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Understanding Your Health Plan Drug Formulary

Drug Formulary: What You Need to Know

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What Is a Drug Formulary?

A drug formulary is a list of prescription drugs, both generic and brand name, that are preferred by your health plan. Your health plan may only pay for medications that are on this "preferred" list. Additionally, health plans will only pay for medications that have been approved for sale by the U.S. Food and Drug Administration (FDA).

The purpose of your health plan's formulary is to steer you to the least costly medications that are sufficiently effective for treating your health condition.

You will pay more if you and your doctor choose a medication that is not covered on your health plan's formulary.

Health plans frequently ask doctors to prescribe medications included in the formulary whenever possible. Many health plans review whether or not a doctor is using the health plan formulary. If not, the health plan may communicate with the doctor and encourage her to use medications on the formulary.

A Dr. Mike tip: If you don't understand your plan's drug benefits, you may be surprised when you have to pay the full retail cost for your prescription.

Who Chooses the Drugs on the Formulary?

In most health plans, the formulary is developed by a pharmacy and therapeutics committee composed of pharmacists and physicians from various medical specialties.

The committee reviews new and existing medications and selects drugs to be included in the health plan's formulary based on safety and how well they work.

The committee then selects the most cost-effective drugs in each therapeutic class. A therapeutic class is a group of medications that treat a specific health condition or that work in a certain way. For example, antibiotics are used for the treatment of infections.

Under reforms brought about by the Affordable Care Act, individual and small group plans must include at least one drug from every U.S. Pharmacopeia (USP) category and class, OR the same number of drugs in each USP category and class as the state's benchmark plan, whichever is greater.

Usually, the formulary is updated yearly, although it is subject to change throughout the year. Some changes depend on the availability of new drugs, and others occur if the FDA deems a drug to be unsafe.

What Is a Co-payment?

The co-payment is your share of the cost of a prescription, when it's designated as a flat-dollar amount. For example, if your plan covers Tier 1 drugs with a $20 copayment and Tier 2 drugs with a $40 copayment, those are the amounts you'll pay when you fill a prescription, and the remaining cost is paid by your health plan.

What is Coinsurance?

If your health plan uses coinsurance for prescription coverage (very common for drugs in Tier 4 and above), it means you'll pay a percentage of the cost of the drug, rather than a set copay amount. So if a Tier 4 drug costs $1,000 and your plan has 30 percent coinsurance for Tier 4, that means you'd be responsible for $300 of the cost when you fill the prescription.

For some conditions—like MS, for example—all of the available drugs are considered specialty drugs, which means they are typically in Tier 4 or above, and coinsurance often applies. The result can be very high cost-sharing for the insured, but the total out-of-pocket limits imposed by the ACA result in the health plan eventually picking up 100 percent of the cost, once the member has met her cost-sharing limit for the year.

What Is a Formulary Tier?

Drugs on a formulary are usually grouped into tiers, and your co-payment or coinsurance is determined by the tier that your medication is on. A typical drug formulary includes four or five tiers. The lowest tier will have the lowest cost-sharing, while drugs on the highest tier will have the highest cost-sharing.

Tier 1 has the lowest co-payment and usually includes generic medications.

Tier 2 has a higher co-payment than tier 1 and can include non-preferred generics and/or preferred brand name medications.

Tier 3 has an even higher co-payment and can include preferred or non-preferred brand name medications.

Tier 4 and 5 Depending on the plan, your highest-cost drugs will typically be in Tier 4 or 5. Your health plan may place a medication in the top tier because it is new and not yet proven to be safe or effective. Or, the medication may be in the top tier because there is a similar drug on a lower tier of the formulary that may provide you with the same benefit at a lower cost. Specialty drugs are included in the highest tier. Drugs in the top tier are typically covered with coinsurance rather than a copay, so your out-of-pocket costs at this level could be quite high.

For some of these drugs, your health plan may have negotiated with a pharmaceutical company to obtain a lower price. In return, your health plan designates the medication as a "preferred drug" and hence makes it available in a lower tier, resulting in lower cost-sharing for you.

Your health plan may also provide you with list of medications that are not covered and for which you have to pay the full retail price. This list may include experimental medications, over-the-counter medications, and so-called lifestyle drugs, such as those used to treat erectile dysfunction or weight loss.

Do Formularies Have Any Restrictions?

Most health plan formularies have procedures to limit or restrict certain medications. This is done to encourage your doctor to use certain medications appropriately, as well as to save money by preventing medication overuse. Some common restrictions include:

Prior Authorization: a process by which your doctor must obtain approval from your health plan for you to obtain coverage for a medication on the formulary. Most often, these are medications that may have a safety issue, have a high potential for inappropriate use, or have lower-priced alternatives on the formulary.

Quality Care Dosing: a process in which your health plan checks prescription medications before they are filled to ensure that the quantity and dosage is consistent with the recommendations of the FDA

Step Therapy: a process in which your health plan requires you to first try a certain medication to treat your health condition before using another medication for that condition. Usually, the first medication is less expensive.

Are There Exceptions to These Rules?

Your health plan may be open to making an exception for several situations:

- You ask the plan to cover a medication that is not on the formulary.
- You ask the plan to waive coverage restrictions or limits on your medication.
- You ask the plan to provide the medication with a more affordable co-payment.

In general, your health plan will consider these exceptions if their lack of coverage of your medication would cause you to use a less effective drug or cause you to have harmful medical event.

If your request for an exception is turned down, you have the right to appeal that decision. All health plans have an appeal process, which may include impartial people who are not employed by the plan. Moreover, if your appeal is denied you can still choose to have your doctor prescribe the medication, but you will be responsible for the full charge of the drug.

Some Advice from Dr. Mike

Know Your Health Plan's Formulary

All health plans have different formularies, and it is important for you to understand your plan's formulary. When you enrolled, you should have received a booklet that describes the formulary and lists all of the approved medications, along with an explanation of the tier co-payments and/or coinsurance. You can also access your plan's formulary online. If you have not received a formulary, call the customer service number on your drug card to request one.

Talk With Your Doctor

If you need a prescription, talk with your healthcare provider about prescribing a generic drug or a preferred brand name drug if it is appropriate for your heath condition.

Choose Your Health Plan Wisely

If you have a choice of health plans and require medications for a chronic illness, you should look at the different formularies and choose a plan that covers your medications.

Updated by Louise Norris.

Sources:

Center for Consumer Information and Insurance Oversight, Information on Essential Health Benefits (EHB) Benchmark Plans,

Center for Medicare and Medicaid Services, Final Notice of Benefit and Payment Parameters for 2016