



Specialty Tier Reform Update – Week of April 13, 2015

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STATES

California

Covered California seeks \$200-500 monthly caps on specialty drug costs

The board overseeing Covered California is proposing to cap monthly out-of-pocket costs for specialty drugs at no more than \$500 per prescription, starting with the 2016 open enrollment period.

The cap would vary according to metal tier. The \$500 cap would apply to consumers in bronze and gold plans, but be lowered to \$300 per specialty drug for platinum plans and \$200 for silver plans (to which the Affordable Care Act subsidies are tied).

The board would review and modify the caps annually based on usage data and emerging medications. It also would ask insurers to submit reports detailing how the cost-sharing caps on specialty drugs would impact premiums and recommend alternatives.

Insurance Commissioner David Jones (D) argued that the \$500 cap was too high, would create barriers to care, and was “discriminatory” for those with chronic or high-cost conditions. He recommended a \$200 monthly cap for all metal levels.

The caps are part of changes to prescription drug benefits for participating plans that were approved by the board, which also voted to require at least one drug for a certain condition be included in the lowest drug tier. Plans must define what drugs will be placed in specific pricing tiers (including the highest specialty tier) and post that information online.

However, the board postponed a vote on the drug caps until their May meeting, insisting that more time was needed to evaluate input from consumer advocates and health plans.

Committee amends bill requiring “reasonable” drug cost-sharing

A measure to require “reasonable” prescription drug cost-sharing has been amended to include a specific annual out-of-pocket (OOP) limit.

The Assembly Health Committee will hear the revised measure (A.B. 339), which would now limit cost-sharing on outpatient prescription drug to 1/24 of the annual OOP limit that the Affordable Care Act (ACA) requires for individual coverage (currently \$6,350 per year) for a supply of up to 30 days. An earlier version had required just that the cost-sharing be “reasonable” to ensure access (see Specialty Tier Reform Update for the Week of February 16th). The version of this bill that stalled in last year’s session similarly included cap of 1/12 of the OOP limit (see Specialty Tier Reform Update for the Week of September 1st).

A provision that bars plans from placing most or all of the drugs to treat a specific condition on the highest cost tiers of a formulary remains in the amended version.

A committee hearing on the measure is still set for April 28th.



Committee rejects bill to prohibit discriminatory cost-sharing designs

The Assembly Health and Government Operations Committee issued an unfavorable report last week on legislation that would prohibit plans participating in the Maryland Health Benefit Exchange from using a benefit design that relies upon discriminatory drug formulary management or medical management practices.

Under both H.B. 990 and its counterpart S.B. 834, differential reimbursement rates or cost-sharing for covered benefits is one criterion that the Insurance Commissioner could consider when determining whether a drug formulary is discriminatory (see Update for Weeks of February 23rd). The latter bill has not moved since a late March committee hearing.