Specialty Tier Reform Update – Week of February 23, 2015

By Mark Hobraczk, JD, MPA

STATES

California

Kaiser Permanente backtracks on decision to move HIV/AIDS drugs into specialty tiers

Kaiser Permanente became the latest insurer this week to stop moving most or all drugs for HIV/AIDS into specialty tiers that require a percentage coinsurance.

The insurer had put a new policy into effect starting January 1st that shifted medications for chronic conditions like HIV/AIDS into their highest tier that forced subscribers to pay 20 percent of the drug's cost instead of a fixed copayment amount. Similar moves by insurers in at least 12 other states have sparked a backlash from consumer advocates, as well as several complaints with state regulators arguing that the practice violates the non-discrimination provisions of the Affordable Care Act (ACA) and is effectively a means to circumvent the law's prohibition on pre-existing condition denials (see Update for Week of January 5th).

Insurance commissioners in at least two states (Florida and Illinois) have already taken enforcement action to curtail the practice (see Update for Weeks of February 9th and 16th), while the federal Centers for Medicare and Medicaid Services (CMS) has finalized rules that would allow it to deny certification to Marketplace insurers that rely in such discriminatory cost-sharing designs (see below).

In response, Kaiser announced that it would return to fixed copayments for brand-name HIV drugs, as well as refund coinsurance to some subscribers that purchase the applicable drugs during January. The insurer also agreed to work with Covered California and other insurers on alternative cost-sharing designs for specialty drugs.

However, Kaiser has yet to revert to fixed copayments for other drugs moved into specialty tiers according to the *San Francisco Chronicle*, nor did it indicate an intent to do so.

The Assembly is currently considering legislation (A.B. 339) that would require specialty tier placement to be based on clinical guidelines and impose only "reasonable" cost-sharing that does "not discourage medication adherence" (see Update for Weeks of February 9th and 16th).

Maryland

Senator files counterpart to House bill prohibiting discriminatory cost-sharing designs

Senator Catherine Pugh (D) introduced S.B. 834 this week, which is the counterpart to H.B. 990 introduced the week prior.

Both bills would prevent 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 bills direct the Insurance Commissioner to consider when determining whether a drug formulary is discriminatory (see Specialty Tier Reform Update for Week of February 16th).

Minnesota

New bill would sets new transparency and disclosure requirements for prescription drugs

Rep. Tony Albright (R) introduced H.F. 1060 last week, which sets new transparency and disclosure requirements for prescription drugs. The measure will be heard in the Health and Human Services Reform Committee.

H.F. 1060 still allows health plans to expand formularies or reduce prescription drug cost-sharing during a plan year. They also can move a drug to any benefit category that reduces cost-sharing for subscribers. However, the plan can only remove a brand-name drug approved by the Food and Drug Administration or increase enrollee cost-sharing for the drug only if it adds an "A-rated generic or multisource brand name equivalent at a lower cost" to the formulary and provides a 60-day notice to prescribers, pharmacists, and affected enrollees.

The bill requires that any enrollee cost-sharing be consistent with any cost-sharing that the plan charges for non-formulary drugs under a medication exceptions process.

Plans must likewise establish and maintain a transition process of at least 60 days to prevent gaps in drug coverage for both new and continuing enrollees with ongoing prescription drug needs who are affected by changes in formulary drug availability.

Oregon

New bills would limit discriminatory cost-sharing for prescription drugs

The House Health Care Committee introduced legislation last week that would require health plans in Oregon to limit cost-sharing for prescription drugs to no more than $100 for a 30-day supply. H.B. 2951 also would prohibit deductibles for drug coverage and require drug cost-sharing to apply to any other plan deductible.

Similar to measures being advanced in several other states, the bill specifically would bar insurers from moving all drugs within a therapeutic or pharmacological class into the highest cost-sharing tier. It likewise requires the insurer to create an exception process for the coverage of drugs not on a formulary or preferred drug list.

Separate legislation sought by former Governor John Kitzhaber (D) prior to his resignation (see Update for Weeks of February 9th and 16th) that sets new minimum standards for provider networks also includes a provision prohibiting insurers from using affordability or cost containment measures that effectively discriminate against subscribers based on health status (H.B. 2468). It was heard last week in the Department of Commerce and Business Services.

Rhode Island

New bill would require 60-day notice for cost-sharing changes to formulary drugs

Rep. Arthur Corvese (D) introduced H.5599 this week, which would require all insurers give at least a 60-day notice to subscribers, prescribers, pharmacists, and network pharmacies whenever they remove a prescription drug from the plan formulary. The same notice must be issued if the plan makes any change in the preferred or tiered cost-sharing status of a covered drug. It will be heard in the House Corporations Committee.

Patient Services Inc.
A non-profit 501(c)(3) premium and copayment foundation

P.O. Box 5930
Midlothian, VA 23112

1.800.366.7741
www.patientservicesinc.org