



Specialty Drug Benefit Design and Patient Out-of-Pocket Costs in the ACA Marketplaces

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Expensive “specialty” drugs are becoming more prevalent

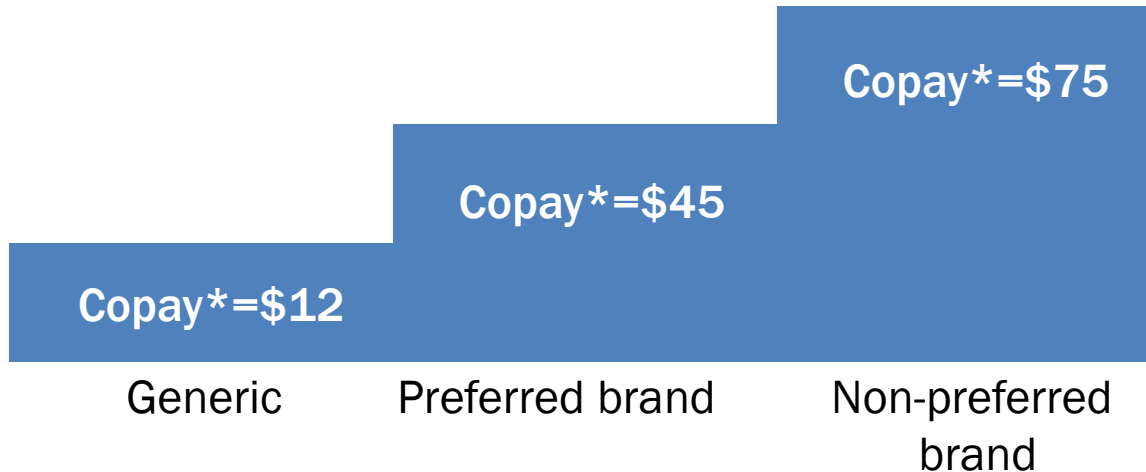


- Generally biologic products for chronic conditions, prescribed by specialists
- Usually very effective treatments
- Often very expensive, due to:
 - Few substitutes
 - Costly to produce
- Annual treatment costs can exceed \$40,000
 - 30-day supply of adalimumab = \$2,905 (Part D average)
 - Sovaldi course of treatment = \$72,000
- Pose financial burden for both patients and payers (government and insurers)

To address costs, insurers are altering the traditional cost sharing structure

Traditional 3-tier formulary with modest, fixed copays

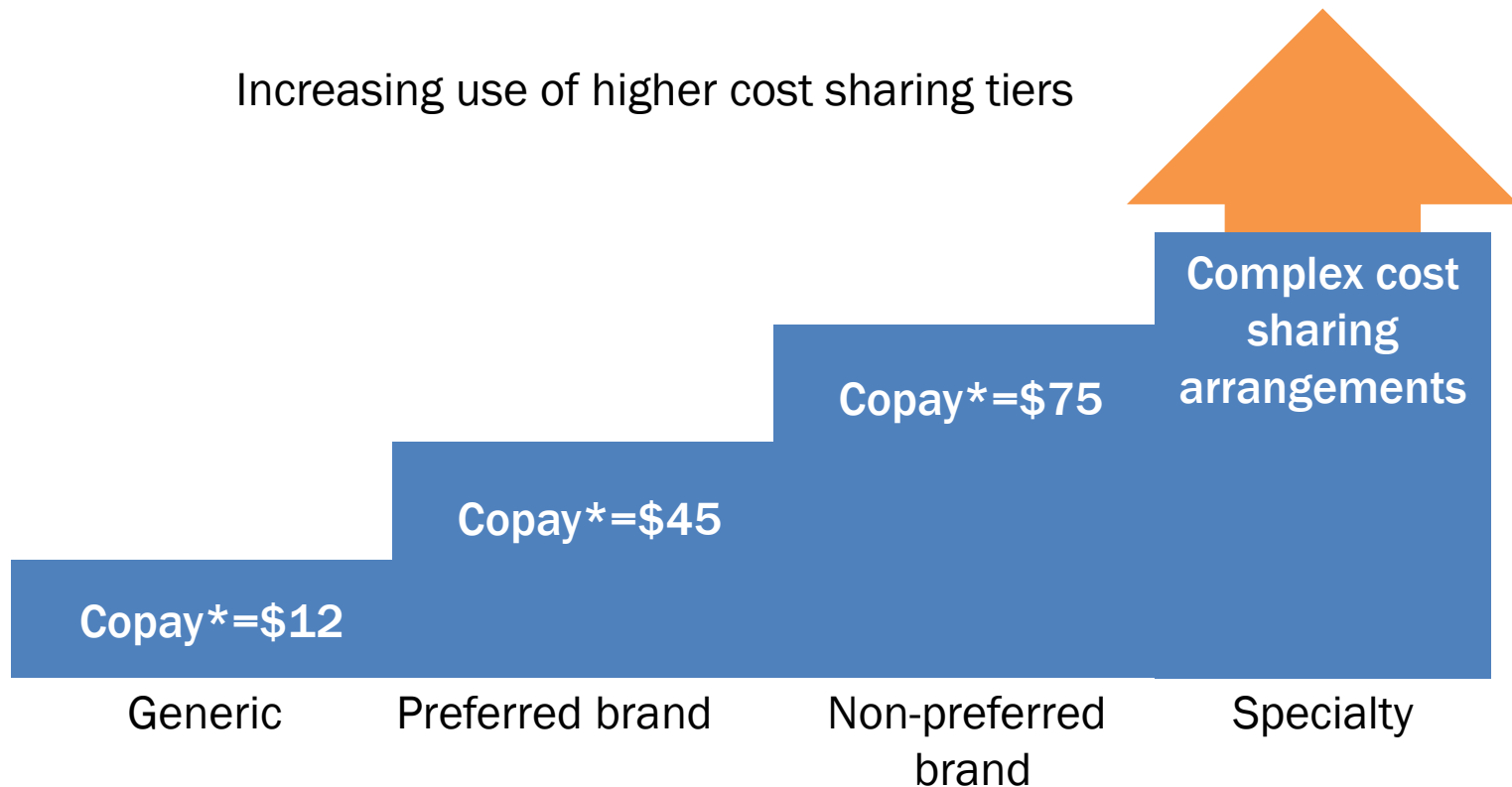
Insurers negotiate discounts with manufacturers for preferred placement → lower premiums



* Average copayments for Silver plans in Marketplace

To address costs, insurers are altering the traditional cost sharing structure

Increasing use of higher cost sharing tiers



* Average copayments for Silver plans in Marketplace

Specialty tiers raise questions about tiered formularies



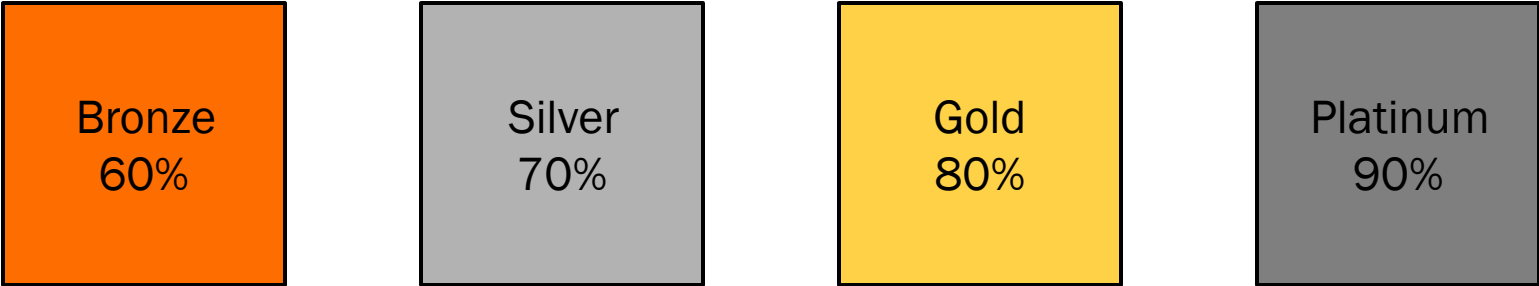
- Specialty drug users have always faced high costs
- Affordable Care Act (ACA) increased access to insurance
 - Did it go far enough for specialty drugs?
- Costs may deter utilization (moral hazard)
 - Out-of-pocket maximum limits may temper effects of high cost sharing
- Costs may also deter enrollment (adverse selection)

Focus of this Study

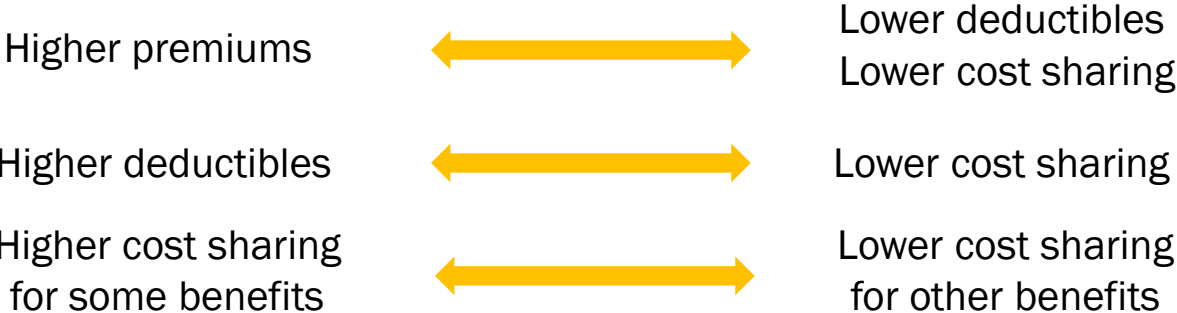
- Comparing coverage of specialty drugs in 37 Marketplaces
- Simulate patient out-of-pocket costs for specialty drugs
 - Focus on drugs used to treat rheumatoid arthritis, HIV, organ transplants, and multiple sclerosis
 - Compare costs in ACA Marketplace plans to costs incurred by Medicare Part D patients taking same drugs
- Data sources
 - Publicly available benefit design data, MEPS prescription drug utilization
 - Assumptions related to medical benefits utilization
- Part D is a reasonable comparator because:
 - Both offered by private insurers that are subject to regulation
 - Coverage under Part D is also subject to catastrophic spending limits

Marketplace plan design is extremely complicated

Different metal tiers cover different levels of average medical spending



Insurers make tradeoffs to achieve these coverage levels



While plans cover a certain percent of average medical spending . . .

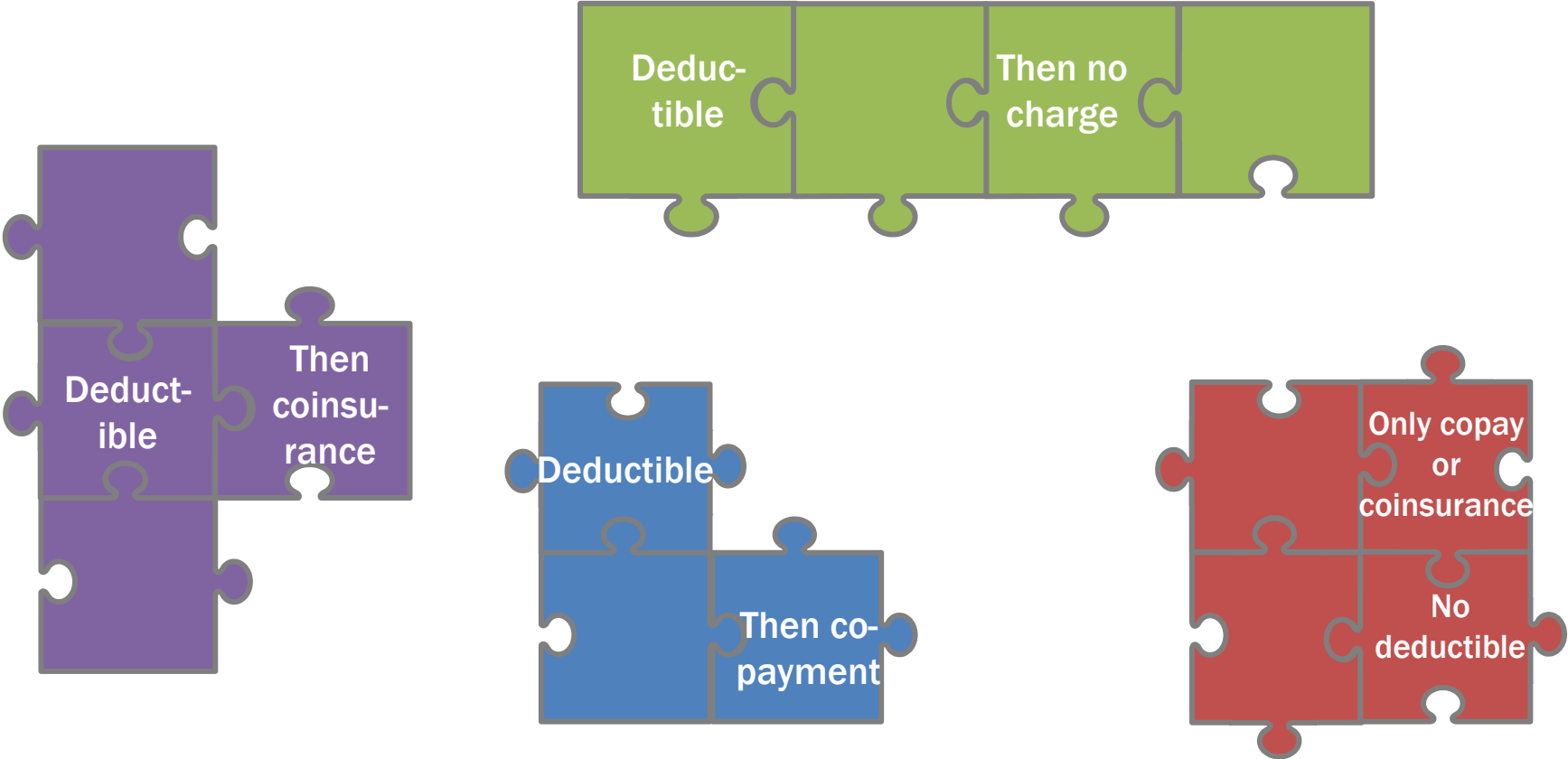
Specialty drug users likely spend more than the average



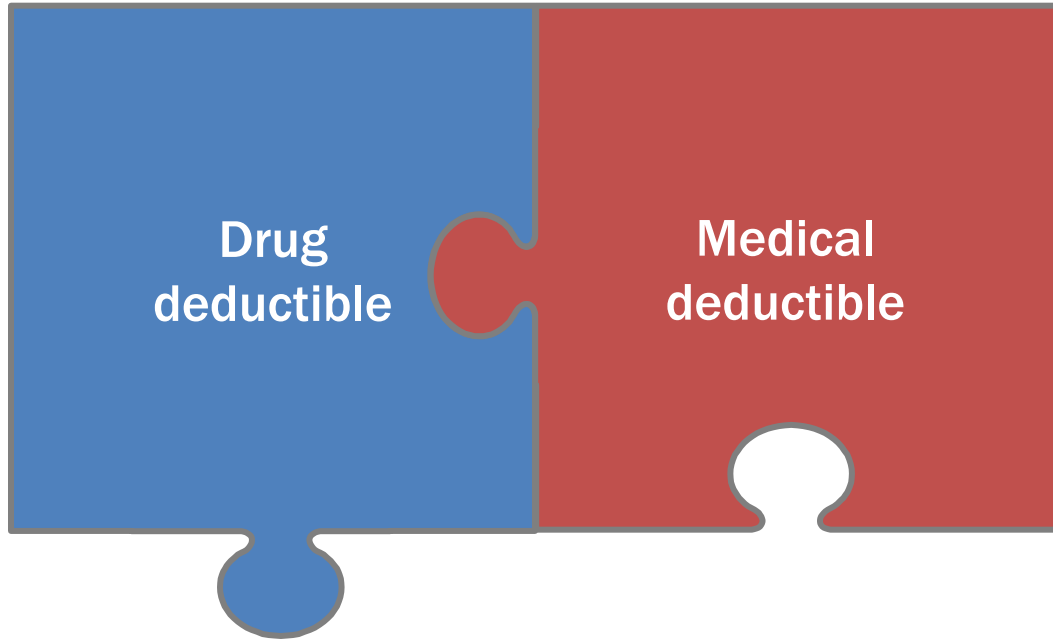
This can make selecting a plan more complicated



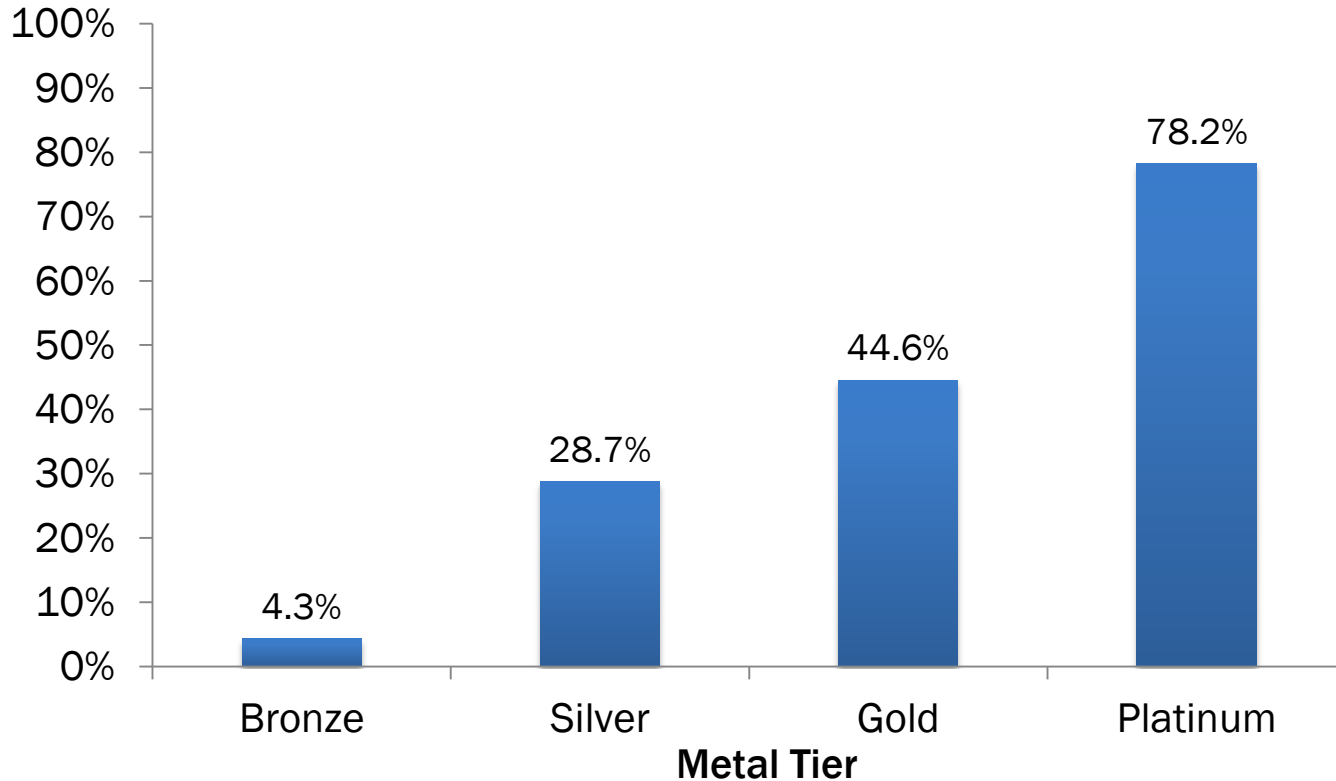
Specialty drug coverage design is part of a complex puzzle



Plans can also combine a drug deductible with a medical deductible

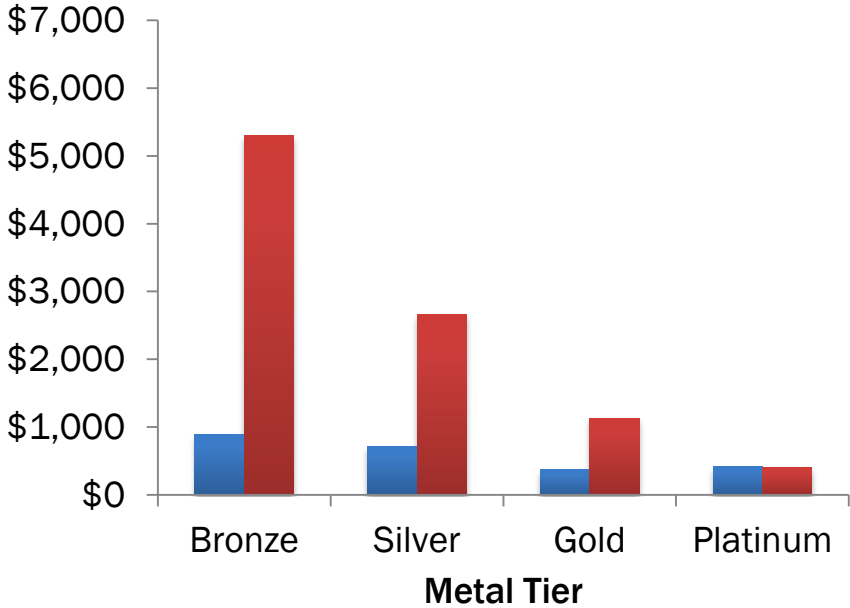


Higher proportion of Gold and Platinum plans offer \$0 drug deductible

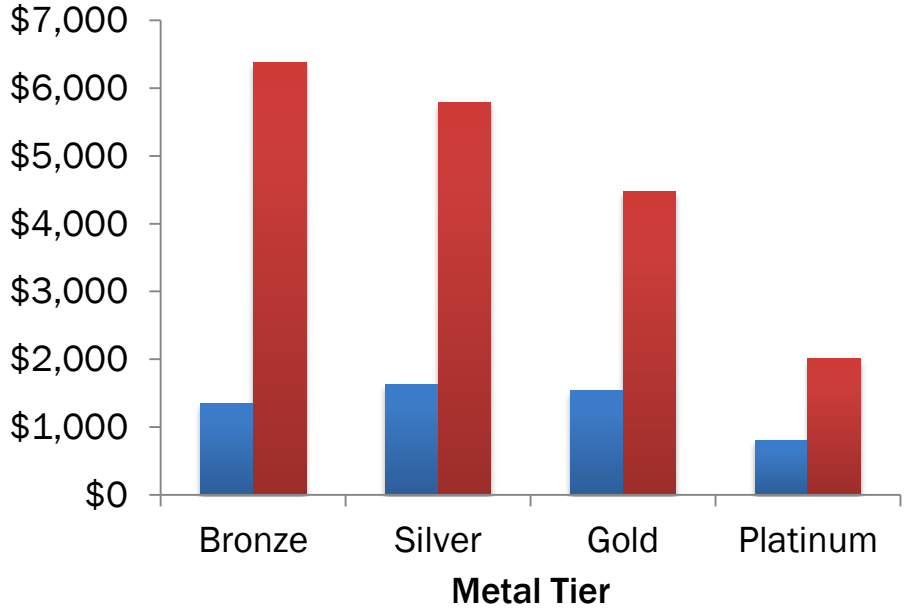


On average, more generous plans offer lower deductibles and out-of-pocket maximums

Average Deductible



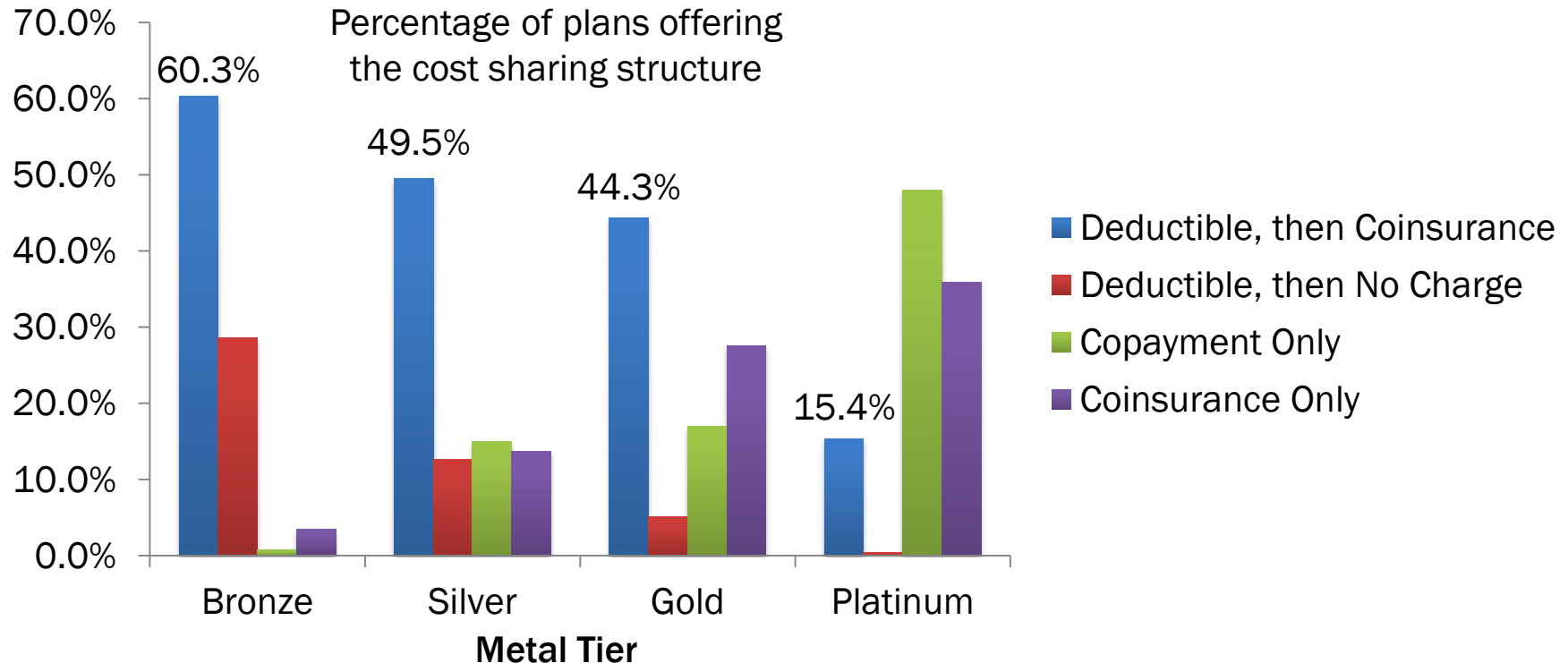
Average Out-of-Pocket Maximum



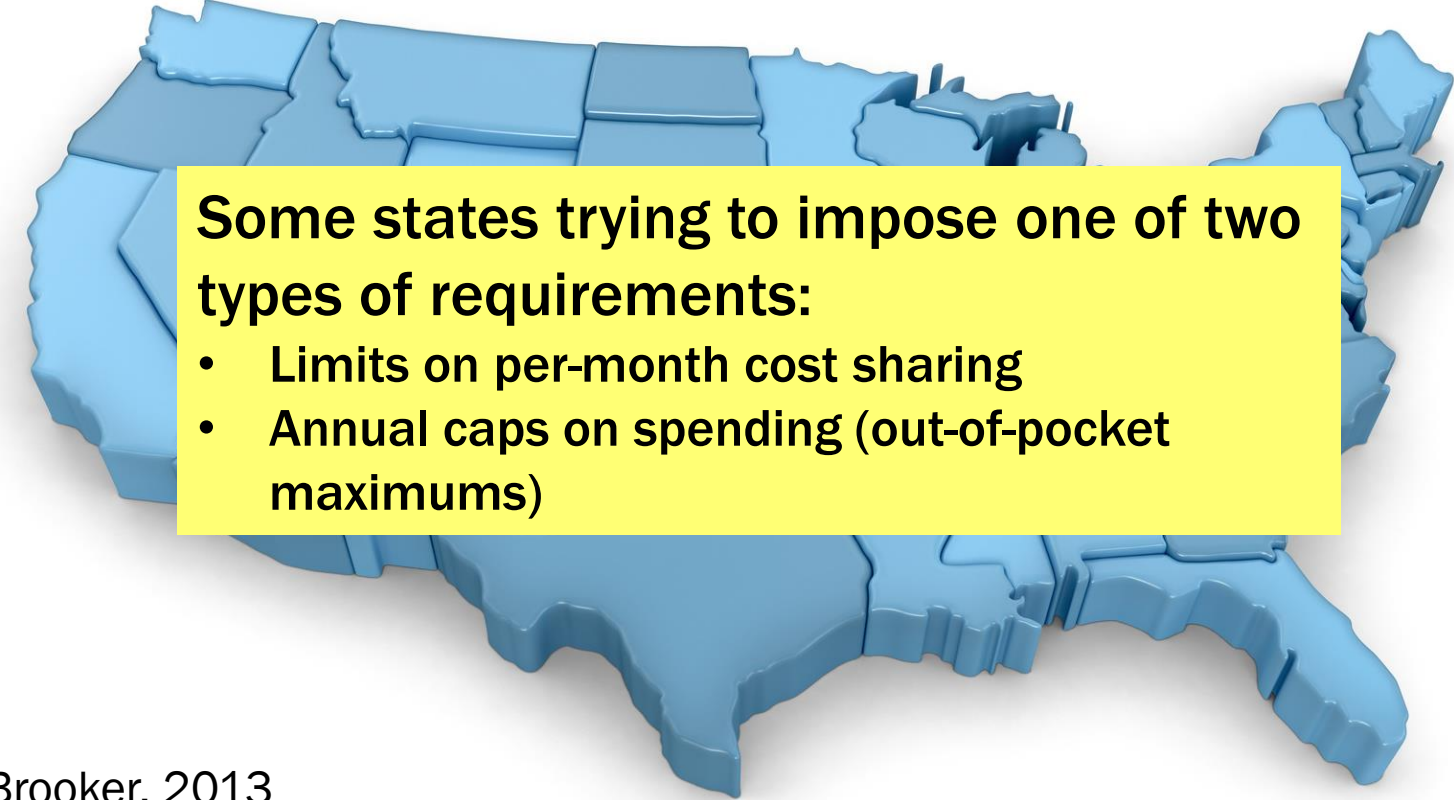
■ Drug-Only Deductible ■ Included in Medical

■ Drug-Only OOP Max ■ Included in Medical

Plans offering more generous benefits less likely to charge deductible plus coinsurance for specialty drugs



While ACA established broad Marketplace plan requirements, states may set specialty drug coverage requirements



Some states trying to impose one of two types of requirements:

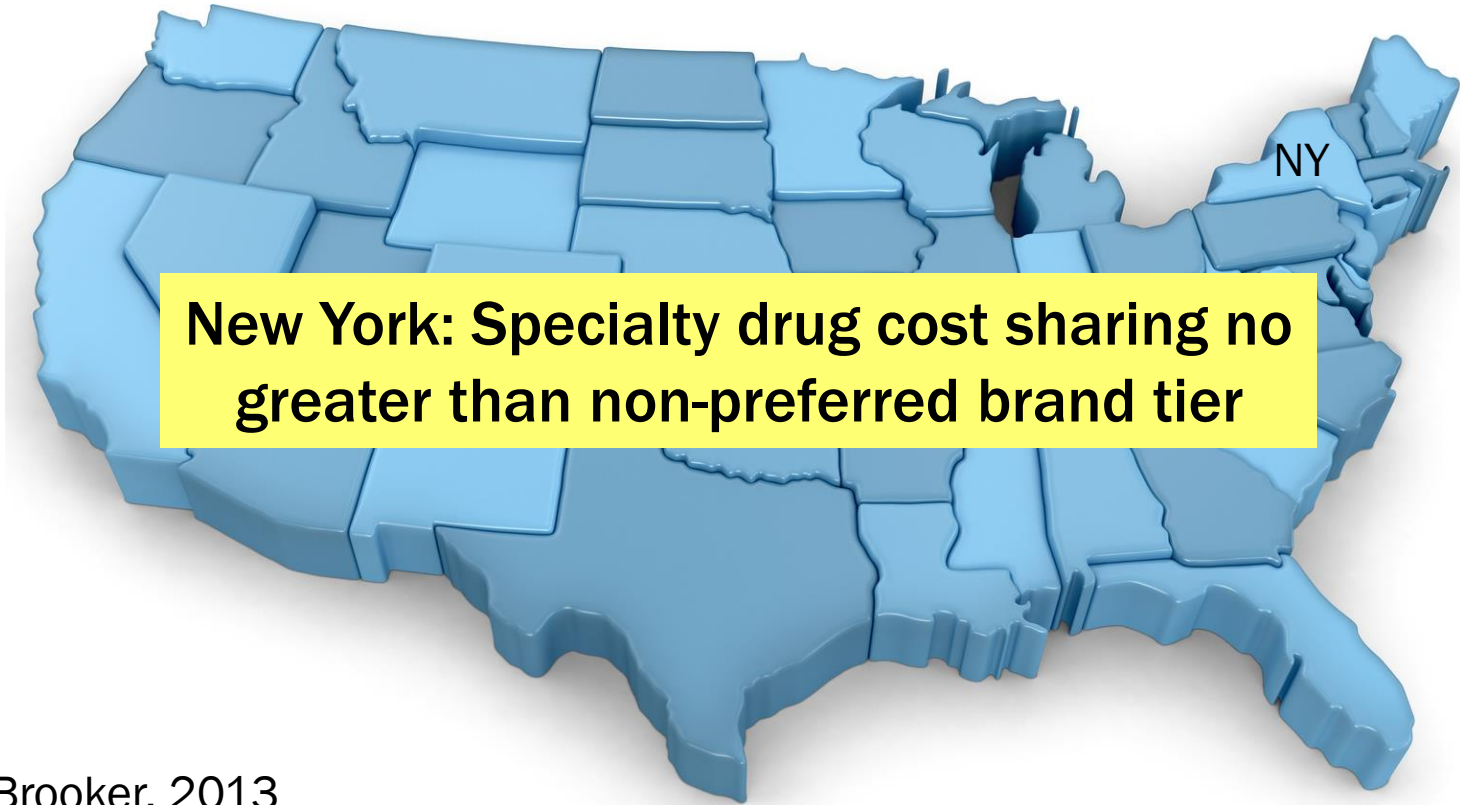
- Limits on per-month cost sharing
- Annual caps on spending (out-of-pocket maximums)

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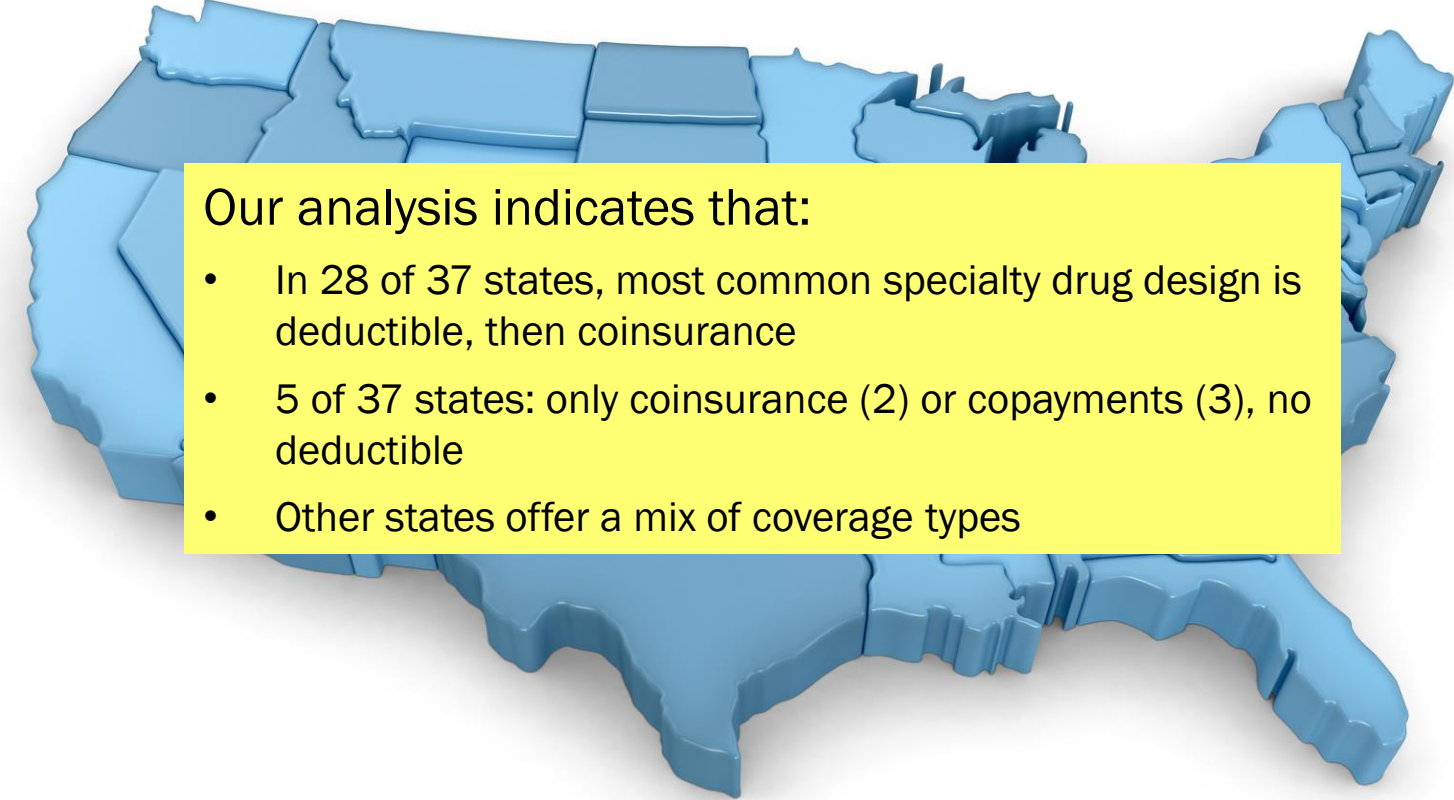
Maine: Specialty drug cost sharing no greater than \$3500 per year

While ACA established broad Marketplace plan requirements, states may set specialty drug coverage requirements



New York: Specialty drug cost sharing no greater than non-preferred brand tier

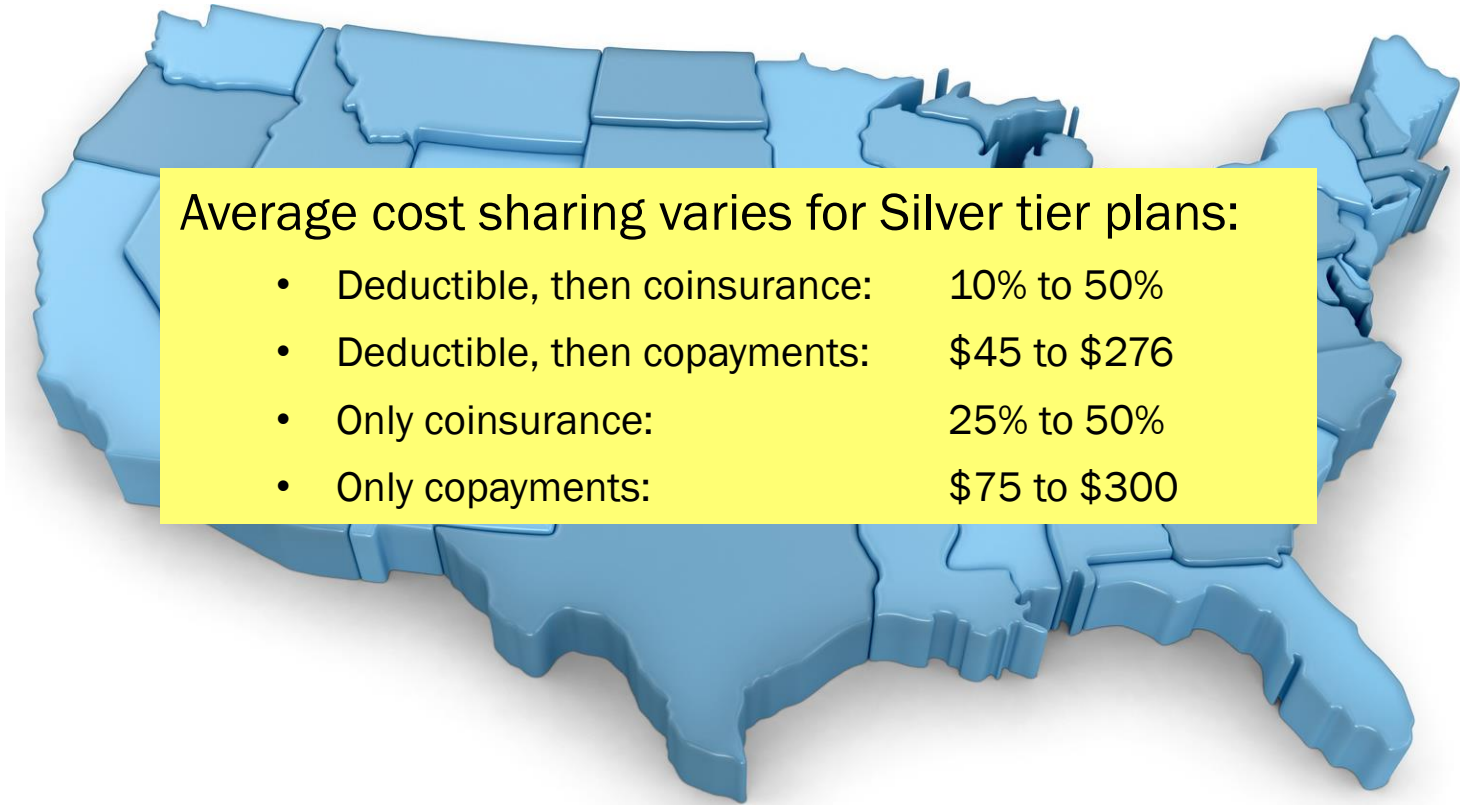
Variation across states is more likely due to the way ACA is structured than to state-specific characteristics



Our analysis indicates that:

- In 28 of 37 states, most common specialty drug design is deductible, then coinsurance
- 5 of 37 states: only coinsurance (2) or copayments (3), no deductible
- Other states offer a mix of coverage types

We found some variation in benefit design across states



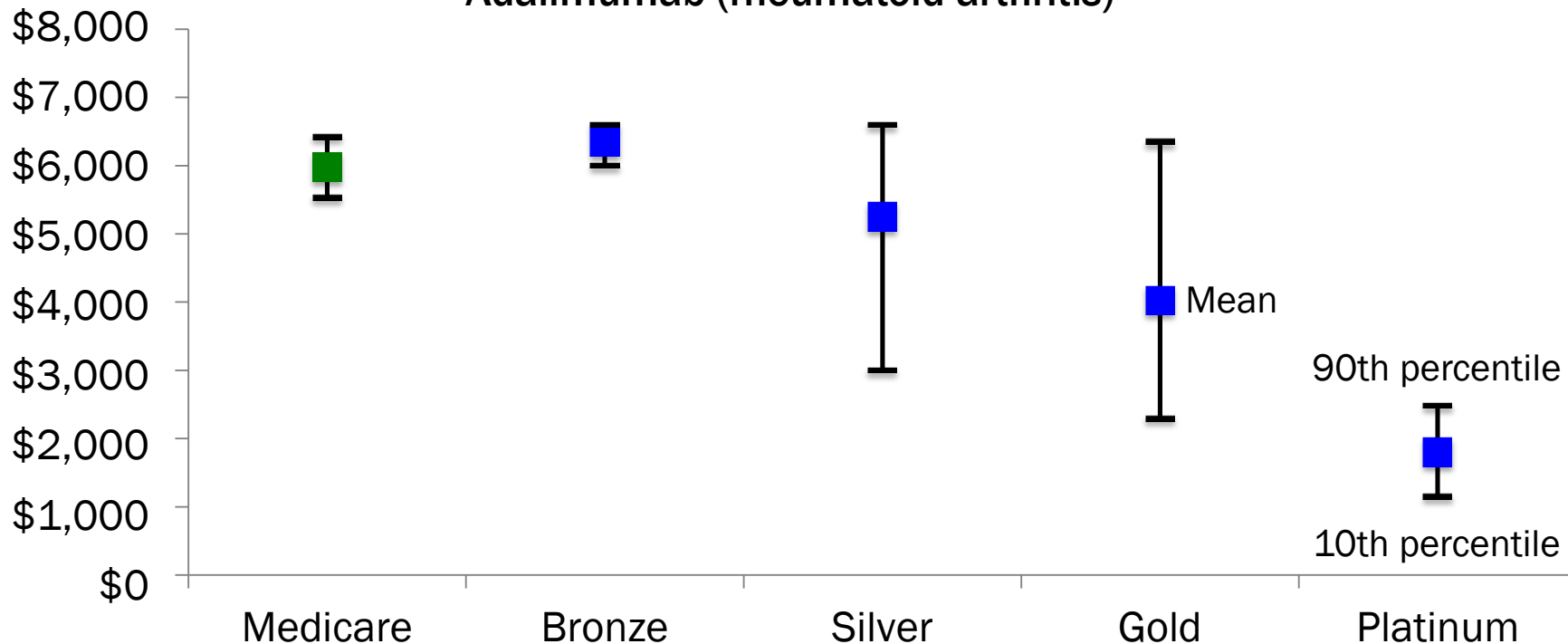
Average cost sharing varies for Silver tier plans:

- Deductible, then coinsurance: 10% to 50%
- Deductible, then copayments: \$45 to \$276
- Only coinsurance: 25% to 50%
- Only copayments: \$75 to \$300

On average, more generous plans have lower OOP costs

Medicare OOP cost comparisons vary by drug

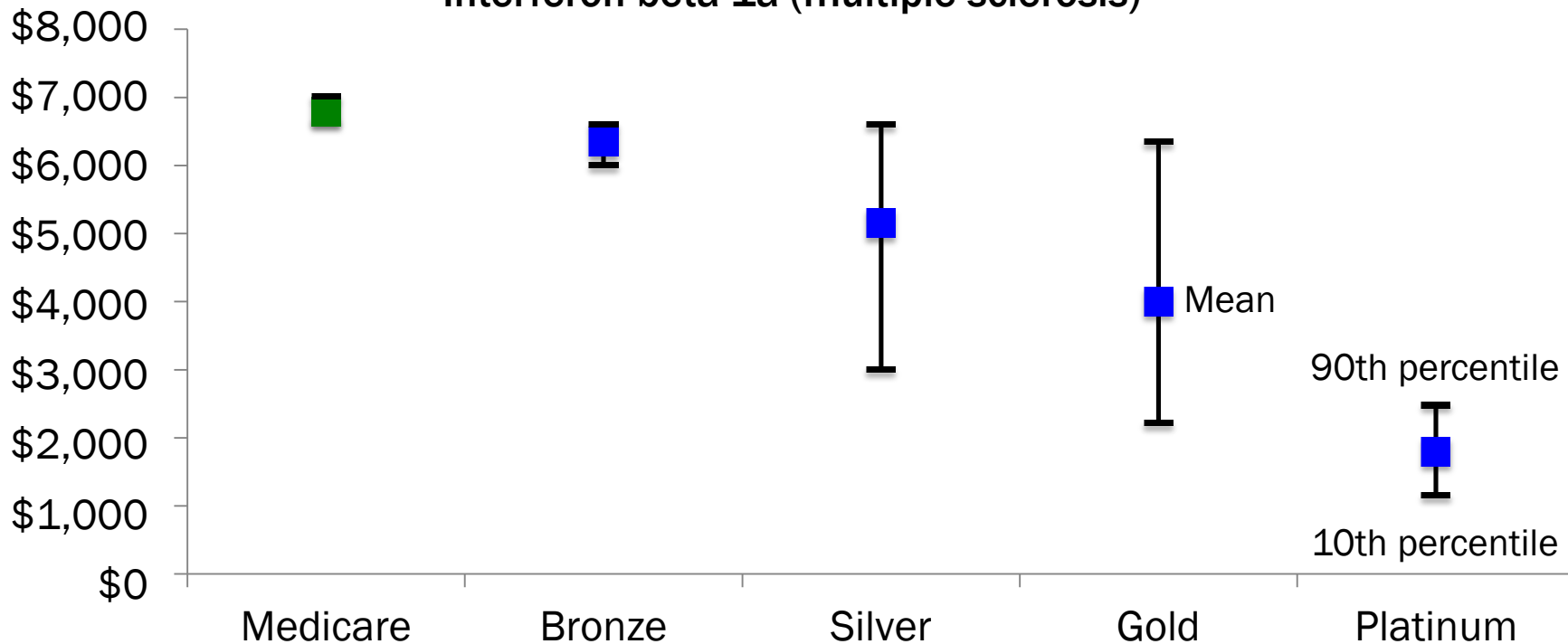
Adalimumab (rheumatoid arthritis)



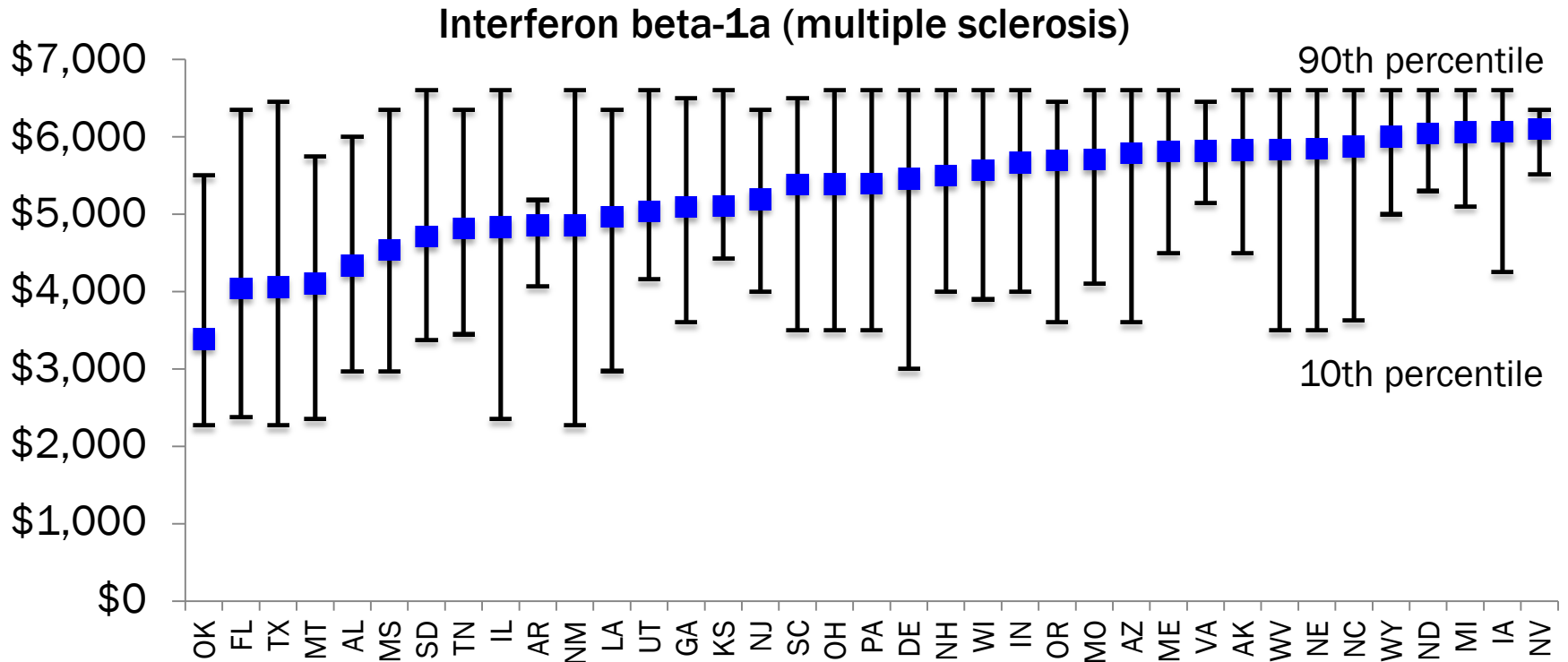
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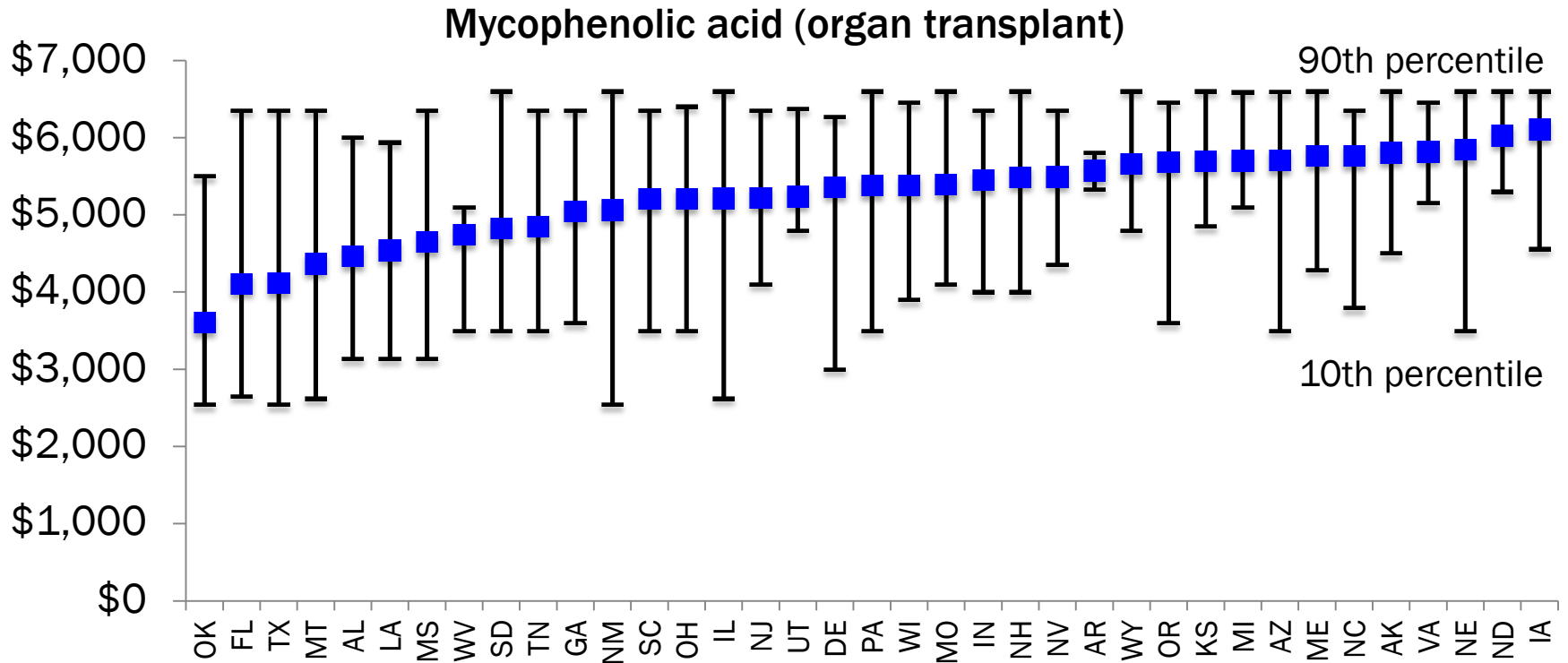
Interferon beta-1a (multiple sclerosis)



Silver plan enrollees face variation in expected out-of-pocket costs both within and across states



Silver plan enrollees face variation in expected out-of-pocket costs both within and across states



Policy lessons

- Limits on specialty drug cost sharing
 - To maintain coverage level, must trade off other benefits
- Benefit harmonization
 - Results in fewer plan parameters
 - Can make it easier for consumers to shop and compare plans
- Require plan standardization
 - Easy comparisons across plans
 - Drawbacks:
 - Restricts ability to innovate
 - May result in worse coverage for people with certain conditions

Why we need to get this right

- Specialty drugs pose an increasing burden on payer budgets, possibly resulting in limited access
- Use of specialty tiers shifts costs to patients, raises concerns about:
 - Affordability of essential / high-value medicines
 - Adverse selection
- Our research explores cost sharing effects on patients and payers
- More research needed to inform potential solutions, for example:
 - Effects of other payment mechanisms (value-based purchasing, bundled payment)
 - Impacts of biosimilars



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