

## 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 traditionally is used by most prescription drug plans. These tiers have fixed co-pays; for example, a \$10 flat rate 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 of a drug’s cost. 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.<sup>1</sup>

The most common drug tiering structure used by insurers that use specialty tiers is the following:

- 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 biological 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.

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<sup>1</sup> 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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In 2015, the ACA will require out-of-pocket maximums for health care costs of \$6,600 for individuals and \$13,200<sup>2</sup> for families. Out-of-pocket maximums will continue to rise annually. While they are critical to keeping health care affordable, it's important to remember that out-of-pocket maximums do not apply to premiums and only apply to in-network services. Also, 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 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 for that year. 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.<sup>3</sup> 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

Currently, Alaska, Delaware, Louisiana, Maine, Maryland, Montana<sup>4</sup>, New York, and Vermont have enacted legislation that limits or prohibits higher coinsurance rates for drugs in specialty tiers. Many other states have introduced similar legislation, passed study bills, or passed bills requiring notification that a drug has been placed on a specialty tier.

Federally, a bill is currently before congress which supports minimizing the cost of specialty tier drugs in commercial health plans, H.R. 460 the *Patients' Access to Treatment Act*. HR 460 will only apply to plans that are under the jurisdiction of the Employment Retirement Income Security Act (ERISA) which includes employer plans. State legislation is still needed to regulate those plans under jurisdiction of states, such as Marketplace plans.

**For more information, contact HFA at [advocacy@hemophiliafed.org](mailto:advocacy@hemophiliafed.org)**

**We are here to support your advocacy efforts!**

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<sup>2</sup> These limits do not apply to High Deductible High Premium plans which have out-of-pocket maximums of \$6,450 and \$12,900 in 2015.

<sup>3</sup> Osterberg L, Blaschke T. *Adherence to medication*. N Engl J Med 2005;353:487-97.

<sup>4</sup> Montana did not pass legislation. Marketplace plans agreed to limit the use of specialty tiers and coinsurance based on negotiations held with the Insurance Commissioner.

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### 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](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](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](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/>