



Specialty Tier Reform Update – Week of February 16, 2015

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STATES

California

New bill would limit use of specialty tiers, require “reasonable” drug cost-sharing

Assemblyman Richard Gordon (D) introduced legislation this week that would specifically prevent insurers from placing all prescription drugs for costly conditions into specialty tiers that require a percentage coinsurance.

The measure differs from Gordon’s previous effort to cap prescription drug cost-sharing that passed the Assembly last session but stalled in the Senate (see Specialty Tier Reform Update for Week of September 1st). A.B. 339 would instead direct the Department of Managed Health Care and Department of Insurance to create by January 1, 2017 a category of “specialty prescription drug[s]” that would be subject to new limitations in the bill. For example, all health plans that cover outpatient prescription drugs would have to cover any medically necessary medication that lacks a therapeutic equivalent, starting January 1, 2016.

Under the bill, the use of the highest-cost tier of a drug formulary would have to be based on clinical guidelines and medical evidence and not the cost. A.B. 339 also would require cost-sharing for all outpatient prescription drugs to be “reasonable” to ensure access. Insurers must demonstrate to the Insurance Commissioner that the proposed cost-sharing design “will not discourage medication adherence.”

The California Association of Health Plans promptly opposed the bill, insisting that out-of-pocket costs would simply be shifted to higher premiums, without reducing the actual price of the drug. They argued that it would be more beneficial to consumers for lawmakers to require that health plans and drugmakers be more transparent about how specialty drug prices are set.

A report released this week by Avalere Health affirmed that comprehensive information on drug coverage and out-of-pocket costs under Covered California plans for individuals were very difficult to find, particularly for high-cost conditions like HIV/AIDS. The researchers concluded that this lack of transparency often hindered consumers from making informed purchasing decisions.

Florida

New bill would prohibit discrimination in cost-sharing design

Rep. Matt Harrison (R) introduced his *Florida Patient Protection Act* this week, which prohibits health insurance benefit designs from discriminating against consumers based on age, gender, or health status, consistent with the Affordable Care Act (ACA). However, unlike comparable bills in several other states (see S.F. 349 in Iowa), H.B. 863 adds a specific provision that allows the Florida Office of Insurance Regulation (OIR) to assess a plan’s cost-sharing structure for prescription drugs when reviewing whether a plan’s benefit design is discriminatory.

The bill also sets minimum network adequacy standards for managed care plans and requires that their prescription drug formularies cover a “broad range of therapeutic options for the treatment of disease states” that should include “at least two products in a therapeutic class.” These formularies must be easily accessible on plan websites and updated within 24 hours of any change.



At least three Marketplace insurers have already settled complaints filed with OIR by The AIDS Institute and other consumer groups, documenting that they were moving all or most drugs for a therapeutic class such as HIV/AIDS or Hepatitis C into their highest-cost specialty tiers that require patients to pay 30-40 percent of more of the drug's total cost (see Specialty Tier Reform Update for Week of December 15th).

Illinois

Senator resurrects bill to limit cost-sharing for specialty medications

Senator Linda Holmes (D) introduced S.B. 1359 this week. The measure renews her effort from last session to limit the cost-sharing for specialty medications to \$100 per month for up to a 30-day supply of any single drug (see Specialty Tier Reform Update for Week of February 17, 2014). It also would cap annual out-of-pocket expenditures for prescription drugs to no more than 50 percent of the annual cap under the Affordable Care Act (ACA).

Similar to measures introduced in other states, S.B. 1359 requires plans with a tiered formulary for prescription drugs to create an exceptions process that allows enrollees to request an exception. Plans would also be specifically prohibited from placing all drugs in a given class on a specialty tier.

Illinois was one of roughly a dozen states where Marketplace insurers were identified as placing all or most HIV/AIDS drug into specialty tiers. The Illinois Department of Insurance was the first in the nation to warn insurers as early as last May that such a practice violated the ACA's non-discrimination provision and that they would be barred from the state partnership Marketplace if they relied on such unlawful cost-sharing designs. The Florida Office of Insurance Regulations and federal Centers for Medicare and Medicaid Services have since made similar findings (see Specialty Tier Reform Update for Week of December 15th).

Maryland

New bill would prohibit discriminatory cost-sharing designs

Delegate Kevin Kelly (D) introduced H.B. 990 this week, which prohibits qualified health plans participating in the Maryland Health Benefit Exchange from using a benefit design that relies upon discriminatory drug formulary management or medical management practices.

Differential reimbursement rates or cost-sharing for covered benefits is one criterion that the bill directs the Insurance Commissioner to consider when determining whether a drug formulary is discriminatory. In addition, medical management practices could not be applied only to specific diseases or conditions unless they comport with generally-accepted best medical practices among peer-reviewed medical journals or medical specialty societies.

The Health and Government Operations Committee has scheduled a March 12th hearing on the legislation.

Maryland already enacted legislation last year that prohibits health plans from imposing a copayment or coinsurance for covered specialty drugs that exceeds \$150 for up to a 30-day supply (see Specialty Tier Reform Update for Week of May 5th).