HIV+HEP

POLICY INSTITUTE

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Biden Administration Takes on Insurer Abuses in Prescription Drug Coverage

Codifies that All Covered Drugs Must Count as Essential Health Benefits

*Washington DC…*The Biden administration has released a proposed rule that will govern how private health plans must operate in 2025. CMS is proposing as part of the *Notice of Benefits and Payment Parameters* rule to close a loophole that some insurers are exploiting in order to collect additional revenue that they are not entitled to. Further, they continue to warn insurers about discriminating against certain beneficiaries, such as those with HIV and hepatitis C, through their prescription drug coverage and are proposing to add patient representatives to Pharmacy & Therapeutics (P&T) committees that select drug coverage. They continue standard plan options that limit patient cost-sharing and propose to move to a new drug classification system to determine drug coverage. Missing though was any mention of the need for insurers to count copay assistance in accordance with the recent federal District Court ruling in the case *HIV and Hepatitis Policy Institute et al. v HHS*.

"While we are pleased that CMS is taking steps to clamp down on insurers who are abusing the system by covering drugs without including them as part of essential health benefits, we are disappointed they are not directing payers to immediately count copay assistance, at a minimum, for brand name drugs without a generic alternative," commented **Carl Schmid, executive director** of the **HIV+Hepatitis Policy Institute**. "While we understand that the case was recently decided, it will be important that CMS issue guidance that directs payers to comply now with the Court's decision and ensure enforcement."

CMS is proposing to codify their existing policy, in place since 2016, that plans covering prescription drugs in excess of the state's benchmark plan are considered essential health benefits (EHB) and are therefore subject to EHB protections, including annual cost-sharing limits. In recent years, some insurers have been abusing the system by covering drugs but classifying them as "non-EHB," forcing patients to pay more in cost-sharing. Payers who use this scheme also attempt to exploit copay assistance from drug manufacturers far in excess of the annual amount payers are entitled to.

The recent court ruling in the case led by the **HIV+Hepatitis Policy Institute** striking down the rule that allowed insurers and PBMs not to count copay assistance and now prohibiting

most copay accumulators, in combination with the proposed EHB clarification from CMS, will now also eliminate copay maximizers for small group and individual market plans. Payers are still exploiting this in large group and self-insured plans and the government must now take further action to block it.

In the draft letter to issuers CMS again cautions payers that it is presumptive discrimination to design drug formularies by placing "all or a majority of drugs needed to treat certain chronic medical conditions" on high cost-sharing tiers. Once again, they said they will conduct adverse plan reviews of four drugs classes, including HIV and hepatitis C.

Despite these repeated statements, the **HIV+Hepatitis Policy Institute** has continued to identify plans in states including North Carolina and Texas that violate these patient protections and have repeatedly called for better oversight and enforcement by both federal and state regulators.

HIV+Hep is pleased that CMS is continuing to require issuers to offer standard plans that do not allow co-insurance and limit patient cost-sharing for prescription drugs. We continue to believe that some of the copay costs, especially for specialty drugs, are still too high and would like all prescription drugs not to be subject to a deductible for all metal tiers. We look forward to reviewing the proposal that issuers can offer additional non-standard plans that would benefit consumers with chronic and high-cost conditions, such as HIV and hepatitis C, if patient cost-sharing is 25 percent lower than their corresponding non-standard plan.

CMS is also proposing to add patient representatives to P&T committees that payers use to select drugs on plan formularies. Adding consumer representatives who have direct experience with the conditions that the drugs are used for will add an important viewpoint and CMS is lauded for this step. **HIV+Hep** has recently identified a plan in Texas that is blatantly not following treatment guidelines. While P&T committees are already supposed to have representatives with clinical experience, adding a patient perspective should improve compliance and add an important perspective.

Finally, **HIV+Hep** looks forward to commenting on CMS' proposal to move away from the current drug classification system to develop the essential health benefit component for prescription drugs. The current system is developed for Medicare and does not include all drug classes, including weight loss and reproductive drugs, and is only updated every three years.

Comments on the draft rule will be due in 45 days; comments on the letter to issuers are due on January 2, 2024.

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