CMS Stands Pat on Exchange Formulary Requirements
States May Jump Into the Void

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The Centers for Medicare and Medicaid Services (CMS) took a very stand-pat position on formularies and P&T committees in its parallel 2017 final rule and Call Letter for qualified health plans (QHPs) that offer individual and small-business health insurance policies on the federal and state marketplace exchanges. There has been considerable controversy over alleged discriminatory drug tiering, within the marketplace exchanges and in Medicaid and employer plans, too. But to the dismay of disease advocacy groups and the relief of insurance companies and pharmacy benefit managers, the CMS’s March publication of the rule and letter makes almost no policy changes in the pharmaceutical access category. The agency simply restates that it will continue to perform “outlier analyses” of potential tiering improprieties and a second review of whether formularies are omitting certain drugs as a way of warding off members of certain disease groups from joining their plan.

Prescription drugs are one of 10 “essential health benefits” every QHP must provide. The CMS has established some general requirements in each of the 10 categories, but the CMS has never spoken on the issue of acceptable tiering. That won’t change based on the 2017 Notice of Benefit and Payment Parameters, which establishes legal obligations, and the associated Call Letter, which provides unenforceable guidance.

P&T committee responsibilities go pretty much unmentioned in both documents. In 2016, the CMS established a new requirement that all QHPs have a P&T committee. The 2017 Parameters rule and the Call Letter don’t follow up, which was a disappointment for Carl Schmid, Deputy Executive Director of the AIDS Institute, who doubles as the coordinator of the “I Am Essential” Coalition, a group of patient advocacy groups formed when the CMS first considered what should be included in essential health benefits. Schmid had expected the CMS to provide additional guidance on P&T committees at a minimum, and worries that the agency may be delegating that requirement to a far back burner.

Nor does the CMS establish any new requirements with regard to tiering of drugs, a controversial issue among many disease advocacy groups given that some QHPs have put expensive drugs—sometimes all the drugs for a single disease—in the highest tier requiring substantial patient copayments. The CMS, as it has said in past years, is continuing to do “outlier analyses” of QHPs to see whether QHPs are discriminating against any patient population via adverse tiering. But the agency has neither established any standards in this area nor publicly disclosed any remedial actions it has forced QHPs to take.

Some believe these outlier analyses are flawed. Beatriz Duque Long, Senior Director of Government Relations at the Epilepsy Foundation, says, “We believe the outlier analysis can be faulty because if all issuers engage in discriminatory practices, then they are not outliers and would not be identified by the analysis. We’ve shared this concern with CMS on several occasions.”

The Call Letter elsewhere refers to an apparently separate analysis that examines whether the formulary carries the drugs for certain diseases that are recommended by nationally recognized clinical guidelines. This review includes the following diseases: bipolar disorder, breast cancer, diabetes, hepatitis C, human immunodeficiency virus (HIV), multiple sclerosis, prostate cancer, rheumatoid arthritis, and schizophrenia. This review appears to differ from the outlier review in that it looks to see whether the QHP is using drug nonavailability as a way of discouraging certain patient groups from becoming members of the plan.

While the CMS has talked about potential adverse tiering and discriminatory cost sharing, the state of Florida has done something about it. It forced four QHPs to reposition their acquired immune deficiency syndrome (AIDS) drugs on lower tiers in 2016 as the result of an administrative complaint filed at the CMS by the AIDS Institute and the National Health Law Program. In reviews of silver plans, the AIDS Institute found that some issuers were placing every HIV drug, including generics, on the highest cost tiers and beneficiaries would be responsible for paying 30%, 40%, or even 50% of the cost of the drug until they met the plan’s maximum out-of-pocket limit.

The CMS never did anything about that complaint. However, Florida Insurance Commissioner Kevin McCarty sent a memo to all insurers in November 2015 saying that he would deem plans to be discriminatory if they did not limit patient cost sharing for HIV medications to levels that are similar to Florida’s “benchmark” plan. The benchmark limits patient copays to $40, $70, or $150 per 30-day supply, depending on the medication.

A spokesman for Humana in Florida says, “We changed our formulary requirements with respect to HIV/AIDS drugs in compliance with all Florida laws, including Florida’s HIV/AIDS Safe Harbor regulation.” CoventryOne, Cigna, Humana, and Preferred Medical were the four plans cited in the AIDS Institute’s complaint.

Given the AIDS Institute’s success in Florida, more disease advocacy groups may be starting to think about pursuing changes at the state level to marketplace exchange formularies perceived as discriminatory, an effort that may have a parallel prong as those groups also press the National Association of Insurance

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Commissioners to add tiering prohibitions to its formulary model act, which is currently being modernized.3

REFERENCES