NCAPIP
National Council of Asian Pacific Islander Physicians

NCAPIP Position Statement: Specialty Tier Drug

Lawmakers Join in Navigating the Cost of Specialty Tier Medication

- State Rep. Jehan Gordon (D-Peoria, IL): "There should not have to be a choice between medication and the other necessities in life," said Gordon. "Specialty tier medications place a significant financial burden on people with chronic illnesses, which result in some patients having to stop taking their prescribed medication because they simply cannot afford it. It is unacceptable that we have categories of drugs that seem to be virtually unregulated when it comes to the cost passed on to consumers."

- Assemblywoman Fiona Ma (D-12th Assembly District, CA) is proposing legislation to prevent health insurers from moving vital medications to Tier 4 status: "What we're trying to do is make sure that patients are able to afford the medication they need. We are looking at cap system and cost containment for individuals who are on medication," said Ma. "Sixty-one percent of Americans take prescription medication daily. It is alarming when health plans are reclassifying drugs into a new Tier 4 category."

- Georgia's Congressman Hank Johnson, along with many other Members of Congress, recently wrote in a letter to the Administrator of Medicare and Medicaid services: "We are troubled by the proliferation of "specialty tiers" for high-cost drugs that treat conditions such as rheumatoid arthritis, multiple-sclerosis, and hemophilia. Unlike generic and preferred brand drugs that generally require co-pays, therapies placed on a specialty tier are subject to coinsurance, requiring the beneficiary to pay a percentage of the drug's cost. This can amount to patients having to spend thousands of dollars to obtain needed medication, leading many to forego or alter treatment and suffer worse health outcomes that ultimately increase costs for Medicare and the health care system overall."

- The New England Coalition for Affordable Prescription Drugs (NECAPD) first major initiative is the preclusion of specialty tiers in all six New England States.

- Right now, New York is the only state with a law preventing specialty tiers.

What are "specialty tiers"?

Between 2000 -07 health expenditures grew 89% in the United States with prescription drugs representing about 10% of the total spent. Since 2000, increases in health care premiums have outpaced inflation and changes in worker earnings (2-4% annual wages growth vs. 5-14% health care premiums growth). Many health insurance plans have implemented cost sharing mechanisms in their drug plans, including specialty tiers in their drug formularies: a. **Tier 1:** Generic/Preferred Brand Drugs, lowest-cost drug tier; b. **Tier 2:** Preferred Brand/Non-Preferred Generic Drugs, middle-cost tier; c. **Tier 3:** Non-Preferred Generic/Non-Preferred Brand Drugs, higher-cost tier; and d. **Tier 4:** Specialty Drugs**:** highest-cost tier (a percentage of the cost as opposed to a fixed amount).

Specialty drugs are usually prescribed for patients with serious chronic diseases such as cancer, autoimmune conditions like Crohn's disease, lupus, multiple sclerosis, rheumatoid arthritis, and hemophilia. Transplant patients are also charged specialty tier prices.

Between 2006-08 the number of Medicare Part D prescription drug plans using coinsurance rates of 33% for specialty tiers increased more than five-fold. In 2009, Humana, the second largest provider of Medicare drug plans increased the coinsurance on specialty medications from 25% to 43%.

Medicare Part D prescription drug plans establish formularies listing specific drugs they cover and the level of cost sharing charged to Medicare enrollees. Plans can offer a "standard" benefit with 25 % coinsurance for all covered drugs or a benefit with tiered cost sharing. Most plans use tiers with different cost-sharing amounts for generic, preferred, and non-preferred drugs, and a specialty tier for very high cost and unique drugs. Placing a drug on a specialty tier has cost implications for enrollees. For example, Kaletra and Truvada (to treat HIV) have a monthly cost of $738 and $925 respectively. On preferred tier coverage, the monthly cost sharing is $23 or $35 vs. $228 and $285 (ten times higher) when placed on specialty tier. Regardless of the cost-sharing amounts enrollees pay during the initial coverage period, those who take expensive specialty tier drugs quickly reach the coverage gap (donut hole) ($2,700 in 2009). Enrollees who pay the full cost of their drugs during the gap, a total $4,350 out of pocket, reach catastrophic coverage. Unfortunately not everyone can afford to do so.

The National Council of Asian Pacific Physicians (NCAPIP) Position

NCAPIP is a non profit organization of Asian American, Native Hawaiian and Pacific Islander physicians advocating for the health and well being of their patients and communities. The patients they serve originate from almost 50 countries and speak 100 languages, constituting one of the fastest growing ethnic populations and presenting with conditions that negatively impact on their health, such as limited English proficiency (LEP), high poverty rates, a low level of high educational attainment and a high rate of being uninsured. Up to 35 % of Asian Americans, Native Hawaiians and Pacific Islanders live in linguistically isolated households (Census 2000), are unable to access basic health care services since few are offered in their respective languages and are more likely to live in poverty.

As a cost sharing strategy, specialty tier is problematic for a number of reasons:

1. Specialty tier violates the basic principal of insurance whereby individuals and employers purchase health insurance plans to preclude the risk of needing to pay for highly expensive medical treatments. "They're just so frustrated because they're paying their premiums and this runs completely counter to what insurance is supposed to be about, which is equitably spreading the risk. So this is antithetical to the very nature of insurance," said Stewart Ferry, the public policy director for the National MS Society.

2. Insurers can change specialty tier coinsurance rates unpredictably and arbitrarily. Patients cannot anticipate and budget for health care costs or have informed discussions with their doctors on containing their treatment cost. With a low English proficient population, this problem is more pronounced.

3. High out-of-pocket costs for medications prohibit people from complying with the treatment prescribed, especially for lower-income groups who are more likely to experience chronic illness and severely ill people are four to five times as likely to delay or avoid medical care when faced with financial problems due to medical bills. In both instances, the problem is intensified in Asian American, Native Hawaiian and Pacific Islander populations.

While NCAPIP fully supports the passage of the recent health care bill (PPACA) that provides patients with many protections, out-of-pocket prescription medication costs are not sufficiently protected. To fully protect patients, steps must be taken to prohibit or stem the practice of specialty tiered co-insurance.

Therefore, legislation to restrict specialty tier is one approach to help ensure that every person living with chronic and/or severe illnesses and requiring high cost drugs, has access to the therapies that can slow disease progression and increase quality of life, without subjecting the patient to the potentially devastating cost of specialty tier coinsurance. NCAPIP fully supports this needed legislation.

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