CareFirst Sales Flash

CareFirst Family of health care plans

For Distribution to Brokers/General Producers/Full-Service Producers Only
(Not intended for distribution to Groups and Members)

Date: August 11, 2017
Market: 51+ Groups

2018 Formulary Changes for 51+ Groups

In 2018, CareFirst BlueCross BlueShield (CareFirst) will implement changes to our formulary for 51+ groups upon renewal. The 2018 pharmacy portfolio will include new plans and changes to existing pharmacy plans that will help us remain competitive in the industry and address specialty drug costs.

What are the changes?
51+ Risk groups will transition to Formulary 3, with a 5-Tier benefit structure that breaks out tiers for preferred and non-preferred specialty drugs.

Non-risk groups will have the option of selecting a 5-Tier benefit structure for Formularies 1, 2 and 3.

What is the impact?
Members transitioning to Formulary 3 may have drugs that move to a different tier or be excluded (not covered on the formulary). Changes will also be made to the prescription guideline requirements, which include prior authorization, step therapy and quantity limits. An exception process exists if a member needs to take an excluded drug for medical necessity reasons.

Members with plans that have self-injectables as the 4th tier transitioning to a 5-Tier benefit structure will be impacted due to the benefit design change. The 4th and 5th tiers will now cover preferred and non-preferred specialty drugs. Members may see the following changes:

- Members taking oral specialty drugs* may have their drug moved to a higher cost-share tier.
- Members taking non-specialty self-injectables may have their drug moved to a lower cost-share tier.

Members who are negatively impacted by a formulary or tier change will be notified by letter about the change and covered alternatives.

Upon renewal, benefits for covered specialty drugs are available for members in Virginia (51+ Risk) when purchased by mail order. Members will receive convenient delivery through mail order from CVS Specialty Pharmacy to the address of their choice, including their doctor's office or a CVS Pharmacy retail location. **Maryland and DC members already have this benefit requirement.**

*Excluding members taking oral chemotherapy specialty drugs.

Employer Notifications

- 51-199 Accounts: the notification letters for each jurisdiction (DC/MD and VA) will be mailed to accounts in quarterly batches according to the schedule below:
  - September 1, 2017
  - December 1, 2017
  - March 1, 2018
  - June 1, 2018
- 200+ Risk and Non-Risk Accounts: The Account Executive must send the notification letters for each jurisdiction (DC/MD and VA) directly to the account or to the broker to be distributed to the account.

Quotes for 2018 Effective Dates

Renewals will be released in the normal timeframes, unless you have received approval for an early renewal release. Risk renewals will be released with a 5-Tier benefit design and Formulary 3.

For Non-risk renewals, you should consult with your underwriter on the appropriate 5-Tier design and formulary to be quoted. Quotes are now available for new business prospects.

Marketing Materials

The following marketing materials will be available on the broker portal by mid-September.

- 2018 Formulary Enhancements FAQs
- 2018 Formulary Changes Flier
- Customizable Benefits Grid for 51+ groups
- Rx Overviews: 3-Tier, 4-Tier and 5-Tier (for members)
- 2018 Open Enrollment Slides for 51-199 and 200+ groups
- Benefit Summaries for 51+ groups

2018 Formulary Lists

The comprehensive 2018 formulary lists, including tier changes, will be available in mid-October.
A sales flash will be sent as soon as they are posted.

Should you have any questions, please contact your broker sales representative.

C. Shekar Subramaniam

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Vice President, Sales
Small Medium SBU

CareFirst
Family of health care plans

2018 Formulary Changes

Pharmacy costs are expected to have double digit trend increases over the next few years driven primarily by the increase in specialty drug utilization and costs. To address this trend, CareFirst is implementing additional strategies and cost measures to contain rising costs.

What is a formulary?

A formulary is a list of covered prescription drugs. CareFirst's drug list is reviewed and approved by an independent national committee comprised of physicians, pharmacists and other health care professionals, known as the Pharmacy and Therapeutics Committee. This committee makes sure the drugs on the formulary are safe and clinically effective.

Why is your formulary changing in 2018?

Upon renewal, clients will be transitioning to Formulary 3, with a 5-tier benefit structure that breaks out tiers for preferred and non-preferred specialty drugs. CareFirst is making these changes to remain competitive with our plan offerings, enhance our focus on utilization of specialty drugs and reduce overall drug costs.

Preferred Specialty Drugs
Consist of both generic and brand-name specialty drugs that are used to treat chronic, complex and/or rare health conditions. These drugs are generally more cost-effective than other specialty drugs.

Non-Preferred Specialty Drugs
These drugs likely have a more cost-effective generic or preferred brand alternative available.

How will the 5-tier design impact my members?

Members with self-injectables as the fourth tier will have drugs covered under the preferred and non-preferred specialty cost share.

- Members taking oral specialty drugs* may have their drug moved to a higher cost-share tier.
- Members taking non-specialty self-injectables will have their drug moved to a lower cost-share tier.

With the change in formulary, some drugs will move to a different tier and other drugs may be excluded (not covered) from the formulary.

To ensure members are receiving the most appropriate drug for their condition(s), additional information may be required from their doctor before filling certain prescriptions. In those instances, we will work with your member and their doctor to manage prescription guidelines for:

- **Quantity limits**—Address safety concerns and minimize waste by setting limits on the amount of a covered drug that can be dispensed.
- **Prior Authorization**—Helps ensure the appropriate use of drugs by requiring doctors to request approval for members to obtain certain drugs.
- **Step Therapy**—Promotes the use of clinically proven and cost-effective drugs before members try equally effective, but more costly brand-name drugs.

There is an exception process if a member needs an excluded drug to be covered for medical necessity reasons.

Members can call the pharmacy number on the back of their member ID card for more information on how their doctor can submit an exception request.

*Excluding members taking oral chemotherapy specialty drugs

How will impacted members be notified?

Members negatively impacted by formulary or tier changes will be notified by letter about alternatives.

For more information, members can visit **carefirst.com/rx** during Open Enrollment to view their 2018 formulary (available mid-October).

Covered specialty drugs are available for members when purchased by mail order. Convenient delivery is available through mail order from CVS Specialty Pharmacy to the address of their choice, including their doctor's office or a CVS Pharmacy retail location.

If you have any questions in regard to the change in formulary, please contact your account executive.

SUM4115-1P (8/17)

2018 Formulary Enhancements FAQS

Overall Impact and Communications

1. Why is CareFirst transitioning to a formulary with a 5-Tier benefit structure?

These changes allow CareFirst to remain competitive in the industry, while incentivizing the use of lower-cost drug options. The transition enables us to meet the market needs, as accounts frequently request specialty drug tiers as a benefit offering. It will also make it easier for prescribers and members to identify preferred specialty drugs.

2. How will Risk members be impacted by the migration to Formulary 3?

Due to the change in formulary, some drugs will move to a different tier and other drugs may be excluded (not covered) from the formulary. Changes will be made to the prescription guideline requirements, which include prior authorization, step therapy and quantity limits.

3. Is there an exception process for a member to receive coverage for an excluded drug?

Yes, an exception process exists if a member needs to take an excluded drug for medical necessity reasons. A provider must submit clinical documentation to support an exception for an excluded drug to be covered. Members can call the pharmacy number on the back of their ID card for more information on how their physician can submit an exception request.

4. Will Non-risk members be impacted by the migration to a 5-Tier benefit design?

Members with a 3-Tier design in Formulary 1 and 2 migrating to a 5-Tier design will not be impacted.

Members with self-injectables as the 4th tier will be impacted due to the benefit design change. Members will now have drugs covered under the preferred and non-preferred specialty cost-share tiers.

- Members taking oral specialty drugs will have their drug moved to a higher cost-share tier.
- Members taking non-specialty self-injectables will have their drug moved to a lower cost-share tier.

5. Why are drugs excluded from the formulary?

The formulary is evaluated quarterly to reflect change in medical prescribing patterns, new drug products, and to help ensure we are delivering financial value to our members. Certain drugs are excluded from the formulary to drive utilization to lower cost brand and generic alternatives that offer similar clinical results.

6. **If a member gets a prior authorization on a drug required under Formulary 2 and the same drug is excluded on Formulary 3, will that drug continue to be covered?**

If a member has a prior authorization for a non-specialty drug under Formulary 2, and the same drug is excluded on Formulary 3, the prior authorization cannot be transferred. However, most specialty drugs prior authorizations will be transferred from Formulary 2 to Formulary 3 except for select drug classes. How will members know if they're impacted by these changes?

Members negatively impacted by a formulary or tier change will be notified by letter about the change and covered alternatives. Members on multiple impacted drugs will receive one letter listing all impacts. If multiple family members are impacted, each individual will receive a letter.

7. **Can groups get information on the number of impacted members for those moving from Formulary 2 to Formulary 3?**

ASO groups can get that information but it must be requested. The overall disruption for Risk groups is 8% of members. Group specific data would need to be requested and approved for certain groups.

8. **How can members/accounts look up formularies during their Open Enrollment period?**

Members and accounts can look up covered drugs by tier or prescription guideline requirements at carefirst.com.

- During Open Enrollment period, **Risk** members can go to carefirst.com/rx, then select Formulary 3 (5-Tier) under 2018 (available mid-October).
- During Open Enrollment period, **Non-Risk** members can go to carefirst.com/rxgroup, then select Formulary 1 (5-Tier), Formulary 2 (5-Tier) or Formulary 3 (5-Tier) under 2018 (available mid-October).
- After the effective date, members can find their specific drug costs by logging into *My Account* at carefirst.com/myaccount and selecting *Drug and Pharmacy Resources* under *Quick Links.*

9. **When will the 2018 formularies be posted on carefirst.com?**

Information on excluded drugs on Formularies 2 and 3 should be available in early October. Formularies are targeted to be available around mid-October. Risk formulary information is available at carefirst.com/rx and Non-Risk formulary information is available at carefirst.com/rxgroup.

10. **Are the formularies offered directly through CVS Caremark the same as what CareFirst offers to their clients?**

Yes, the formularies are the same.

Formulary Offerings

11. What formulary options exist?

Risk accounts must migrate to Formulary 3, there are no other options for them.

Non-Risk accounts can choose between Formulary 1, 2 or 3 (though Formulary 3 is the preferred formulary and only offered in a 5-Tier benefit design).

12. Can Non-Risk accounts offer a 5-Tier design for Formulary 1 and Formulary 2?

Yes, Formulary 1, 2 and 3 can have a 5-Tier design. Formulary 1 and 2 can also have a 3-Tier or 4-Tier benefit structure.

If an account wants to retain the 4-Tier design, the 4th tier will remain self-injectable.

If the account wants to have specialty as the 4th tier, they will need to move to a 5-Tier design with Tiers 4 and 5 having the same member cost-share.

Benefit Offerings

13. What is the default benefit design for Specialty Tiers 4 and 5?

For 200+ risk and non-risk groups, the default design takes the current drug benefit and maps it to a 5-Tier design. The intent is to provide a similar design to what is offered today, but introduce Specialty drug tiers. The default strategy varies, depending on the group's current drug design (3-Tier vs. 4-Tier).

- For 3-Tier plans, the default plan matches cost-shares for Preferred Brand and Preferred Specialty (Tiers 2 and 4) and Non-preferred Brand and Non-preferred Specialty (Tiers 3 and 5) drugs.
- For 4-Tier plans, the default plan maps the current self-injectable cost-share to the new Preferred and Non-preferred Specialty Tiers 4 and 5.
    - Prospects with a 4-Tier plan likely have specialty as the 4th tier with their current carrier, and should be mapped similarly (that is, with their current specialty cost-share to the new Preferred and Non-preferred Specialty Tiers 4 and 5).
- EXCEPTION: Based on filed contract ranges, if a 200+ risk group has a coinsurance other than 50%, the incentive alternative, and not default matching approach, must be used.

14. What are the incentive alternative cost-share options for Specialty Tiers 4 and 5?

Alternative cost-share options are available in addition to the default "matching" design that is initially offered.

- 200+ risk groups have two incentive alternatives available for Tiers 4 & 5.
    - For consistency, the $150 specialty drug max will be applied across ALL jurisdictions even though regulations on Specialty drug caps only exist in MD and DC. Therefore, due to the $150 cap on the Specialty drug copay, there are limited cost-share options that can be offered.
- Non-Risk groups have five incentive alternatives available for Tiers 4 & 5.

15. When should I recommend the default cost-share benefits vs. incentive cost-share alternatives for Tiers 4 & 5 for 200+ risk and non-risk?

The default option will be more attractive for accounts who are looking to retain a similar design that is offered today and limit the impact on their members.

The incentive alternative option would be better for accounts who are looking toward future cost trend reductions for specialty drugs. An account with high specialty drug costs or with above average number of members taking specialty drugs may be inclined to move to an incentive alternative option. Plus 200+ risk accounts with a drug plan that has a coinsurance other than 50% would need to select the incentive alternative option.

16. Why aren't there more cost-share options for Tiers 4 & 5?

While specialty drugs are the most expensive drug type (averaging $8,000 per fill), less than 2% of members are prescribed these drugs. Also, drug costs are included in the member's out-of-pocket costs, so there is a limit on the member liability of these costly drugs. There is minimal impact to drug rates by changing cost share in Tiers 4 and 5.

17. What is the rate impact for groups migrating to Formulary 3?

On average, drug rates for Risk groups will have a 2.5% decrease due to this migration. You should talk with the underwriter if a more precise estimate of decrease is needed.

Non-Risk groups should request an opportunity analysis to determine account-specific cost impacts for formulary changes.

<u>Obtaining Specialty Drugs</u>

18. Where can my members fill their specialty drugs?

Upon renewal, benefits for covered specialty drugs are available for members in Virginia (Risk 51+) when purchased by mail order. Members will receive convenient delivery through mail order from CVS Specialty Pharmacy to the address of their choice, including their doctor's office or a CVS Pharmacy retail location. **Maryland and DC members already have this benefit requirement.**

Group Customization

19. My group has a custom drug benefit design, what customization will exist in the future?

There are different customization options available, depending on risk arrangement.

For 200+ Risk accounts:

- Groups can continue to customize member cost-share for Tiers 1, 2 & 3. Customization is available within constraints of filed contract ranges.
- For Tiers 4 & 5, Risk groups can choose between the mapping default or one of the two incentive alternatives for Tiers 4 & 5. Based on filed contract ranges, if a 200+ risk group has a coinsurance other than 50%, the incentive alternative, and not default matching approach, must be used.

For Non-Risk accounts:

- Groups can continue to customize member cost-share for Tiers 1, 2 & 3.
- For Tiers 4 & 5, Non-Risk groups can choose between the mapping default or one of the five incentive alternatives for Tiers 4 & 5.
- If a group wants to offer a specialty drug tier or Formulary 3, they must offer a 5-Tier benefit design.

Obtaining a Pharmacy Benefit Summary

20. The 5-Tier benefit summaries aren't available on carefirst.com, how do I obtain a 5-Tier Pharmacy Benefit Summary?

Standard pharmacy benefit summaries will be available on the Sales Ordering System beginning August 10th.

Pharmacy benefit summaries for can be obtained now through the following interim process:

Step 1: Send an email to the custom material mailbox (custommaterialrequests.com) to request a 5-Tier summary.

Step 2: Indicate in the email the jurisdiction, the funding arrangement (risk or non-risk) and which 5-Tier drug template is required:

- Non-integrated deductible
- No drug deductible
- HealthyBlue CDH plan (which has HealthyBlue Select Generics)
- Integrated deductible
- Minimum value

Step 3: You will receive the requested pharmacy benefit summary template or templates for mark-up.

Step 4: Mark up the templates to reflect any changes from the standard.