans started to adopt the same approach across all of their lines of business. By 2013, fully a quarter of drug plans had a fourth or “specialty” tier in their drug plans.

The construction of the exchanges also made it easier for insurers to fashion these restrictive networks and formularies. For example, the ACA allows health plans to bid for consumers on a county-by-county basis. That has led to the creation of networks that are sometimes only countywide. They comprise doctors that are only located only within a narrow, countywide geographic area. These extremely narrow networks are being referred to as “Exclusive Provider Organizations” or EPOs. Since many plans have limited co-insurance outside of their networks (sometimes drugs also aren’t covered if they are prescribed by a non-network provider) patients who seek care outside of these narrow provider networks can be saddled with high costs. Under many plans, when patients are out of their networks, these costs don’t count against deductibles or out of pocket maximums.

This can apply equally for all consumers, regardless of their income, level of subsidies, or whether they are eligible for cost sharing subsidies. The benefit designs are typically consistent across the different metal plans. When consumers are eligible for bigger subsidies to offset their deductibles, or to lower out of pocket limits, they are still getting the same basic benefit design. If the plan doesn’t provide adequate co-insurance (or any coverage at all) outside of a narrow network of providers or a closed drug formulary, then consumers will be saddled with the full costs of their choices whether the plan is bronze or gold.

So far, the restrictive benefits have been more obvious when it comes to providers, in part because the plans are relatively new, and consumers have not maxed out deductibles or tried to tap the drug benefits in big numbers. While the narrow provider networks have been widely discussed, I want to first focus on the drug plans, and new data that we developed that illustrates some of the hardships certain consumers might confront.

The Example of Multiple Sclerosis and Rheumatoid Arthritis

To get a snapshot of how restrictive the drug formularies are, and the impact that this could have on patients, we looked at drugs in two different disease areas – rheumatoid arthritis and multiple sclerosis. We chose to look at these diseases because patients with these conditions often require chronic therapy. Moreover, in recent years, the treatment of each of these diseases has also benefited substantially from the introduction of highly effective therapies.

But many of these new drugs are also very costly. If patients lack adequate drug coverage, they can be saddled with substantial costs. Finally, for each of these diseases (and especially for MS) if patients are controlled on a particular medicine, there is a great reluctance to switch them off their current drug regimen for fear that their disease could flare. The question is whether health plans offered in the ACA are meeting the needs of these patients.

The results are discouraging. Take the example of multiple sclerosis. We looked at lower cost silver health plans offered in 10 different states. For each state, we selected the most populous county in order to maximize the likelihood that we would find competitively priced insurance plans. We chose silver plans because of the availability of cost sharing subsidies (to offset the out of pocket costs) for consumers who select these options. It is my view that the availability of these cost-sharing subsidies often makes the silver plan the best choice for a consumer shopping for coverage under the ACA.ⁱⁱ We then looked at how the plans covered ten drugs that are widely prescribed for patients suffering from MS.

None of the plans provided coverage for all of the drugs. None of these plans covered these drugs without significant cost sharing that would burden the patients with thousands of dollars of out of pocket expenses, even after they had exhausted their deductible. One plan provided partial coverage for eight of these medicines, four plans partially covered seven of the drugs, three plans provided partial coverage for six of the ten drugs, one plan only covered five, and a final plan only provided partial coverage for three of these medicines.

The challenge for consumers is that the co-pay structure, and the caps on out of pocket spending, often only applies to costs incurred on drugs that are included on a plan's drug formulary. This is the list of medicines that the health plans have agreed to provide some coverage for. If the drug isn't on this formulary, then a patient could be responsible for its full cost (with little or no co-insurance to help offset that cost). Most of the plans offered under the ACA have "closed" formularies where non-formulary drugs aren't covered.

For costly specialty drugs, this can add up to substantial annual costs. Right now, the use of closed formularies is far more prevalent in the ACA than they are in the existing commercial market. The vast majority of ACA carriers also use similar formularies across their different metal tiers and network type within a given state. So by "buying up" to a higher metal, consumers are not getting a better benefit package in the form of a more inclusive drug formulary. In most cases, consumers are just paying higher premiums to buy down co-pays and deductible. It's worth noting that earlier this year, Express Scripts announced that it intended to remove several drugs for the treatment of Rheumatoid Arthritis from its national formulary. This could be interpreted as another example of constructs that have been rendered political palatable, if not appropriate by the ACA starting to seep into other insurance markets. In the 1990s there was a widespread movement away from closed formularies to tiered formularies that reduced restrictions. In many respects, the ACA has re-embraced and popularized the concept of the closed formulary.

So how does this translate into the actual costs that consumers will face if they need a particular medicine for the treatment of multiple sclerosis. To provide an estimate of what the actual costs could be to some patients, we used the retail prices of these medicines listed on the Walmart pharmacy. We chose this price list because it represented one of the lowest cost retail prices available in the public domain. Some of these drugs are dosed by weight, or

dosed on different intervals depending on a patient's severity of symptoms. In these cases, monthly and annual costs were a rough approximation, imputed off an assumption around the proper dosing for a conservatively managed, 70kg patient. We used the terms of the health plan to estimate what the cost for a one month supply of medication would be if the drug was not included on a plan's formulary list. Most formularies were missing at least some key drugs. We focused on cases where a closed formulary excluded a drug. In most of these situations, the patient would be expected to pick up the entire cost of the drug. In most cases, that spending would not count against a person's deductible or out-of-pocket limits.

We didn't focus on cases where the drugs were included on formularies. But it's worth noting that in almost all of these cases, under the contract terms, patients were exposed to significant co-insurance costs if they were prescribed one of these drugs. It's probably reasonable to assume that patients prescribed any one of these drugs would end up reaching their out of pocket limits, even in cases where the medicines were included on the formulary.

Among our findings related to the drugs that were not included on drug formularies: The multiple sclerosis drug Aubagio wasn't included on the closed formularies of two of the ten silver plans that we examined. That means that patients on these plans could have to pay the full \$4,420 monthly retail cost of this medicine. That comes out to about \$53,000 annually. Avonex wasn't included on the formularies of two of the ten plans, potentially saddling patients with the drug's \$4,805 monthly cost (\$57,660 annually). Extavia (Interferon beta 1b) wasn't included on two of the ten closed formularies, at a monthly cost of \$4,625 (\$55,500 annually). Tecfidera wasn't included on the formularies of six of the ten plans at a monthly cost to patients of \$5,209 (at a total cost of \$62,508 annually).

We found similar findings when it came to drugs targeted to the treatment of rheumatoid arthritis. The RA drug Xeljanz wasn't included on the closed formularies of four of the ten silver plans we examined (with a monthly cost to the patient of \$2,485, or \$29,820 annually); Orencia wasn't included on the formulary of two plans (monthly cost of \$2,673 or \$32,076 annually); Kineret wasn't included in two plans (monthly cost \$2,978 or \$35,736 annually); Remicade was left off the formulary of three plans (about \$3,592 for a two-month supply for a 70kg patient, or \$21,552 annually); Rituxan was left off of six plans (a course of therapy will cost about \$2,868); Actemra was left off four plans (about \$1,555 every two weeks for a bi-weekly course of therapy, or \$37,320 annually); and Simponi was left off two plans (at a cost of about \$2,867 for a one-month 50mg supply for a 70kg patient, or \$34,404 annually).

The high cost of developing innovative medicines, which translates into high retail prices for these medicines, is no doubt a challenge for our healthcare system. But for diseases like MS, the unwillingness to cover these costs is not easily understood. The number of patients with these diseases is well defined. Insurance companies can develop actuarial models to predict these costs with precision. Moreover, the cost of disease progression, and the ensuing disability, can far outweigh the cost of effective management with some of these new medicines. One would hope that an insurance scheme would provide comprehensive and deep coverage for rare and debilitating diseases like MS. Yet these plans seem to be tightening up their rules and their coverage precisely for these kinds of dreadful ailments.

In response to these drug formulary issues, and the potential for important drugs to remain completely uncovered, staff at the Centers for Medicare and Medicaid Services (CMS) is

arguing that patients will have the option to appeal formulary decisions — to try and compel a health plan to cover a given drug. But this appeals process can take months. And there is no sure chance of winning. If a drug costs tens of thousands of dollars a year, how many patients will be able to foot that bill out of pocket until they win an appeal? Or take the chance that they could lose the appeal, and be stuck with the full cost of the medication?

These findings have been replicated by other analyses. One study by Avalere Health of 22 carriers in six states looked at the benchmark plans that the ACA coverage would be tied to. It found that the numbers of drugs listed as available on formularies ranged from about 480 to nearly 1,110. Even if your drug makes it onto the ACA plan's formulary, getting access to a medicine can still be a costly affair for patients. In the same study, researchers found that 90% of the lowest-cost bronze plans require patients to pay 40% (on average) for drugs in tiers 3 and 4, compared with 29% co-pays in current commercial plans. Most of the Obamacare silver plans also require patients to pay 40% for the highest-tier drugs.

Another analysis by Avalere, released this week, looked at 123 formularies from different exchange-based plans. It found that more than one-fifth of silver plans require co-insurance of 40% or more for drugs in one of seven different classes that the authors examined (HIV/AIDS, mental health, oncology, diabetes, rheumatoid arthritis, and asthma). The anticipated out of pocket costs were generally greatest when it came to costlier medicines used to treat cancer or chronic diseases like multiple sclerosis. The analysis found that more than 60% of plans placed all of their covered molecularly targeted oncology drugs, their anti-angiogenic oncology drugs (like Avastin), and their drugs for multiple sclerosis in their highest tier, requiring the greatest amount of out of pocket spending by patients. For MS, 50% of plans required co-insurance of 30% or more. In about 30% of cases, the plans provided no coverage at all for an MS drug, which is consistent with our findings.ⁱⁱⁱ

Restricting Access to Providers

The same challenges are being seen when it comes to the networks of doctors that the health plans offer. More than two-thirds of health plans on the exchanges have assembled provider networks considered “narrow” or “ultra-narrow,” in which as many as 70% of hospitals and other local health providers aren't included (according to a recent study by the consulting firm McKinsey & Co.) Earlier this year, we released similar analysis on these networks. We looked at health plans offered by BlueCross, BlueShield. We focused on a BCBS PPO for six specialist provider categories, and looked at the plans being sold in each state's largest county. We consistently found that exchange plans offered just a fraction of the specialists available in the PPO plan offered by the same carrier and offered in the same region.

Even in cases where plans offer choice among a larger complement of providers, the networks are still granting their exchange plan enrollees access to just a fraction of the providers available in their commercial plans. Statewide in California, Blue Shield of California reports that its exchange customers will be restricted to about 50 percent of its regular physician network offered in its commercial plans. This seems fairly consistent across different plans and different markets. Some plans appear to offer much less. The lack of contracted providers may strain the ability of patients to get non-urgent appointments.

Moreover, it's now been well documented that specialty hospitals like cancer centers and academic medical centers are being excluded from these networks. This is largely because these top tier institutions – which often deliver the highest levels of care – are nonetheless seen as too costly. For routine health matters, this may be of less concern. But if patients develop serious conditions that require expert attention, the out-of-pocket cost of going “out of network” to seek care at a specialty institution is likely to be prohibitively expensive.

These narrow provider networks lower costs, and in that way, help accommodate the other expensive but more routine benefits mandated by the law. Across various markets analyzed by McKinsey, the median increase in the premium for the same product type (e.g. HMO, PPO) offered by the same carrier, in the same metal tier, but utilizing a broad versus narrow hospital network, is 26%. In other words, when a carrier offered a product with both a narrow and an expanded network, the narrow network made the same basic benefit package 26% cheaper than if the same benefits were offered under a plan with a broader network. The same held true when it came to access to hospitals. Plans that offered access to academic medical centers had insurance costs that were 10% higher on average ^{iv}

Reforming Access to Drugs and Doctors

In the 1990s, consumers firmly rejected the idea of very restrictive health plans when they spurned HMOs in favor of PPOs that offered wider choice, but in some cases reduced benefits. In short, consumers showed through their collective choices that they were willing to trade the first dollar coverage that HMOs offered for a lot of routine care, in favor of greater choice and flexibility when it came to their formularies and networks. Yet the structure of the ACA is premised on a view that consumers were making a bad trade when they showed this widespread preference for PPOs over HMOs. The ACA effectively codifies the HMO model into law – forcing consumers into restrictive networks and formularies as a way to offset the costs of the mandated benefits that ACA plans must offer.

The most meaningful change that Congress could make to the ACA is to curtail this forced migration into HMO style plans, and enable consumers to have a wider set of options. Congress could allow a wider choice in the state-based exchange; to provide consumers a greater choice of PPO style plans. Consumers could select plans with wider formularies and networks in lieu of the benefits that are mandated by the ACA. Congress could reform the ACA by allowing any health plan that previously met state eligibility (prior to the ACA) to be offered on the ACA exchanges and eligible for the cost-sharing subsidies. This would allow a much wider selection of plans that make different tradeoffs between benefit design and networks. For consumers who want more flexible provider networks and broader drug formularies, they would have a greater selection of plans that embodied these constructs.

For now, consumers need to be vigilant when they buy coverage on the exchange. The terms of coverage can be convoluted despite steps to simplify their presentation. Many consumers will be unaware, for example, that their drugs are not covered unless prescribed by an in-network doctor. They may not know that drug co-insurance sometimes doesn't count against their out-of-pocket limits. They won't be aware that drugs that aren't included in a closed formulary may be completely uncovered by the plan. Moreover, in these cases, the money that consumers spend will not count against deductibles and out-of-pocket limits. The ACA could benefit from rules that require greater transparency around these terms. To

these ends, there is activity in the states that bears watching. In California, proposed legislation (SB 1052) would require a health plan to post its formularies on its Internet and include easy-to-understand details on how much each drug will end up costing patients.

The restrictive networks and formularies are an unfortunate consequence of the way that the ACA structured the exchanges. It is within Congress' power to fix these rules.

ⁱ McCain-Edwards-Kennedy Patients' Bill of Rights S.1052 2001

ⁱⁱ Scott Gottlieb. In Obamacare, Go For Bronze Health Plans -- Buying Platinum Is Often A Waste Of Money. January 24, 2014.

<http://www.forbes.com/sites/scottgottlieb/2014/01/24/in-obamacare-go-for-bronze-for-most-consumers-buying-up-to-gold-or-platinum-plans-may-be-waste-of-money/>

ⁱⁱⁱ Source: Avalere Health PlanScape, data as of October 31, 2013

^{iv} McKinsey Center for U.S. Health System Reform. Hospital Networks: Configurations on the Exchanges and their Impact on Premiums. McKinsey & Co. December 14, 2013