

Formulary Transparency Helps Cancer Patients



Most health insurance plans that cover prescription drugs use formularies for categorizing the drugs the plan will cover and determining the amount of cost-sharing that will be applied. Formularies are generally organized into “tiers” – starting with the least expensive generic drugs on the lowest tiers and the most expensive drugs on the top or specialty tier. The placement of a drug on a particular tier has a direct bearing on the copay or coinsurance a patient will pay.

Formulary Transparency

Health plans generally are permitted to offer different formularies for different products offered to consumers. For an individual with specific health care needs – like cancer patients and survivors – the drugs covered by a health plan and the corresponding cost-sharing for each drug is important to patients when choosing a health plan. However, in order for the consumer to make an informed choice of health plans, formulary information must be disclosed to the individual.

ACS CAN Position

Health plans should abide by the following disclosure requirements:

- Formularies should be disclosed to individuals before the individual enrolls in a health plan. This means that formulary information must not reside behind a “pay wall” and must be easily accessible via a website and through a toll-free number.
- Prescription drug information – including the list of drugs covered, the cost-sharing, and any utilization management tools – must be disclosed to the consumer via the formulary.
- Because prescription drugs used by cancer patients may be covered under a health plan’s medical – as opposed to prescription drug – benefit, the formulary must also disclose any drugs covered under a medical benefit.

ACS CAN supports policies at the state and federal level that require plans to follow these principles.

Appeals and Exceptions

While the Affordable Care Act requires certain insurance plans to cover Essential Health Benefits,¹ and there is some indication that these requirements have worked to reduce the number of denials cancer patients face,² insurance plans do still deny coverage of certain treatments to cancer patients. Insurance plans may also have particular requirements for a treatment – like step therapy, prior authorization, or high drug tier placement – that inhibit cancer patient access to needed drugs. One of the fundamental ways these denials and policies inhibit access is by increasing treatment costs for patients. If a plan does not agree to cover a particular drug for a cancer patient, that patient must decide to pay the full cost of the drug, seek charity care, or use a different – perhaps less effective – treatment.

When an insurance plan makes a coverage determination that a patient or her doctor is unhappy with, in almost all cases the patient and/or doctor has the right to appeal the decision or ask for an exception. Patients submit **appeals** when the plan denies coverage outright, whereas they ask for an **exception** if the plan covers the treatment, but has a requirement for the treatment that will be too burdensome.

The following are situations in which cancer patients and doctors commonly ask for an appeal or exception:

- The plan/formulary does not cover a drug the doctor considers to be medically necessary.
- The doctor has prescribed Drug B, but the plan requires the patient to try Drug A first.
- The plan requires prior authorization for a drug, which is difficult or impossible to obtain by the time the patient needs the drug.
- The drug a patient needs is on a high formulary tier and therefore requires cost-sharing that is unaffordable to the patient.
- The plan has moved a drug to a higher tier on its formulary during the plan year, resulting in higher cost-sharing required for the patient.

Requirements for appeals and exceptions processes differ by plan type, but all non-grandfathered private insurance and Medicare Part D plans are required to have internal and external appeals processes, as well as processes allowing patients and doctors to request exceptions and receive responses within certain timeframes.

ACS CAN Position

- ACS CAN believes robust and transparent appeals and exceptions process are crucial to helping cancer patients and their families afford prescription drugs.
- ACS CAN supports the federal rules currently in place that require all non-grandfathered private plans and Medicare Part D plans to have internal and external appeals processes, and to have exceptions processes with strict deadlines for plan responses.
- ACS CAN supports the federal rules currently in place that require appeals and exceptions processes to be transparent, and supports further efforts by federal or state regulators to require plan processes to be open, transparent and easily understandable by the average consumer. Appeals and exceptions must not be tools only for well-educated patients, or for patients who receive help from navigators. All patients must be able to effectively use these processes to help them afford their drugs.

¹ American Cancer Society Cancer Action Network. Cancer Patients Need Access to Comprehensive Health Insurance. January 10, 2017.

<https://www.acscan.org/policy-resources/cancer-patients-need-access-comprehensive-health-insurance>.

² Volk, J. & Ahn, S. Navigating the Coverage Experience and Financial Challenges for Cancer Patients: Affordable Care Act Brings Improvements, but Challenges Remain. July 2017. <https://www.acscan.org/policy-resources/navigating-coverage-experience-and-financial-challenges-cancer-patients>.