

# Comparing policies that limit pharmacy out-of-pocket expenses in the commercial fully-insured market

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In recent years, several states have implemented policies in the commercial fully-insured market that attempt to limit patient out-of-pocket (OOP) expenses for pharmacy benefits. This report examines key considerations for states, payers and patients for a range of policies, including the potential impact on member premiums and OOP costs for patients that rely on specialty drugs.

## Executive summary

Most of the policies in our study introduced caps on patient OOP costs either pre- or post-deductible. Because caps increase the portion of spending that a plan is liable for, these policies typically result in premium increases. We found that policies that cap OOP costs pre-deductible offer first dollar protection for a larger portion of members in a plan and therefore result in relatively higher premium increases than policies that cap OOP costs post-deductible.

Policies that cap OOP costs post-deductible, on the other hand, benefit a relatively smaller pool of members (those that satisfy the annual deductible). Therefore, they result in lower premium increases than pre-deductible OOP caps. Our study also shows that post-deductible OOP caps provide substantial reductions in OOP costs for patients using specialty drugs.

When a carrier implements a cap (or other benefit enhancements) in only a portion of its plan offerings, the change can influence which plan members choose, potentially drawing more high cost members to the plan with a cap in anticipation of reduced OOP costs. This dynamic is called adverse selection and often results in premium increases due to higher plan liabilities. Policies that are implemented across the entire market minimize the potential for adverse selection and therefore mitigates premium increases.

## Background

Multiple studies have highlighted the increasing cost sharing burden on patients for specialty prescription drugs, and the potential for prescription abandonment associated with high cost sharing.<sup>1 2 3 4</sup> In the commercial small- to mid-size group market, benefits tend to include high deductibles (\$1,750 to 4,050 in 2019), and patients on specialty drugs are most likely to be subject to a percent coinsurance (as opposed to a flat copay), exposing some patients to potentially high OOP expenses before they reach the maximum OOP (MOOP; \$4,700 to \$7,450 in 2019).<sup>5 6</sup>

Several states have implemented policies in the commercial market that limit patient exposure to pharmacy OOP costs.<sup>7</sup> Bristol Myers Squibb engaged Milliman to: 1) compare the premium impact of these implemented policies, 2) quantify their impact on a typical patient filling a specialty script, and 3) identify actuarial considerations for operationalizing policy proposals that cap pharmacy OOP costs in fully-insured plans.

While we discuss pricing and other considerations in order to compare and contrast policies that limit pharmacy OOP costs, we are not advocating for a particular policy, nor are we

FIGURE 1: STATE-IMPLEMENTED POLICIES IN THE COMMERCIAL MARKET, AND CORRESPONDING MODELED BENEFITS

POLICY	PHARMACY BENEFITS	STATE(S) THAT IMPLEMENTED OOP POLICY
Pre-deductible per prescription caps	1. Pre-deductible cap @ \$150/rx 2. Pre-deductible cap @ \$500/rx (copay only)	1. New Jersey <sup>8</sup> 2. Colorado; \$500 cap estimated as 1/12th \$6,000 MOOP <sup>9</sup>
Post-deductible prescription caps	3. Post-deductible cap @ \$150/rx 4. Post-deductible cap @ \$250/rx 5. Post-deductible cap all Rx @ \$130/month 6. Post-deductible cap all Rx @ \$1,400/year 7. Post-deductible cap @ \$90/rx (no specialty tier)	3. Delaware, Maryland, and Louisiana <sup>10</sup> 4. California <sup>11</sup> 5. No state implementation; \$130 monthly cap* 6. Vermont; 2020 federal HDHP deductible of \$1,400 and MOOP of \$6,900 <sup>12</sup> 7. New York; \$90 non-preferred brand copay <sup>13</sup>
Standardized benefit design – Richer	8. Separate Rx deductible @ \$250	8. Connecticut and Washington, D.C. <sup>14 15</sup>
Standardized benefit design – Leaner	9. 50% Rx coinsurance	9. Maine, New Mexico, and Oregon <sup>16 17 18</sup>

\* Variation of state-implemented policies and estimated as the monthly pharmacy proportion of the baseline \$7,800 integrated MOOP. Assumes a monthly cap equal to 1/12<sup>th</sup> of the annual cap and pharmacy spend equal to 20% of the integrated MOOP.

commenting on a specific state’s law. A particular policy proposal should be evaluated in detail and within the appropriate market context.

Using an administrative claims data subset representative of the fully-insured commercial group market, we simulated pharmacy plan liability and patient OOP costs under a baseline benefit and nine alternative pharmacy benefits (keeping medical benefits constant). The simulated pharmacy benefits reflect policies that have already been implemented in certain states across the nation, as shown in Figure 1.

The policies we modeled can be grouped according to the following benefit features:

- Pre-deductible caps: Cost sharing is capped from the first fill, as prescription drugs are not subject to deductible.
- Post-deductible caps: The deductible must be met to activate the OOP cap feature.
  - We modeled OOP caps in three ways: per prescription, per month, and per year.
  - This group includes the elimination of the specialty tier, which effectively implements a flat copay after the deductible is met.
- Standardized benefits: All carriers must offer a predefined benefit design (varies by state). We modeled two variations:
  - Richer benefits – Separate drug deductible: A separate, lower pharmacy deductible, contrasts with most benefit designs in the commercial fully-insured market, where integrated medical and pharmacy deductibles are the norm.<sup>19</sup>
  - Leaner benefits – 50% coinsurance on specialty tier: the 50% upper-bound coinsurance on specialty drugs is higher than common specialty coinsurance levels found in the commercial fully-insured market, which average about 20%<sup>19</sup> nationwide.

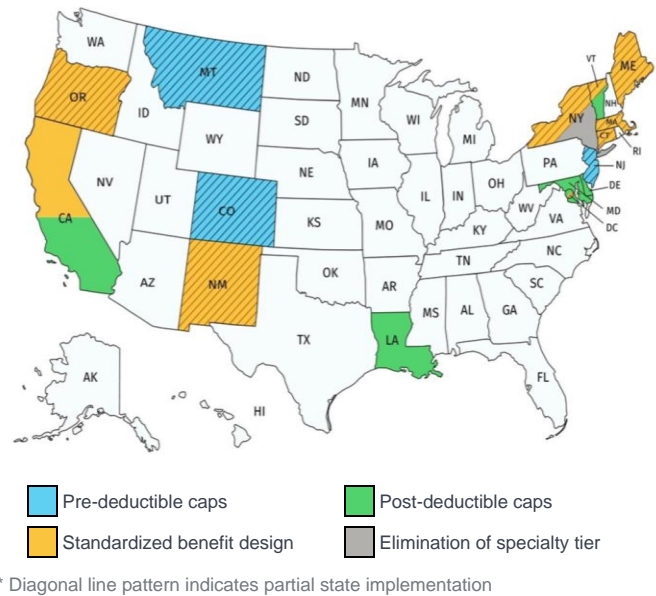
Figure 2 summarizes the state policies that limit OOP expenses for pharmacy benefits according to the above grouping. These policies can apply either to the entire state (full market implementation) or to a subset of the market in the state (partial market implementation). In a partial market implementation, the state mandates carriers to comply with the policy in only a subset of the plans offered. For example, New Jersey’s pre-deductible cap policy is required to be offered in at least 25% of a carrier’s plans offerings per metal level, per geographic rating area (or at least one plan if offering less than four plans).<sup>20</sup> As shown in Figure 2, some states such as California, New York and Vermont have implemented more than one policy limiting pharmacy OOP costs.

## Impact on member premiums

With one exception, the policies modeled provide reductions in members’ OOP costs, shifting liability to carriers. Increased

plan liabilities typically result in higher premiums. The impact will be a one-time increase in premium (the year the benefit change occurs) followed by potentially higher annual rate

**FIGURE 2: POLICIES THAT LIMIT PHARMACY OUT-OF-POCKET COSTS IN THE COMMERCIAL MARKET (AS OF SEPTEMBER 2020)**

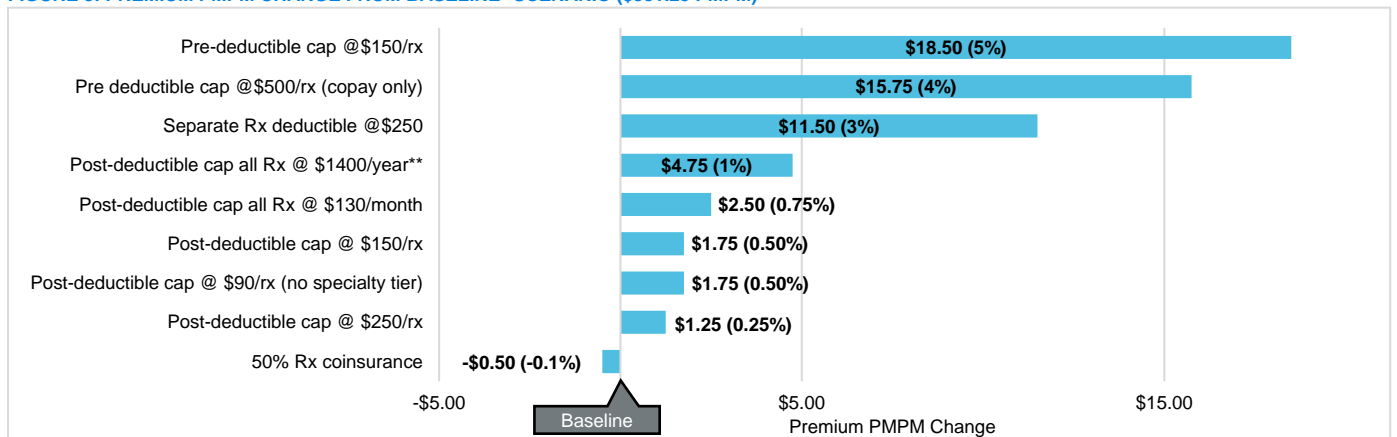


trends in subsequent years, depending on future prescription drug utilization and costs. Figure 3 shows the first year change in premium per member per month (PMPM) from the baseline scenario for each policy that limits pharmacy OOP costs. As shown, policies that include pre-deductible or separate (lower) deductible features result in the largest premium increases due to their potential to impact a large portion of members. Policies with post-deductible features result in much lower premium increases, likely because a smaller portion of patients will satisfy the deductible in a given year and thus the impact will be more limited. By contrast, a 50% specialty coinsurance feature results a slight premium decrease, as the baseline scenario reflects 20% coinsurance on specialty drugs.

The two policies with pre-deductible OOP caps would increase monthly premiums for all members by about \$16 to \$19 (or 4% to 5%), while a separate \$250 pharmacy deductible would increase premiums by about \$12 (or 3%). On the other hand, four of the five post-deductible cap policies result in monthly premium increases of \$2.50 or less, or under 1%, while the fifth policy (an annual \$1,400 OOP cap) would increase premiums by about \$5 (or about 1%). To put these premium impacts in perspective, CMS Part D rules allows plans to voluntarily waive premiums that meet the definition of "de minimis", set at \$2 in 2021.<sup>21</sup>

We note that these figures do not consider the induced utilization that may result from lower OOP costs for patients; however, we expect that policies that limit patient OOP costs

**FIGURE 3: PREMIUM PMPM CHANGE FROM BASELINE\* SCENARIO (\$381.25 PMPM)**



\*Baseline benefits: \$2,500 integrated deductible, \$7,800 integrated MOOP, and \$17/\$65/\$90/20% cost sharing for generic/preferred brand/non-preferred brand/specialty drugs.

\*\*Post-deductible cap all Rx @ \$1400/year also reflects a reduced MOOP of \$6,900 (vs \$7,800 for all other policies).

will result in higher therapy initiation and adherence rates, and therefore higher plan liabilities and premiums. The level of induced utilization is also likely to vary by benefit feature, with richer benefits resulting in higher utilization. For example, reducing the pharmacy deductible from \$1,000 to \$0 is expected to result in about a 10% increase in the number of annual scripts.<sup>22</sup> Additionally, carriers may have other levers to limit premium increases, such as changes in formularies or benefit design; however, we have not reflected any action from carriers in order to isolate the impact of each policy on premiums.

When OOP costs are reduced, the lower financial burden may make some patients more willing to start on new prescriptions and to adhere to their existing prescribed medications more fully. This dynamic is called *induced utilization*.

## Impact on specialty drug patients' out-of-pocket expenses

While the average member can expect a reduction in OOP costs commensurate with an increase in premiums, patients using specialty drugs will see their premium and OOP combined costs go down significantly. Because the increased plan liabilities are spread across all members in the plan in the form of higher premiums, patients who fill specialty prescription drugs will benefit the most from policies that limit OOP prescription drug costs. Indeed, specialty drugs can be many times more costly than the average prescription drug: the average specialty gross drug costs about \$4,500 per 30-day supply compared to non-specialty brand gross drug costs of

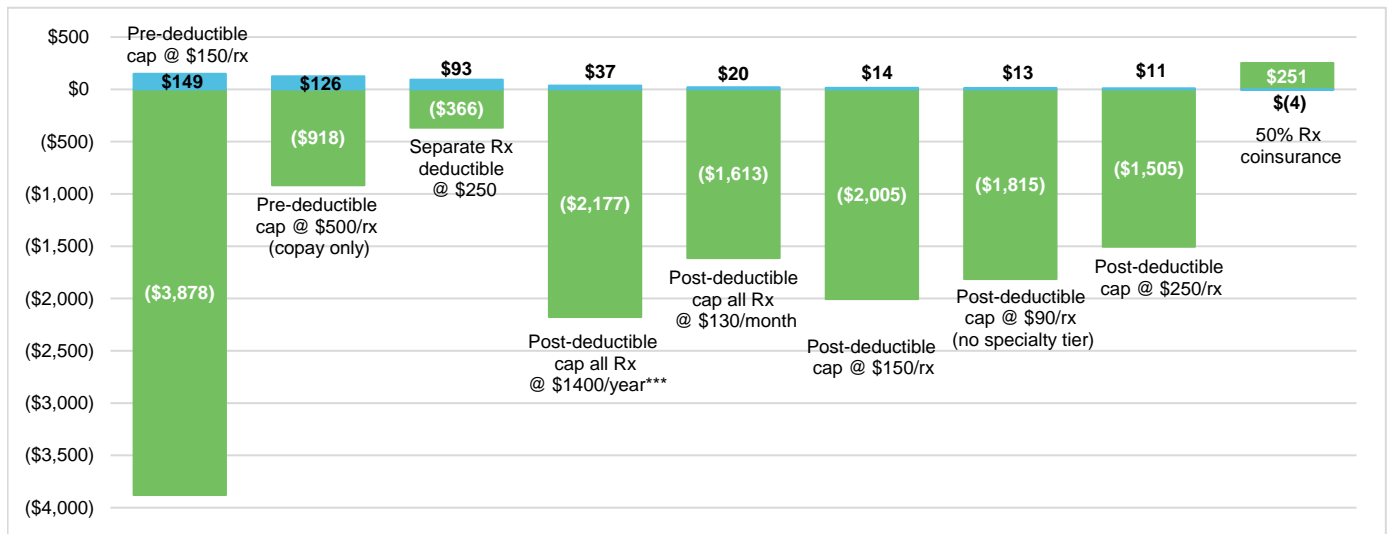
about \$400 per 30-day supply.<sup>22</sup>

Figure 4 displays the changes in annual plan liability and OOP costs for an illustrative specialty patient filling a script of about \$5,000 per 30-day supply. The pre-deductible cap for specialty drugs at \$150 per prescription provides the most OOP cost reductions for patients on specialty drugs as the deductible is eliminated and all specialty scripts are capped at \$150 (under the baseline benefit, a 20% coinsurance would result in \$1,000 in cost sharing, after the deductible). However, the OOP cost reductions for pre-deductible caps are accompanied with the largest premium increases in Figure 3. Policies that include post-deductible features also provide substantial OOP protection to patients on specialty drugs; these policies, as shown in Figure 3, result in more modest premium increases. The least favorable benefit design features for patients on specialty drugs include a separate pharmacy deductible, pre-deductible \$500 cap per script, and 50% specialty coinsurance.

The Patient Protection and Affordable Care Act (ACA) requires that group policies limit out-of-pocket costs for members on an annual basis (\$8,150 for individual coverage in 2021). The OOP impacts shown in Figure 4 take into account the current levels of MOOP prevalent in the market, and reflect an average patient filling a specialty script of \$5,000 per month. Patients with lower- or higher-than-average specialty spending may see different impacts in OOP costs from those shown here. For example, patients with annual pharmacy OOP costs levels below the MOOP can potentially see their OOP costs reduce by several thousands of dollars (a patient with current pharmacy OOP costs of \$600/month would save \$450/month, or over \$5,000 in one year, with a \$150 monthly cap). By contrast, patients who currently meet their annual MOOP are unlikely to see reductions in their overall OOP costs (although the timing of their OOP cost would change).

## Actuarial considerations

**FIGURE 4: CHANGE IN ANNUAL PLAN LIABILITY FOR AVERAGE MEMBER AND ANNUAL OOP COSTS FOR ILLUSTRATIVE PATIENT WITH A \$5,000 PER MONTH SPECIALTY SCRIPT\***



\*Baseline benefits: \$2,500 integrated deductible, \$7,800 integrated MOOP, and 17%/65%/90%/20% cost sharing for generic/preferred brand/non-preferred brand/specialty drugs.

\*\*\*Net premium = plan liability = premium before 'loading' (typically ~15%) for administration and profit.

\*\*\*\*Post-deductible cap all Rx @ \$1400/year also reflects a reduced MOOP of \$6,900 (vs \$7,800 for all other policies).

In addition to premium and patient OOP implications, stakeholders should consider other aspects of policy implementation, such as the potential for adverse selection, operational changes, and the interaction with other benefit features such as copay card accumulators.

**ADVERSE SELECTION**

Our model assumes a full market implementation scenario where benefit features are mandated across all plans in the state's market. A mandatory change for all plans means less migration between plans from members selecting based on their anticipated prescription drug utilization. However, policies that apply to a subset of the market (partial market implementation) and, therefore, provide members a choice between plans with and without pharmacy OOP limit features, may create significant member migration among plan options.

To illustrate a scenario of adverse selection, consider a policy with partial implementation where OOP limits are mandated in only half of the market. Assuming that patients taking specialty drugs 1) are currently evenly distributed throughout the market, and 2) make perfect enrollment decisions based on forecasts of their own drug costs; specialty drug use would double for plans with pharmacy OOP limits (as the other half of the patients with specialty use migrate to these plans). A doubling of specialty use (and spending) would result in premium increases of around \$60 PMPM, or 15%.

The impact of selection will vary by policy. For instance, annual caps may appear less attractive to most members than monthly or per prescription caps. Pre-deductible pharmacy caps and a separate pharmacy deductible are likely to be attractive to all patients filling a brand script, not just those filling specialty scripts, and therefore may create more adverse selection.

Conversely, patients with specialty drug use will likely avoid plans with 50% coinsurance on the specialty tier, which may result in positive selection for these plans.

Selection can also vary by market, depending on the prevailing benefits and premium levels, and by each patient's spending patterns, such as those that satisfy the annual deductible and/or MOOP through spending on medical (non-pharmacy) benefits.

**OPERATIONAL CONSIDERATIONS**

Carriers that operate in certain markets have already implemented many of the policy features discussed in this paper. However, others may need to develop the ability to administer new benefit features within their claims administration systems. For example, some of the policies we modeled are likely to require a separate "accumulator" such as an annual cap feature (a standard feature in Medicare Part D). The elimination of the specialty tier may require carriers to work with their pharmacy benefit manager (PBM) and pharmacy and therapeutics (P&T) committee to revise the formulary. In addition, explaining new benefit features to members may require updated marketing materials and member education/communication.

**INTERACTION WITH COPAY CARD ACCUMULATORS**

The use of copay card accumulators is becoming more common in the commercial market.<sup>23</sup> These accumulators exclude the value of drug copay cards (typically, debit cards with a fixed dollar amount funded by pharmaceutical manufacturers to reduce patient OOP costs) from counting towards a patient's deductible and MOOP. Once the copay card value is exhausted, patients resume paying OOP costs toward their plan deductible and MOOP.



Plans that use copay card accumulators may see a different impact of the policies to limit drug OOP costs. In particular, policies with post-deductible features may see a smaller reduction in member OOP costs, since the accumulator delays the point during the year at which OOP costs begin to count toward the deductible. On the other hand, policies with pre-deductible features would see reductions in OOP costs earlier in the year, although likely dampened by accumulators.

## Summary

Affordability of specialty drugs in the commercial fully-insured market has gained attention in recent years. States have implemented policies to limit pharmacy OOP costs to patients. Our data-driven analysis suggests that:

- Policies that cap OOP costs pre-deductible reduce average OOP costs the most and produce the highest premium increases. These policies are likely to attract patients with brand and specialty drug use, and may present the highest potential for member selection.
- Policies that cap OOP costs post-deductible produce substantial reductions in OOP costs for patients taking specialty drugs (ranging from \$1,500 to \$2,200 per year) but do not materially impact annual OOP costs for the average member. For this reason, these policies result in relatively smaller premium increases compared to policies with pre-deductible features (premiums would increase by about \$10 to \$40 annually, or under 1%). This finding is also supported by a recent analysis from *The New England Journal of Medicine*, which found that post-deductible caps, as implemented in Delaware, Maryland, and Louisiana, resulted in substantial reductions in OOP costs for patients that use specialty drugs without detectable increases in plan liability.<sup>24</sup> However, these policies may have a muted effect if the carrier has implemented copay card accumulators.
- Mandatory, full market implementation policies substantially limit the potential for adverse selection and plan migration. Partial market implementation policies are more likely to lead to strong adverse selection behavior and plan migration.
- Lower OOP costs may induce greater utilization of prescription drugs. This may come in the form of greater adherence to prescriptions, higher rates of therapy initiation, or fewer patients abandoning their prescriptions at the pharmacy.
- Some carriers may need to undertake operational efforts to implement pharmacy OOP limits, while others are likely to have systems in place that can handle these changes.

Our analysis assumes benefits with an actuarial value (the portion of spending that is paid for by the carrier) of about 70%, typical of a Silver plan in the marketplace. The impact on premium for groups with richer benefits (such as Gold and Platinum benefits with 80% and 90% actuarial values) are likely to be lower than presented in our report. Conversely, the

impact would be higher for groups with leaner benefits (Bronze). Likewise, members in groups with richer benefits (Gold and Platinum) are likely to see a smaller impact in their OOP costs than those in leaner benefits (Bronze).

## Methodology and data sources

The findings in this report are based on an analysis of 2018 IBM® MarketScan Commercial Claims Database.<sup>25</sup> We simulated claims for a typical commercial fully-insured population consisting of groups of 3 to 500 employees using Milliman's Claim Simulation Model (CSM).<sup>26</sup> Claims were trended to 2020 and re-adjudicated under the nine pharmacy benefit design scenarios listed in Figure 1. We modeled a constant baseline of medical benefits and varied only the pharmacy benefit in each scenario in order to compare the impact on plan liability and patient OOP costs of each pharmacy OOP policy. The baseline medical benefits and non-specialty prescription drug copays were based on the California's 2020 small group coinsurance Silver Plan.<sup>27</sup> We assumed a Silver Plan pharmacy benefit design with a \$2,500 integrated deductible, \$7,800 integrated MOOP, and 20% specialty coinsurance. The patient OOP cost impact for an illustrative patient on specialty drugs was measured on actual patients in our database having at least one 30-day script costing between \$4,000 and \$6,000. To estimate the potential premium impact of severe adverse selection, we assumed specialty drug use would double relative to baseline due to adverse selection, across all policies. We did not attempt to model specific levels of selection for each policy, as this will depend on the characteristics of each market.

## Limitations and caveats

This report was commissioned by Bristol Myers Squibb, a biopharmaceutical company. The findings reflect the research of the authors. Milliman does not endorse any product or organization.

Material presented in this report is our opinion and is not representative of the views of Milliman. As such, Milliman is not advocating for, or endorsing, any specific views in this report related to policies requiring caps on prescription drug out-of-pocket costs.

The findings in this report are based on national averages for a fully insured, small and mid-size employer population with Silver commercial benefits. It does not reflect specifics of state markets and may vary in other market segments (such as the individual and large group markets). The patient cost sharing impact will depend on specialty spending levels, other medical and pharmacy spending levels, current drug adherence, and stages/severity of diagnoses (newly diagnosed patient starting therapy late in the year vs an ongoing patient). Induced demand will vary by policy and adverse selection may vary widely by market specific features such as number of benefit offerings, market competition, current premium levels and

current level of selection, among others.

The American Academy of Actuaries requires its members to identify their credentials in their work product. Gabriela Dieguez and Jennifer Carioto are members of the American Academy of Actuaries and meet its relevant qualification standards for performing the analyses in this report and rendering the

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<sup>25</sup> The IBM® MarketScan Commercial Claims Database (MarketScan) contains all paid claims generated by more than 30 million commercially insured lives. The MarketScan database represents the inpatient and outpatient healthcare service use of individuals nationwide who are covered by the benefit plans of large employers, health plans, government, and public organizations. The data includes diagnosis codes, procedure codes, and DRG codes, as well as NDC codes and the amounts paid by commercial insurers.

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