October 23, 2015

Rachel Bowden
Life, Health & Licensing Division
Texas Department of Insurance
333 Guadalupe, MC 113-1C
Austin, Texas 78701

Via email: LHLcomments@tdi.texas.gov

RE: Comments on the informal working draft of rules relating to formulary disclosure requirement in Title 28 Texas Administrative Code, Chapter 21, Subchapter V.

Dear Ms. Bowden:

Thank you for the opportunity to provide feedback on the informal working draft rules relating to formulary disclosure requirements. The consumer and health advocacy organizations listed below supported HB 1624 during the 84th Legislative Session and were pleased to see so many strong consumer protections in the informal draft rules. We have identified the sections that we believe do the most to increase transparency for consumers who are shopping for health insurance, and have some suggestions for additional ways to ensure Texans are have all the information they need to pick a health plan that works for their families and their budgets.

Currently, shopping for health insurance on the private market can be a frustrating experience. Tara Seidenberg, a Texan living with multiple sclerosis (MS), recently tried to find a health insurance plan that had reasonable out-of-pocket costs, including co-pays and co-insurance. Because most MS drugs are very expensive even with health insurance, access to the complete prescription drug formulary and detailed information about what she could expect to pay for a drug was critical to be able to pick the plan that worked for her. Researching health insurance plans was extremely time consuming – Tara described feeling lost in a spider web of links and web pages trying to find the information she needed to make the best choice to cover her complex health care needs. We are hopeful that the final rules released by the Department will result in consumers like Tara being able to more easily access all of the information they need to make an informed decision about their health insurance plan.

§21.3031(c)

On behalf of Texas consumers and those living with a chronic illness, we fully support the goal behind the Department's proposal to require insurers to include *all requirements* under §21.3033 and §21.3034 in one place, either the web tool or electronic formulary disclosure document. We believe that this approach is best for consumers. However, we want to acknowledge that we believe the statute does not require this approach. We helped draft the bill language in Ch. 1369.0543(e) to allow flexibility for cost-sharing information to be displayed separately from the rest of the formulary disclosure. The intent behind allowing this separation was to encourage health plans to create web tools which could provide more precise drug cost-sharing information, while allowing plans to maintain fewer electronic formulary documents (so that a separate online PDF was not required for every plan design variation).

We support the use of web tools in addition to the formulary disclosure, even if the information they provide is incomplete, provided that they deliver cost-sharing information that is more precise, up-to-date and plan-specific. In other words, if the quality of information provided by the web tool increases,

we believe it would justify the potential confusion created by requiring a consumer to reference two separate tools to get complete information about their prescription drug. Note that we believe that the statute requires the web tool alternative to provide plan-specific cost-sharing information, as is shown in Ch. 1369.0543(e)(2), which requires that consumers be able to search for formularies by the marketing name of the health benefit plan.

> Recommendation: Allow web tools to be used to display drug cost-sharing information, provided that the web tool delivers more precise, timely, and plan-specific cost-sharing information.

We see the obvious downsides to having critical information spread across several places (the Summary of Benefits and Coverage, the formulary disclosure, and the web tool), which will make it harder for consumers to find and utilize information. We also question the inability, over time, for web tools to incorporate the largely-static additional information required in the formulary disclosure. If the Department allows cost-sharing information to be displayed separately, we ask that the Department help mitigate any potential harm to consumers in two ways: (1) ensuring consumers know how to access complete information, and (2) by encouraging health plans to include complete information in web tools over time.

> Recommendation: the Department should require that a web tool provide disclaimer language which notes that additional information is available to help consumers fully understand their drug coverage in the Summary of Benefits and Coverage (SBC) and the electronic formulary document, and provide direct links to these documents.

> Recommendation: The Department should allow for an implementation window in which web tools can provide incomplete information, with the goal of eventually requiring all necessary information in one place. A phased-in approach could give health plans and PBMs time to create online interfaces for the information that will already be available in the electronic formulary document.

§21.3033(a)(2)

We strongly support the inclusion of drugs administered by a physician or other provider within the formulary disclosure, as is required by Ch. 1369.0543(b)(2). Many of our organizations' members use both physician-administered drugs and drugs dispensed by pharmacies. Including all drug coverage information in one document, even if it has not been the practice in the past, will be extremely helpful to our members. In particular, it will help consumers discern which drugs are subject to deductibles and other cost sharing under medical or pharmacy benefits.

We understand that PBMs manage drug benefits and carriers separately manage medical benefits and that the information needed to comply with statute will therefore need to come from two different sources. We would support the incorporation of the medical benefit information as an addendum to the pharmacy-benefit drug list.

We know that at least some carriers are already including coverage information for drugs covered under a plan's medical benefit. In a study of drug coverage transparency conducted by ACS CAN, four drugs administered exclusively by IV injection were examined (Arzerra, Avastin, Herceptin, Rituxan). For all silver level marketplace plans sold in Texas, these four drugs were included on plan formularies or search tools 56%, 28%, 44% and 78% of the time, respectively.

In addition, disclosure of coverage ***and cost*** information for drugs covered under a plan medical benefit is already being done by at least one insurance carrier in Texas, Molina Healthcare Inc. As you can see by the screen shots provided, Molina's drug search tool provides coverage and estimated cost information for three of the four drugs ACS CAN examined in their study.

> Recommendation: We would suggest the Department examine how Molina Healthcare Inc. is calculating the estimated costs associated with drugs administered in a provider's office. As an alternative, we would also suggest that carriers provide such costs by looking at the previous year claims data and calculating estimates similar to how PBM's are being directed to calculate estimates for drugs covered under a plan's pharmacy benefit.

§21.3033(c)(6)

We strongly support the Department's requirement that the formulary document include information on cost-sharing amount by drug *after* the deductible has been met. People with chronic conditions generally understand plan designs and know that they have to meet their deductibles first before coverage begins. Our members often satisfy their deductibles within the first few months, and then must be able to afford their prescription drug cost-sharing for the remainder of the year. The most notable piece of missing information for our members today is what dollar amount they will owe in coinsurance. This alternative also has the advantage of incorporating the cost-sharing features of the plan design for the consumer, so the consumer doesn't have to also consult the formulary document to get tier information, check the SBC to get cost-sharing amounts by tier, and then accurately piece the information together to end up with a price.

We think that the post-deductible information is also directed by statute. Ch. 1369.0543(e)(2) requires that consumers be able to search for formulary information by the marketing name of the health benefit plan. If the pre-deductible allowed amount was intended, there would be no need for a consumer's plan design/plan name to be taken into account when displaying cost-sharing information in a web tool.

We had several discussions among ourselves and with our members to try to decide whether providing cost-sharing information before or after the deductible would be most meaningful. While all of our groups feel that post-deductible costs are critical, some of our groups believe that also providing pre-deductible costs are necessary. Without this additional piece of information, consumers cannot know how much they will owe out-of-pocket for drugs pre-deductible and for how many months they will be subject to a deductible. We encourage the Department to consider requiring plans to provide both pre- and post-deductible cost-sharing amounts, but again, note that requiring post-deductible amounts is paramount.

> Recommendation: Maintain the requirement in §21.3033(c)(6) to display post-deductible amounts. Consider also requiring the pre-deductible amount as an additional piece of information.

Regardless of which option is adopted in the final rule, the wording consumers will read that explains what cost is displayed needs to be crystal clear, so that consumers fully understand whether the price displayed is pre-deductible or post-deductible.

Recommendation: the Department should establish suggested language carriers can use to describe the displayed cost. If possible, language should be consumer-tested to ensure it is as clear as possible.

In addition to our top priorities noted above, we have the following comments on the rules.

§21.3001 Scope and Severability
§21.3001(a)(3) should also apply rules at §21.3034 to plans subject to TIC 1369 Subchapter B.

§21.3032(a)
We strongly support maintaining the requirement that consumers be able to obtain a paper copy of a formulary document upon request. This requirement is clearly consistent with the goals of HB 1624 to provide more information on drug benefits to enrollees and potential enrollees. Information that a consumer has access to should not be limited simply because the consumer lacks a computer or internet access.

§21.3032(b)(1)
In general, we understand why the Department proposes to allow plans to exclude cost-sharing information from paper formularies and strongly support the protections in §21.3032(b) that ensure consumers would get cost-sharing information in other ways. We suggest updating §21.3032(b)(1) to clarify that should a health plan make cost-sharing information available by phone, the consumer must get access to all information provided in the disclosure document from one phone call.

Recommendation: Update §21.3032 (b)(1) to read "a toll-free number through which a current or prospective enrollee may obtain cost-sharing information for any formulary drug and other information required by §21.3033 and §21.3034."

§21.3033(b) and §21.3033(c)(2)
These sections of the statute are clear that the formulary disclosure required by law must clearly differentiate between drugs covered under the plans' pharmacy benefit and medical benefit, and for each drug indicate whether a pharmacy or medical deductible applies. These sections are critical to helping people with chronic conditions understand their benefits.

The standard summary of benefits document required for all plans sold on healthcare.gov include a section disclosing the "overall deductible" applied to the plan, as well as a separate section indicating whether there are "other specific deductibles for specific services". If there is a separate deductible applied only to items covered under the pharmacy benefit, it should be indicated in this section. The formulary document or search tool should then indicate which drugs are covered before or after the "overall deductible" or the "other specific deductible", if one is indicated for any subgroup of drugs, including some or all those covered under the pharmacy benefit. Please see summary of benefits screenshot example from a Texas Blue Cross and Blue Shield Gold Marketplace plan, attached.

§21.3033(d)
We have concerns about the data used to calculate the cost of the allowed amount of a drug in §21.3033(d). Allowing an insurer to calculate cost-sharing for a 31-day supply of a prescription drug using claims data for a 12-month period ending not more than 12 months before the date that the information is provided is likely to lead to inaccurate information about the cost of the drug. Using this

method could result in the consumer getting information that was calculated using data that is up to 24 months old.

> Recommendation: Electronic documents should use the most recent pricing information available and be updated no less than every 12 months. We suggest that for an electronic document, plans be directed to use pricing information from as near to the start of Marketplace open enrollment as possible. Web tools should use the most real-time or near real-time pricing information.

We believe the cost information should allow consumers to make apples-to-apples comparisons between different plans, to the extent possible. To do that, consumers need to know what amount of the drug was used to calculate cost-sharing, if something other than a 31-day supply. As written in §21.3033(d), it appears as if day-supply information would not need to be noted if it was less than 31 days, for example antibiotics commonly dispensed in a 5 or 10-day supply.

> Recommendation: For drugs not commonly dispensed in a monthly supply, the electronic document or web tool should note what alternative timeframe was used to calculate the price.

§21.3033(e)

We applaud the Department for including in the draft rules a provision that would require insurers to provide a legend on each page with an explanation of each abbreviation used in the formulary, and the dollar amount that corresponds to each cost-sharing range if the insurer is disclosing a range instead of a dollar amount. §21.3033(e) will prevent consumer confusion about abbreviations and help consumers more easily understand which Medical Management Requirements they must meet to access a drug and approximately how much a drug will cost. Without a legend at the bottom of each page, a consumer would have to scroll or flip back and forth through a very lengthy document if they were unsure of what an abbreviation meant or forgot how much "$$$" might cost. This small item has the potential to greatly improve the shopping experience for a Texas consumer.

§21.3034(a)

We strongly support the Department's intent behind section §21.3034, which will promote consistency and clarity of formulary information and facilitate comparison shopping, as is required under Ch. 1369.0543. Our members are continually frustrated by their inability to effectively choose a plan based on out-of-pocket drug costs – and these are by-and-large sophisticated consumers who, by necessity, are good at reading formularies.

Given that the formulary disclosure contains several sections, we would like to highlight the information that we feel is most valuable to our members. We strongly support maintaining the requirements for information under §21.3034(a)(6)(E) "Cost Sharing," §21.3034(a)(6)(F) "Medical Management Requirements." We also support including §21.3034(a)(6)(B) "Right to Appeal," and §21.3034(a)(6)(C) "Continuation of Coverage."

We would like to ensure that the formulary document is a clear and useful as possible. We believe that some of metrics required in §21.3034(a)(1) – (4) could be confusing to consumer or provide them with little useful information for comparison shopping.

Given that some consumers who are not on any drugs today, or even our members who are, may find some value in a metric that compares drug coverage generally, we strongly recommend that the Department identify just one metric that all plans can use, as opposed to the four that are proposed.

Of the metrics proposed by The Department, we believe that Coverage for Commonly Prescribed Drugs in §21.3034(a)(3) would provide the most usable snapshot of the scope of drug coverage. This was the consensus among both the patient advocates who reviewed the rule and a "focus group" of National MS Society members who discussed proposed metrics.

We feel that the proposed metrics in §21.3034(a)(1) and (2) are confusing, and even if understood by a consumer, would provide little information to help a consumer pick a plan with the right drug coverage.

> Recommendation: Maintain the one comparison metric in §21.3034(a)(3) or a roughly equivalent way to showing the relative scope or robustness or a formulary. Remove the other comparison metrics from the subsection.

Thank you for the opportunity to provide feedback on these important rules at this early stage. We are grateful for the hard work of the Department on these rules and believe that they will greatly benefit consumers by increasing understanding of formulary coverage and facilitating comparison shopping. If you have any questions about our comments, please contact Simone Nichols-Segers at simone.nichols-segers@nmss.org or 512.340.2707.

Sincerely,

Simone Nichols-Segers
National MS Society, South Central Region
Simone.nichols-segers@nmss.org
512.340.2707

Stacey Pogue
Center for Public Policy Priorities
pogue@cppp.org
512.823.2863