
HEALTH REFORM WEEK

Pharmacy Benefits on Exchanges May Start Off Open, Become Restrictive Over Time

By Neal Learner, editor

Insurers selling products on the health exchanges this fall are expected to offer consumers relatively generous choices on the pharmaceutical formularies. But those drug lists likely will become more restrictive, and consumers could be required to fill their prescriptions through a limited pharmacy network, in subsequent years as plans implement strategies to ratchet down costs, observers and plan executives tell *HRW*. Meanwhile, at least one lawmaker is concerned that some states are implementing policies that will require patients to foot much of the bill on high-cost specialty medications.

For now, health plans still are trying to figure out how to design the pharmacy benefit, says Brian Bullock, CEO of The Burchfield Group, a pharmacy benefit consulting firm.

"They're plowing new territory," he tells *HRW*. "There's not a lot of strong guidance coming out of the feds or CMS on how the marketplace formularies are going to operate. It's even unknown if plans are going to be able to modify or delete drugs from the marketplace formulary once it's in. A normal insurance plan is able to modify the formulary during the plan year. We don't know at this point if that's going to happen."

CMS officials contacted by *HRW* say that states will be responsible for monitoring drug lists for compliance with the "essential health benefits" (EHB) policy as part of their review and enforcement responsibilities. Issuers will submit their drug lists to CMS's Health Insurance Oversight System (HIOS) once during the April submission period.

"As drug lists change, issuers are still responsible for meeting the EHB standard (i.e., the greater of one drug or the number of drugs in the state EHB benchmark plan in each USP [i.e., U.S. Pharmacopeia] category and class)," says the CMS official, who asked not to be identified.

"State-based exchanges could set their own rules in terms of requiring plans to notify the exchange of any drug list changes or limit the frequency," the official explains. "Regardless, midyear formulary changes should be infrequent. In addition to assuring formu-

lary compliance with EHB, marketplaces should be aware of the potential for formulary discrimination."

One factor that is clear is that all plans must provide the same breadth of drugs on their formularies as is offered in the state's "benchmark plan" — i.e., a commercial plan selected by the state, or the largest small-employer plan in the state, that determines the minimum level of so-called essential benefits on the exchange.

Relying on the benchmark plan raises its own set of challenges, says Bullock, pointing to the example of infertility treatments. "Mostly in the individual market, the infertility benefit has been an unusual inclusion," he says. "But there are states now that are requiring it. How do you underwrite these things?"

Open vs. Restricted Formularies

Benchmark plan formularies will vary greatly from state to state, says Caroline Pearson, a director at consulting firm Avalere Health LLC.

Twelve states require the benchmark plan to cover more than 97.5% of all unique chemical entities. But another 12 states have requirements that range from 54% to 84% of all unique chemical entities, according to Avalere research. Colorado, for instance, has only 54% of all chemical entities counted on its benchmark, Pearson told a May 2 session of Global Health Care, LLC's Health Insurance Exchange Summit in Arlington, Va.

"You start to see some really significant state-to-state variation in terms of what minimum coverage is going to look like," she says. "We're going to have states that have uniformly open formularies, and everything will be on at some tier, and then you'll have states where you could see a much stricter management among the health plans. Thinking about the national carriers, they're going to need to target their strategies on a state-by-state basis."

Robert Dubois, M.D., Ph.D., chief science officer at the National Pharmaceutical Council, a drug manufacturer-backed research organization, says formularies could be a source of adverse selection for plans, as the

first consumers to sign up on the exchanges are widely expected to be among the sickest.

"A person is going to look to see whether their drug is covered," he told the conference session. "The better the formulary, the worse it is for the health plan. It's a race to the bottom."

As such, Dubois expects that health plans will return to the environment of the 1990s, "where we had narrow, closed formularies. We may be going back to a world of a very narrow set of choices."

Mark Merritt, president and CEO of the pharmacy benefit manager trade group Pharmaceutical Care Management Association, says he expects formularies on the exchange at first likely will mirror those in the commercial world. However, they may require more generic-drug offerings, given that generics have penetrated about 80% of the U.S. pharmaceutical market, he adds.

Where he does see a likely change is in the advent of pharmacy networks, which would require patients to fill prescriptions at certain drugstores in order to get coverage.

"Right now there are more pharmacies than there are McDonalds, KFCs, Taco Bells, Wendy's, and all of the other fast-food chains combined," Merritt tells *HRW*. "The era of preferred pharmacy networks is something we're on the very, very front end of. There is enormous potential to save millions of dollars with more efficient pharmacy networks in the exchanges. It's a new trend you're going to see a lot more of over the next few years."

For now, BlueCross BlueShield of Tennessee appears to be on familiar ground as it builds pharmacy benefits for the exchange plans.

"We're not seeing anything too drastically different than what we're building for our commercial or Medicare Part D formularies," says Elaine Manieri, vice president of pharmacy management at the Blues plan. But she acknowledges that there are many unknowns in 2014.

"We do have our Medicare Part D experience on the pharmacy side of things, so that helps inform us how that individual market works," she tells *HRW*. "Only it's going to be a drastically different kind of population — younger and things like that."

Manieri downplays the risk of the formularies creating adverse selection.

"Our Medicare and commercial formularies are transparent," she tells *HRW*. "I think most health plans — if not all health plans — are really concerned about putting out a formulary that offers options in all the therapeutic categories. Of course they're going to think about adverse selection, but that's not going to

be their motivating factor in designing their formulary, and that's how we approach it here."

Nationwide, Bullock says that he's hearing health plans might operate on a relatively open formulary and open network in 2014. But that could change in the next year. "They may have some options to experiment with limited networks and restricted formularies," he says. "But I don't think you'll see great migration in that direction until 2015."

Bullock agrees that Medicare Part D has helped lay the groundwork for what's ahead, including with the development of Web-based tools that allow consumers to compare products and categories on different formularies. But he still predicts a "messy" rollout in the first year or two, and says plans have a long way to go to get ready for Oct. 1 enrollment.

"They're better prepared today than they would have been prior to Medicare Part D, because Medicare Part D introduced a new set of interfaces and expectations and standards into the market," he asserts. "But Medicare Part D was a drug benefit, and it didn't reach across the entire benefit program. What you've got is a much more highly integrated set of services — billings [and] other administrative services — that have to be accommodated in these exchanges. And they're not ready for that."

While most drugs are expected to be available on the exchange in the first year, patient out-of-pocket costs could be high in some states, especially for specialty drugs, says Avalere's Pearson. Some plans could have cost-sharing arrangements in which the consumer pays up to 50% of the cost of the drug. "That is going to make them incredibly price sensitive," she says of consumers shopping on the exchange.

At least one lawmaker would like to see states reconsider rules that allow high cost sharing. Rep. Doris Matsui (D-Calif.) wrote a letter last month to directors of the California exchange expressing concerns about the potential effect of the state's policy on patients with serious illnesses such as cancer.

"I am particularly concerned about the across-the-board patient coinsurance requirements for specialty medications in every metal tier, with patient out-of-pocket costs as high as 30% for specialty medications," she said in the April 17 letter obtained by *HRW*. She notes that for the leukemia drug Gleevec, this would require a patient to pay roughly \$2,500 per month.

Matsui urged California to look to states like New York, which offer "stable and affordable copays rather than high patient coinsurances."

Contact Bullock via Christine Hanson-Ehlinger at chanson-ehlinger@burchfieldgroup.com, Merritt via Charles Coté at ccote@pcmanet.org and Manieri via Kelly Allen at kelly_allen@bcbst.com. ♦