

FACT SHEET #5

Prescription Medication Benefits

This fact sheet is intended to help Navigators answer specific questions that people with disabilities might ask about prescription medication benefits when they are considering buying health insurance through the Marketplace

Q1. What do I need to know about prescription drug coverage as I evaluate plans I am considering purchasing?

A. Prescription drugs are included in the list of ten Essential Health Benefits (EHBs) that each individual and small group health plan must offer in order to participate in and out of the Health Insurance Marketplace. Health plans will help pay the cost of certain prescription medications. Health plans must offer either at least one drug in every treatment category, for example, antidepressant, anti-smoking or high blood pressure medications, or the same number of drugs in each category as the plan your state has selected as a guide, or benchmark for determining EHBs, whichever is greater. If the benchmark plan does not include a specific category or class of drug, then plans must offer at least one drug in that category or class. Some drugs might also be listed within a category even though they do not belong to a specific class.¹

Q2. I take several prescription muscle relaxants that control spasms related to my disability. How can I find out what medications are covered by the health plans I am considering?

A. Once you have selected a plan, click on “List of Covered Drugs,” which appears at the top of the window summarizing deductibles, annual out-of-pocket expenses, and required co-payments and coinsurances. You should be able to navigate to a list of drugs that plan covers. The list will be organized in various ways depending on the plan. For example, the list might be organized by “Tier” (see Question 3 for more information on Tiers), which relates to cost, or by the type of drug or its main purpose, for example, musculoskeletal medications (including muscle relaxants), drugs to treat headaches, and antidepressants. Then each drug in the category will appear in an alphabetized list. Look for the medications you are taking and compare the drugs that various plans cover.

¹ In conjunction with the policy that plans must offer the greater of one drug in every United States Pharmacopeia (USP) category and class or the number of drugs in each USP category and class offered by the EHB-benchmark, HHS is considering developing a drug counting service to assist states and issuers with implementation of the proposed prescription drug policy, as described in the following methodology document: [EHB Rx Crosswalk Methodology; http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html](http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html)

Q3. What is the “tiered” pharmacy benefit structure and how does it apply to the muscle relaxants I must take?

A. It is likely that the medications that appear on the list of covered drugs for plans you are considering will be organized in “tiers” from lowest to highest copayments. Typically, you will pay the least out of pocket for drugs that are listed in Tier 1. These are sometimes referred to as “value drugs.” In a four tier plan, Tier 2 includes brand-name drugs that the plan prefers. You will pay the most out of pocket for non-preferred brand or generic drugs that are listed as Tier 3 and for specialty drugs designated as Tier 4. Look for the muscle relaxants you are taking and the tier to which they have been assigned. (Some plans list common muscle relaxants such as Baclofen in Tier 1, meaning it will cost the lowest amount the plan charges.)

Q4. How can I tell if the health plans I am considering require preauthorization for the drugs I need?

A. It is likely that the health plans you are considering will require preauthorization for certain drugs. This means that your doctor must request approval from the plan before the prescription can be filled. If the medication you require is included on the list of covered drugs, you might see the letters “PA” next to the medication that is of interest to you. These letters stand for “Prior Approval.” If they appear by your needed drug, then that plan requires preauthorization before the prescription can be filled.

Q5. How can I tell if I will be required to try a generic or other drug before the plan will cover a brand-name drug prescribed for me?

A. Health plans sometimes require that you first try a generic drug for your condition or a different brand name drug than the one prescribed for you. If you cannot tolerate that medication or it is ineffective, then the plan likely will approve the prescribed brand-name drug. This is often referred to as “Step Therapy (ST).” On the list of drugs the plan covers, look for the letters “ST” next to the drug you need. If ST appears, then that plan requires step therapy before it will approve the medication. Plans might require step therapy for certain drugs but fail to include that restriction on the list of covered drugs. If you think the drug you must take might be subject to step therapy, contact the plan you are considering for additional information.²

² See “Contacting Your Health Plan’s Customer Service Phone Number” at <http://marketplace.cms.gov/getofficialresources/publications-and-articles/contact-health-plan.pdf>

Q6. I frequently travel out-of-state to visit my family and require refills for several months. Will the plans I am considering provide these refills?

A. Most covered prescriptions have a “day supply” limit, typically a 30-day supply when the prescription is filled at a retail pharmacy and a 90-day supply when the prescription is filled by a mail-order service. Plans refer to these limits as “Quantity Per Dispensing (QPD)” limits or “Quantity Limits (QL)”. Be aware, though, that some states have dispensing laws that allow for more than a 30-day supply of certain medicines, even at a retail pharmacy. While these limits are based on clinical studies and the recommended dosage and treatment duration for specific conditions, limits vary by plan. If the letters, QDP or QL, appear on the list of covered drugs next to the drugs you need to take, then you will know that plan limits how frequently you can get certain medications refilled. Plans might limit refill quantities for certain drugs, but do not indicate that restriction on the list of covered drugs. If you think the drug you must take might be subject to day-supply limits, contact the plan you are considering for additional information. (<http://marketplace.cms.gov/getofficialresources/publications-and-articles/contact-health-plan.pdf>)

Q7. I take a specialty drug related to my disability. It must be hand formulated by a specialty pharmacy. Will the plan I am considering cover that specialty drug?

A. Certain drugs are commonly called “specialty drugs.” Specialty drugs might include biotechnology drugs or other drugs that require special ordering, handling, formulation, or customer service. Although coverage for specialty drugs will vary by plan, covered specialty drugs are often included in Tier 4 of the list of covered drugs. Plans might require you to buy these drugs at a network specialty pharmacy in order to receive the lower-cost, in-network benefits. Plans might also limit specialty drugs to a specific day-supply, for example, a 30-day supply. Plans might cover different specialty drugs, but do not list what is and is not covered on the list of covered drugs that you can review through the Marketplace website. In order to be sure that the plan you are considering covers the specialty drug you must take, contact the plan directly for additional information. (<http://marketplace.cms.gov/getofficialresources/publications-and-articles/contact-health-plan.pdf>)

Q8. I have a mental health disability and require a specific brand-name medication. My previous health plan required that I take a generic drug first, even though my doctor said I needed the brand-name medication. Can Marketplace plans do the same thing?

A. Plans cannot use treatment limitations, such as “step therapy” requirements, for mental health pharmacy benefits that are more limiting than are permitted for treatment of other illnesses and conditions. Based on your condition and treatment history, and

with your physician's approval, plans might approve the brand-name drug without requiring that you take the generic version to prove it is ineffective or causes a negative reaction. However, they likely will require preauthorization before the brand-name prescription can be filled.

Q9. I have difficulty getting to the pharmacy, so my neighborhood pharmacy delivers my prescriptions to my home. Can I go to my regular pharmacy to get my medications?

A. Health plans contract with certain pharmacies, called "in-network pharmacies." In order to learn what pharmacies various plans use, you must call those plans or visit their websites to find out whether your regular pharmacy is included. If it is not, the plan can tell you what pharmacies in your area are in the network. You can also learn if you can get your prescription delivered in the mail.

Q10. I need a prescription medication that the plans I am considering do not cover. Is there anything I can do to get these medications covered?

A. Plans participating in the Marketplace must have procedures in place to ensure that individuals receive clinically appropriate medications not covered by the plan. Once you have selected a plan and become a member, you have the right to follow your plan's pharmacy exceptions process, which allows you to get a prescribed drug that's not normally covered by the plan. Because the details of every plan's exceptions process are different, you should contact your plan directly for more information. If your health plan won't pay for your prescription, you have the right to appeal the decision and have it reviewed by an independent third party.³

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³ See "How do I appeal a health plan decision?" at <https://www.healthcare.gov/how-do-i-appeal-a-health-insurance-companys-decision/#part=1>