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Covering Pre-existing Conditions Isn't Enough

Too often, even patients who have coverage can't afford their medications.

By Douglas Jacobs
Dr. Jacobs is an internal medicine resident.

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When patients enroll in health insurance, they are often met with a stark reality: Even with insurance, they can't afford their treatment. With the Affordable Care Act and its protections for people with pre-existing conditions in limbo once again, it's important to remember that those with such conditions need more than health insurance. They also need to be protected from discriminatory pricing so that they can afford the medications they need.

In 2015 I published a paper in The New England Journal of Medicine that detailed how some insurers were raising costs for H.I.V. medicines to dissuade H.I.V.-positive people from selecting their plans. Insurers frequently raise the price of certain medicines to encourage people to select cheaper alternatives, but these insurers raised the cost of *every single H.I.V. medicine* — leaving many enrollees with no affordable options.

The difference for someone with a pre-existing condition like H.I.V. was staggering (in some cases more than $10,000 annually for H.I.V. medicines in one plan compared with less than $1,000 in another). This practice was later recognized by the Department of Health and Human Services as a form of discrimination by insurers.

Unfortunately, pharmaceutical companies and insurers are still getting away with raising their prices in a way that has a disparate impact on those with pre-existing conditions. A 2019 report by Harvard Law School's Center for Health Law and Policy Innovation found that some insurers continue to price all recommended H.I.V. regimens in a way that makes them prohibitively expensive. In Georgia, for example, three out of the four insurers place all recommended H.I.V. regimens on the most expensive tiers (costing more than $1,000 a month) or do not cover them at all.

As another example, the high price of hepatitis C medicines set by pharmaceutical companies caused many state Medicaid programs to institute discriminatory prior authorization requirements. Those requirements effectively barred people who had a diagnosis of alcohol use

disorder and had not refrained from drinking for a specified period of time from treatment — even though we know that hepatitis C medicines are just as successful in people who drink alcohol.

In many cases, this administration has made matters worse. With the repeal of the A.C.A.'s individual mandate by the 2017 tax bill, healthy individuals can forgo insurance altogether, causing premiums to rise for everyone else. The Trump administration also made it easier to establish association health plans and short-term plans (often referred to collectively as "junk health plans" because they aren't required to cover many services). This forces those with pre-existing conditions to either stay in their A.C.A. plan and see their premiums rise as healthy individuals move to junk insurance because it's cheaper, or sign up for a junk plan and risk extreme charges when services they need are not covered.

While some association health plans have received positive press, these kinds of plans are notorious for cherry-picking healthy enrollees and even committing fraud. As for short-term plans, they are simply denying coverage to those with pre-existing conditions altogether.

Fortunately, with the shutdown finally over, both sides of Congress are getting to legislating, and an issue that both Republicans and Democrats campaigned on is the protection of those with pre-existing conditions. Safeguarding the A.C.A. — by supporting its existence and by eliminating the threat of junk insurance — is a first step.

But protection also means making sure that those who have pre-existing conditions can afford plans that cover the medications they need, which requires instituting policies aimed at both insurers and pharmaceutical companies. After all, what a consumer pays for a medicine is a mix of the price set by a pharmaceutical company, the cost assigned to the drug by the insurer and countless negotiations among pharmaceutical companies, insurers and the pharmacy benefit managers that serve as middlemen.

Accordingly, the administration's announcement to tie Medicare Part B drug prices to an international drug-pricing index should be lauded and expedited. National policymakers should also emulate California, which will band together all state entities into a single purchaser of drugs, adding leverage to efforts to negotiate down drug prices. They could combine federal employee health benefits, Medicare, Medicaid, the Department of Veterans Affairs, Tricare (the health program for uniformed service members) and other public purchasers into the largest single purchaser of drugs our nation has ever seen, one with enormous leverage to reduce drug costs. And with prices lowered, they should require insurers to keep medications affordable.

Obviously, protecting the A.C.A. comes first. But to provide meaningful protections to people with pre-existing conditions, we need to go further. Lowering the cost of drugs achieves the same end: access to care for those who need it most.

Douglas Jacobs is an internal medicine resident at Brigham and Women's Hospital and Harvard Medical School.