MARKETPLACES AND CANCER CARE

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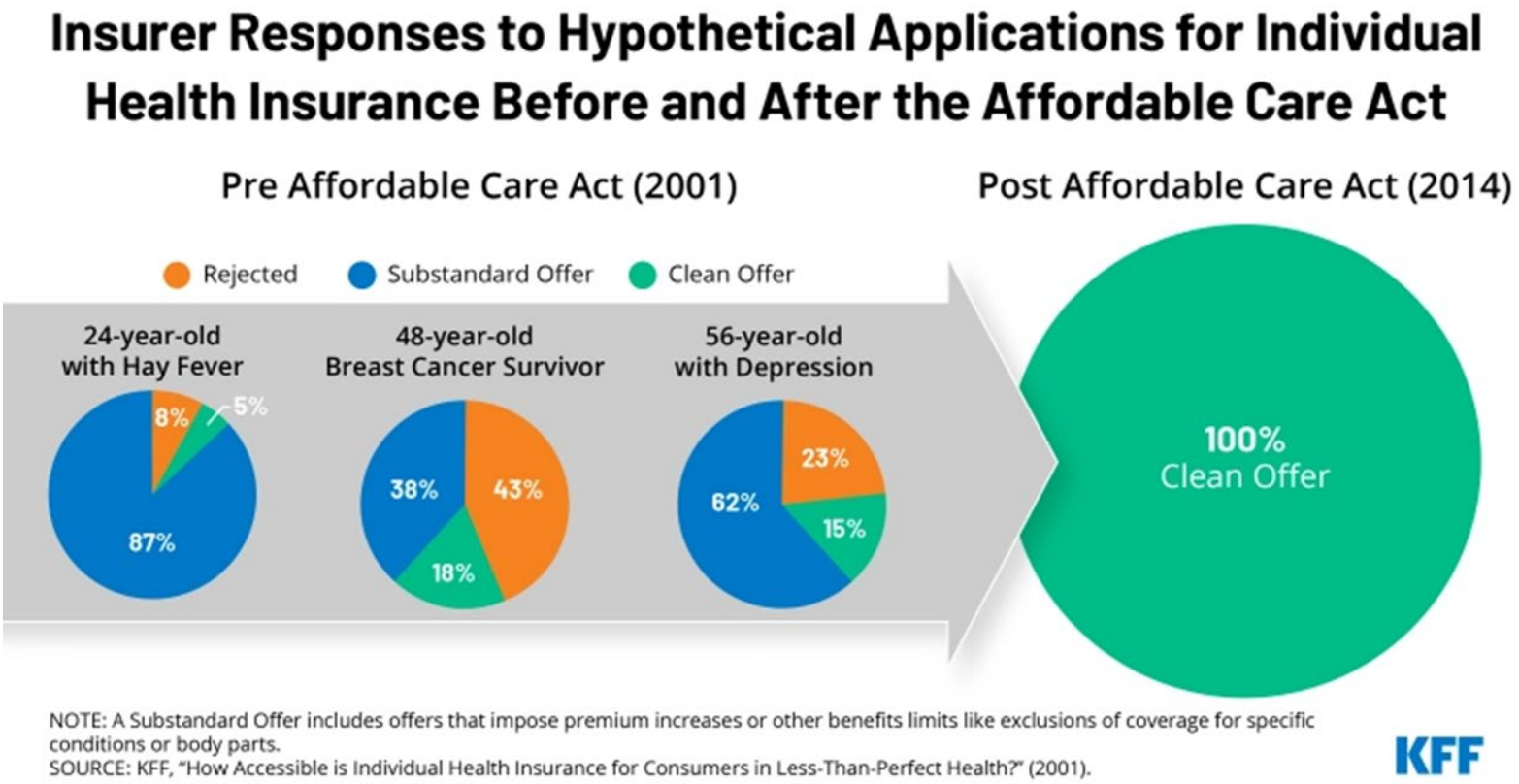
Dean and Professor of Public Service

NYU | WAGNER

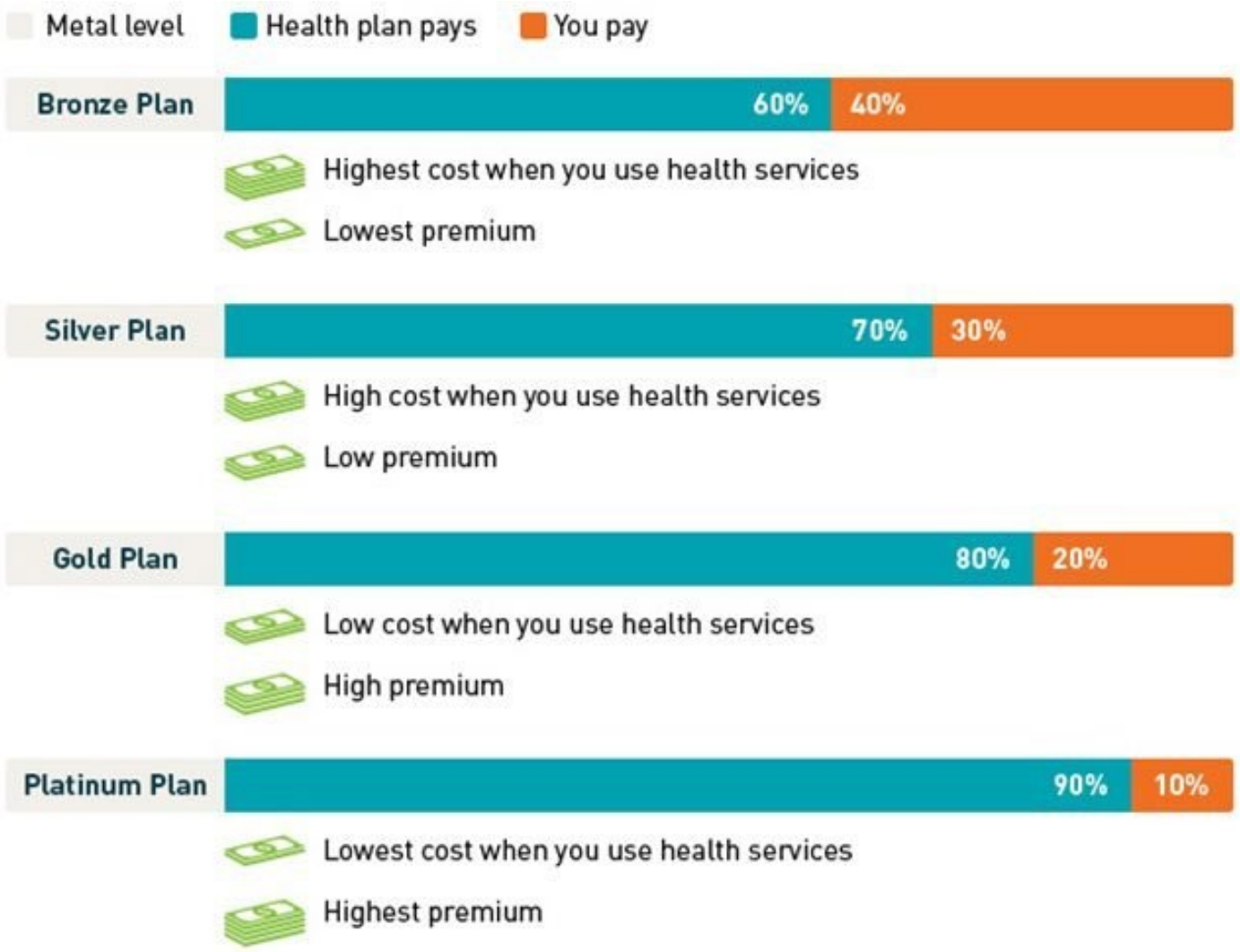
Eliminate Pre-existing Condition Exclusions and Restrictions



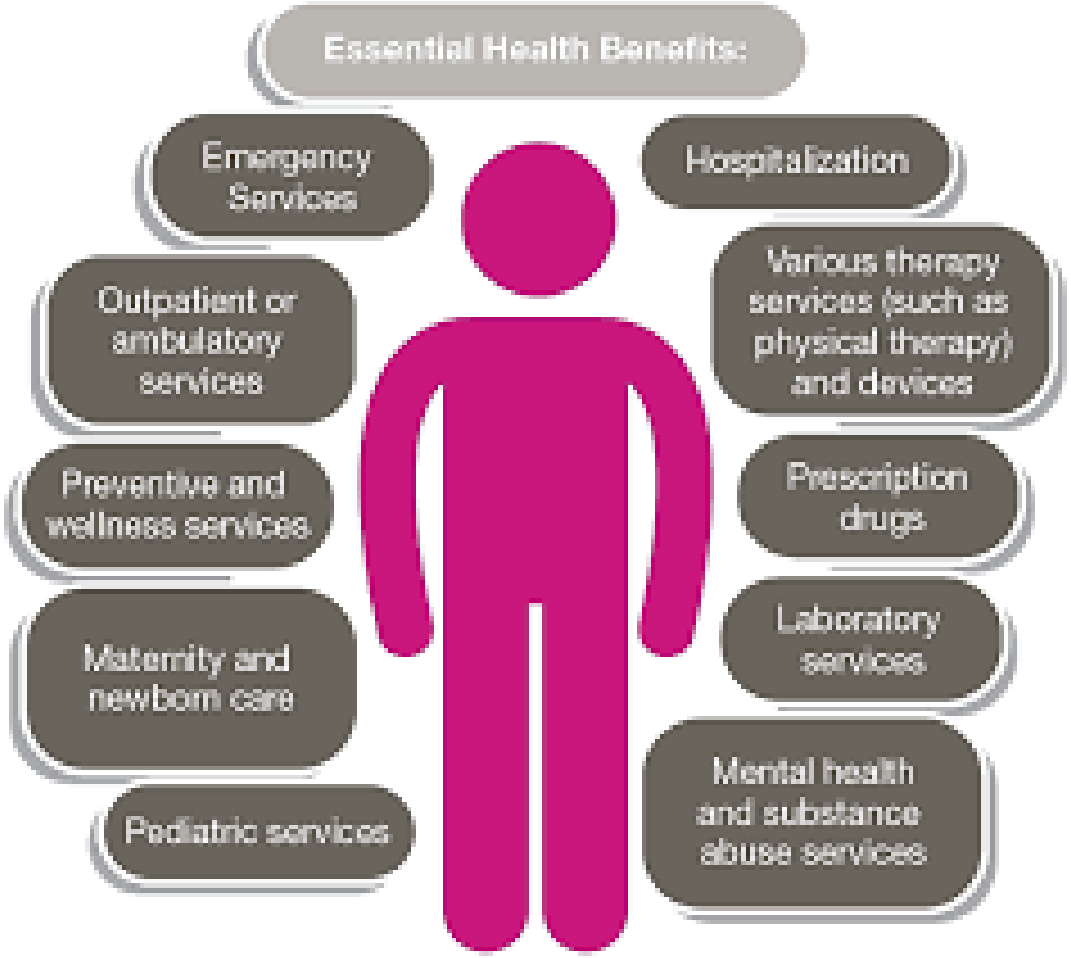
Marketplace Subsidies

Table 2: Change in the Average Lowest-Cost Premium by Metal Level After Tax Credit, 2020-2021			
40-year-old with $20,000 income (157% of poverty)	**2020**	**2021**	**% Change**
Lowest Cost Bronze Premium	$2	$2	–
Lowest Cost Silver Premium	$60	$62	3.2%
Lowest Cost Gold Premium	$118	$105	-10.9%
40-year-old with $25,000 income (196% of poverty)			
Lowest Cost Bronze Premium	$25	$24	-3.3%
Lowest Cost Silver Premium	$117	$118	0.6%
Lowest Cost Gold Premium	$177	$163	-7.7%
40-year-old with $30,000 income (235% of poverty)			
Lowest Cost Bronze Premium	$75	$76	1.1%
Lowest Cost Silver Premium	$180	$180	–
Lowest Cost Gold Premium	$239	$226	-5.6%
40-year-old with $35,000 income (274% of poverty)			
Lowest Cost Bronze Premium	$140	$143	1.9%
Lowest Cost Silver Premium	$249	$250	-0.3%
Lowest Cost Gold Premium	$308	$295	-4.4%
40-year-old with $40,000 income (313% of poverty)			
Lowest Cost Bronze Premium	$197	$205	4.4%
Lowest Cost Silver Premium	$307	$313	2.0%
Lowest Cost Gold Premium	$366	$358	-2.2%

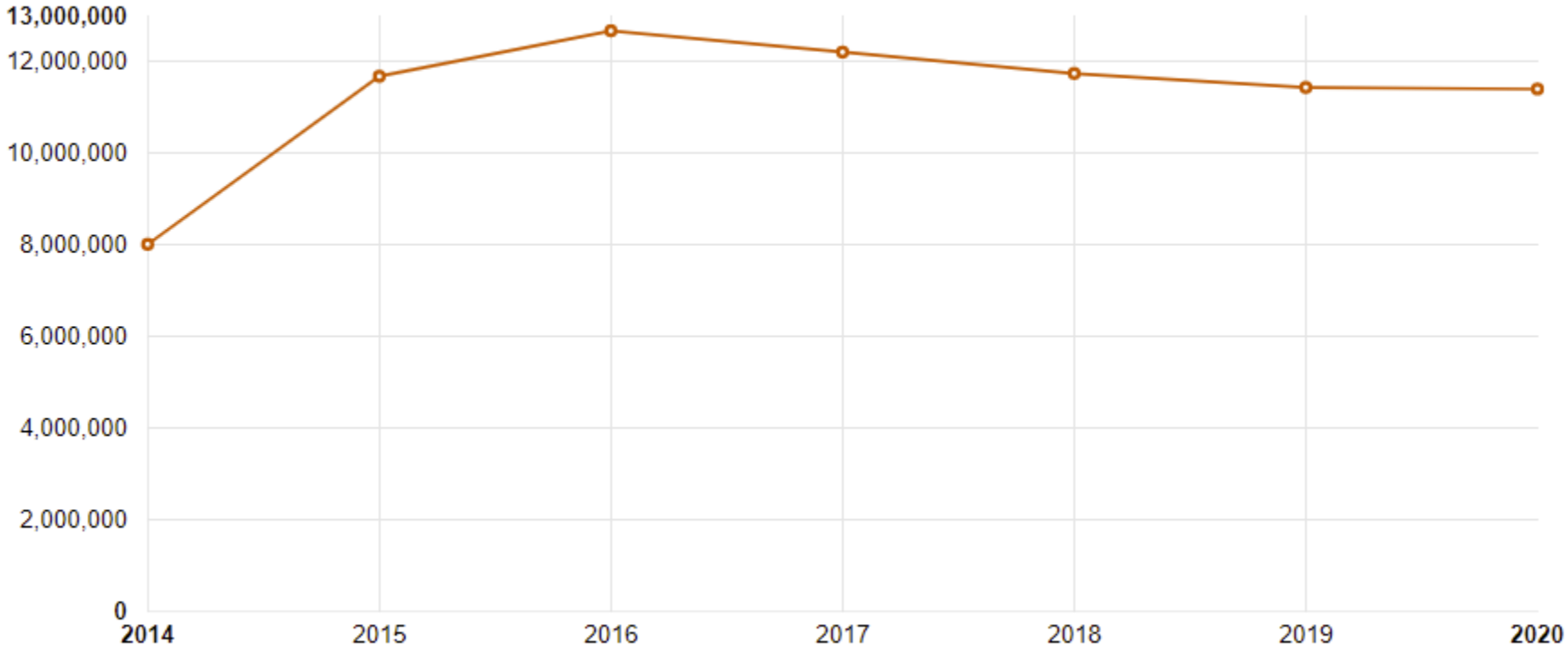
Coverage Availability



Essential Benefits



Enrollment in Marketplaces

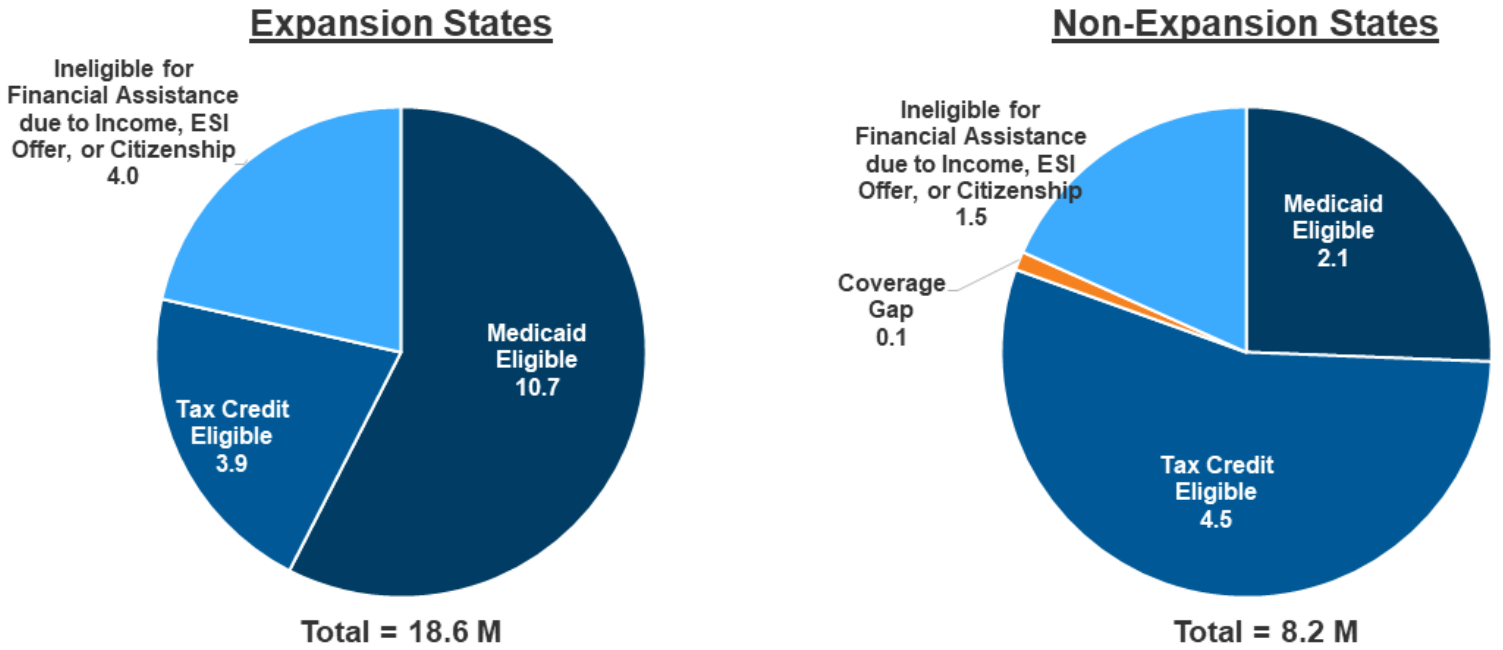


Kff.org

Backstop

Figure 3

May 2020 Eligibility for ACA Coverage among People Becoming Uninsured Due to Loss of Employer-Sponsored Insurance, by State Medicaid Expansion Status



Notes: Medicaid eligible includes people eligible for other public coverage, such as CHIP. Totals may not sum due to rounding.
Source: KFF. Job Losses occurred March 1st through May 2nd, 2020. See Methods for more details.

KFF
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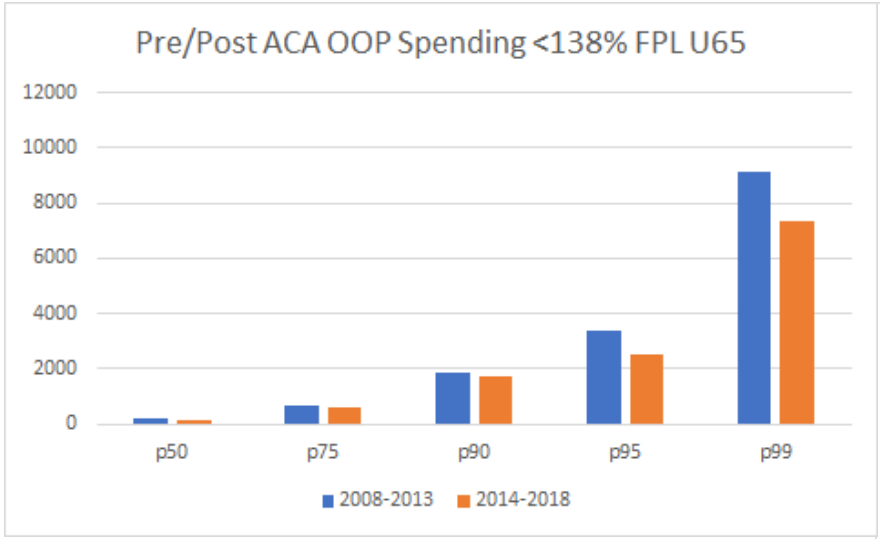
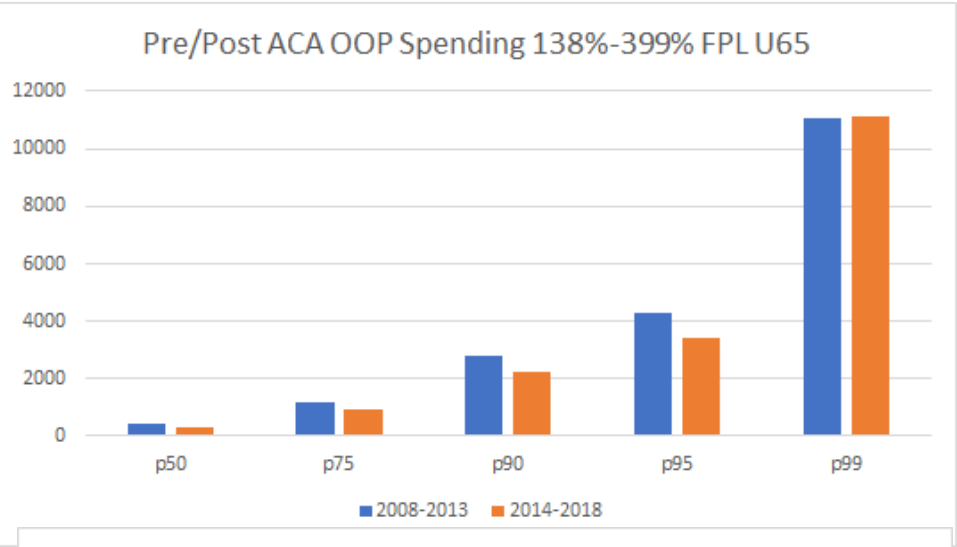
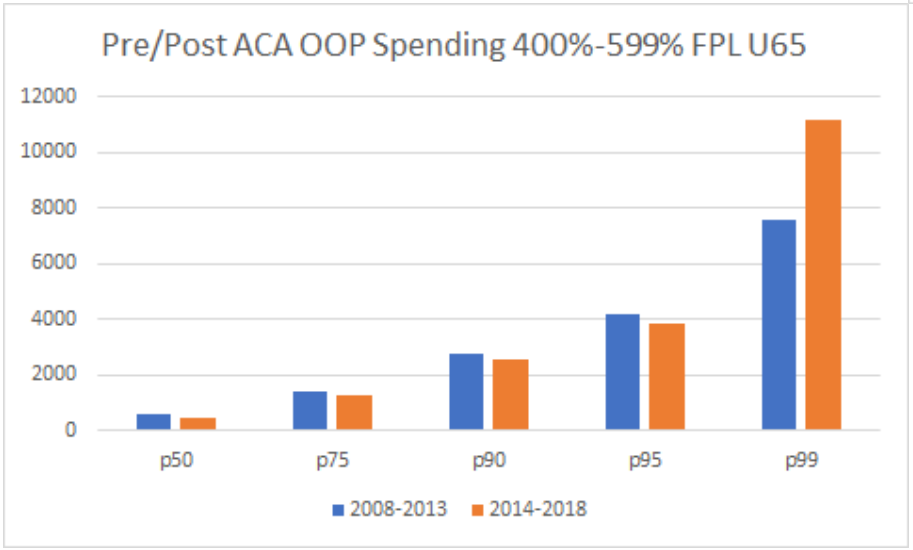
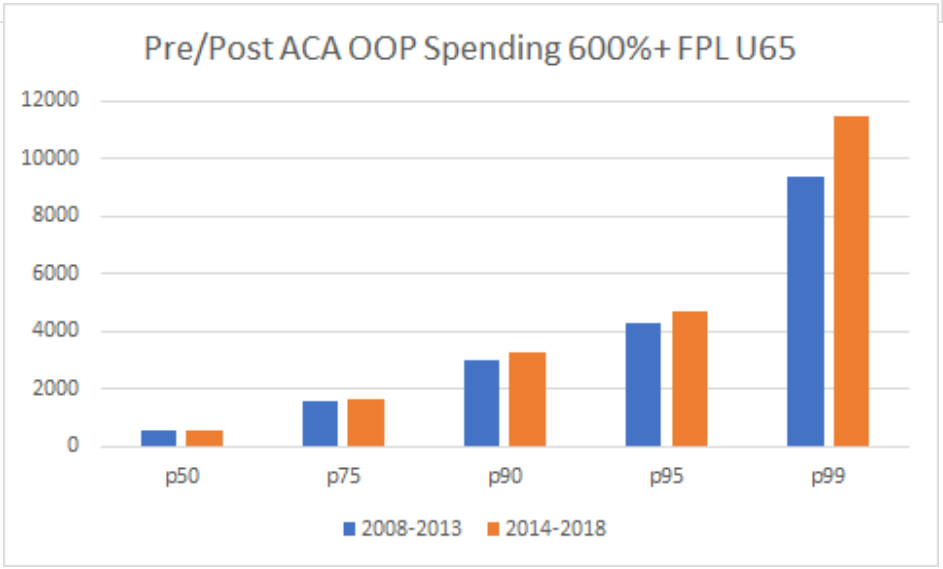
Out-of-pocket – Current Cancer under 65









Formulary

§ 156.122 Prescription drug benefits.

(a) A health plan does not provide essential health benefits unless it:

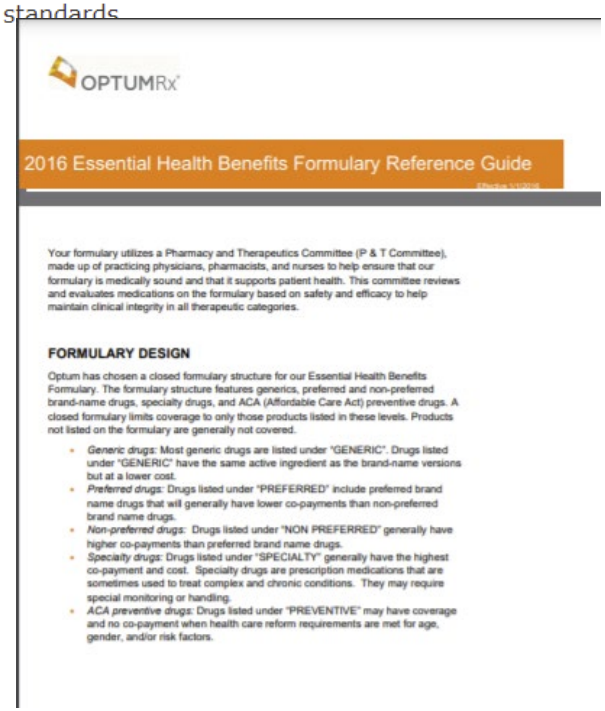
(1) Subject to the exception in paragraph (b) of this section, covers at least the greater of:

(i) One drug in every United States Pharmacopeia (USP) category and class; or

(ii) The same number of prescription drugs in each category and class as the EHB-benchmark plan;

(2) Submits its formulary drug list to the Exchange, the State or OPM; and

(3) For plans years beginning on or after January 1, 2017, uses a pharmacy and therapeutics (P&T) committee that meets the following standards



OPTUMRx

2016 Essential Health Benefits Formulary Reference Guide

Your formulary utilizes a Pharmacy and Therapeutics Committee (P & T Committee), made up of practicing physicians, pharmacists, and nurses to help ensure that our formulary is medically sound and that it supports patient health. This committee reviews and evaluates medications on the formulary based on safety and efficacy to help maintain clinical integrity in all therapeutic categories.

FORMULARY DESIGN

Optum has chosen a closed formulary structure for our Essential Health Benefits Formulary. The formulary structure features generics, preferred and non-preferred brand-name drugs, specialty drugs, and ACA (Affordable Care Act) preventive drugs. A closed formulary limits coverage to only those products listed in these levels. Products not listed on the formulary are generally not covered.

- *Generic drugs:* Most generic drugs are listed under "GENERIC". Drugs listed under "GENERIC" have the same active ingredient as the brand-name versions but at a lower cost.
- *Preferred drugs:* Drugs listed under "PREFERRED" include preferred brand name drugs that will generally have lower co-payments than non-preferred brand name drugs.
- *Non-preferred drugs:* Drugs listed under "NON PREFERRED" generally have higher co-payments than preferred brand name drugs.
- *Specialty drugs:* Drugs listed under "SPECIALTY" generally have the highest co-payment and cost. Specialty drugs are prescription medications that are sometimes used to treat complex and chronic conditions. They may require special monitoring or handling.
- *ACA preventive drugs:* Drugs listed under "PREVENTIVE" may have coverage and no co-payment when health care reform requirements are met for age, gender, and/or risk factors.

- Specialty drugs are usually on high tiers, requiring more cost-sharing
- Transparency around which drugs are on the formulary exists through integrated prescription drug formulary lookup tools on HealthCare.gov and in some state-run marketplaces – but not always fully accurate.

Network Adequacy

Exhibit 1: CMS Quantitative Network Adequacy Standa

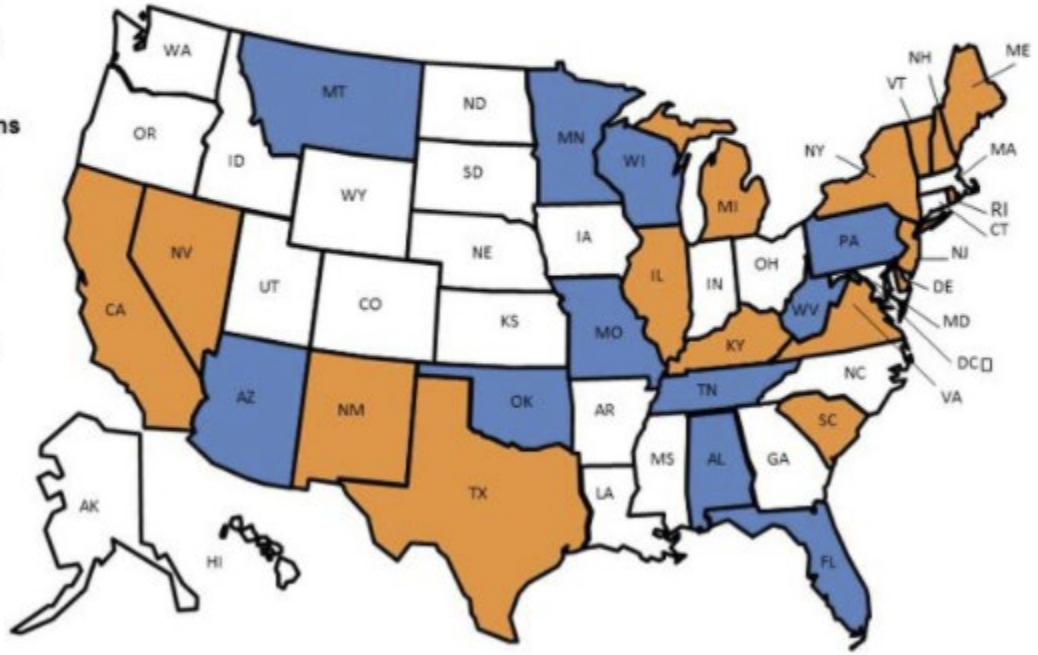
Specialty Area	Maximum Time and Distance Standards (Minutes/Miles)				
	Large	Metro	Micro	Rural	Counties with Extreme Access Considerations (CEAC)
Primary Care	10/5	15/10	30/20	40/30	70/60
Dental	30/15	45/30	80/60	90/75	125/110
Endocrinology	30/15	60/40	100/75	110/90	145/130
Infectious Diseases	30/15	60/40	100/75	110/90	145/130
Oncology - Medical/Surgical	20/10	45/30	60/45	75/60	110/100
Oncology - Radiation/Radiology	30/15	60/40	100/75	110/90	145/130

Hall, Brandt HA, 2017

State Adequacy Regulation

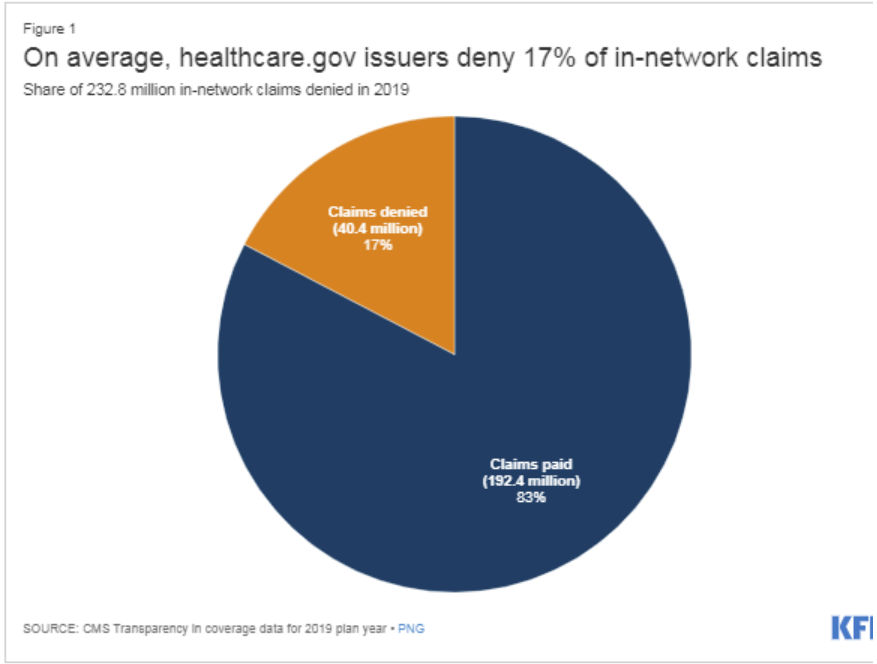
Exhibit 2: States With Marketplace Plans Subject To One Or More Quantitative Standards For Network Adequacy (January 2014)

- All marketplace plans subject to state quantitative standard: 16 states
- Some marketplace plans subject to state quantitative standard: 11 states
- State did not regulate marketplace plan networks using a quantitative standard: 23 states and DC

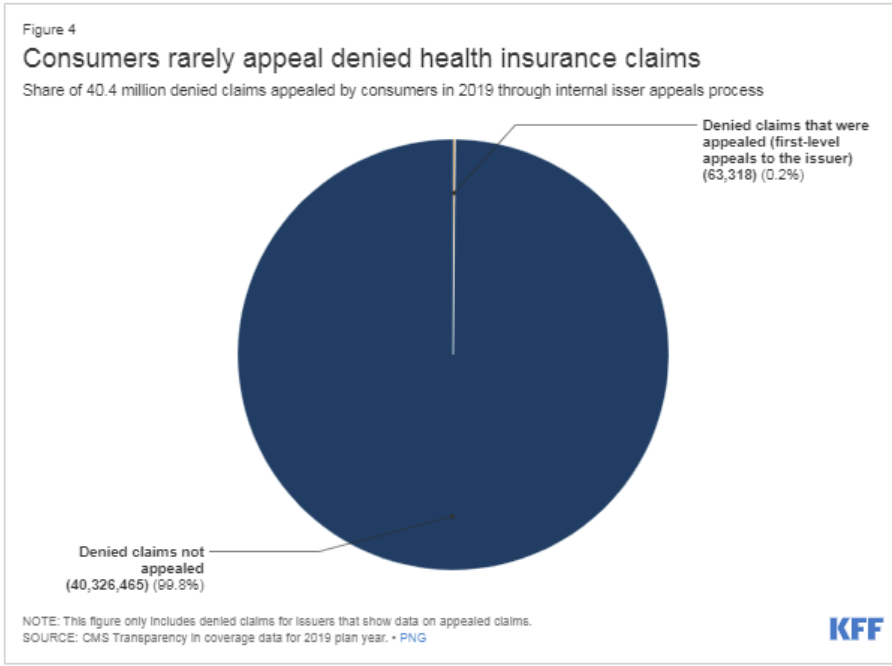


Denials And Appeals

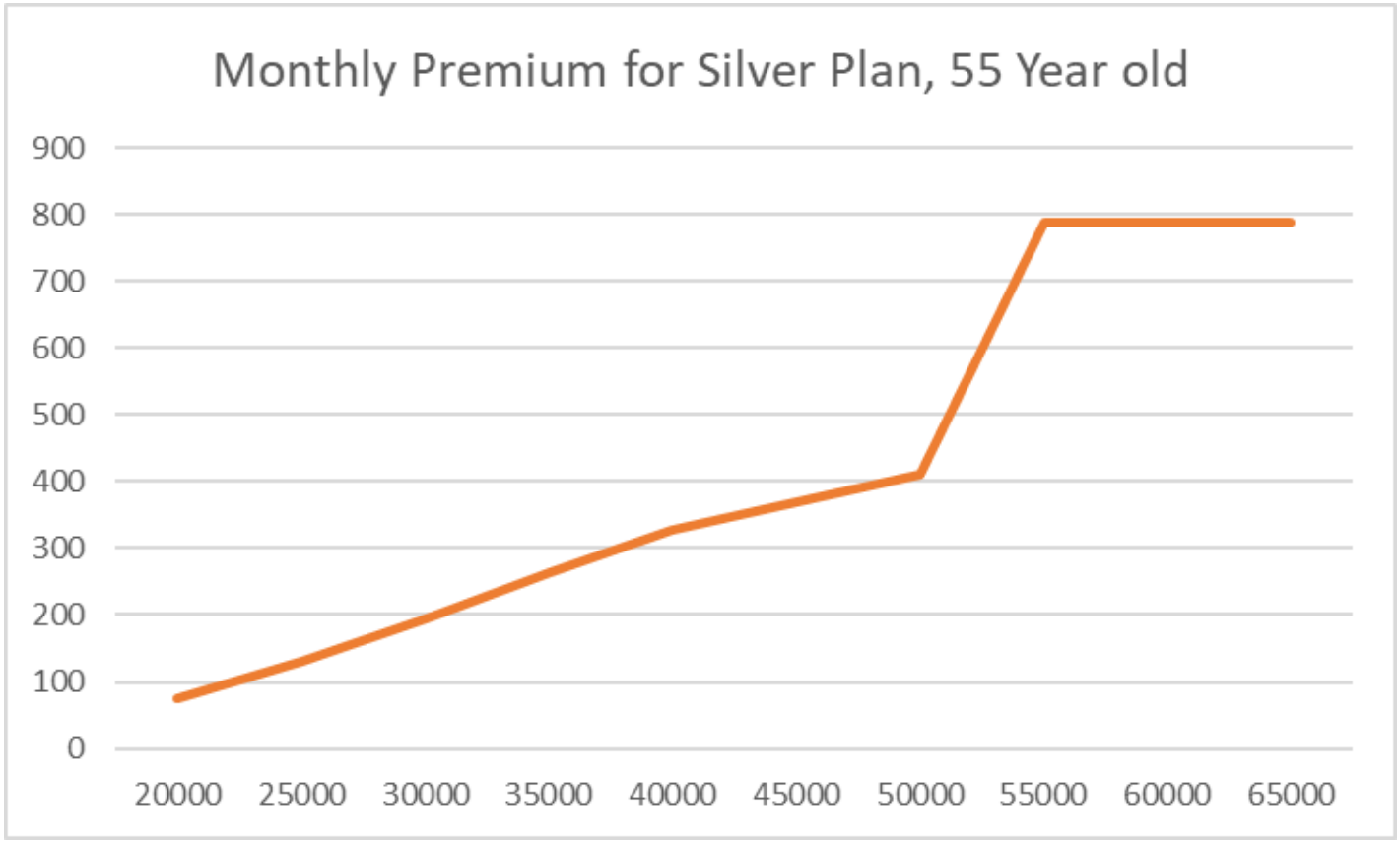
Denials



Appeals

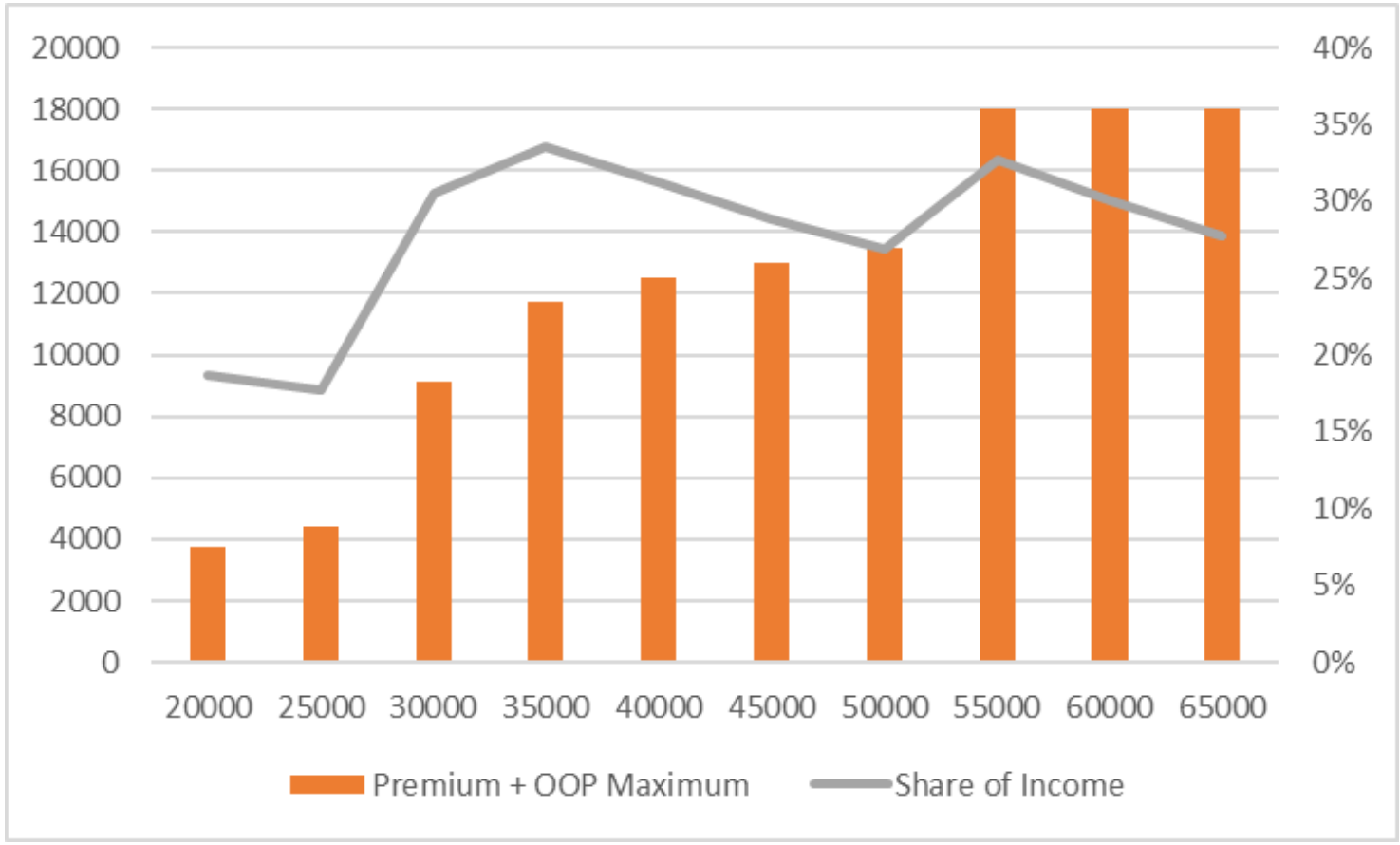


Premiums Can Be Out Of Reach



2021, KFF Calculator

Total Costs Can Be Prohibitive



THANK YOU