ISSUE BRIEF

SPECIALTY TIERS

As the cost of health care continues to rise, more and more health plans are transferring the increased cost of prescription drugs on to patients in the form of cost-sharing arrangements. These cost sharing arrangements include higher premiums, co-payments, deductibles, and coinsurance. Patients living with rare, serious, or chronic conditions are disproportionately impacted by this shift in cost-sharing. A priority concern for these patients is insurers who are implementing "specialty tiers" for prescription drug plans (PDP's).

Background

Tiering is a cost-sharing strategy employed by insurers that places drugs into groups called "tiers" based on criteria determined by the insurer. A three-tiered drug formulary is traditionally used by many prescription drug plans. These tiers have fixed co-pays, for example, a $10 monthly prescription refill for a generic drug. For drugs in specialty tiers however, instead of requiring flat rate co-pays, insurers often require patients to pay a percentage of the cost of a drug. This is known as coinsurance. Specialty tier coinsurance rates can vary from 20% to 50% or more. A specialty tier drug is defined as a category of prescription drugs within a tier in a drug formulary for which a beneficiary's cost-sharing is greater than tiers for generic drugs, preferred brand drugs, or non-preferred drugs in the prescription drug plan's formulary.[1]

The most common drug tiering structure used by insurers categorizes drugs in the following way:

- Tier I – Generic Drugs, typically the lowest, flat rate copay
- Tier II – Preferred Drugs, typically a medium, flat rate copay
- Tier III – Non-Preferred Drugs, typically a higher, flat rate copay
- Tier IV, Tier V (Specialty Tier) Unique, high cost drugs, patients charged percentage of cost

In the 2013 survey of Employer Health Benefits, the Kaiser Family Foundation found that 81% of covered workers are in plans with three or more cost-sharing tiers. They also found that coinsurance is the most common form of cost-sharing for the fourth tier.

Impact

Patients living with chronic or life-threatening diseases such as hemophilia are disproportionately impacted by the shift in cost-sharing by insurers who are implementing specialty tiers as part of their drug formularies. Drugs placed in specialty tiers are typically high cost drugs, biologics, and drugs that need special administration and monitoring. Hemophilia drugs are biologics derived from natural sources and can have a higher manufacturing cost than chemically derived formulas. Patients with chronic or life-threatening diseases like hemophilia are reliant upon these expensive medications to stay well.

[1] Summary of H.R.460 - Patients' Access to Treatments Act of 2013, http://beta.congress.gov/bill/113th/house-bill/460. Accessed December 2, 2013.

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The ACA currently requires out-of-pocket maximums for health care costs of $6,350 for individuals and $12,700 for families. However, for plans that use more than one administrator, the prescription drug plans will not be required to comply with the out-of-pocket maximum requirement until 2015. Even with out-of-pocket limits, a patient using a specialty tier drug could face financial hardship every year because of annual out-of-pocket limit resets.

The cost for medication for adults with hemophilia can range anywhere from $250,000 to over $1 million annually. If an individual with hemophilia who uses medication costing $30,000/month and has a plan with a 25% coinsurance rate, then each year their January out-of-pocket costs would be the full annual out-of-pocket limit of $6,350. For most patients, this kind of financial outlay in one month is not feasible.

Numerous studies demonstrate that high out-of-pocket costs for medication lead to decreases in compliance to medical treatment, especially for lower-income groups who are more likely to experience chronic illness. Non-adherence to medication regimens results in $100 billion spent each year in the US on avoidable hospitalizations.[2] The use of specialty tiers by insurers will continue to escalate this cost even with out-of-pocket limits offering some degree of a safety net for financial catastrophe.

Legislation

Several states such as Delaware, New York, Vermont, and Maine, have enacted legislation that limits or prohibits higher coinsurance rates for drugs in specialty tiers.

Federally, a bill is currently before congress which supports minimizing the cost of specialty tier drugs in commercial health plans. H.R. 460 *Patients' Access to Treatment* Act.

For more information, contact HFA at advocacy@hemophiliafed.org

We are here to support your advocacy efforts!

ADDITIONAL RESOURCES

Kaiser Family Foundation. Employer Health Benefits 2013 Annual Survey. September 2013, http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8466-employer-health-benefits-2013_summary-of-findings1.pdf

Health Care Reform Update: July 2013 – Cost-Sharing Requirements http://www.makinghealthcarereformwork.com/healthcarereform/assets/library/ANS_Cost_Sharing_Fact_Sheet_FAQ_13_0531.pdf

National Patient Advocacy Organization. White Paper: Specialty Tiers. May 2013 http://www.npaf.org/files/5%207%2013%20Specialty%20Tiers%20White%20Paper%20Final_0.pdf

Rare Disease Legislative Advocates. H.R. 460 – Patients' Access to Treatments Act http://rareadvocates.org/h-r-460-patients-access-to-treatments-act-pata/

[2] Osterberg L, Blaschke T. *Adherence to medication*. N Engl J Med 2005;353:487-97.