Obamacare drug benefits block access to vital medicines

By Kate Randall
8 July 2014

[description]Many ACA plans have “closed” drug formularies that exclude some drugs to treat chronic diseases, saddling patients with the full cost of these medications.[/description]

An estimated eight million people have signed up for health care insurance under the Affordable Care Act (ACA). The Obama administration has touted this figure as proof that significant numbers of Americans now have access to “affordable,” “high quality,” health care. A look behind the numbers, however—examining the actual content of the plans offered through what is commonly known as Obamacare—reveals a different story.

Many of those enrolling have been shocked to find that many of the more affordable plans offered by private insurers on the ACA health care exchanges come with narrow networks, severely restricting their choices of doctors, hospitals and drugs. Those stepping outside of these networks can face massive deductibles and other out-of-pocket costs.

Many of the Obamacare plans are specifically designed to restrict provider networks and drug benefits. While the ACA mandates that certain “essential” benefits must be covered, such as preventive care, and that those with preexisting conditions cannot be excluded, the insurance companies have set premiums and trimmed benefits to make sure their bottom lines are not adversely affected.

Most of the least expensive ACA plans have “closed” drug formularies—a list of allowable prescription drugs, both generic and brand name, that are allowed through the policy. When vital drugs to treat chronic diseases are excluded from the formularies, patients can be saddled with the full cost of theses medications. Making matters worse, these out-of-network costs do not count against deductibles or out-of-pocket maximums.

An article by Dr. Scott Gottlieb at *Forbes* looked at drugs to treat two chronic conditions: rheumatoid arthritis (RA) and multiple sclerosis (MS). It examined the drug coverage for these conditions offered through the lower-cost, mid-range “silver” ACA plans in the most populous counties in ten states, and found that “none of the plans provided coverage for all of the drugs, or covered any of them without significant cost sharing.”

If paid for outright, the cost of these disease-modifying drugs can run into the tens of thousands of dollars annually. According to the *Forbes* examination, three drugs used to treat MS were each excluded from two of the ten plans. Estimated annual retail costs for these drugs were staggering: $53,000 for Aubagio, $57,660 for Avonex, and $55,500 for Extavia. Another MS drug—Tecfidera, which costs $62,508 annually—was left off of six of the ten plans.

Of the ten plans studied, similar results were found for drugs to treat RA:

* Xeljanz, annual cost $29,820, excluded from four plans.

* Orencia, annual cost $32,076, excluded from two plans.

* Kineret, annual cost $35,736, excluded from two plans.

* Remicade, annual cost $21,552, excluded from three plans.

* Actemra, annual cost $37,320, excluded from four plans.

Adding to the nightmare for consumers, the precise drug formularies are often difficult to determine before selecting a plan. According to a study by Avalere Health, this formulary information is difficult or impossible to access in almost half of plans sold on the federal healthcare.gov site and the state-run sites. On 38 percent of sites the formulary is not accessible at all, while it was very difficult to access on four percent of sites, and difficult on seven percent.

This means that an individual or family facing a medical diagnosis such as rheumatoid arthritis or multiple

sclerosis may sign up for a plan through one of the exchanges, only to find that the drug they need to treat the disease will either not be available, or will have to be obtained outside the plan network at a steep cost.

Patients and their families will be faced with the difficult decision of obtaining the drug at an exorbitant cost, plunging them into debt or personal bankruptcy. Others unable to secure the finances to pay for the drugs will be forced to go without, spelling undue suffering and possible premature death.

As with other aspects of the Affordable Care Act, the restrictive drug policies reflect trends in the health care system overall, as well as serving as a launching pad for instituting even deeper cuts to patient care and treatments. Unlike Medicare, the national insurance program for the elderly and disabled, the ACA offers insurance for sale on the exchanges directly from private insurers, with modest subsidies available for low-income people.

Obamacare's "individual mandate" requires individuals and families without insurance through their employer or a government program such as Medicare or Medicaid to obtain coverage or pay a fine. These penalties will rise to 2.5 percent of taxable income by 2016, guaranteeing a steady stream of cash-paying customers to the for-profit insurers.

Outside of the ACA exchanges, drug manufacturers and the pharmacy benefit management (PBM) organizations are currently sparring over drug prices, particularly for so-called specialty drugs to treat conditions such as asthma, diabetes, cancer and multiple sclerosis. The battle has nothing to do with providing access to these valuable medicines and everything to do with boosting the companies' profit margins.

More than 210 million Americans nationwide currently receive drug benefits administered by PBMs, which are responsible for processing and paying prescription drug claims as well as developing drug formularies and negotiating prices with pharmaceutical companies. The largest PBM is Express Scripts, a Fortune 100 company with 2013 revenues of $104.62 billion.

In an effort to get the drug companies to lower their prices on certain drugs, Express Scripts recently removed 48 drugs or medical products from a formulary covering more than 25 million people that went into effect in January. One of these was the respiratory drug Advair, produced by GlaxoSmithKline. Advair sales in the US fell 30 percent in the first quarter as a result, while sales of Symbicort, a drug made by rival AstraZeneca that remained on the formulary, rose by 20 percent.

Dr. Steven Miller, chief medical officer of Express Scripts, told the *New York Times* that the PBM's new formulary would save the clients who adopt it about $700 million this year, or about 2 to 3 percent of their spending on drugs. These clients are in the main corporate customers looking to reduce health care costs by restricting provider networks and increasing out-of-pocket costs.

David Lassen, chief clinical officer at Prime Therapeutics, a PBM owned by various Blue Cross and Blue Shield plans, told the *Times*, "We are seeing an increased request for these narrower formularies and excluded drugs."

Patients who rely on these drugs to treat debilitating and life-threatening medical conditions are often forced to stop using the prescription drug recommended by their doctors, with the decision left up to the bureaucrats at Express Scripts, CVS Caremark and the other big PBM's as they wheel and deal over prices with the profit-gouging pharmaceutical giants.

A report last year by the research and consulting firm GlobalDate of London projected that the pharmaceutical industry will reap between "$10 billion and $35 billion in additional profits over the next decade" as a result of the new plans sold under the Affordable Care Act. This means the US drug industry's market value would mushroom overall by 33 percent, from $359 billion in 2012 to $476 billion in 2020.