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Memorandum

TO: Representative Beth Kerttula
FROM: Chuck Burnham, Legislative Analyst
DATE: March 9, 2012
RE: Prescription Drug Formulary "Tiers" in Health Insurance Plans and the Impacts of HB 218
LRS Report 12.228

You asked a number of questions about prescription drug formulary tiers in health insurance plans and the impacts of HB 218. Specifically, you wanted to know the following:

- ***The definition of "drug formulary" and "value-based drug formulary;"***
- ***Whether insurers in Alaska use tiered formularies and a list of drugs included in tiers 4 or higher;***
- ***The states that have prohibited coinsurance on "specialty tiers" in prescription drug formularies for high cost pharmaceuticals and the costs and benefits to those states of doing so;***
- ***The impacts on health insurance premiums for Alaskans should HB 218 be enacted, thereby requiring insurers to provide policyholders with notice at least 90 days prior to increasing premiums, co-pays, or coinsurance for prescription drugs.***

Brief Summary

Alaska's major private health insurers employ 4-tier prescription drug formularies in a number of their various plans. New York is the only state thus far to prohibit such plans; however, Vermont has placed a one-year moratorium on the practice, and numerous other states are variously studying the issue and considering measures to curb or eliminate specialty drug tiers.

Because HB 218 primarily seeks to increase notification timeframes for a relatively small percentage of the state's population, it is unlikely that its passage will have a significant impact on health premiums in Alaska.

Formulary Basics

Health insurance plans that offer prescription drug coverage for pharmaceuticals and other patient-administered treatments often categorize those medications under a formulary, which lists drugs approved for coverage by the insurer for specific medical conditions. For many years, insurers often divided these drugs into three tiers according to their costs, and required differing levels of co-pay—typically a flat rate paid by the policyholder—for each tier. So, for example, an insurer may charge a $10 co-pay for less expensive, "tier 1" substances, and respective co-pays of $20 and $50 for higher cost drugs in tiers 2 and 3. This flat-rate co-pay model serves both to reduce costs to the insurer, thereby allowing for lower premium rates system wide, and to provide predictable and relatively low-cost medications to the insured.

Enter Tier 4

Two events in recent years combined to challenge the traditional 3-tiered system. First, in recent decades pharmaceutical companies have increasingly developed highly effective "specialty drugs" to treat complex chronic diseases like rheumatoid arthritis, multiple sclerosis, and certain cancers. These drugs are very expensive to develop and produce and extremely costly to purchase. Further, because these substances are used to treat chronic diseases, the costs are not only very high per dose but potentially recurring monthly throughout a lifetime of disease. Second, the 2006 enactment of the Medicare "Part D" prescription drug plan allowed insurers participating in the program to place specialty drugs in a separate tier and charge more for them. Private insurers rapidly adopted the model, creating tiers 4 and higher, and switched their policyholders' portion of costs from *co-pay* to *coinsurance*, which charges a *percentage* of the price of the prescription rather than a flat rate.

As a result, policyholders who had been paying $10, $20, or $50 per month for their medications were met with pharmacy bills many times those amount—upwards of $2,000 per month in some cases.[1]

To be fair, the advent of specialty drugs has placed insurers in a difficult situation. Annual inflation rates on such medications have increased much faster than for other healthcare services, which, in turn, have been climbing at a rate multiple times that of overall inflation in the U.S. economy. The Kaiser Family Foundation reports 17 percent inflation for specialty drugs in 2010, and that spending on these medications often accounted for 15 percent to 25 percent of an employer's total pharmacy benefit costs.[2] Insurers, employers and benefit plan designers have stemmed, somewhat, the rate of growth of specialty tier plans over the past two years through various methods, including steering clients to "value-based formularies," which offer access to generic drugs and pharmacies through which discount prices have been negotiated. Nonetheless, the proportion of plans that use specialty tiers doubled from 2008 to 2011, comprising 14 percent of all prescription drug benefit plans by the end of that period.[3]

Specialty Tiers in Alaska

In fiscal year 2011, the private health insurance market in Alaska—that which would be impacted by HB 218 (we provide information on plans not covered under the bill below)—was dominated by two insurers: Premera Blue Cross Blue Shield and Aetna. The companies respectively hold 56.69 percent and 10.19 percent of the total market, and their collective market share of over two-thirds dwarfs the next largest private health insurer, United Healthcare Insurance, and its 3.97 percent of the customer base.[4]

According to plan documents, Premera's standard tier 4 coinsurance rate is 30 percent, although this rate may differ under the variables of specific plans.[5] Aetna publishes multiple rates for its various small group prescription drug plans, ranging from 30 percent to 50 percent.[6] These rates compare to typical co-pays for tiers 1-3 of $10-$100.[7]

States Respond

We found just one state—New York—that has prohibited insurance companies from creating specialty tiers with coinsurance models. (Vermont put in place a one-year moratorium on specialty tiers effective May 6, 2011.) California Assembly Bill (AB) 310, which is currently under consideration, proposes to ban specialty tiers and limit co-pays to $150 per monthly prescription. Other states, such as Louisiana and Texas, have set mandatory 60-day notification schedules that must be met before changes to prescription drug costs can be made. At least seven other states have undertaken studies of the impacts of specialty tiers on costs, access to drugs, and outcomes, among other measures, as a first step toward regulating the issue. Various measures prohibiting, limiting, or otherwise regulating the use of specialty tiers are currently under consideration across the country.[8]

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[1] Julie Appleby, "Workers Squeezed as Employers Pass Along High Costs of Specialty Drugs: Some Employers Make Patients Pay a Percentage of Cost Instead of a Co-Pay," Kaiser Health News, August 22, 2011, *http://www.kaiserhealthnews.org/Stories/2011/August/22/Workers-Squeezed-As-Employers-Pass-Along-High-Costs-Of-Specialty-Drugs.aspx*.

[2] Richard Farris, Vice President and National Practice Leader, Rare and Specialty Therapeutics, Medco Health Solutions, Inc., as quoted by Julie Appleby.

[3] "Employer Health Benefits 2011 Annual Survey," Exhibit 9.1, Kaiser Family Foundation, *http://ehbs.kff.org/Default.aspx?page=abstract&id=2*.

[4] "Division of Insurance 73rd Annual Report," Alaska Department of Commerce, Community, and Economic Development, *http://commerce.alaska.gov/insurance/Insurance/programs/Consumers/pubs/annual%20reports/annual_report_73.pdf#page=86*.

[5] "How Drug Benefits Work," Premera Blue Cross Blue Shield, *https://www.premera.com/stellent/groups/public/documents/xcpproject/pharm_tier_drug_benefits.asp*.

[6] "Alaska Plan Guide," Aetna, *http://www.aetna.com/employer-plans/document-library/states/ak_plan_guide.pdf*.

[7] Aetna appears to offer low-cost plans that charge a co-pay for certain tier 2 and tier 3 drugs.

[8] "Specialty Tiers/Coinsurance," The Alliance for Biotherapeutics, June 2011, *http://www.bioalliance.org/Downloads/Policy-CoinsuranceAndSpecialtyTiers.pdf*.

Impacts on Premium Costs

You were particularly interested to know if prohibiting specialty tiers increased health insurance premium rates in New York, which enacted its prohibition October 31, 2010. Our research located no study of the law's impact on premiums, and we expect that insufficient time has elapsed to allow a complete understanding of the law's impact on costs.

California's Health Benefits Review Program—comprised of a research team from several of the state's prestigious universities—conducted a study of the medical, financial, and public health impacts of AB 310, the bill currently under consideration. The group projected that the prohibition on specialty drug tiers would increase per month, per member premiums by an average of between zero and $3.69, depending on the market in question (group, individual, Health Management Organizations [HMO], etc.). Total net premium expenditures were projected to increase by roughly $31.7 million (0.0332 percent) as aggregate premium increases caused by the bill would be largely offset by reduced overall co-pays across the pool of 20.9 million policyholders impacted by the bill.[9]

Projected Impact of HB 218 on Premiums

As you know, HB 218 does not contemplate an outright prohibition on specialty tiers per se. Rather, the bill prohibits the use of the 4-tier model for the purpose of establishing deductibles, co-pays, or coinsurance unless the insurer provides policyholders notice of at least 90 days prior to changing the cost terms of their prescription drug coverage. Nonetheless, in a letter to House Health, Education, and Social Service Committee Chair Representative Wes Keller, Premera Blue Cross Blue Shield of Alaska Senior Vice President Jack C. McRae states that the notification timeframe in HB 218 will "inflate costs for specialty drugs and will increase overall healthcare premiums for Alaskans."[10]

Although not required by Alaska law, Premera's current policy, as stated by Mr. McRae, is to provide its policyholders notice 30 days prior to changes on costs associated with prescription drugs. Therefore, assuming that the insurer would comply with the increased notification timeline in HB 218 rather than discontinue its tier for specialty drugs, the impact of the legislation would be to increase by 60 days the amount of notice required prior to changing costs associated with medications. Further limiting the impact of the bill is the proportion of Alaskans to which it would apply if enacted. According to Insurance Division Director Linda Hall, the bill does not apply to public plans (state and federal employees, Medicare, Medicaid, Indian Health Service) or self-insured plans that are merely administered by insurers, which are most commonly funded by large organization like the State of Alaska and companies with a large pool of employees.[11, 12] Individuals covered by public and self-insured health plans, combined with the approximately 16 percent of uninsured Alaskans, total 85 percent of the state's population. The provisions of HB 218 would, therefore, apply to the remaining 15 percent of residents covered by state-regulated, "fully-insured" health plans in the private market.

The change to which Mr. McRae refers in his letter of opposition to HB 218 is, then, an additional 60 days of notice provided to 15 percent of the Alaska population. Presumably, the cost associated with the bill would be two months of the difference in cost between the proposed increase in price to drugs for which Premera is, by definition, already funding at a lower rate (that is, if the drug in question were not already being funded, notification of price change would not be in question). Although we are aware of no study on the impact of the changes described above, assuming the cost projections in the study of California AB 310—which, again, would *completely prohibit* specialty tiers—are remotely accurate, the cost of a 60-day delay in implementing increased costs for specialty drugs would, presumably, be a small fraction of the maximum per month premium increases projected by that study. We asked Director Hall for her views on the likely impact of HB 218 on premiums. She stated that the bill was unlikely to bring significant increases.

We hope this is helpful. If you have questions or need additional information, please let us know.

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[9] "Analysis of Assembly Bill 310," California Health Benefits Review Program Report to the 2011-2012 California Legislature, April 14, 2011, p. 11, *http://www.chbrp.org/docs/index.php?action=read&bill_id=120&doc_type=3*.

[10] Documents associated with HB 218 are available online at *http://www.legis.state.ak.us/basis/get_documents.asp?session=27&bill=HB218*.

[11] Ms. Hall can be reached at (907) 269-7900.

[12] Self-insured and public plans are exempted from state regulation under the federal Employee Retirement and Security Income Act of 1974 (ERISA), as amended (P.L. 93-406, 29 USCS § 1002). More information on ERISA and its treatment of different types of plans is available at *http://www.allhealth.org/briefingmaterials/erisaregulationofhealthplans-114.pdf*.