Specialty Tier Reform Update – Week of March 9, 2015

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STATES

Arkansas

Senate passes bill requiring notice for cost-sharing changes on specialty tier drugs

The Senate unanimously passed legislation this week that would require health plans relying on tiered copayments for prescription drugs to notify subscribers at least sixty days in advance of any increase in cost-sharing due to drug formulary changes.

Beginning January 1, 2017, S.B. 466 would also force plans to detail coverage benefits and costs for prescription drugs on their websites in a "readily accessible format". This information must include coverage exclusions or restrictions, as well as whether the drug is subject to a flat copayment or percentage coinsurance.

Illinois

Committee amends bill limiting cost-sharing for specialty drugs

The Senate Insurance Committee amended legislation this week that seeks to limit subscriber cost-sharing for specialty medications to $100 per month for up to a 30-day supply.

Under the initial version of S.B. 1359, the $100 limit applied to all metal tiers required by the Affordable Care Act (ACA) (see Specialty Tier Reform Update for Week of February 16th). However, the amended version would apply the $100 limit to silver, gold, and platinum coverage, while raising the limit to $200 for bronze coverage. Catastrophic policies for young adults remain exempt.

The amended bill also retains 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 still be required to implement a process by which subscribers can request an exemption from the drug formulary.

However, the amendments removed 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 February16th).

Kansas

Insurance department warns that new bill limiting drug cost-sharing could increase premiums

The Senate Committee on Financial Institutions and Insurance is considering legislation to limit prescription drug costs for subscribers to $100 per month for up to a 30-day supply, if the plan is required to offer coverage under the four metal tiers created by the Affordable Care Act (ACA). However, similar to pending legislation in Illinois (see above), a higher $200 limit would apply to those enrolled in the lowest bronze-level coverage. (The monthly limit would not apply to high-deductible health plans).

Under S.B. 202, these limits shall be inclusive of any subscriber's out-of-pocket spending, including deductibles, copayments, or a percentage coinsurance required for specialty tier drugs. Similar to comparable bills nationwide, S.B. 202 would also that plans create a process for subscribers to request an exception to the plan formulary.

If enacted, the Department of Insurance cautions that S.B. 202 would increase plan premiums for all metal levels. In addition, the difference between amounts that are currently charged and the S.B. 202 limits would be considered mandated health coverage. As a result, if state law mandates insurers cover benefits that are not included in the minimum essential benefits package adopted by Kansas pursuant to the ACA, the state would be required to pay the additional costs for those benefits for those enrolled in the Marketplace. The Department would incur the cost of reviewing all metal level plans available in Kansas as of January 1st.

Nevada

Proposed bill would set out-of-pocket limits for prescription drugs

Senator Kelvin Atkinson (D) introduced legislation last week that would limit cost-sharing for prescription drugs to no more than $50 per prescription per month, or not more than 20 percent of the maximum annual out-of-pocket limit required by the Affordable Care Act ($6,600 for individual coverage in 2015, $13,200 for families). These limits apply regardless of whether the subscriber has met their annual deductible. In addition, insurers must allow subscribers to request an exception to the drug formulary.

As with comparable bills pending in several states, insurers would also be prohibited from moving all drugs for a given class into their highest-cost drug tier, in direct response to discrimination complaints filed by consumer advocates with the Obama Administration and several state insurance commissioners (see Specialty Tier Reform Update for Week of February 16th).

The measure will be heard in the Senate Committee on Commerce, Labor, and Energy.