NASTAD’s 2019 ADAP Insurance Cost-Effectiveness Tool
November 2018

When an ADAP establishes an insurance purchase program, there are two key requirements outlined by the HRSA HIV/AIDS Bureau:

1) The insurance plan must include at least one drug in each class of core antiretroviral therapeutics from the HHS Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV; and

2) The cost of paying for health insurance coverage (through payment of a client’s premiums and cost sharing) must be less in the aggregate (across all insured clients) as compared to ADAP purchase of full-pay medications.¹

NASTAD’s 2019 ADAP Insurance Cost-Effectiveness Tool allows ADAPs to assess the relative cost-effectiveness of on and off-Marketplace plans, helping them to make the most cost-effective choice for their program. Because NASTAD’s tool only assesses on and off-Marketplace individual market plans, ADAP must still assess whether the insurance purchase program as a whole (inclusive of other forms of coverage, such as employer-sponsored insurance and Medicare plans) is cost-effective in the aggregate compared to full-pay purchase of medications.

How the Tool Works

What data is included in the tool?

NASTAD’s tool includes on and off-Marketplace individual market plan data for all 50 states and the District of Columbia. Plan data is obtained by NASTAD through a data-use agreement with Vericred, a healthcare data services company providing health plan design and formulary data for commercial plans. The tool does not include data on employer-sponsored coverage or Medicare plans. The tool allows ADAPs to compare the following across plans in their jurisdictions:

- Plan name, ID, metal level (including cost-sharing reduction silver plans), and whether the plan is offered on the Marketplace, off the Marketplace, or both
- Deductible
- Annual maximum out-of-pocket amount (MOOP)
- Formulary information for most commonly prescribed anti-retroviral medications and hepatitis C (HCV) direct acting antivirals, including tier and cost sharing

How does the ADAP net savings/cost calculation work?

As discussed above, ADAPs must assess insurance coverage to ensure it includes an adequate prescription drug formulary and to ensure it is cost effective (in the aggregate). NASTAD’s tool includes a formula to determine the net savings or costs based on one year of single tablet regimen (STR) coverage and incorporating premiums, cost sharing, and rebate generation. The formula makes a few assumptions about average costs, client demographics, and utilization; actual information about your jurisdiction’s costs, client demographics, and utilization may be different. The tool provides an estimate of net savings or costs and should not replace detailed financial forecasting activities. The assumptions built into our calculation are described below.

<table>
<thead>
<tr>
<th>Composite STR &amp; Rebate</th>
<th>Average Drug Tier</th>
<th>Average Client</th>
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<tbody>
<tr>
<td>NASTAD calculated an average wholesale acquisition cost (WAC) from the five most commonly prescribed STRs. This average WAC was used to calculate pre-deductible drug costs and co-insurance amounts.</td>
<td>For each plan, NASTAD assessed the formulary tiers associated with each of the five most commonly prescribed STRs and identified an average tier for the composite STR for each plan. This tier was used to determine pre- and post-deductible cost sharing for the composite STR.</td>
<td>Using NASTAD ADAP client demographic data and sampling a small group of states, NASTAD developed an “average” ADAP client for the purposes of calculating average insurance costs: a 40-year old male with an income of 200% of the federal poverty level (FPL). Because of the prevalence of tobacco use and the impact of tobacco rating on premiums, the tool provides two client scenarios with the demographics described above: one for a person using tobacco products and one for a person not using tobacco products.</td>
</tr>
<tr>
<td>➢ Composite STR WAC: $2,393</td>
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<tr>
<td>➢ Composite STR rebate: $1,200</td>
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<tr>
<td>NASTAD created a composite rebate amount, using average rebates for the five most commonly prescribed STRs. No confidential rebate information is included in this tool; all calculations are based on a composite STR.</td>
<td>Using the composite STR WAC, NASTAD calculated the number of fills needed to hit the annual MOOP for each plan, incorporating pre-deductible and post-deductible cost sharing. NASTAD then used the composite STR rebate amount to calculate net savings/costs per plan.</td>
<td>The average premium and Advanced Premium Tax Credit (APTC) amounts are calculated by state and using the average client demographics described above.</td>
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</table>
The expected per client net annual savings or costs of a plan is the difference between the expected rebate savings for the plan and the expected premium and out-of-pocket costs for the plan. This model does not account for any medical cost sharing. Importantly, this tool assumes that only a patient’s STR drug costs will count towards the plan’s deductible and MOOP costs; if the patient sees a provider or receives other prescriptions during the plan year, these costs will reduce the deductible and MOOP paid by the ADAP, which may reduce the number of rebate payments received. ADAPs should use the tool to determine which plans are most cost-effective relative to other plans; for budget projections, ADAPs are recommended to reduce any expected rebate savings to account for other plan utilization that will help clients reach the MOOP earlier in the year.

| Annual premium payments (using average client assumptions described above) | Annual cost sharing for one STR (using composite STR and plan design assumptions described above) | Annual rebate savings (using composite STR and plan design assumptions described above) | = Annual ADAP net savings or cost per client per plan |

ADAPs can use the annual ADAP net savings or cost for each plan, in combination with other cost information for other insurance coverage (e.g., employer-sponsored insurance and Medicare) to compare aggregate insurance costs to estimated full-pay medication costs. The latter must be no more expensive than the former to be cost effective. As a reminder, if ADAPs incorporate rebates into the net savings/cost calculation for insurance purchase, then ADAPs should also incorporate rebates into the full-pay medication calculation.

Does the tool tell me what specific drugs are covered on the plan’s formulary?

ADAPs should review the “Drug Coverage” tab to see which HIV and HCV drugs are covered on each plan and on what cost-sharing tier. The tab includes commonly prescribed HIV ARVs and HCV direct acting antivirals. ADAPs should manually review plans with step therapy or prior authorization requirements to STRs or regimen components to determine if these requirements will adversely affect ADAP clients.
Manual Entry Option

Because the tool relies heavily on assumptions about average plan cost and ADAP client demographics, ADAPs may want to use the manual entry option to enter more tailored state-specific assumptions. For instance, ADAPs may want to use a different client age bracket or average client income amount to better reflect the jurisdiction’s ADAP populations. ADAPs may also want to review geographic variations in premiums within the state to assess a more accurate average premium amount rather than a statewide average.

On this tab, ADAPs should enter plan reference data, the applicable drug or combined deductible, the applicable drug or combined MOOP, the average monthly premium, the average APTC, and certain drug data. For the drug data, NASTAD recommends that the ADAP complete the tool multiple times, separately assessing the cost-effectiveness for various STRs or other commonly used drugs in the ADAP population. For the drug data, the “Drug Cost Before Deductible” is the amount charged for a drug before the deductible has been met; typically, this is WAC for the drug, but some plans may cap pre-deductible cost-sharing. The “Drug Cost After Deductible” is the cost-sharing payment paid after the deductible has been reached but before the MOOP is reached; to determine this, review the plan’s formulary to determine each drug’s tier and use the appropriate co-pay or co-
insurance amount from the plan benefit design. To determine the co-insurance amount, multiply the co-insurance percentage by the drug’s WAC. Some states may cap the amount of cost-sharing payments; if the co-insurance payment calculated exceeds your state’s cost-sharing payment cap, enter the cap instead.

Please contact Amy Killelea with questions.