Paper Related to Proposed Legislation Entitled: An Act Regarding Continuity of Prescription Drug Coverage Senate Bill 433

Provided for The Joint Committee on Health Care Financing

May 2009

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Commonwealth of Massachusetts

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Introduction

This paper was prepared by the Division of Health Care Finance and Policy (Division) pursuant to the provisions of M.G.L. c. 3 § 38C requiring the Division to review and evaluate the impact of a mandated benefit bill referred to the agency by a legislative committee. The Joint Committee on Health Care Financing referred Senate Bill 433 (S. 433), "An Act Regarding Continuity of Prescription Drug" to the Division for review.

Legislative Background and Intent[1]

Under the Massachusetts "right of free petition," Hayward Zwerling, MD brought what is now S. 433 to Senator Susan Tucker. Senator Tucker sponsored the bill on behalf of Dr. Zwerling as a "by request" bill.

1. S. 433 is intended to address issues of continuity of prescription drug coverage when a member changes from one health insurance carrier to another. More specifically, the bill is intended to address the following issues raised by the petitioner.
    - When patients who change health insurance carriers, they may be forced to change their prescription drugs to adhere to the policies of the new carrier. These policies may require the patient try an alternate (less expensive) drug prior to coverage of their current medication and/or require a higher level of copayments for coverage of the current medication.
    - These policies often involve a review of medical necessity and/or other administrative and clinical review that may have already been conducted under the prior insurance carrier.

Written Comments of Dr. Zwerling related to the Petition

"Presently, when consumers change health insurance carriers, they often are forced to change their prescription drugs and try lower-cost generic alternatives before their medications will be covered by the new insurance carrier. This is frustrating for the consumer as well as the prescribing physician, because in many cases the generic alternative has been tried before and deemed ineffective.

This legislation mandates that when an individual changes insurance carriers, that their existing medications be covered by the new carrier at the most favorable rate."

1. Legislative intent is based on a conference call with and subsequent feedback from the office of Senator Tucker.

2. The bill would address these issues by requiring the following:
    - When a member changes insurance carriers, the new carrier shall be required to provide coverage of current prescription drugs at the "most favorable coverage rate for any prescription medication under the policy."
    - For example, if the new insurance carrier benefit structure included tiered copayments that require higher patient payments for certain drugs, this bill would require that copayments for current medications be set at the lowest level defined under the new policy, even if the current plan policies would otherwise require a higher copayment level.
3. A more exhaustive description of various benefit structures is presented in later sections of this paper.

Summary of Proposed Mandate

If enacted, S. 433 would mandate coverage for patients under an insurance policy through the Group Insurance Commission (GIC), fully insured plans offered by commercial insurers, Health Maintenance Organizations (HMOs), and Blue Cross Blue Shield Plans. The bill would accomplish this by amending the Massachusetts General Laws to insert the following sections.

Chapter 32A, Section 17J	GIC
Chapter 175,Section 47AA	Commercial Insurer
Chapter 176A, Section 8BB	BCBS Hospital
Chapter 176B, Section 4BB	BCBS Physician
Chapter 176G, Section 4T	HMOs

Using Chapter 32A, Section 17J as an example, the text below presents the language of the section that would be inserted into the current General Law. Since the language related to the mandated benefit is materially the same in each Chapter/Section, we have presented the language of only one

> SECTION 1. Chapter 32A of the General Laws is hereby amended by inserting after section 17I the following section:
>
> "In providing coverage for an insured who was previously insured by a separate policy of insurance, the commission shall provide coverage of each specific prescription medication being prescribed to said insured as of the initial date of the insured's coverage under the policy that is equal to the most favorable coverage rate for any prescription medication under the policy."

Chapter/Section. Only the reference to the health insurers to which the mandate applies materially differs in the text of each Chapter/Section.

The full text of S. 433 is included as an attachment at the end of this paper.

Methodology

The Division prepared this paper related to S. 433 by conducting interviews with legislative staff, reviewing the relevant literature relative to prescription drug coverage and benefit structure, and drawing from an understanding of health care financing and economics. The paper does not include either an actuarial analysis or a review of medical efficacy. In consultation with the legislature, the following objectives and scope were defined for this paper.

- Provide a more thorough description of what the bill would require of health plans, including a description of typical health plan benefit structures and policies. Include examples of scenarios under which a health plan might need to change their policies and copayment structure for a given patient. These examples are intended to provide a more descriptive picture of some of the implications of the proposed legislation. However, they are not intended to represent an exhaustive list of potential implications.
- Provide a description of how such a mandate could change the experience for some patients (this would only be an example since the range of patients impacted would be too broad to generalize).
- Provide examples of how S. 433 could impact costs and utilization. These would only be selected illustrative examples to identify areas in which costs or utilization could change. They would not attempt to quantify the magnitude of any change.

The Division engaged consultant James Donohue of Boston Healthcare Advisors, LLC to write the paper and conduct background research. Commonwealth Enterprise Group (CEG) secured the contract with the Division under which Mr. Donohue performed this work.

Discussion of Prescription Drug Coverage and Management

This section presents a description of the range of prescription drug benefits and cost/utilization management approaches typically found in health plans today. It is intended to provide a context for considering the proposed legislation and its potential impact on patients and physicians as well as costs and utilization.

The information in this section is based on publicly available information and draws from policy papers, published Health Plan policies, and selected surveys of health plan benefits. A list of these sources is included at the end of this document. While these sources include information related to the policies of some Massachusetts health plans, the plans were not explicitly surveyed for this paper.

Components of Prescription Drug Benefits

Although the approach varies by health plan and by product within a health plan, the design of prescription drug benefit typically includes some or all of the following features:

Drug Formulary

The drug formulary represents the list of drugs covered by the health plan policy. These typically include most, if not all, FDA approved drugs. Formularies are often described as "Open Formularies" and "Closed Formularies" though other terms are used as well.

An Open Formulary is one that includes all or most FDA approved drugs. Open formularies do not always include all FDA approved drugs and may include selected exclusions. There appears to be a trend to differentiate "lifestyle" drugs or expensive biologics.[2]

A Closed Formulary is one that limits the number of eligible medications reimbursed by the plan. Non-covered drugs are typically only covered if the prescribing physician appeals the health plan for an exception to the formulary.

Formularies also often group covered drugs into several tiers (typically 2 or 3), which correspond to different levels of copayment levels (copayment tiers are discussed below). These tiers of drugs may include the following:

Tier 1: Includes mostly generic drugs that are less expensive

Tier 2: Includes preferred brand name drugs (typically more expensive and may not have a generic substitute)

Tier 3: Non-preferred brand name drugs (may have a generic substitute available)

2. Kaiser Family Foundation: Employer Health Benefits 2008 Annual Survey Page 140
http://ehbs.kff.org/?page=sections&id=1
Massachusetts Medical Society: Massachusetts Outpatient Formulary Guide, 11th Edition
http://www.massmed.org/conv/formulary/default.aspx

Tiered Copayment Structure

Health plan benefits also typically include a two or three tiered copayment structure. This generally corresponds to the structure within the formulary that applied to the policy, with a higher copayment associated with higher tiers. A tiered copayment structure could be structured as follows:

Tier 1: Includes Tier 1 drugs (see above). Lowest copayment

Tier 2: Includes Tier 2 drugs (see above). Higher copayment

Tier 3: Includes Tier 3 drugs (see above). Highest copayment

The copayment amount varies depending upon the policy, but all are designed to provide an incentive for the patient to consider costs as they chose which drug they wish to be prescribed.

If a patient/prescribing physician is granted an exception and allowed to purchase a drug not covered on the formulary, the patient generally pays the highest tier copayment for that medication.

Prior Authorization, Step Therapy, and Dispensing Limits

Health plans also typically establish policies related to selected drugs that require prior authorization before the drug can be dispensed and/or before a defined quantity of the drug can be exceeded. Each of these is discussed below and examples of these policies can be found in the links to health plan web pages found in the Resources section of this paper.

Prior Authorization

A health plan may require that a prescribing physician request prior authorization from the health plan before the medication can be prescribed and reimbursed. This if often called "formulary exception." This process can apply to either drugs that are covered under the formulary, but still require approval, or drugs that are not on the formulary and require an exception to be paid for under the policy.

Step Therapy

Some drugs on a formulary may require a process called step therapy prior to health plan approval for reimbursement. Step therapy is a component of prior authorization that requires that a physician and patient first try alternate drugs prior to coverage of the drug requiring step therapy. The "first step" medication is generally one that has been identified as a lower-cost alternative. If after the alternate drug(s) has been prescribed and it is found (and documented) to be inappropriate for the patient, the requested drug would be approved.

Dispensing Limits

Some drugs are also identified as requiring prior approval if the prescribed quantity exceeds pre-defined limits within a given time period. Different limits may be identified for different populations (e.g., patients under or over a certain age). Dispensing limits can be related to medication safety guidelines, cost management or both.

Examples of Potential Impacts of Proposed Legislation

This section provides select scenarios and describes the potential impact to the patient, provider and/or on the cost and utilization of services. The examples are intended to provide a context for considering the proposed bill, but do not represent an exhaustive list and are not based on claims or medical efficacy data.

Patient Scenario #1
Medical Exception/Prior Authorization for a Non-Covered Drug

A patient has just changed from Health Plan A to Health Plan B. Under Health Plan A, the patient's physician had appealed for a medical exception to allow coverage of Accolate for treatment of asthma. This drug was also subject to step therapy and the patient/physician completed this process to receive approval to prescribe Accolate under Health Plan A. The patient copayment was Tier 3 under Health Plan A (assumed to be $25 for this example). When the patient changed to Health Plan B, the physician needed to appeal for a medical exception and step therapy again to receive approval under the new plan.

Potential Patient/Provider Impact

1. If enacted, S. 433 would require Health Plan B to cover Accolate from the first day the patient was enrolled in their plan even though this drug would not otherwise be covered under their standard policies. The physician/patient would not be required to appeal for coverage or complete step therapy as would otherwise be required.
    - This would provide greater continuity of medication coverage for the patient and avoid repeating similar prior authorization steps already completed under Health Plan A.
    - This would reduce the administrative burden on the physician.
2. The patient copayment would be set at the lowest copayment tier under Health Plan B. With few exceptions, this would mean that the patient copayment would decrease under Health Plan B compared with Health Plan A.

Potential Cost and Utilization Impact

1. The Health Plan B insurance premium for the policy under which the patient is covered was established assuming the shared costs of higher copayments associated with higher cost medication.
2. The requirement that the patient be offered the most favorable coverage rate (i.e., lowest copayment tier) would increase the cost to Health Plan B since the patient would pay a smaller percentage of the drug cost than would otherwise be the case.
    - This increase would likely be reflected in the calculation of premiums in subsequent years.

- It may also result in higher levels of utilization since the patient incentive to control costs would have been reduced.

3. It is not clear how the Health Plan B would verify and document the prior authorization of Accolate under Health Plan A.
   - The prior authorization and documentation requirements of the two Health Plans may differ.
   - The Health Plans would also need to establish a means of sharing information in a manner that is compliant with HIPAA and other patient confidentiality requirements. This could increase the administrative costs for the Health Plans.
4. The level of coverage for the patient who changed plans would differ from that of patients who remained with the same health plan.
   - The copayment requirement for Accolate for the patient who changed health plans would be lower than that for a patient who remained with the same health plan (i.e., one patient's copayment would be at Tier 1 [lower payment], while the other would be at Tier 3 [higher payment]).
   - This creates a potential incentive for a patient to change health plans in order to lower their copayment obligation.

Patient Scenario #2
Medical Exception to Dispensing Limits

A patient has just changed from Health Plan A to Health Plan B. Under Health Plan A, the patient's physician had appealed for a medical exception to the dispensing limitation on a medication for the patient to meet the patient's medical needs. The patient copayment was Tier 3 under Health Plan A (assumed to be $25 for this example). When the patient changed to Health Plan B, the physician needed to appeal for a medical exception again to receive approval to exceed the drug dispensing limit.

The impacts of Scenario #2 are materially similar to that in Scenario #1 and include:

Potential Patient/Provider Impact

1. S. 433 would provide greater continuity of medication coverage for the patient and avoid repeating similar prior authorization steps.
2. This would reduce the administrative burden on the physician.
3. The patient copayment would be set at the lowest copayment tier under Health Plan B. With few exceptions, this would mean that the patient copayment would decrease under Health Plan B compared with Health Plan A.

Potential Cost and Utilization Impact

1. S. 433 would increase the cost to Health Plan B since the patient would pay a smaller percentage of the drug cost than would otherwise be the case.
   - This increase would likely be reflected in the calculation of premiums in subsequent years.
   - It may also result in higher levels of utilization since the patient incentive to control costs has been reduced.
2. It is not clear how the Health Plan B would verify and document the prior authorization processed under Health Plan A.

Resources

Kaiser Family Foundation Employer Health Benefits 2008 Annual Survey
http://ehbs.kff.org/

Massachusetts Medical Society: Massachusetts Outpatient Formulary Guide, 11th Edition
http://www.massmed.org/conv/formulary/default.aspx

Aetna Pharmacy Transition of Coverage Information
http://www.aetna.com/products/rx/rx_trans_cov.html

Congressmen Henry Waxman report on Access to Formulary Drugs
http://oversight.house.gov/documents/20060323101029-28542.pdf

Pharmacy Policies of Selected Massachusetts Plans (available on Plan Web sites)

Blue Cross Blue Shield of Massachusetts
https://www.bluecrossma.com/pharmacy/en_US/pharmacyIndex.jsp?repId=Repositories.MainContent.guest_specialtyPharmacy.xml&templateType=QualityCareDosing.jsp

Harvard Pilgrim Health Care
https://www.harvardpilgrim.org/portal/page?_pageid=253,41644&_dad=portal&_schema=PORTAL

Tufts Health Plan
http://www.tuftshealthplan.com/providers/provider.php?sec=pharmacy&content=programs

Fallon Community Health Plan
http://www.fchp.org/Extranet/Providers/Pharmacy.htm

Neighborhood Health Plan
http://www.nhp.org/Pages/members_yourpharmacy.aspx

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Attachment: An Act Regarding Continuity of Prescription Drug Coverage, Senate Bill No. 433

SENATE, No. 433

By Ms. Tucker (by request), a petition (accompanied by bill, Senate, No. 433) of Hayward Zwerling for legislation regarding continuity of prescription drug coverage. Elder Affairs.

Version with line numbers

The Commonwealth of Massachusetts

In the Year Two Thousand and Seven.

AN ACT REGARDING CONTINUITY OF PRESCRIPTION DRUG COVERAGE

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Chapter 32A of the General Laws is hereby amended by inserting after section 17I the following section:-

Section 17J. In providing coverage for an insured who was previously insured by a separate policy of insurance, the commission shall provide coverage of each specific prescription medication being prescribed to said insured as of the initial date of the insured's coverage under the policy that is equal to the most favorable coverage rate for any prescription medication under the policy.

SECTION 2**.** Chapter 175 of the General Laws is hereby amended by inserting after section 47Z the following section:-

Section 47AA. Any blanket or general policy of insurance, except a blanket or general policy of insurance which provides supplemental coverage to Medicare or other governmental programs, described in subdivision (A), (C) or (D) of section 110 which provides hospital expense and surgical expense insurance and which is issued or subsequently renewed by agreement between the insurer and the policy holder, within or without the commonwealth, during the period this section is effective, or any policy of accident or sickness insurance as described in section 108 which provides hospital expense and surgical expense insurance, except a policy which provides supplemental coverage to Medicare or other governmental programs, and which is delivered or issued for delivery or subsequently renewed by agreement between the insurer and the policy holder in the commonwealth, during the period that this section is effective, or any employees' health and welfare fund which provides hospital expense and surgical expense benefits and which is promulgated or renewed to any person or group of persons in the commonwealth, while this section is effective, in providing coverage for an insured who was previously insured by a separate policy of insurance, shall provide coverage of each specific prescription medication being prescribed to said insured as of the initial date of the insured's coverage under the policy that is equal to the most favorable coverage rate for any prescription medication under the policy.

SECTION 3. Chapter 176A of the General Laws is hereby amended by inserting after section 8AA the following section:-

Section 8BB. A contract between a subscriber and the corporation under an individual or group hospital service plan which provides hospital expense and surgical expense insurance, except contracts providing supplemental coverage to Medicare or other governmental programs, delivered, issued or renewed by agreement between the insurer and the policyholder, within or without the commonwealth, shall provide to all individual subscribers and members within the commonwealth who were previously insured by a separated policy of insurance and to all group members having a principal place of employment within the commonwealth and who were previously insured by a separated policy of insurance, coverage of each specific prescription medication being prescribed to said subscribers and members as of the initial date of said subscribers' and members' coverage under the policy that is equal to the most favorable coverage rate for any prescription medication under the policy.

SECTION 4. Chapter 176B of the General Laws is hereby amended by inserting after section 4AA the following section:-

Section 4BB. (a) Any subscription certificate under an individual or group medical service agreement, except certificates which provide supplemental coverage to Medicare or other governmental programs that shall be delivered, issued or renewed within the commonwealth shall provide, as benefits to all individual subscribers or members within the commonwealth who were previously insured by a separate policy of insurance and to all group members having a principal place of employment within the commonwealth and who were previously insured by a separate policy of insurance, coverage of each specific prescription medication being prescribed to said subscribers and members as of

the initial date of the subscribers' and members' coverage under the policy that is equal to the most favorable coverage rate for any prescription medication under the policy.

SECTION 5. Chapter 176G of the General Laws is hereby amended by inserting after section 4S the following section:-

Section 4T. (a) In providing coverage for an insured who was previously insured by a separate policy of insurance, individual and group health maintenance contracts shall provide coverage of each specific prescription medication being prescribed to said insured as of the initial date of the insured's coverage under the policy that is equal to the most favorable coverage rate for any prescription medication under the policy.

SECTION 6. This act shall apply to all policies, contracts, agreements, plans or certificates of insurance issued or delivered within the commonwealth on or after January 1, 2008, or upon renewal to all policies, contracts, agreements, plans or certificates of insurance in effect before January 1, 2008.