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Prescription Drug Coverage Overview

Health insurance providers negotiate with drug manufacturers to lower drug costs and design plans to encourage enrollees to consider lower cost drugs that can safely and effectively treat a condition before trying higher costs drugs that treat the same condition.

The "formulary" (also referred to as the "preferred drug list") is a list of drugs covered by the plan, the amount of the copay or coinsurance for each specific covered drug and information on any specific requirements that might apply for a drug to be covered. Prescription drug coverage features are summarized for enrollees, providers, regulators and people shopping for insurance in the drug formulary associated with a specific health insurance policy.

Below we provide a general overview of how drug coverage and formularies work. Prescription drug coverage details and processes for spcific plans can be found in member materials, on the plan's website or by calling the plan.

a. Who Decides What Is Covered?

There are some drugs that state or federal law require be covered.[1] Other decisions about which drugs are included on a formulary are made by a Pharmacy and Therapeutics Committee (P&T Committee). A P&T Committee is a group of doctors, pharmacists and other experts who make decisions about prescription drug coverage and determine which copay or coinsurance level (tier) will apply to each drug. Members of the P&T Committee review scientific evidence on drugs and meet at least quarterly to discuss how specific drugs should be covered.

For individual and small group plans, regulations require that the P&T Committee:

- Has a majority of practicing physicians, pharmacists and other licensed prescribers;
- Has a sufficient number of different kinds of doctors;
- Has at least 20% committee members who don't have conflicts of interest;
- Prohibits anyone with a conflict of interest from voting on formulary decisions;
- Meets at least quarterly; and
- Documents all coverage decisions and retains that documentation. [2]

Employers often require any insurance provider used to be accredited by NCQA or URAC. To qualify for this accreditation, the formulary must be governed by a P&T Committee.

[1] Federal law requires group and individual health insurance plans to cover drugs with no patient out-of-pocket cost if the United States Preventive Care Task Force determines the drug is likely to prevent illnesses and related problems based on high-quality scientific evidence (see 45 CFR 147.130). For individual and small group plans subject to the federal requirement to cover essential health benefits (EHBs), certain drugs must be covered based on EHB rules and the state's EHB benchmark plan (See 45 CFR 156.122 and state benchmark plans).
[2] See 45 CFR 156.122.

b. How Does the P&T Committee Decide?

If a drug is covered and is "on formulary" the P&T Committee has decided - based on review of scientific evidence - there are patients for whom that drug is a safe, therapeutically appropriate choice. For individual and small group plans, federal regulations require the P&T Committee:

- Base decisions on scientific evidence;
- Consider the safety and effectiveness of drugs;
- Review all new drugs and new FDA-approved uses of previously approved drugs; and
- Ensure the formulary doesn't discourage enrollment of people with specific medical conditions. [3]

The vast majority of drugs will retain their formulary status and tier for the whole policy year. However, to promote clinically effective drugs, protect patients when safety issues come to light and respond to drug manufacturers' ad-hoc price increases, health plans occasionally make mid-year formulary changes. When a mid-year formulary change occurs, health insurance providers and PBMs have processes for identifying enrollees who are taking the specific drug and notifying them of the change.

c. How Do Patients Know What's on the Formulary?

Health insurance providers and group health plans are required by law to provide enrollees and prospective enrollees with a Summary of Benefits and Coverage (SBC) document. Federal regulations require that a link to the plan's formulary be included in the SBC.[4]

Here's what the information that must be included in SBC's looks like.[5]

Drug Coverage Explanation in the Summary of Benefits and Coverage

Example Benefits in CMS Sample – Actual cost-sharing for a plan would be here.

Link to Plan Formulary is Here

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	$10 copay/prescription (retail & mail order)	40% coinsurance	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
More information about prescription drug coverage is available at www.[insert].com	Preferred brand drugs (Tier 2)	$30 copay/prescription (retail & mail order)	40% coinsurance	
	Non-preferred brand drugs (Tier 3)	40% coinsurance	60% coinsurance	
	Specialty drugs (Tier 4)	50% coinsurance	70% coinsurance	

Qualified health plans (QHPs) sold on individual and small group exchanges are also required to publish formularies in an easily accessible format that can be viewed by the general public and in a manner where a person can easily tell which formulary applies to which plan.[6] In the 39 states using the federally-facilitated exchange (FFE) platform, health insurance providers provide formulary data in a machine readable format, updated monthly, and made available to the public.[7]

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[3] See 45 CFR 156.122.
[4] See 45 CFR 147.200.
[5] https://marketplace.cms.gov/technical-assistance-resources/summary-of-benefits-fast-facts.pdf
[6] See 45 CFR 156.122.
[7] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces-and-February-17-Addendum.pdf

Shoppers on exchanges using the FFE platform also have access to a drug look-up tool to check the formulary status of their drugs for different plans as they shop.

Beyond what's required by law, health insurance providers offer consumer-friendly online formulary search tools where consumers can look up whether specific drugs are covered. Consumers can also call their health plan and ask about the coverage of specific drugs.

d. Patient Out-of-Pocket Costs

Health insurers cover the majority of the total cost of prescription drugs[8] and federal law caps what patients can be required to spend out-of-pocket on EHBs, including EHB prescription drugs.[9] Once a patient or family has spent the amount specified as the annual maximum out-of-pocket (MOOP), they do not pay any more copays or coinsurance that plan year for covered prescriptions purchased at an in-network pharmacy.

e. Formulary Tiers – Lower Patient Costs for More Cost-Effective Drugs

Coverage for prescription drugs is designed to lower out-of-pocket costs for patients who choose a relatively lower-cost, safe, effetive drug. Cost-sharing tiers are the main incentive for doctors and patients to consider lower-cost drugs first.

Each tier has a cost-sharing level assigned, with the most expensive drugs usually being assigned to a higher cost-sharing level. After determining a drug is safe and effective and should be covered, the P&T committee assigns each drug to a cost-sharing tier. The relative cost of the drug is one factor considered when assigning tiers. The annual MOOP applies no matter what tier a drug is assigned to, and once an enrollee or family reaches their MOOP they won't pay any copays or coinsurance for covered EHB drugs.

To understand formulary tiers, it's important to understand the role of generic drugs and therapeutic alternatives.

> ***Generics*** **-** Generics are drugs that are chemically equivalent to the corresponding brand drug but are usually far less expensive than they brand-name version of the same drug. Many plans cover generics at a very low cost to patients.
>
> ***Therapeutic Alternatives & Preferred Brands*** **-** For conditions that can be treated by multiple safe and effective brand-name drugs but that have no generic options, the lowest-cost brand name drug that treats the condition may be placed on a lower cost-sharing tier, sometimes labeled as the "preferred brand" tier. Drugs that treat the same condition but are not chemically equivalent are called "therapeutic alternatives."

Here's an example of what cost sharing might look for different drug tiers in CMS' sample SBC.

[8] https://www.healthsystemtracker.org/brief/tracking-the-rise-in-premium-contributions-and-cost-sharing-for-families-with-large-employer-coverage/

[9] See 45 CFR 156.30.

Drug Coverage Tiers and Cost Sharing Example

Example Benefits Cost Sharing by Tier in CMS Sample

*Remember that once the MOOP limit is reached for the year the patient does not pay any more cost-sharing.

Example Tiers

Services You May Need	What You Will Pay	
	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)
Generic drugs (Tier 1)	$10 copay/prescription (retail & mail order)	40% coinsurance
Preferred brand drugs (Tier 2)	$30 copay/prescription (retail & mail order)	40% coinsurance
Non-preferred brand drugs (Tier 3)	40% coinsurance	60% coinsurance
Specialty drugs (Tier 4)	50% coinsurance	70% coinsurance

Step therapy or prior authorization apply to a limited number of drugs and are also employed to encourage patients and providers to first consider safer and/or lower cost drugs. Consumers can learn about how these features apply to a specific drug by looking up the drug in the plan's formulary.