

Patient Perspective In State Drug Pricing Transparency

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National Council of Insurance Legislators
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Outline

- Patients Concerned with what they pay for Rx
- Higher & Greater Use of Deductibles
 - Fewer plans with separate Rx Deductible
- Higher & Greater Use of Co-insurance
 - Fewer Plans Using Co-pays
 - High patient cost-sharing for Rx compared to other EHBs
- High Cost-sharing leads to Rx Abandonment
- Importance of Co-pay Assistance
- States can Limit Cost-sharing
- Price Transparency

Percent who say they or a family member have done the following in the past year

	NO CHRONIC CONDITION IN FAMILY	WITH CHRONIC CONDITION	
		All	Highest deductible
Postponed or put off care	23%	42%	60%
Treated at home instead of seeing doctor	28	41	58
Avoided doctor-recommended test or treatment	15	31	44
Not filled a prescription or skipped doses	12	23	35
Yes to any	40	60	75

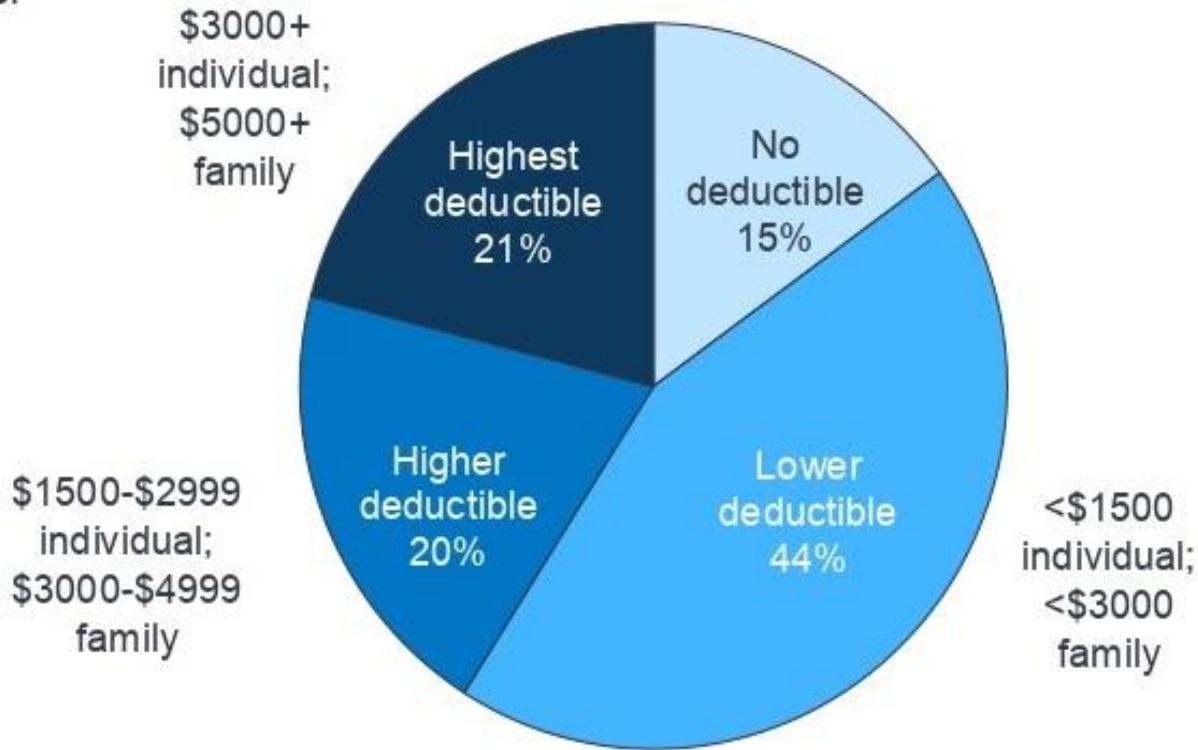
Data: [Kaiser Family Foundation](#); Chart: Axios Visuals

<https://www.axios.com/sick-people-affordability-health-care-b7306504-ec13-484f-8021-6b0a9d2ac789.html>

Figure 1

Four In Ten Adults With Employer-Sponsored Insurance Report Having High Deductible Plans

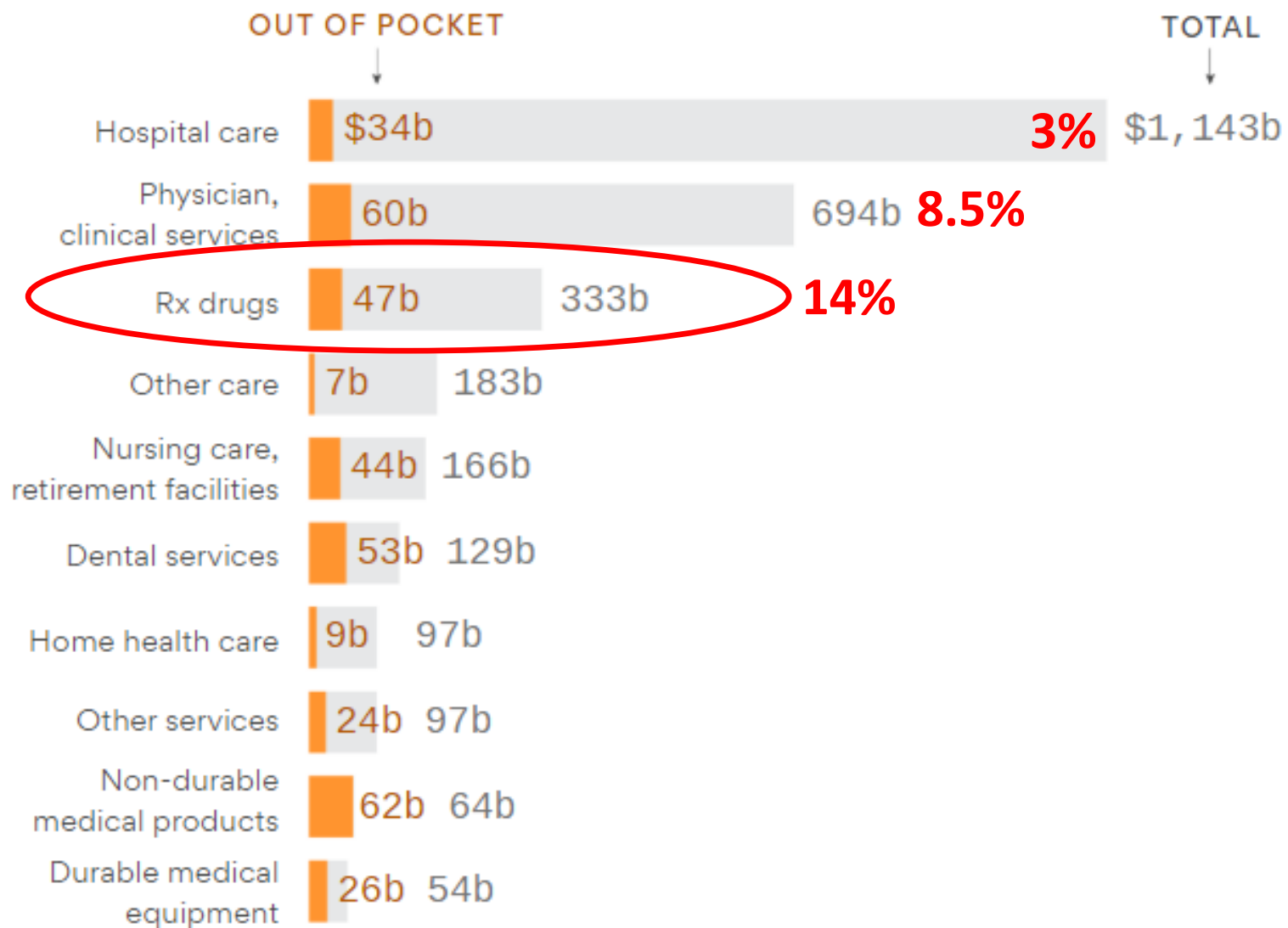
AMONG ADULTS WITH EMPLOYER-SPONSORED HEALTH INSURANCE: Percent who say their annual deductible is:



SOURCE: KFF/LA Times Survey of Adults with Employer-Sponsored Health Insurance (Sept. 25-Oct. 9, 2018). See topline for full question wording.



Personal health care spending, 2017



Adapted from [Ezra Golberstein](#) using [NHEA](#) data; Chart: Axios Visuals

Patient Cost Sharing Individual Silver Plans

Preferred Specialty Drugs

Before Deductible

8% Plans Use Copays/Median: \$550

12% Plans Use Co-insurance/Median: 50%

After Deductible

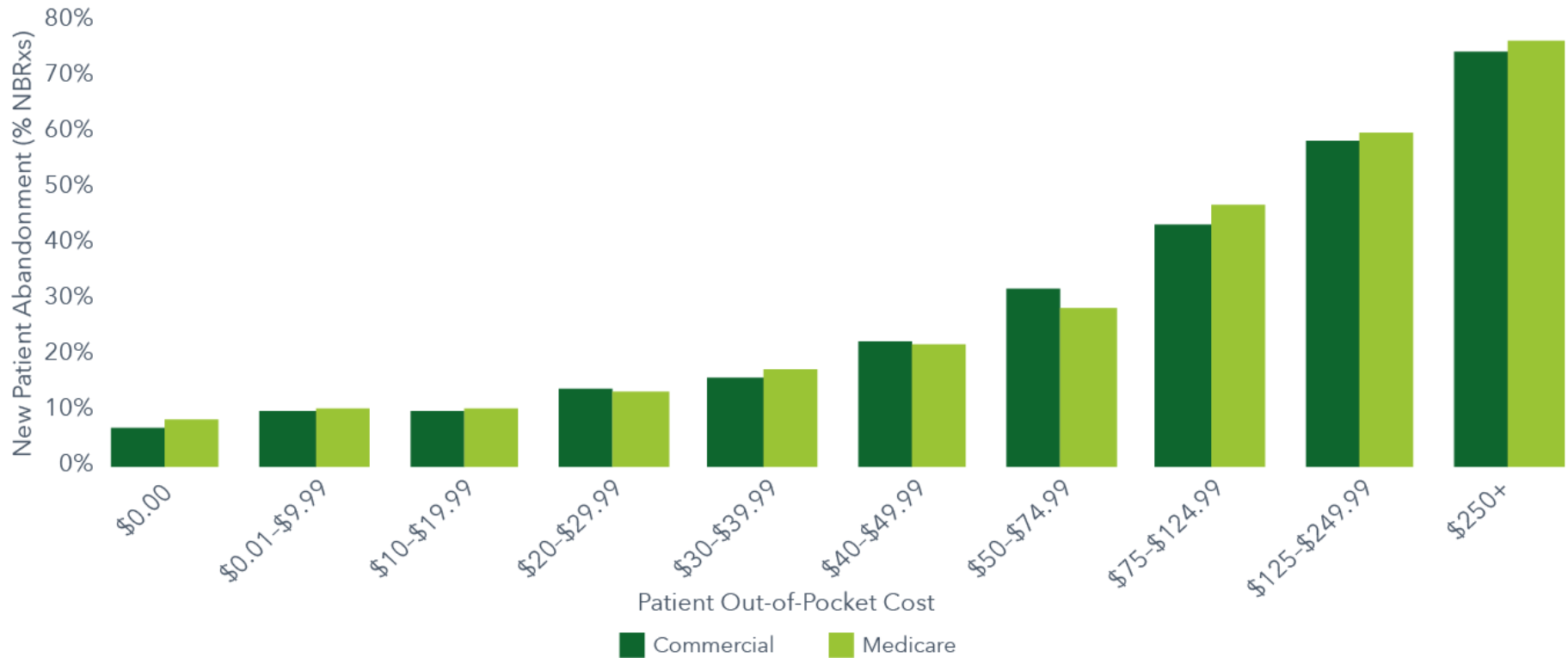
10% Plans Use Co-pays/Median: \$0

69% Plans Use Co-insurance/Median: 40%

Patient Pays Full Price of Drug Until Deductible is Met

Cost-Sharing and Rx Abandonment

30-Day New-to-Brand Abandonment by Patient Out-of-Pocket Cost in 2018 (Top Brands)



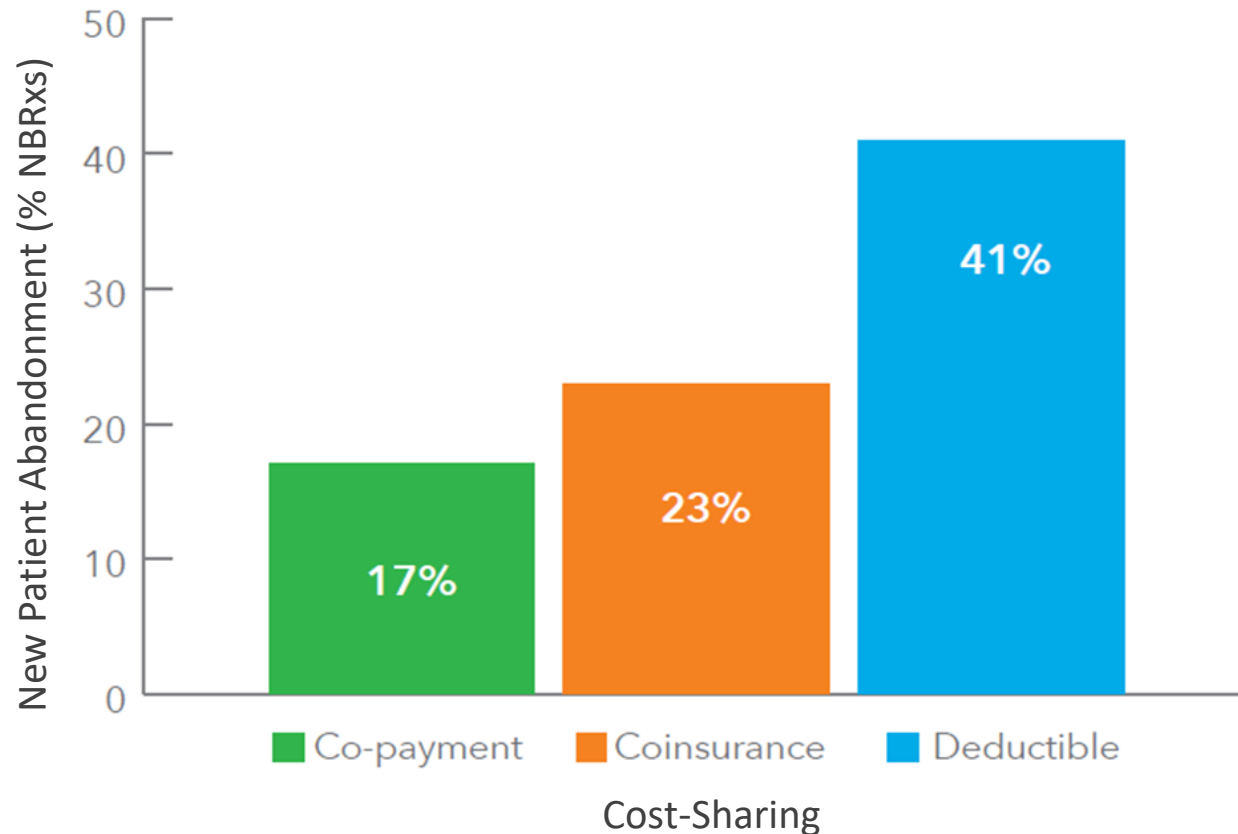
Source: IQVIA Formulary Impact Analyzer; IQVIA Analysis, Dec 2018

Chart notes: Analysis for sample of branded products representing 55% of branded prescription claims. 30-Day New-to-Brand abandonment for Commercial and Medicare Part D patients was measured from Jan 2015 to Mar 2018 and estimated for April to December 2018. Patients did not pick up relevant prescription or switch to another product during the 30 days after the initial prescription was abandoned. Patients were also analyzed to determine how many filled another prescription in the month following initial claim approval, which was abandoned.

Report: Medicine Use and Spending in the U.S. – A Review of 2018 and Outlook to 2023. IQVIA Institute for Human Data Science, May 2019

Benefit Design and Rx Abandonment

Overall New Patient Abandonment by Cost-Sharing Design (Commercial, Top Brands, 2017)

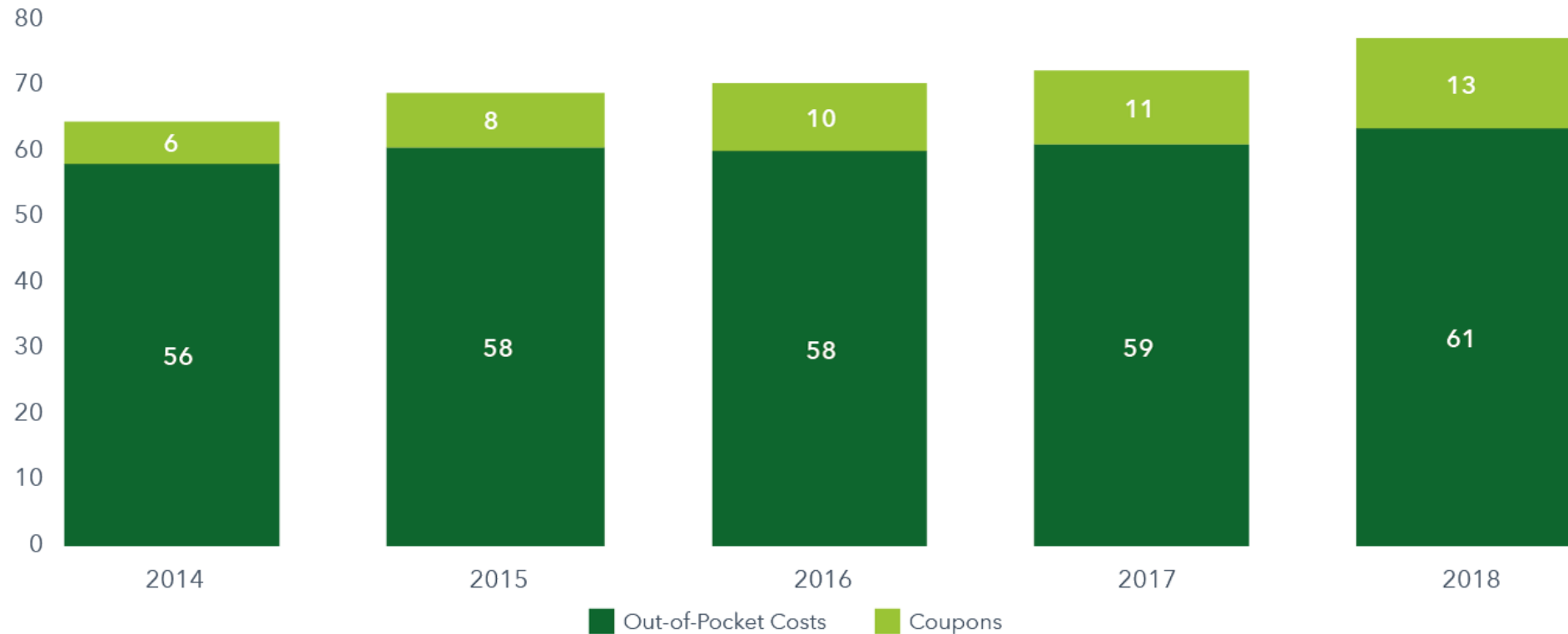


Note: Sample limited to new patient approvals across Top Brands which span over 25 traditional and specialty therapeutic areas

Source: IQVIA *Patient Affordability Part Two: Implications for Patient Behavior & Therapy Consumption*.
Available at: <https://www.iqvia.com/locations/united-states/patient-affordability-part-two>.

Role of Copay Assistance

Patient Out-of-Pocket Cost for Prescriptions in Aggregate and Value Offset by Coupons, \$Bn



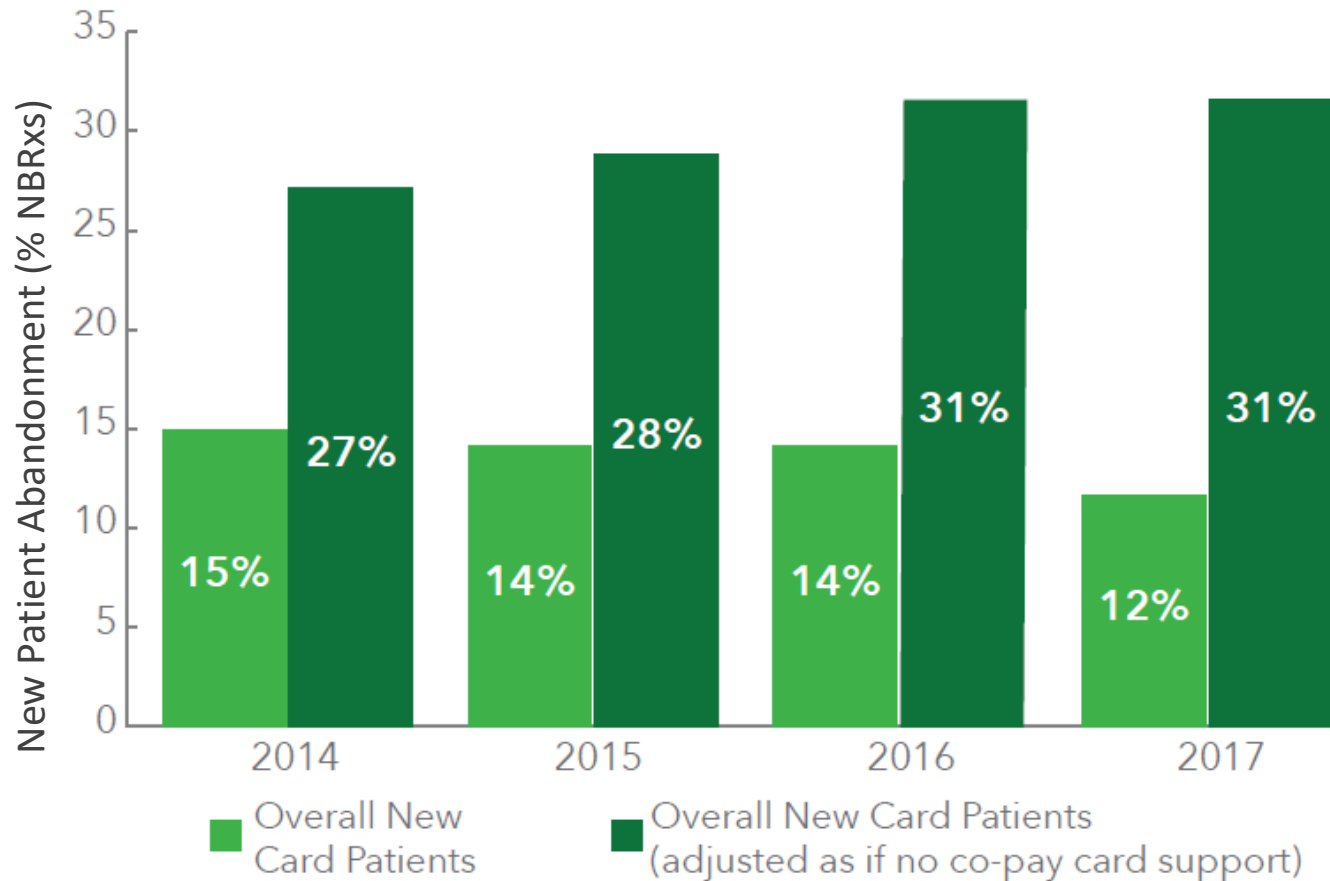
Source: IQVIA National Prescription Audit, Formulary Impact Analyzer, Jan 2019

Chart notes: OOP (out-of-pocket) costs estimated based on prescription volumes and observed OOP costs. OOP costs projected from sample in FIA to a national estimate using national adjusted prescriptions which were backprojected to estimate the trend prior to the trend break after 2016 due to restatement of NPA volumes (see Methodology section for more details).

Report: Medicine Use and Spending in the U.S. – A Review of 2018 and Outlook to 2023. IQVIA Institute for Human Data Science, May 2019

Copay Cards and Rx Abandonment

New Patient Abandonment by Year and Patient Coupon Use (Commercial, Top Brands)



Note: Sample limited to new patient approvals across Top Brands which span over 25 traditional and specialty therapeutic areas

Source: IQVIA Patient Affordability Part Two: Implications for Patient Behavior & Therapy Consumption.
Available at: <https://www.iqvia.com/locations/united-states/patient-affordability-part-two>.

State Responses

Prohibit Specialty Tiers

- **New York:** Plans can not charge cost-sharing amounts higher than amount for non-preferred brands

Co-pay Caps

- **California:** \$250/Rx after deductible met; \$500/Rx for Bronze plans
- **Delaware:** \$150/Rx after deductible
- **Louisiana:** \$150/Rx after deductible
- **Maryland:** \$150/Rx after deductible
- **Washington DC:** \$150/Rx after deductible (\$300/Rx for 90 day supply)

State Responses

- **Maine:** \$3,500 Annual limit for Rx subject to co-insurance
- **Vermont:** Annual limit for Rx can not be greater than minimum annual deductible for high deductible health plans per Internal Revenue Code (\$1,350/individual; \$2,700/family)
- **California:** Standardized plans differing by metal level:
 - Co-pay caps
 - Nominal separate Rx deductible (some metal levels exempt)
 - Co-insurance level capped for Specialty Tier Rx (between 10% and 20%)
 - Requires plans to place at least one Rx on Tiers 1-3 when multiple Rx are available for chronic conditions

Benefit Design Requirements

- **Montana:**
 - Requires insurers to have at least one plan that includes co-pays for all tier levels
 - Cost-sharing must be reasonably graduated and proportional
 - Review Rx tier placement for discrimination
- **Colorado:**
 - Not more than 50% of Rx to treat a certain condition can be on highest tier
 - At least 25% of the plans in each metal level must use co-pays & copays not subject to deductible
 - Co-pays limited to no more than 1/12 plan's out of pocket limit for individuals

Co-pay Assistance

- Growing number of plans using copay accumulators
- ***2020 Notice of Benefit and Payment Parameters will limit their use and require copay assistance to count in most situations***
 - For brand name drugs with no generic
 - When access brand drug that has a generic through exceptions or appeals process
 - *May* limit for brand name Rx when generic exists
- **Several states pass legislation requiring copay assistance to count**
 - AZ, IL, VA and WV
 - Others pending

Transparency

- **Patients need to know how much their Rx will cost them**
 - Require plans to translate co-insurance into real dollars
- **Drug Companies**
- **Strong Focus on PBMs**
- **Health Plans**
 - Percent increase in Rx spend and impact on premiums, should also compare to other health services
 - In addition to Utilization Management, should ask amount of Rx have co-insurance and charged list price until deductible met

Thank you!

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Impact of CO & MT Plan Design

- **Milliman Report:**
 - Insurers used range of plan design adjustments to offset the Rx requirements: higher medical deductible, out of pocket maximums and cost-sharing, but differences were “modest & diffused”
 - Bottom line: “no discernable benefit design changes”
 - Number of Silver & Bronze plans decreased and premiums increased in both states over 3 years “in a manner comparable to the changes observed nationwide”