



Specialty Tier Reform Update – Week of March 30, 2015

By Mark Hobraczk, JD, MPA

STATES

California

Health committee sets hearing on bill to prevent discriminatory cost-sharing designs

The Assembly Health Committee has set an April 28th hearing on legislation that would specifically prevent insurers from placing all prescription drugs for certain costly conditions into specialty tiers that require a percentage coinsurance.

The consumer group Health Access California, pursued the measure (A.B. 339) that was sponsored by Assemblyman Richard Gordon (D) (see Specialty Tier Reform Update for Week of February 16th). However, it continues to be opposed by the California Association of Health Plans, which insists that the bill would merely transfer costs back to insurers and consequently increase premiums.

Under the bill, the use of the highest-cost tier of a drug formulary would have to be based on clinical guidelines and not 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.”

Connecticut

Senate to vote on bill increasing consumer transparency for drug cost-sharing

The Joint Insurance and Real Estate Committee has sent a measure to the floor that would give consumers greater information about cost-sharing for prescription drugs.

Introduced by committee chair Joseph Crisco (D), S.B. 24 would require insurers to publish “easily readable and understandable” information on their websites (with links from the Marketplace web portal) detailing the restrictions and out-of-pocket expenses for essential health benefits including prescription drugs. This specifically includes the dollar amount of any copayment or percentage of coinsurance applied to each covered prescription drug.

Senator Crisco initially included a provision in S.B. 24 backed by consumer groups that would prohibit insurers from moving a drug to a higher cost-sharing tier unless at least one therapeutically equivalent drug is available in a preferred or lower cost-sharing tier (see Specialty Tier Reform Update for Week of January 5th). However, the Connecticut Association of Health Plans and the Insurance Department insisted that such a restriction could create “unintended consequences if carriers are limited in their formulary flexibility.” The Department noted that carriers have already “voluntarily” agreed to provide advance notice to subscribers of any “adverse” formulary change (such as removing a drug or shifting it to a tier that would increase their cost-sharing) and not do so more than twice per year.

As a result, the measure that was unanimously approved by the committee requires only that the Insurance Department evaluate whether insurers are complying with the ACA prohibition against discriminatory benefit and cost-sharing designs and provide information upon request detailing which drugs are placed on specific cost-sharing tiers.

The federal Centers for Medicare and Medicaid Services (CMS) articulated this standard in their final their Notice of Benefit and Payment Parameters (BPP) regulation for 2016, stating that “placing most or all drugs for a specific condition on a high cost-sharing tier” may be considered to violate the ACA anti-discrimination provision (see Specialty Tier Reform Update for Week of February 23rd). However, CMS

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



only enforces this provision when certifying federally-facilitated Marketplace (FFM), while Connecticut conducts its own certification for its state-based Marketplace.

Illinois

House committee passes bill limiting prescription drug cost-sharing by metal tier

The House Human Services Committee passed H.B. 3605 last week. The measure sponsored by Rep. Jaime Andrade (D) would limit prescription drug cost-sharing for health plans offered at the silver, gold, and platinum levels to \$100, while raising the limit to \$200 for bronze coverage. Catastrophic policies for young adults remain exempt.

H.B. 3605 is essentially the House counterpart to S.B. 1359, which was amended to include the same limits (see Specialty Tier Reform Update for Week of March 9th). That bill remains pending in the Senate Insurance Committee with an April 24th deadline.

Both bills retain the annual out-of-pocket limit for all prescription drugs, which is set at 50 percent of the annual out-of-pocket maximum under the ACA Act (\$6,600 for individual coverage in 2015, \$13,200 for families). All plans would also still be required to implement a process by which subscribers can request an exemption from the drug formulary.

S.B. 1359 was also amended to remove the prohibition on placing all drugs for a given class into a specialty tier. This provision had been sought by consumer advocates in response to a discrimination complaint settled by the Illinois Insurance Commissioner last year and has been included in comparable bills nationwide (see Specialty Tier Reform Update for Week of February 16th).

Oregon

House passes bill that would limit discriminatory cost-containment measures by health plans

The House passed H.B. 2468 this week with only one dissenting vote. The legislation introduced at the request of former Governor John Kitzhaber (D) would set new minimum standards for provider networks and includes a provision prohibiting insurers from using affordability or cost containment measures that effectively discriminate against subscribers based on health status (see Specialty Tier Reform Update for Week of February 23rd). It now moves to the Senate Health Care Committee