# Commercially-Insured Patients Pay Undiscounted List Prices for One In Five Brand Prescriptions, Accounting for Half of Out-of-Pocket Spending on Brand Medicines

## Introduction

Patients with deductibles and coinsurance for prescription medicines pay cost-sharing that is based on the undiscounted list price of a medicine, rather than the discounted price negotiated by their health plan or pharmacy benefit manager (PBM). In the commercial market, one in five prescriptions for brand medicines are filled in the deductible or with coinsurance and cost-sharing for these prescriptions accounts for more than half of patients' total out-of-pocket spending on brand medicines.

## Background

Commercially insured patients pay cost-sharing for prescription medicines through deductibles, copays, and coinsurance. When a patient fills a prescription in the deductible, the patient pays the entire list price of the medicine up to the deductible amount. Patients with copays pay a fixed amount for each prescription (e.g., $30), while those with coinsurance pay a percentage of the medication's total list price (e.g., 30%).

A decade ago, out-of-pocket spending for prescription medicines consisted almost entirely of copays, but use of deductibles and coinsurance in commercial insurance has increased rapidly in recent years. Consequently, the share of patient out-of-pocket drug spending represented by coinsurance has more than doubled over the past ten years, while the share accounted for by deductibles has tripled.[i] Between 2012 and 2016 alone, the share of commercial health plans requiring patients to meet a deductible for prescription medicines increased from 23% to 49%.[ii]

When patients receive medical care from an in-network hospital or physician, deductible and coinsurance payments are based upon discounted rates negotiated between the health plan and the provider. Yet this is not the case for prescription medicines. Health plans (and the PBMs that represent them) negotiate discounts on brand medicines, but the discounts are given in the form of rebates paid directly to the health plan or PBMs after the prescription is purchased by the patient. These discounted prices are not available to patients with deductibles or coinsurance at the time they fill prescriptions; instead, their cost-sharing is calculated by the health plan based on the medicine's full list price.

Recent research shows that rebates paid by biopharmaceutical companies substantially reduce the list prices of brand medicines.[iii] For certain medicines used to treat diabetes, asthma, high cholesterol, and hepatitis C, rebates can reduce list prices by as much as 30% to 55%.[iv] However, since list prices do not reflect rebates, these savings are not directly passed on to patients through lower cost-sharing, and patients' out-of-pocket costs for prescriptions filled in the deductible or with coinsurance are higher than they otherwise would be if based on the discounted cost of the medicine.

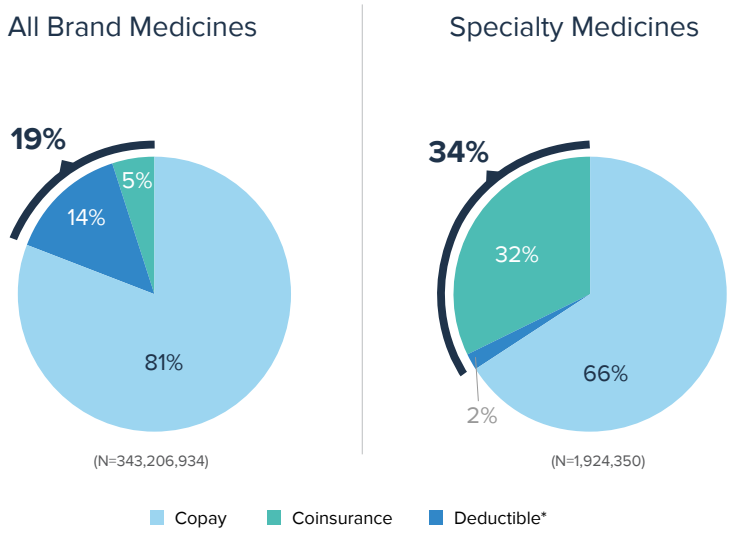
To understand how often patient cost-sharing is based on the undiscounted list price of a medicine and its impact on patients, PhRMA worked with Amundsen Consulting, a division of QuintilesIMS, to identify the share of retail prescriptions and patient out-of-pocket spending for brand medicines that were filled with coinsurance or in the deductible in 2015.[1] The findings in this report are presented for all brand medicines, as well as for a subset of medicines commonly referred to as "specialty" medicines.[2]

# Findings

**Cost-sharing for nearly one in five prescriptions for brand medicines and more than one-third of specialty medicines is based on list price.** As shown in Figure 1, roughly one in five prescriptions for brand drugs (19%) were filled in the deductible or with patient cost-sharing calculated as coinsurance in 2015. This includes 14% of all prescriptions filled in the deductible and 5% with coinsurance.

Looking only at the subset of brand prescriptions made up of specialty medicines, more than one-third (34%) were filled in the deductible or with coinsurance in 2015. The large majority of these prescriptions were filled with coinsurance (32%); 2% were filled in the deductible.

## Figure 1: Share of Prescription Fills in the Commercial Market by Type of Cost-Sharing, 2015




*Includes prescriptions adjudicated entirely within the deductible and prescriptions for which the full cost of the medicine was less than the patient's copay, resulting in the patient paying the full amount out-of-pocket.

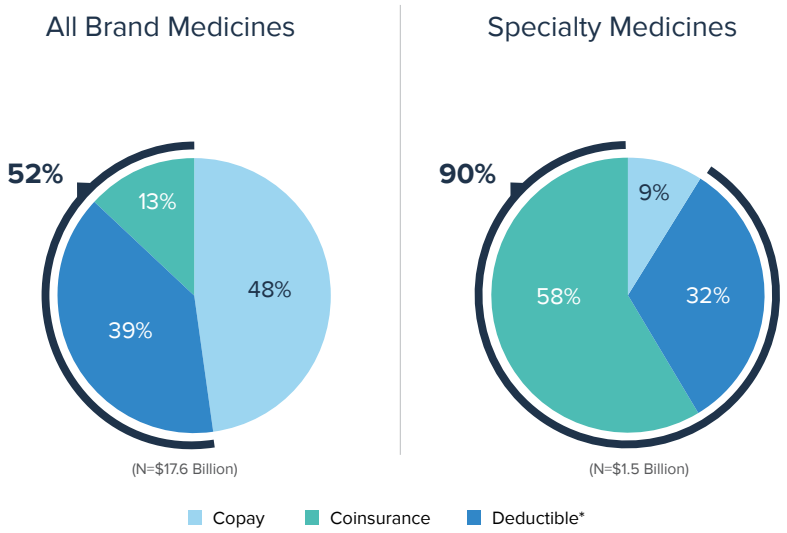
Source: Amundsen Consulting analysis for PhRMA; IMS FIA; Rx Benefit Design

[1] Spending in the deductible includes prescriptions adjudicated entirely in the deductible (i.e., claims straddling both the deductible and the next phase of coverage were categorized according to the next phase of coverage) and prescriptions for which the full cost of the medicine was less than the patient's copay, resulting in the patient paying the full amount out-of-pocket. Out-of-pocket spending measures patient cost-sharing as determined by the health plan and does not account for the use of any cost-sharing assistance.

[2] QuintilesIMS/Amundsen defines specialty medicines as those used to treat chronic, complex, or rare diseases. To qualify as a specialty medicine, a drug must meet four or more of the following criteria: costs exceed $6,000 annually, initiation/maintenance by a specialist, generally injectable and/or not self-administered, requires special handing, requires patient reimbursement assistance, distributed through non-traditional channels such as specialty pharmacies, and/or has significant side effects requiring additional monitoring.

**More than half of patient out-of-pocket spending for brand medicines and 90% of out-of-pocket spending for specialty medicines is accounted for by prescriptions filled in the deductible or with coinsurance.** Prescriptions filled in the deductible or with coinsurance accounted for more than half (52%) of patient out-of-pocket spending for all brand medicines and nearly all (90%) of patient out-of-pocket spending for the subset of specialty medicines. Across all brand medicines, spending in the deductible accounted for 39% of total out-of-pocket spending and prescriptions with coinsurance accounted for 13%. The share of out-of-pocket spending associated with either deductibles or coinsurance was much larger for the subset of specialty medicines. Coinsurance accounted for more than half (58%) of all out-of-pocket spending for specialty medicines and deductibles accounted for 32% (Figure 2).

## Figure 2: Share of Patient Out-of-Pocket Spending in the Commercial Market by Type of Cost-Sharing, 2015



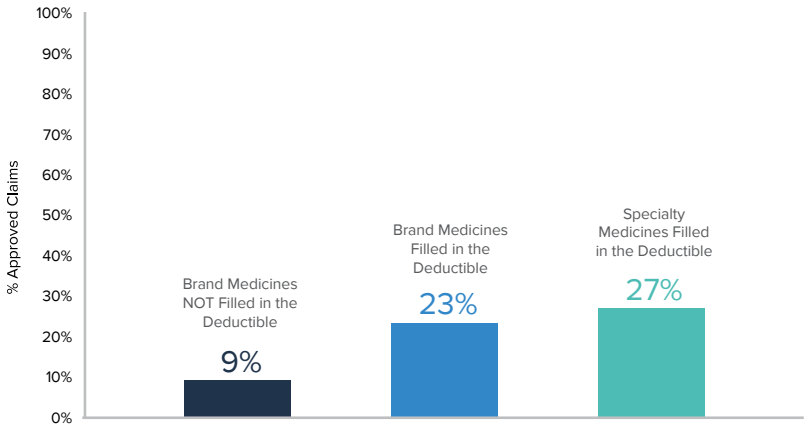

*Includes prescriptions adjudicated entirely within the deductible and prescriptions for which the full cost of the medicine was less than the patient's copay, resulting in the patient paying the full amount out-of-pocket.

Source: Amundsen Consulting analysis for PhRMA; IMS FIA; Rx Benefit Design

**Prescriptions subject to a deductible are more likely to be abandoned at the pharmacy counter.** Deductibles can negatively impact patients' ability to afford their medicines. A medicine is considered abandoned if a patient does not pick up a prescription after it has been processed by the pharmacy.[3] As shown in Figure 3, brand medicines filled in the deductible are more than twice as likely to be abandoned as brand medicines not filled in the deductible (23% vs. 9%). Patients with deductibles who need specialty medicines are even more likely to abandon their prescriptions – nearly three in ten specialty prescriptions in the deductible were abandoned in 2015.

[3] Prescriptions that were cancelled by the patient or not picked up at the pharmacy within 14 days of approval were considered abandoned.

## Figure 3: Abandonment Rates for Brand Medicines Filled in the Deductible vs. Those Not Filled in the Deductible*




*Includes prescriptions adjudicated entirely within the deductible and prescriptions for which the full cost of the medicine was less than the patient's copay, resulting in the patient paying the full amount out-of-pocket.

Source: Amundsen Consulting analysis for PhRMA; IMS FIA; Rx Benefit Design

**The use of deductibles and coinsurance for brand medicines in commercial insurance varies widely across the country.** In three states (IA, NE, and UT) at least 25% of all prescriptions for brand medicines are filled in the deductible or with coinsurance, while for seven states (CA, DE, HI, MI, NJ, NM, and NY), the share of brand prescriptions subject to list price-based cost-sharing is 15% or less (Figure 4). Geographic variation in the share of prescriptions subject to list price-based cost-sharing is primarily driven by nationwide differences in the use of insurance plan designs requiring deductibles and coinsurance.

## Figure 4: Share of Brand Medicines Filled in the Deductible* or With Coinsurance by State

| State | Share of Brand Prescriptions | State | Share of Brand Prescriptions |
|---|---|---|---|
| Alabama | 20% | Montana | 24% |
| Alaska | 19% | Nebraska | 27% |
| Arizona | 18% | Nevada | 17% |
| Arkansas | 20% | New Hampshire | 16% |
| California | 15% | New Jersey | 15% |
| Colorado | 22% | New Mexico | 13% |
| Connecticut | 19% | New York | 12% |
| Delaware | 15% | North Carolina | 18% |
| District of Columbia | 23% | North Dakota | 19% |
| Florida | 24% | Ohio | 19% |
| Georgia | 23% | Oklahoma | 21% |
| Hawaii | 11% | Oregon | 19% |
| Idaho | 21% | Pennsylvania | 18% |
| Illinois | 17% | Rhode Island | 16% |
| Indiana | 24% | South Carolina | 20% |
| Iowa | 29% | South Dakota | 23% |
| Kansas | 21% | Tennessee | 18% |
| Kentucky | 17% | Texas | 21% |
| Louisiana | 16% | Utah | 25% |
| Maine | 19% | Vermont | 17% |
| Maryland | 18% | Virginia | 19% |
| Massachusetts | 16% | Washington | 17% |
| Michigan | 14% | West Virginia | 21% |
| Minnesota | 20% | Wisconsin | 19% |
| Mississippi | 19% | Wyoming | 23% |
| Missouri | 22% | **United States** | **19%** |

*Includes prescriptions adjudicated entirely within the deductible and prescriptions for which the full cost of the medicine was less than the patient's copay, resulting in the patient paying the full amount out-of-pocket.

Source: Amundsen Consulting analysis for PhRMA; IMS FIA; Rx Benefit Design

# Discussion

The growing use of deductibles and coinsurance in the commercial market has substantially altered patient cost-sharing for brand medicines. Although the majority of brand prescriptions were filled with copays in 2015, those filled in the deductible or with coinsurance represented a disproportionately large share of patients' total out-of-pocket spending for medicines. This was particularly true for specialty medicines, for which prescriptions filled in the deductible or with coinsurance represented 90% of out-of-pocket spending.

Health plans and PBMs negotiate increasingly large rebates that reduce list prices of brand medicines, but unlike for hospital care or physician services, deductibles and coinsurance payments for medicines do not reflect discounts received by the health plan. Biopharmaceutical manufacturers negotiate rebates in an effort to improve the affordability of their products; however, this strategy has limited benefit for the one in five prescriptions filled in the deductible or with coinsurance. While rebates and discounts may indirectly benefit patients by lowering insurance premiums, they are not directly passed through to patients facing high cost-sharing at the pharmacy counter. Studies have shown that patients facing high cost-sharing are less likely to take medicines as prescribed, more likely to abandon therapy, and more likely to delay or forgo treatment, putting them at higher risk for expensive emergency room visits, avoidable hospitalizations, and poorer health outcomes.[v]

Basing deductibles and coinsurance for medicines on undiscounted list prices effectively shifts more of the cost of care to the patient, unfairly penalizing sicker patients with high spending. This is at odds with the traditional notion of insurance, which is to spread the high costs of a small share of individuals across all members of the health plan. Payers have begun to recognize that using the undiscounted list price of a medicine to set cost-sharing is problematic for patients: recent statements from the two largest PBMs note that high deductibles for medicines put patients in a "very difficult position" and indicate that sharing rebate savings directly with patients should be considered as a "best practice."[vi]

# References


[i] Claxton G, Levitt L, Long M. Payments for Cost Sharing Increasing Rapidly Over Time. Peterson-Kaiser Health System Tracker. April 2016. http://www.healthsystemtracker.org/insight/examining-high-prescription-drug-spending-for-people-with-employer-sponsored-health-insurance/

[ii] PwC Health and Well-Being Touchstone Survey. http://nationalacademies.org/hmd/~/media/Files/Activity%20Files/HealthServices/Affordable%20Drug%20Therapies/ADS%20Presentation%20II/Tenaglia.pdf

[iii] Berkeley Research Group. The Pharmaceutical Supply Chain: Gross Drug Expenditures Realized by Stakeholder. January 2017. http://www.thinkbrg.com/media/publication/863_Vandervelde_PhRMA-January-2017_WEB-FINAL.pdf

[iv] QunitilesIMS Institute. Estimate of Medicare Part D Costs After Accounting for Manufacturer Rebates. October 2016. http://www.imshealth.com/en/thought-leadership/quintilesims-institute/reports/estimate-of-medicare-part-d-costs-after-accounting-for-manufacturer-rebates; Gronholt-Pedersen J, Skydsgaard N, Neely J. Novo Nordisk Defends U.S. Diabetes Drug Pricing. *Reuters*. November 4, 2016. http://www.reuters.com/article/us-novo-nordisk-prices-idUSKBN12Z184; Silverman E. What the 'Shocking' Gilead Discounts on its Hepatitis C Drugs Will Mean. *Wall Street Journal*. February 4, 2015.

[v] IMS Institute for Healthcare Informatics. Emergency and Impact of Pharmacy Deductibles: Implications for Patients in Commercial Health Plans. September 2015. http://www.imshealth.com/en/thought-leadership/quintilesims-institute/reports/emergence-and-impact-of-pharmacy-deductibles:-implications-for-patients-in-commercial-health-plans; Doshi JA, Li P, Huo H, Pettit AR, Kumar R, Weiss BM, et al. High Cost Sharing and Specialty Drug Initiation Under Medicare Part D: A Case Study in Patients with Newly Diagnosed Chronic Myeloid Leukemia. *American Journal of Managed Care*. 2016;22(4 Suppl):S78-S86; Brot-Goldberg ZC, Chandra A, Handel BR, Kolstad JT. What Does A Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics. NBER Working Paper 21632, October 2015; Eaddy MT, Cook CL, O'Day K, Burch SP, Cantrell R. How Patient Cost-Sharing Trends Affect Adherence and Outcomes. *Pharmacy & Therapeutics*. 2012;37(1):45-55.

[vi] Seeking Alpha. Express Scripts Holding (ESRX) Q4 2016 Results – Earnings Call Transcript. February 15, 2017. http://seekingalpha.com/article/4046365-express-scripts-holding-esrx-q4-2016-results-earnings-call-transcript; Seeking Alpha. CVS Health (CVS) Q4 2016 Results – Earnings Call Transcript. February 9, 2017. http://seekingalpha.com/article/4044425-cvs-health-cvs-q4-2016-results-earnings-call-transcript?part=single


PhRMA

RESEARCH • PROGRESS • HOPE