TIME FOR AFFORDABILITY

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MID-YEAR DRUG FORMULARY CHANGES

THE FACTS ABOUT S.5022-C (SERINO)/A.2317-C (PEOPLES)

Myth: Mid-year formulary changes take away options from consumers.

Reality: Health plan formularies provide enrollees access to effective drugs in every therapeutic class to ensure efficacious treatment. While plans may move a drug to a different tier, the member still has access to the drug. Decisions to change tiers are made by plans' Pharmacy and Therapeutic Committees (P&T). These committees, comprised of experts in the diagnosis and treatment of disease, review new drugs and the latest clinical information to ensure plan members have access to needed medications while also helping reduce the cost of member premiums, incentivize use of the most effective drugs, and ensure patient safety.

Myth: Mid-year formulary changes are driven by costs.

Reality: Prescription drug costs are a primary driver of annual premium increases. Although cost can be a factor, it is not the sole determiner when a drug is moved or removed from a formulary. As new drugs come to market, plans' P&T Committees review for efficacy and opportunities to control and reduce prices.

Myth: Mid-year formulary changes happen frequently and without any warning to consumers.

Reality: The Department of Financial Services limits how often plans may update formularies to no more than six times a year. However, plans typically make changes less frequently and rarely remove drugs from the formularies. Medicare as part of the federal Final Rule for 2019, is moving towards New York's more flexible approach regarding formulary changes. Currently, when an individual is impacted by the move of their drug to a higher tier, or when a drug has been removed from the formulary, there must be a therapeutic equivalent drug that is as effective as the drug that was moved/removed. In all cases, plans must notify affected members about the formulary changes.

Myth: Consumers have no recourse when plans make formulary changes.

Reality: New York law requires plans to have "exception" processes that enable consumers or their providers to access specific treatments, including prescription drugs. This ensures members get the most effective drugs regardless of whether the drug is on the formulary. While health plans encourage use of the preferred drug, members have access to the drugs they want even when not on the formulary, although the cost sharing may be higher than the preferred products. This enables the health plan to offset increased pharmacy benefit costs, and for the member to access the medications they want.

Myth: The bill would require health plans to "lock in" drugs currently on the formulary for a year.

Reality: As individuals and employers renew policies at different times over the calendar year, "locking-in" the formulary for the policy year has the unintended result of creating multiple formularies each month for each new or renewing policy. While the current structure promotes efficiency and clarity on what the plan formulary covers, under this bill there will be multiple formularies with differing coverage of medications dependent on when a policy renews, which will promote confusion among consumers, physicians and pharmacies, and significantly drive up health plan administrative costs.

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The following are examples of mid-year formulary changes plans have made to provide both quality and cost benefits to consumers.

Hepatitis C:	Current regulations have allowed plans to modify prior authorization criteria for Hepatitis C medications to dramatically decrease cost while maintaining equal efficacy. The typical cost per treatment regimen for Hepatitis C ranged from $54,600-$72,800. Marvyret was introduced at $26,400 – *half* the price of the cheapest drugs already on the market — and considerably shortened the treatment duration. Not only were plans able to significantly reduce costs, but patients also required less treatment, which encouraged better adherence and treatment success.
Glumetza:	Prior to June of 2013, the cost of this drug was approximately $9,000 per year. In June 2015, the cost increased to more than $50,000 per year when the rights to the drug were acquired by Valeant. The following month July 2015, Valeant increased the price to more than $80,000 per year. There is no clinical evidence that the drug is more effective than other metformin products that already exist - and which cost less than $100 per year. As a result of the price increase, plans were able to apply utilization management requirements on Glumetza and/or remove it from the formulary to help drive utilization to the lower cost but equally effective Metformin ER.
Fluticasone/Salmeterol:	In 2017 the first-ever generic asthma combination inhaler became available. It contains the same active ingredients as Advair, but for a fraction of the price – $119 per inhaler compared to $360 per inhaler. Following the drug's introduction, one health plan moved to add the drug to its formulary, saving an average of $3,500 per patient per year.
Cuprimine:	The cost per capsule of Cuprimine was $62 until July 30, 2015 but increased to $261 per capsule on July 31, 2015, after Valeant acquired it. The chemical used to make the medication (penicillamine) is available from a different manufacturer as brand name Depen and has an annual cost of $84,000 – significantly less than Cuprimine's annual cost of $380,000.
Solaraze:	Based on utilization and trend data, plans identified that Solaraze was being potentially prescribed inappropriately for off-label use. PA was added to this drug midyear to allow for review for a medical appropriate diagnosis and steer towards an equally effective but lower cost alternative.
Levorphanol:	This opioid medication has specific FDA labeling indicated that it should be reserved for patients for whom alternative treatment options are not effective or appropriate. Recently all but one manufacturer of Levorphanol ceased making the drug. As a result of this market change, the cost of the drug went from $0.75 to $53 per tablet. Plans were able to implement utilization management to the drug that complimented the FDA indication and will also steer utilization to lower cost opioids if needed.

SAY "NO" TO S.5022-C/A.2317-C