

Prescription Drug Coverage

Qualified Health Plans: Part 4 of 4



Introduction

Medications for health conditions may also be called “drugs,” “prescriptions,” or “prescription drugs.” In a health plan, covered prescriptions will be listed in a formulary. A formulary is a clinical drug list that provides visibility into what drugs are covered and what tier applies for cost-sharing purposes.

Main Topics

- The prescription formulary
- Listed and unlisted prescriptions
- Costs of prescription drugs

The Formulary (1 of 3)



- The information available in the prescription formularies will vary between carriers, and not all covered medications are shown.
- Consumers who use prescription drugs should check if the medications they use are covered by their health insurance plan.
- Consumers may want to check with their prescribing provider to see if changing a drug's brand or even the medication itself is recommended for their care.

The Formulary (2 of 3)



- Formulary documents can be found through formulary lookups from each carrier.
- Consumers can see if the medications they take will be covered by the plans they are interested in when using the [Shop and Compare Tool](#).

The Formulary (3 of 3)

- While formulary layouts vary, assisters and consumers should expect to see the medications listed by classification (or the clinical definition of what the drug treats) and then alphabetically.
- Generic medications will typically appear in lower case italics and brand medications will be capitalized.
 - **Note:** Selecting “CTRL” + “F” in the formulary can be helpful in searching for a specific prescription name.
- Most formulary changes will happen at the beginning of a plan year. However, carriers can make changes to their formulary throughout the year, especially as new drugs become available.

Listed and Unlisted Medications



- If a prescription is listed:
 - Additional restrictions may still apply. To keep patients healthy and costs managed, carriers may use additional, clinically defined steps for a drug to be covered when filled. Collectively called “Utilization Management” (UM), these levels may include:
 - Quantity Limits
 - A restriction on the amount or quantity of medication that is covered by the plan during a specific period of time.
 - Prior Authorization
 - A requirement for prescriber preauthorization before consumers receive certain services, except in an emergency.
 - Preauthorization is not a promise the carrier or plan will cover the cost.
 - Carriers may use additional, clinically defined steps for a drug to be covered when filled, which may also include step therapy and age restrictions.
 - Consumers should check with their carriers to determine prescription coverage and restrictions.

Listed and Unlisted Medications (Continued)



- If a drug is not listed
 - A medication may not be on the formulary because there is an alternative proven to be just as effective and safe but less costly.
 - Every carrier has an exception process if a prescriber can prove that a specific, non-formulary drug is clinically necessary for the consumer.

Costs of Prescription Drugs

- If the medication is listed in the formulary, the medications are broken into tiers. The tier level determines the cost to the policyholder.
- If the medication is not listed in the formulary, the policyholder is responsible for 100% of the medication costs.
- In general, tier one is the lowest cost and tier four is the highest cost. Generally, the tiers follow the following guidelines:
 - Tier 1: Generics Drugs
 - Tier 2: Preferred Brand Name Drugs
 - Tier 3: Non-Preferred Brand Name Drugs
 - Tier 4: Specialty Drugs

Key Points

- In a health plan, covered prescriptions will be listed in a formulary. A formulary is a clinical drug list that provides visibility into what drugs are covered and what tier applies for cost-sharing purposes.
- The formulary will show the names of the medications, the plan tier, and any requirements/limitations that may apply. The tier level determines the cost to the policyholder.



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