Cancer Drug Coverage and Transparency in Health Insurance Marketplace Plans

A recent American Cancer Society Cancer Action Network (ACS CAN) analysis of coverage of cancer drugs in the health insurance marketplaces created by the Affordable Care Act has found that coverage transparency has improved somewhat since 2014, but significant barriers remain for cancer patients. The analysis examined formularies in marketplace plans in six states – California, Florida, Illinois, North Carolina, Texas, and Washington – which accounted for 46 percent of all marketplace enrollees as of June 30, 2015. In all, 66 different plan formularies were examined to determine transparency, coverage, and cost-sharing for 22 cancer drugs from 66 silver plan formularies using links provided by the marketplace. In summary, the analysis found:

- Coverage of newer oral chemotherapy medications was limited in some states in 2015;
- Coverage for intravenous medications remains unclear in most plans;
- Cost-sharing structures presented in plan formularies did not match those presented on marketplace websites nearly half of the time;
- Plans continue to place most or all oral chemotherapy medications on the highest cost-sharing tier, presenting transparency and cost barriers for patients; and
- Nearly half of plans placed a generic oral chemotherapy drug on the highest cost-sharing tier, which may constitute a discriminatory cost-sharing design.

Detailed Findings

- Availability of links to prescription drug formularies has improved since ACS CAN performed a similar study in 2014,[1] but transparency issues remain.
    - Among the six states included in our analysis, all marketplaces provided links to prescription drug formularies, though only 58 percent went directly to a prescription drug formulary.
    - Nearly half of formularies (47 percent) had cost-sharing tiers that did not match the cost-sharing information provided on the marketplace website.
- Many cancer drugs are covered by all or most plans, but coverage of IV drugs remains unclear and newer cancer medications appear to be heavily excluded from formularies in some states. Across all six states, 15 of the 18 oral chemotherapy drugs we studied were covered by more than 85 percent of formularies. In general, coverage for chemotherapy drugs administered intravenously is far less clear, as was the case in 2014.
- Limits on coverage of the cancer drugs we analyzed, such as prior authorization, step therapy, and quantity limits, were applied frequently, and information on the specific nature of those limits was generally not available.
- Most cancer drugs are placed on the highest cost-sharing tier, often with significant coinsurance requirements.
    - Of the 18 oral cancer drugs examined, 17 were placed on the highest cost-sharing tier by more than 80 percent of formularies.
    - The placement of all or nearly all cancer drugs on the highest cost-sharing tier, including generics, in many plans appears not to be designed to encourage use of cheaper or more effective alternatives, but to extract the maximum patient cost-sharing for all cancer drugs.
    - Across all six states, between 73 and 100 percent of silver plans use coinsurance on the highest cost-sharing tier, meaning consumers using cancer drugs must pay a percentage of the cost of their drugs rather than a flat copayment.

[1] In 2014, we examined formularies in marketplace plans in six states: California, D.C., Florida, Ohio, New York, and Texas.

Recommendations

ACS CAN strongly recommends that states and HHS pursue the following policy changes to ensure adequate, timely, and affordable access to prescription drugs to treat cancer:

- **Direct links to formularies**: HHS and state-based marketplaces should require insurers to provide direct links to searchable prescription drug formularies for each qualified health plan. HHS and states should have processes in place to verify the accuracy of the submitted links, and to allow insurers to provide updated links during the year if necessary.
- **Cost-sharing transparency**: All drugs listed in formularies should be clearly labeled with a cost-sharing tier that matches those displayed on the marketplace and in the Summary of Benefits and Coverage. HHS and state-based marketplaces should perform periodic checks to ensure that formulary links provided match prescription drug data submitted by qualified health plans and displayed on marketplace websites.
- **Complete tiering information on marketplaces and in the Summary of Benefits and Coverage**: Comparative information on healthcare.gov and state-based marketplaces, as well as the standard Summary of Benefits and Coverage forms used nationwide, should be expanded as needed to include cost-sharing information for plans with five or more tiers in their prescription drug benefit.
- **Standardized cost-sharing**: States and HHS should consider creating standardized cost-sharing for qualified health plans to improve transparency and reduce ability to design plans that discourage enrollment by high-cost consumers. Standardized cost-sharing should use copays, rather than coinsurance, for all prescription drugs.
- **Exceptions process:** HHS and states should strengthen and enforce the exceptions policy allowing enrollees access to non-covered drugs when medically necessary. The exceptions process could be strengthened through standardized cost-sharing requirements and standardized exceptions request forms, and by requiring plans to cover currently-used drugs for those changing plans as they pursue the exceptions process.
- **Coverage limits**: Quantity limits should be clearly described in formulary documents and consistent with clinically appropriate use. Quantity limits should not be used to place additional administrative or cost-sharing burdens on enrollees, such as requiring refills every 15 days. For patients changing plans, any step therapy requirements should be waived if the patient is already being successfully treated on a particular medication.
- **Discriminatory tiering**: HHS and states should monitor prescription drug benefits closely for evidence of discrimination against patients with high-cost conditions. This includes monitoring the cost-sharing for generic and brand drugs used to treat high-cost conditions such as cancer, as well as monitoring coverage limits on these drugs.
- **Copays, not coinsurance**: HHS and states should encourage or require the use of copayments for prescription drugs rather than coinsurance. Coinsurance requirements are not transparent and prevent patients from adequately comparing plans. As a first step, states and HHS should require any plans using coinsurance to provide an estimate of out-of-pocket costs associated with all drugs covered using coinsurance.
- **Consumer tools:** Marketplaces should develop tools that allow consumers to search for plans that cover their prescription drugs. In addition, out-of-pocket cost calculators - including the one available on the healthcare.gov website in 2016 - should allow for input of consumers' specific prescription drug utilization.