Hospital pharmacy directors throughout the U.S. are trying to figure out how their formularies match up with those that will be used by the qualified health plans (QHPs), which will be selling policies under the Patient Protection and Affordable Care Act (PPACA, or “Obamacare”) in their respective states. One West Coast pharmacy director who declined to be named, given the political sensitivity of the topic, says:

Hospital pharmacy formularies and qualified health plan formularies will probably never be aligned, as they have differing financial agendas, costs, etc., due to purchasing differences. If the hospital and the plan are aligned, it would be best for patient care, as there would be no changes between ambulatory care and hospital care and medication reconciliation. But that will probably not happen unless all incentives are aligned or one entity has control of the entire process/longitudinal care.

Of course, differences between commercial plan formularies today and hospital formularies are widespread. But the arrival of QHPs presents a whole new dynamic for hospital pharmacists. That is because QHP formularies must meet minimum federal standards for drug access, whereas commercial (and even Medicare Part D) formularies do not. In addition, the QHPs are under intense pressure to reduce premiums, copays, and co-insurance—again, a challenge of a different order than that faced by employers’ health plans, for example. Limiting access to medications, whether through drug utilization reviews or off-formulary restrictions, might be the best way to keep consumer prices in check.

QHP formulary construction is only one of the matters that must be sorted out as the state health insurance exchanges open for business on January 1, 2014. The exchanges were conceived as a way to make health insurance affordable for about 40 million Americans who did not have coverage. These patients are divided into two groups: The quasi-poor earn too much to qualify for Medicaid but would enter Medicaid as a result of the PPACA. The second group comprises better-off patients are divided into two groups: The quasi-poor earn too much to qualify for Medicaid but would enter Medicaid as a result of the PPACA. The second group comprises better-off individuals, self-employed workers, and employees at smaller companies who currently do not have health insurance coverage. This group would buy their health insurance from the QHPs—the designation under the PPACA—in their state.

The roster of QHPs differs in each state. All QHPs must provide benefits consistent with the federally designated essential health benefit (EHB) standard, which consists of 10 categories.

One category is pharmaceuticals, the only one of the 10 for which the Department of Health and Human Services (DHHS) established a minimum requirement. The EHB rule on drugs says that the QHPs in a given state must provide prescription drug coverage that is at least the greater of the following:

- one drug in every U.S. Pharmacopeia (USP) category and class, or
- the same number of prescription drugs in each category and class as the EHB-benchmark plan designated by the state

In most instances, the states chose a small-group plan as a benchmark. In California, for example, this is the Kaiser insurance plan for small groups.

To comply with the EHB pharmaceutical category requirement, each QHP in California, at a minimum, must have a formulary with the same number of drug categories and classes as the Kaiser small-group plan formulary. The QHP must also have the same number of drugs in each class as Kaiser, although they can be different drugs as well as different formulations. Alternatively, the QHP may follow the USP option. In fact, almost every QHP will echo the benchmark formulary. This is a likely scenario, given that the trade group for health plans—America’s Health Insurance Plans (AHIP)—tried to convince the DHHS to delete the USP option. AHIP was unsuccessful.

QHPs can have more drugs in a class than their state benchmark plan. The variability of benchmark formularies across the country is striking. Avalere Health, a Washington, D.C., consulting firm, looked at the 50 states and assessed the number of total drugs each state’s benchmark plan offered on its formulary. Some formularies were “open” and included 98% of the drugs sold today. Other formularies, like California’s, included about 50%.

Avalere came up with its percentages by studying all 50 benchmark formularies and taking the highest number of drugs, regardless of the state, in each category and class. This denominator was 1,032. Then it looked, for example, at the Kaiser small-group formulary in California and totaled up the drugs offered in its categories and classes; that number is 644. Colorado is the low state on the totem pole, with 565 drugs. Connecticut is at the top, with 1,023 drugs.

Most QHPs will not supplement the benchmark, because limiting drug access is one of the few levers that the plans have to control costs. Avalere Vice President Caroline Pearson says, “Plains have significant flexibility on formularies. That is something we will have to watch.”

The QHPs will use that formulary flexibility when setting drug deductibles, tiers, and the specific drugs they will cover. Most commercial plans today charge dollar copays in the higher-drug tiers. However, based on some initial submissions from some states, QHPs could charge copays in the 30% to 50% range.

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for their “tier 4” drugs, especially in the “Bronze”-level plans (the least costly).

“That is just not done today,” she notes.

Conventional wisdom says that formulary restrictions will have their biggest impact on outpatient access at retail pharmacies and will be of only limited concern to inpatient pharmacies, because drug costs for inpatients are bundled into the Diagnosis-Related Groups. Also, the final EHB rule from the DHHS said nothing about whether drugs on an inpatient pharmacy could apply toward the QHP “counts” in each category and class.

The Centers for Medicare & Medicaid Services (CMS) attempted to clarify that question after the final rule came out. A drug company policy expert explained:

The CMS did say it would allow ‘medical benefit’ drugs to count toward minimum requirements on pharmacy, but I don’t think they realized the full implications. There could be some gaming. Allowing medical benefit drugs to count toward the minimum requirements for pharmacy benefit drugs is like comparing apples to oranges.

Here is how that might work. Take the case of a QHP operating in a state with a benchmark formulary requiring 10 drugs for a chemotherapy “class.” One drug class can cover multiple conditions. Further assume that the typical benchmark formulary today includes 10 oral drugs, perhaps the most recently approved ones. If a hospital in that QHP’s network uses five IV chemotherapy agents for that particular class instead, those five would count toward the 10 on the QHP formulary and would delete, from the QHP formulary, five of those other oral medications, some of which might be the only oral agent available for that condition.

The second potential impact affects hospitals in a network of numerous QHPs. What if each of those QHPs uses a slightly different formulary? Would the hospital inpatient formulary be compelled to carry all the drugs on all the formularies of the 12 QHPs currently operating in California, for example?

Greg Low, RPh, PhD, Program Director of the Massachusetts General Physicians Organization (MGPO) Quality and Efficiency at Massachusetts General Hospital (MGH) in Boston, thinks there might be a potential impact on the hospital in that scenario, but he believes it would be very small. He explains:

“The inpatient P&T committee does consider how frequently its formulary is causing switches and nonformulary requests. The hospital does make some effort to align with ambulatory insurers’ formularies, but this is a tertiary concern to safety, efficacy, and economics.” He illustrates a common situation:

For example, Nasonex (mometasone) is a formulary product for many of our local payers, but it is not on the hospital formulary. A patient who uses Nasonex who is admitted will either use MGH’s formulary nasal steroid (fluticasone) or go through [the hospital’s] nonformulary process. Or if the drug is unnecessary during the admission, it would simply be restarted at discharge.

Yet for both inpatient and outpatient pharmacies, there is the rub: the nonformulary process. The EHB final rule is unclear about when QHPs must pay for a nonformulary product. Drug companies wanted the DHHS to spell out specific requirements, such as more specific appeal rights for EHB pharmacy benefits, which should include shorter timelines for appeals determinations. The DHHS did not include any additional safeguards in the final rule and did not alter its proposed rule language in the slightest on that score. Instead, it said that “additional guidance regarding our expectations for the required exceptions process is forthcoming in subregulatory guidance.” It added that its research shows that a large number of plans already offer this option (i.e., access to nonformulary drugs) in the market today.

“It is expected that plans that currently have such a process in place will not be expected to modify their existing process,” the agency said.

Besides DHHS requirements for formulary coverage within the pharmaceuticals category under the EHB rule, insurance plans will also have to meet antidiscriminatory standards that apply to all 10 categories but have unique relevance when applied to pharmaceutical access. The big issue here is whether plans can use utilization-management techniques to minimize unnecessary or overly expensive drug costs.

The final rule simply states the PPACA’s prohibition against discrimination in formulary design and drug access, but then it goes on to approve the use of “reasonable medical management techniques.” The rule explicitly endorses the use of prior authorization, but a plan could not implement prior authorization in a manner that discriminates on the basis of membership in a particular group based on factors such as age, disability, or length of life that are not based on nationally recognized, clinically appropriate standards of medical practice evidence or [that are] not medically indicated and evidence-based. 1

A reasonable medical management technique, for example, would be to require preauthorization for coverage of the zoster (shingles) vaccine in people younger than 60 years of age, which is consistent with the recommendation of the Advisory Committee on Immunization Practices (ACIP).

It is clear that QHPs will be relying on medical management and drug utilization reviews to keep patient drug costs under control. Molina Healthcare, Inc., will be offering a QHP in nine states. Like many of the other QHPs operating across the country, Molina has had a low profile. Companies such as United Healthcare, Cigna, Aetna, and the other “big boys” have been missing from almost all states. Molina, which began in California as a clinic in 1980, has had a thriving Medicaid managed care business in nine states. It is using those platforms to establish QHPs, serving primarily lower-income but not poor, individuals looking for individual or family insurance on an exchange. In California, Molina will be offering exchange policies in Los Angeles, San Diego, and the San Bernardino/ Riverside areas, where its Medicaid business is currently located, for the most part.

California has established requirements for the QHP drug benefit that differ from those in most other states. In the Golden State, all QHPs must offer the same benefit structure with regard to copays and deductibles in each of the four health insurance categories. The least expensive, and therefore the least expensive, is the Bronze plan. Moving up the ladder are the more expensive Silver, Gold, and Platinum plans. So, for example, all QHPs in California must assess a 30% copay for tier 4 drugs in a Bronze plan. For patients with a Bronze health savings plans.
account, the copay is 40%. In a Platinum plan, the copay slides down to 10%. This differs from other states where QHPs have flexibility regarding copays as long as they meet an “actuarial value” for that level plan. In the case of the Bronze plan, insured individuals, on average, must pay 40% of the costs of coverage.

In California, with the pharmacy benefit structure prescribed by the state, QHPs try to keep premiums low by keeping costs low. Kamran Hashim, an associate vice president at Molina, says the key will be keeping administrative costs low, getting discounts from hospitals for medical charges and then “doing a great job in medical management,” which includes prior authorization for off-formulary drugs that physicians may prescribe for patients.

Besides carefully watching drug utilization and probably restricting off-formulary drug access, QHPs have also been careful in establishing hospital networks. He explains:

“Where you can get the most competitive hospital contract is a big driver on how you can price your product. We have a Medicaid plan in the Sacramento area, but we couldn’t get good rates from the providers there, so we aren’t offering a QHP there.”

New Mexico is the only one of the nine states where Molina is operating that require a QHP to serve the entire state. Molina, for example, is including 80% to 90% of the physicians in its Medicaid networks in its QHP networks and 65% to 75% of its physician specialists. But only 40 to 50 of its Medicaid hospitals are included in its QHP networks. Molina is not alone, in California or in any state, in picking and choosing the hospitals it wants in its networks. In some states where there is a dominant hospital provider, the hospital has all the leverage and can force Molina or any other QHP to pay commercial rates, about twice the Medicare rates. That might be the case in eastern Wisconsin, where Aurora Health Care has 15 hospitals and sits astride the health care delivery system like a colossus. In Los Angeles, where there might be much more hospital competition, Molina might get away with paying a hospital 5% above Medicare. Whether Molina or any other QHP in Wisconsin or any of the other 49 states survives depends not only on getting reasonable hospital rates but also on a steady flow of new, profitable patients sent their way via the PPACA. The President and the Democrats, who wrote the PPACA, felt that if they “built it” (to borrow a line from the movie Field of Dreams), “then they will come.” But it isn’t clear that new patients are going to stream in the doors of QHP’s starting on January 1, 2014.

The standoffishness of the major health insurance companies would seem to indicate some healthy skepticism about the profitability of the exchanges. United Healthcare, Aetna, Cigna, and other major players have been aloof. The health plans chosen for the state-run insurance exchanges, such as Covered California and New York State of Health, are a selection of the “no name” entrants. New York, North Carolina, Ohio, and Texas.

Hospitals are supposed to help educate and sign up prospective health exchange entrants. But a report published on September 18, 2013, by PriceWaterhouse Cooper’s (PwC’s) Health Research Institute (HRI) says that although the new customer base could provide a much needed financial boost, few hospitals have developed comprehensive strategies to identify, educate, and enroll people in health plans sold through the new exchanges.

HRI interviewed executives from major health care systems that collectively represent more than 150 hospitals across 25 states, as well as national hospital associations and patient advocacy groups, to understand their plans, progress, and concerns related to participation in the 51 new state exchanges. Many providers have been slow to promote the expanded coverage options, the institute discovered. Health care systems attribute delays in their enrollment efforts to multiple factors, including “reform fatigue;” the need to finalize contracts with insurers; the slow trickle of information from regulators; and the desire for additional regulatory guidance, especially in the areas of outreach designations and certification requirements.

“As the health industry moves from wholesale to retail, the customer takes center stage,” said Ceci Connolly, Managing Director of HRI. She added:

Outreach and education should be top-of-mind for hospitals and health systems, but many are still coping with operational issues to ensure readiness for open enrollment. These companies will have to shift into gear quickly to focus on their consumer strategies and how to attract and retain a diverse mix of exchange customers.”

Some of that caution may have to do with worries about reimbursement concerning the commercial rates that hospitals will be paid and the fact that new enrollees might prefer the Bronze plans (which are supposed to charge policyholders 40% of actuarial value) when cost-sharing deductibles are added up. That 40% is the average for all patients holding this coverage in a given plan, so that 40% will translate into a different dollar amount from state to state. Regardless, Bronze policyholders may leave hospitals with large amounts of unpaid bills. Adding to that hospitals’ angst in some states is the rejection of the Medicaid expansion, which means that the hope of transitioning currently uninsured patients to Medicaid might become a pipe dream.

The promise of the PPACA may be an illusion, or it may be fulfilled. The only certainty is that it is uncertain how hospitals will fare in this brave new world.

REFERENCE