HIV+HEP
POLICY INSTITUTE

January 10, 2023

Dr. Ellen Montz
Deputy Administrator and Director
Center for Consumer Information & Insurance Oversight
U.S. Department of Health and Human Services (HHS)
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Comments on 2024 Draft Letter to Issuers in the Federally-facilitated Exchanges

Dear Dr. Montz:

The **HIV+Hepatitis Policy Institute**, a leading national HIV and hepatitis policy organization promoting quality and affordable healthcare for people living with or at risk of HIV, hepatitis, and other serious and chronic health conditions, is pleased to offer comments on the 2024 Draft Letter to Issuers in the Federally-facilitated Exchanges. Since we will be commenting on the Notice of Benefits and Payment Parameters for 2024 proposed rule, these comments pertain to issues addressed only in the 2024 Draft Letter. Below are our comments presented in the order the subject appears in the Draft Letter.

Chapter 1, Section 9: Standardized Plan Options

Since issuers have had to cover PrEP to prevent HIV due to ACA coverage and cost-sharing requirements of USPSTF Grade "A" and "B" preventive services, the **HIV+Hepatitis Policy Institute** has been examining formularies by various issuers for PrEP drugs. We have noticed that there are no standards among the issuers, which creates vast confusion for beneficiaries. Some issuers place all preventive drugs on the lowest tier, others on the highest. Some place PrEP on higher tiers and denote that there is no cost-sharing through footnotes or opaque abbreviations. Zero cost-sharing for preventive drugs should be clear to beneficiaries and standardized among all issuers.

In the 2024 Draft Letter, CCIIO is requiring issuers to place all Zero Cost Share Preventive Drugs on Tier 1. While we support consistency and standardization of preventive drugs, we also believe that this perpetuates confusion since we assume Tier 1 would also still include generic drugs, which for almost all metal levels include patient cost-sharing. As an alternative, we recommend that preventive drugs form a separate first tier in standardized plans.

Chapter 2, Section 11: Prescription Drugs

The **HIV+Hepatitis Policy Institute** is very pleased that "CMS will begin conducting an adverse tiering review as part of the non-discrimination formulary cost share review," and specifically will be reviewing medications used for HIV and hepatitis C.

We continue to witness issuers that place all or almost all HIV or hepatitis C drugs on the highest tier. We agree with you that this discourages enrollment by individuals in these plans and is a violation of the ACA non-discrimination and EHB laws and regulations. Just last month, we filed a discrimination complaint against North Carolina Blue Cross Blue Shield for placing almost all HIV drugs, including

generics, on the highest tiers. We have evidence of this occurring by other plans in other states.

While we applaud CMS for moving forward with these adverse tiering reviews for plan year 2024, we do not understand why they have not been conducted in the past by both CCIIO and individual state regulators as part of the plan review and approval process. The issue is not a new one, nor are the CCIIO requirements. People with HIV, hepatitis C, and others who rely on prescription drugs are being subjected to these discriminatory practices now and the law and regulations should be enforced now. If states do not have the resources to fully review the plans, CCIIO should provide them with the tools and the reviews to aid them in the process.

In the review of adverse tiering of HIV medications, we assume that CCIIO will be including all HIV drugs--not just those that are used for treatment but for prevention as well.

Chapter 2, Section 12: Third Party Payment of Premiums & Cost Sharing

HIV+Hep is disappointed that CMS continues to allow insurers to collect copay assistance for prescription drugs that are intended for beneficiaries. We believe that continuing to allow this practice is in violation of the ACA and its implementing regulations. Further, it is harming patients by forcing them to pay more for their prescription medications and allowing insurers to collect more money than they are entitled to. We will provide additional comments as part of our comments on the **draft 2024 NBPP proposed rule.**

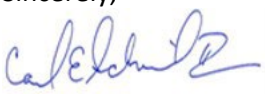
Chapter 3: Consumer Tools and Public Information

We remain deeply disappointed that CMS continues to allow copay accumulators and maximizers to proliferate. Since they have a direct and meaningful impact on beneficiary cost-sharing and their access to prescription medications, we strongly urge CMS to require issuers to be transparent in their treatment of copay assistance policies. Almost all plans bury this information in lengthy plan documents that are difficult to access, while some do not even make their policies public. We believe CMS should require plans to include this information as part of the "Summary of Benefits and Coverage" documents.

According to recent data released from IQVIA, in 2021, 43 percent of covered lives in commercial plans were in plans that have implemented accumulators, while 45 percent were in plans that have implemented maximizers. Given this unfortunate wide proliferation, it is imperative that beneficiaries know up front of these hidden costs and select their plans appropriately.

Thank you for the opportunity to provide these comments. Should you have any questions or comments please feel free to contact me at cschmid@hivhep.org Thank you very much.

Sincerely,



Carl E. Schmid II
Executive Director

cc: Jeff Wu, Deputy Director for Policy