Statement: Let's stop discriminatory prescription drug practices
March 6, 2015

Too many Coloradans pay extraordinarily high amounts for specialty drugs that enable them to maintain their health. That's because of a tier structure that lets health insurers charge up to 50 percent coinsurance on expensive-but-necessary medications for chronic diseases such as MS, leukemia, hepatitis, hemophilia and HIV. This common practice costs Colorado families struggling with the physical, emotional and financial burden of chronic disease thousands of dollars a month in prescription costs. In short, though people with chronic disease can now purchase health insurance products because of the guarantee-issue provisions of the Affordable Care Act (ACA), many experience problems paying for their drugs. Studies show that the high cost of specialty drugs is one of the main reasons people stop taking them – putting their health and life at risk.

Fortunately, the Colorado Division of Insurance (DOI) took a significant step toward addressing this problem by acknowledging that these cost-sharing structures are discriminatory and violate the spirit of the ACA. In January, the DOI issued a bulletin cautioning carriers and consumers that such policies for drug benefits "may constitute a prohibited practice that is in violation of Colorado insurance law and regulations." In addressing the concerns, the DOI advised Colorado insurers to use the coinsurance model for prescription drugs in no more than 75 percent of their plans, meaning that consumers with chronic conditions would have the option of selecting co-payment plans. The DOI also established guidelines for co-payment plans, including limiting copayments to no more than 1/12th of a plan's annual out-of-pocket maximum. For example, if a plan includes an out-of-pocket maximum of $6,000 a year, policyholders should not pay more than $500 per drug on the highest cost tier. Though the DOI's bulletin isn't binding, health plans historically adhere to these documents, which are interpretations of existing insurance law or general statements of DOI policy.

The bulletin was the result of many months of discussion between the DOI, the Colorado Association of Health Plans, pharmacy groups, and consumer advocates initiated at the behest of a coalition of consumer advocacy groups (which included the Colorado Center on Law and Policy, Colorado Consumer Health Initiative, the Chronic Care Collaborative, the Colorado-Wyoming Chapter of the National MS Society, the Colorado Chapter of the National Hemophilia Foundation and the American Cancer Society's Cancer Action Network). Beginning last spring, stakeholders explored different ideas for addressing the cost issue, including legislation, regulatory measures and methods for spreading the costs so the onus didn't fall primarily on people with chronic diseases and disabilities. The goal was to forge solutions that could be put in place for the 2016 health plan year.

Ultimately, the DOI's acknowledgement that the current drug benefit tier structure is discriminatory is significant. But there's still much work to be done on this front. Though the DOI's guidance could ease some of the financial burden for those who need high-priced specialty drugs, the costs are still prohibitively high for many Coloradans. Because the caps only pertain to individual drugs, those who require multiple drugs could still pay thousands of dollars in co-payments every month until they reach their out-of-pocket maximum. Furthermore, the DOI's 75-25 split for coinsurance-copayment plans could force those who need specialty drugs into costlier or less optimal health plans in terms of patients' ability to access particular physicians and facilities -- which one could argue is still a discriminatory price structure. Should carriers not comply consistently, consumers with chronic diseases could be funneled into a limited number of plans. This adverse selection could threaten the viability of particular plans or carriers and potentially destabilize the market.

Though we value the DOI's efforts, further work must still be done in lowering the costs of specialty drugs on consumers. For example, we support eliminating coinsurance structures entirely. Since people with chronic conditions are likely to be taking several medications concurrently, we'd also like to see caps on total monthly co-payments – rather than just setting caps for individual drugs.

Though time has run out to further address the problem for the 2016 health plan year, we welcome the opportunity to continue working with the DOI, health plans and pharmacy groups to make health accessible and affordable for all, and to ensure that plan benefit structures are non-discriminatory.

-- *Colorado Center for Law and Policy, Colorado Consumer Health Initiative, the Chronic Care Collaborative*