

HEPATITIS B FOUNDATION

HEALTH INSURANCE COSTS IMPACTING SHOPPERS LIVING WITH HEPATITIS B

A REPORT ON HEALTH INSURANCE TRENDS IN
THE UNITED STATES THAT MAY INCREASE THE
COST OF HEPATITIS B TREATMENTS

INTRODUCTION

People living with chronic hepatitis B virus infection face numerous challenges, from finding a good doctor to monitoring their health. Sadly, many people with hepatitis B also face high out of pocket costs for their medication, even when they have health insurance. Some of these high costs are due to the way that their health insurance companies require cost sharing. Fortunately, by being savvy shoppers, people living with hepatitis B can find health insurance plans that reduce their chances of facing high out of pocket spending.

Since 1991, the Hepatitis B Foundation (HBF) has advocated for the health and well-being of people living with hepatitis B, a viral infection that can lead to liver damage or cancer. As a trusted global authority on hepatitis B, HBF works with patients, family members and health care providers to provide comprehensive information on the virus. Through our outreach staff, we have heard many stories of individuals who have not been able to afford their hepatitis B medication, despite having health insurance. Therefore, we have written this report to help people shopping through Affordable Care Act (ACA) marketplaces make decisions about what insurance options might be right for them.

This report focuses on the costs of the first-line treatments for hepatitis B: Viread (and its generic, tenofovir disoproxil fumarate), Baraclude (and its generic, entecavir), and Vemlidy (which lacks a generic). These are considered to be the most effective treatment options for someone with chronic hepatitis B. Generic drugs are the same medication but not sold under the brand name. For many patients, they are not interchangeable, with one treatment working more effectively than others. In order to avoid the adverse health consequences of the virus, someone taking these treatments will need to take them regularly. Skipping doses because of cost can have severe impacts on a person's health.

Out of pocket costs for drugs vary significantly among health insurance companies. Depending on the plan a shopper selects, they may pay hundreds or thousands of dollars a year for their medication. This report helps shoppers identify what type of plans they may want to avoid if they are seeking to reduce these costs. It identifies terms such as “deductibles”, “formulary” and “tiering”. Understanding them can help avoid high out of pocket costs for someone with hepatitis B.

Note: The Hepatitis B Foundation is providing this information as a tool for health insurance shoppers with hepatitis B. However, there are many decisions that go into selecting a plan, such as income, family circumstances and other medical conditions. This report solely focuses on costs and coverage of hepatitis B drugs on silver level health plans that are approved under the Affordable Care Act for shoppers buying insurance for themselves and their family. Shoppers buying plans that are not qualified under the Affordable Care Act, such as short-term limited-duration insurance or Association Health Plans, may have less expensive premiums but may not cover any of their costs for hepatitis B. However, the information in this report should be in no way taken as advice about what health insurance someone should finally buy. Those decisions should be made by the shopper and trusted advisors.

METHODOLOGY

To describe practices in health insurance design that might lead to high costs for people living with hepatitis B, the Hepatitis B Foundation undertook a review of silver-level qualified health plans offered on the health insurance marketplace created through the Affordable Care Act. We reviewed the formularies for 284 different health insurance plans in 14 states in 2019 and 10 states in 2020. This sampling is not a fully representative overview of what an average formulary in the United States might look like. The conclusions should not be taken as quantifiable statements of trends, though the states were chosen to have geographic, population size and political diversity, and included states with some of the largest rates of people living with chronic hepatitis B.

The states reviewed were: Arizona, California, Delaware, Florida, Georgia, Hawaii, Illinois, Minnesota, New Jersey, New York, Pennsylvania, Texas, Virginia and Washington.

For each plan, HBF identified relevant insurance design structures, such as the deductible and cost sharing for prescription medication, as well as the formulary design and placement of common drugs taken by people living with hepatitis B in the formulary.

HBF, for use in describing the potential out of pocket costs of different types of health insurance, also examined the average costs for the first-line treatments, using the website GoodRx. According to GoodRx, as of July 2020, the average retail price for a month's supply of Viread is \$1,581 (\$965 for the generic), \$1,923 for Baraclude (\$930 for the generic), and \$1,623 for Vemlidy.

HOW DIFFERENT TYPES OF HEALTH INSURANCE CHARGES IMPACT OUT OF POCKET COSTS

When buying health insurance, persons living with hepatitis B may want avoid plans that could lead to high out of pocket costs due to the medication they are taking. Particularly if they have regular, predictable medical costs, shoppers can determine what types of plans may lead to very high costs by being aware of different ways their health insurance company will require them to pay for coverage and care.

When someone buys health insurance, they may have to pay for their care in different ways. Under the Affordable Care Act, someone shopping on the health insurance marketplace may get assistance paying their monthly **premium**, the regular payment they agree to make to their health insurance company in exchange for coverage.

Many health insurance plans also require their customers to pay a yearly **deductible**. This is a certain amount that the person agrees to pay, out of pocket, for their medical care before the health insurance company will pay for their care. There are exceptions, such as an annual physical or wellness exam where the health insurance company will pay the full costs even if someone has not yet met their deductible. Some health insurance companies may have a **separate deductible for medications**.

Health insurance companies typically also require **cost sharing** when their customers use medical care. Like with deductibles, there are exceptions for care that helps someone avoid getting sick, like the annual physical. Cost sharing may be in the form of a **co-pay**, a set dollar amount per use of health care (like \$20), or **co-insurance**, a percent of the cost of the health care used (like 10%). Some people with lower incomes may receive help with cost sharing through the Affordable Care Act Marketplace.

A person's out of pocket costs may change depending on the medication they buy. Health insurance companies create a drug **formulary** that lists the medications that are covered by the plan and states how much their customers will pay out of pocket for medications. Formularies have **tiers**, which are groups of drugs in the formulary. Each group usually has different cost sharing. Many plans will have four tiers, with Tier 1 being the cheapest and Tier 4 being the most expensive, but some plans will have more. In the analysis, the HBF found plans with up to seven tiers.

Formulary information can be found while viewing plan options on the Affordable Care Act's marketplace. Depending on the health insurance company or the marketplace website (which varies by state), the shopper may have to first read about the drug tiers for the plan and then look up whether their specific medication is covered and if so, under what tier.

Lower tiers will typically have lower cost sharing. For example, in most plans, Tier 1 is reserved for preferred generic drugs and will have a small copay.

Tier 4 or 5 are typically for "specialty drugs" and may have a high coinsurance, such as 50%. However, some plans have coinsurance on all tiers of their formulary, meaning even tier 1 drugs may become expensive.

The Chén Family Shops for a Health Insurance Plan

The Chén family lives in Texas. The family consists of Xià, her husband Li, her mother, Jìng and their child, Vivian. Xià has chronic hepatitis B, and between that condition and her family's other medical costs, they spend a lot every year on health care. It is open enrollment, which is the time each year when someone can sign up for or change health insurance under the ACA. Xià is looking at her family's health insurance options. Their income qualifies the family for reduced premiums on the ACA marketplace.

Xià is looking at two plans. Plan A, would cost \$600 a month in premiums, meaning an annual cost of \$7,200, and has a deductible of \$12,000. Plan B would cost \$800 a month meaning an annual cost of \$9,600 with a \$5,900 deductible. While Plan A was appealing at first because of the lower annual premiums, she expects her family will spend a lot of money on health care this year, so Xià eliminates it due to the high deductible and takes a closer look at plan B.

Formularies may tell you what the limits are on how drugs will be covered. Particularly for hepatitis B drugs, they may state limits on prescriptions, such as:

- **Prior Authorization** – The doctor recommending the medication must get approval from the insurance company before they will cover payment for it. In certain plans, even generic treatments may require prior authorization.
- **Step Therapy** – Before the company will cover a medication, they require the person to try a different type of drug to treat the condition first. For example, a company may require a person try Viread before covering Vemlidy.
- **Quantity Limits** – The company will only cover a certain number of pills or doses at one time.

A health insurance plan's formulary will note when prior authorization, step therapy or quantity limits are required for a medication. The company may also require their customers to shop at specific in-network pharmacies and will not pay for medication bought from other pharmacies. This means you might have to change the pharmacy you use for your hepatitis B medications.

Things to Consider:
Shoppers should note that while pharmaceutical companies and patient assistance organizations have programs to lower drug costs, they are not available to everyone, may be time limited or may not be allowed by the insurance company for certain drugs. They should not be counted on when determining what health insurance to buy.

People living with hepatitis B should be aware of how their plan's **premiums, deductible, cost sharing, and formulary** could lead to high out of pocket costs. In addition, they should be aware that plans also have an **out of pocket maximum**, at least \$8,150 for an individual and \$16,300 for a family in 2020, after which deductibles and cost sharing are no longer required for in-network coverage.

TRENDS IN HEALTH INSURANCE PLANS THAT MAY LEAD TO HIGH COSTS FOR PEOPLE LIVING WITH HEPATITIS B

High Deductibles:

Many plans analyzed by the Hepatitis B Foundation had **very high deductibles**, some as high as \$14,000 for the year. This means that someone taking a first-line treatment such as Viread (tenofovir) or Baraclude (entecavir), which retails for over \$1,500 for a 30 day supply (or \$1,000 for generic), could easily spend that \$14,000 out of pocket for a year for their medication before their health insurance company will begin paying for a portion of the costs. Instead, shoppers may want to consider paying higher monthly premiums in exchange for lower deductibles, overall ending up with lower out of pocket medical costs during the course of the year.

Xià Searches for a Health Insurance Plan that Covers Her Hepatitis B Medication

The Chén family is digging deeper into their health insurance options and found a plan that has a deductible and premiums that meet their budget. However, they know it is important to look at the drug coverage details because of Xià's hepatitis B. Her doctor has prescribed her Baraclude, which she takes daily. When Xià looks at the formulary, she sees that the insurance plan has placed Baraclude on Tier 4, requiring a 50% coinsurance payment even after they meet the deductible, which amounts to about an extra \$1,000 a month for her medication. This makes the plan much less affordable than it seemed. She keeps looking and finds a plan that places Baraclude in a lower tier.

Plans Restricting Hepatitis B Drugs:

In its analysis, the Hepatitis B Foundation found many plans that required quantity limits, step therapy or prior authorization for hepatitis B drugs. People with hepatitis B who have found that other drugs do not work for them may want to avoid plans with step therapy while those who have difficulty getting to a pharmacy may want to avoid plans with quantity limits.

Generic Drugs on High Tiers:

Generic drugs are intended to provide a lower cost solution to brand names. Yet a majority of the plans studied by the Hepatitis B Foundation placed generic hepatitis B medications in a tier requiring significant cost sharing, such as having a high coinsurance. A large portion of plans even placed generic drugs in the same tier as their brand name alternatives, or even in a higher tier. The impact on out of pocket costs of having generics on the same tier as brands depends on whether there is coinsurance or copays for the tier. Consider Viread and its generic, tenofovir disoproxil fumarate, as an example. If placed on a tier with 10% coinsurance after deductible, someone's cost would be \$158

for a 30-day supply of Viread and \$95 for tenofovir disoproxil fumarate. However, if they use co-pays, such as \$150, the cost would be the same for both.

High Cost Sharing for All Hepatitis B Drugs:

Some plans place all drugs for hepatitis B on a high tier, so that people living with hepatitis B will almost certainly have high out of pocket costs for their medication. This action could be viewed as an attempt by the insurance company to discourage people with hepatitis B from purchasing their insurance, something that is illegal under the Affordable Care Act. In its analysis of plans, the Hepatitis B Foundation found dozens of plans with all or most hepatitis B on high tiers. For a shopper, these plans are "buyer beware".

Not Covering Hepatitis B Drugs:

Most plans do not cover all drugs that someone with hepatitis B might take. In fact, most plans do not cover Vemlidy, the newest treatment for the virus and one that lacks a generic alternative. This is concerning, as Vemlidy is one of just three first-line treatments for hepatitis B. Some plans cover the first-line hepatitis B drugs but not in all their forms, such as covering the solution

version of Viread, but not its tablet form. Shoppers who may switch to a different drug in the future should check plans for coverage of not only the medication they are taking now, but also those that they may take in the future.

Shifting Drug Coverage Between Years:

Shoppers should be aware that just because their plan covered their drugs one year, the same coverage is not guaranteed the next year. Several plans between 2019 and 2020, either dropped coverage for a hepatitis B drug or raised it to a higher tier with higher cost sharing. Before renewing their health insurance for a new year, shoppers should review the formulary for coverage and cost sharing changes.

Incomplete Formularies:

Some formularies were missing important information, such as whether brand name drugs or only the generic version were covered or what forms (such as solution or tablet) or dosages would be covered. In addition, while some drugs used to treat hepatitis B can be used for other conditions, the analysis found formularies showed coverage for a drug, but not whether it was covered for hepatitis B. Shoppers should call the insurance company and ask questions if anything in the formulary or plan details is not clear about what might be covered.

Only Covering Physical Pharmacies:

Some companies also do not provide mail order drug coverage for hepatitis B drugs on certain tiers, only covering them at pharmacy locations. Shoppers who need or prefer mail delivery of their medication should ensure this is not the case for their plan.

The Chén Family Switches to a More Affordable Plan for Hepatitis B Medication

The Chén family has been on health insurance for a year. Xià's doctor suggests that she switch from Baraclude to the generic entecavir to save her on costs. However, when Xià looks at her plan's formulary, she sees that entecavir is placed on a higher tier, with a higher level of cost sharing, than Baraclude. Luckily, it is open enrollment under the Affordable Care Act again. The Chén's find and switch to a different plan that has entecavir on a lower tier of drugs, saving them money.

CONCLUSION

Each year, during the Affordable Care Act open enrollment period, people living with hepatitis B have an opportunity to find health insurance that works for their family. Thanks to the law, insurance companies can no longer discriminate against people living with hepatitis B for having a pre-existing condition or charge them more in premiums. However, health insurance companies have found ways to use cost sharing systems to force people living with hepatitis B to pay more out of pocket. By using the warnings in this report, and the following checklist, health insurance shoppers can avoid these plans and find affordable options that cover their medication and health needs.

If you have questions about this report or its findings, please contact the Hepatitis B Foundation at info@hepb.org.

CHECKLIST FOR HEALTH INSURANCE SHOPPERS WITH HEPATITIS B

- What are my expected medical needs and costs this year?
- How do my expected medical costs compare to the deductible?
- Is there a separate deductible for medication?
- Are the medications I take covered by the plan's formulary?
- Are the doses and formulation I take covered?
- Does the plan require prior authorization, step therapy or dosage limits for my medication?
- Is medication I might take in the future covered by the plan?
- What tier of the formulary is my medication on? Does it require a co-pay or co-insurance?
- Between the deductible and cost sharing for a year's worth of my medication, what will my expected out of pocket costs be?

FINDING HELP

If you need help shopping for insurance, enrollment assistance programs are available. You can find them at www.localhelp.healthcare.gov

If you are concerned that a health insurance company is discriminating against you because of your hepatitis B, you may contact your state insurance commissioner. The National Association of Insurance Commissioners has a map here: <http://bit.ly/reporthebdiscrimination>

Use the Hepatitis B Foundation's resources to learn more about living with hepatitis B, including learning more about programs to help you afford your drug costs: <http://bit.ly/HBVPatientAssistance>

HEPATITIS B TREATMENTS AND THEIR AVERAGE RETAIL PRICE (2020)

The Hepatitis B Foundation has provided a summary of the average costs of hepatitis B medications that have been approved for use by the U.S. Food and Drug Administration.

The table depicts the high costs that many people living with hepatitis B may face if treatment is needed. Average retail prices are subject to change over time.

The average costs below are for a 30-day supply.

BRAND-NAME	AVERAGE BRAND-NAME RETAIL PRICE IN U.S.	GENERIC	AVG. GENERIC RETAIL PRICE IN U.S.
Viread* (antiviral)	\$1,586	tenofovir disoproxil fumarate*	\$957
Baraclude* (antiviral)	\$1,362	entecavir*	\$960
Vemlidy* (antiviral)	\$1,610	No Generic Exists	N/A
Epivir-HBV (antiviral)	No Information Available	lamivudine	\$422
Hepsera (antiviral)	No Information Available	adefovir dipivoxil	\$1,289
Pegasys (interferon)	\$8,100	No Generic Exists	N/A
Intron A (interferon)	No Information Available	No Generic Exists	N/A

Tyzeka, a hepatitis B medication that is approved by the FDA, is no longer manufactured.

* first-line treatment



A CLOSER LOOK: INSURANCE COMPANIES THAT EXHIBIT DISCRIMINATORY PRACTICES

Based upon an analysis of health insurance plans in the following states, the Hepatitis B Foundation has compiled a list of insurance companies that showed evidence of one or more of the discriminatory practices discussed in this report in 2019 or 2020. We encourage shoppers and policy makers to take a close look at hepatitis B treatments within these plans.

The complete analysis for each state can be found by clicking the state name.

Arizona

- Blue Cross Blue Shield
- Bright Health
- Ambetter from Complete Health
- Oscar Health

California

- Blue Shield of California
- Chinese Community Health Plan
- Kaiser Permanente
- LA Care Healthcare Plan
- Sharp Health
- Western Health Advantage
- Oscar Health
- Valley Health Plan

Delaware

- Highmark Blue Cross Blue Shield Delaware

Florida

- Ambetter
- Florida Blue HMO
- Health First
- Florida Health Care
- Oscar Insurance Company of Florida

Georgia

- Alliant Health
- Ambetter from Peach State Health Plan
- Anthem Blue Cross Blue Shield Healthcare Plan
- Kaiser Permanente of Georgia

Hawaii

- Kaiser Permente

Illinois

- Ambetter from Illinicare Health
- Cigna Healthcare

Minnesota

- Oscar Health
- Horizon Blue Cross Blue Shield

New Jersey

- Oscar Health
- Horizon Blue Cross Blue Shield

New York

- Capital District Physicians' Health Plan
- Fidelis Care
- BlueCross BlueShield of Western New York
- Oscar Health
- United Healthcare
- MetroPlus Health Plan
- Healthfirst

Pennsylvania

- Ambetter
- Highmark Choice Company
- Independence Blue Cross
- UPMC Health Plan

Texas

- Ambetter from Superior Health Plan
- Blue Cross Blue Shield of Texas
- Community Health Choice
- IdealCare by Sendero Health Plans
- Oscar Health

A CLOSER LOOK: INSURANCE COMPANIES THAT EXHIBIT DISCRIMINATORY PRACTICES

Virginia

- Anthem HealthKeepers
- Optima Health Plan
- Cigna Health & Life Insurance Company
- Kaiser Permanente
- CareFirst BlueChoice
- Virginia Premier HealthPlan
- Piedmont Community HealthCare HMO

Washington

- Coordinated Care by Ambetter
- BridgeSpan

