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Affordability is about more than drug prices

Growing interest in government involvement in drug pricing

Over the past few years, there has been an increased focus on drug pricing, including some proposals for direct government involvement in negotiating or even setting drug prices. In 2019, the House of Representatives passed H.R.3, which would allow the federal government to negotiate drug prices for Medicare and commercial markets. In April 2021, House of Representative Democrats reintroduced H.R.3 with renewed hope of moving forward with the legislation this year.

While none of the policies have been implemented, regulation of drug prices by the federal government would likely impact a variety of stakeholders, particularly those purchasing and managing drugs. And drug pricing is front and center for many voters; 22% of Americans say that addressing prescription drug costs should be the top healthcare priority of Congress.[1]

Yet, it remains unclear if lowering drug prices would actually affect prices for both physician-administered and outpatient prescription medicines. Four in 10 patients with employer coverage report having difficulty affording their medical care[2]; patients are often facing high deductibles and coinsurance for their prescription drugs. The out-of-pocket costs (OOP) of healthcare are daunting for many.

To evaluate the impact of government-mandated price reductions on coverage and patient affordability and access, Xcenda surveyed advisors from health plans, integrated delivery networks (IDNs), and pharmacy benefit managers (PBMs) and asked questions about the impact of government price regulation on access, including cost-sharing and benefit design.

Pricing regulation would have limited impact on patient copays and coinsurance

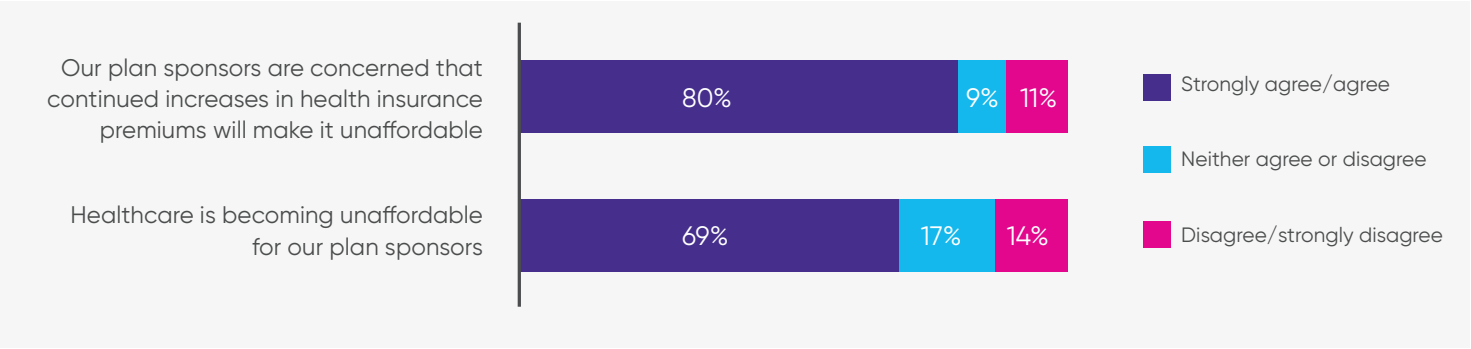
To dive into the question of whether government involvement in drug pricing would impact patient affordability, we set up a scenario, "Let's assume that government price action impacts a meaningful number of medications with significant discounts. Not all therapies are impacted. However, the net impact of government price action of total net drug spending is 15% lower costs…"

Copays: The impact of a 15% drug cost reduction has **no significant impact on copays. Only 1 of 4 payers would pass these savings through to patients in the form of lower copays**. Payers that would lower copays with the 15% price action would only do so for the therapies directly impacted. For most payers, no discount amount would trigger a drop in copays. No differences were found by organization type, size, or national vs. regional coverage.

Coinsurance: Only 11% of payers would lower coinsurance as a result of federal price action. Another **46% acknowledge lower coinsurance as a result of price action due to the drop in drug prices**. Most payers that would lower coinsurance would only do so for the affected therapies. Most would not lower coinsurance with any discount amount. While this sentiment is shared among most payers, especially medical directors, no other organizational or regional differences were found.

Premiums: Nearly half of payers (46%) would lower premiums if they could achieve a drug spending savings of 15%. This is likely due to the perception that plan sponsors find premiums increasingly unaffordable **(Figure 1)** and the reality that many patients shop for plans based on premium costs (a known, fixed expense) without considering their other OOP expenses.

Figure 1. Payer opinions on health insurance affordability



Price regulation unlikely to broaden formulary coverage when rebates are present

To provide a more realistic idea of the payer response to potential price reform, respondents were given scenarios **(Table 1)**, with variations in the wholesale acquisition cost (WAC) and annual net cost for 3 hypothetical medications. In this case study, all 3 therapies were said to be for a fictional treatment of a significant chronic disease, in the same category/class of drugs, and clinically equivalent.

Table 1. Scenarios for clinically equivalent medications

Therapy		Base case scenario Therapy B has a $2,000 rebate	Scenario 1 Drop in WAC to $5,000 for therapies A, B, and C and no rebating	Scenario 2 Drop in WAC to $5,000 for therapies A and C and $3,000 rebate for therapy B
A	WAC	$7,000	$5,000	$5,000
	Net Cost	$7,000	$5,000	$5,000
B	WAC	$7,000	$5,000	$7,000
	Net Cost	$5,000	$5,000	$4,000
C	WAC	$7,000	$5,000	$5,000
	Net Cost	$7,000	$5,000	$5,000

Key: WAC – wholesale acquisition cost.

There are 2 key takeaways from the case study.

1. The first is that discounts broaden coverage when therapies move toward price parity. Payer responses to the scenarios suggest that lowering WAC and providing rebates would expand coverage and may mitigate other pricing efforts.

   Payers reported that lowering the WAC from $7K to $5K improves coverage for the drug and reduces restrictions **(Figure 2)**. While in the base case, there is 1 preferred therapy in 69% of respondents, when there is price parity **(Scenario 1)**, by removing the rebate and lowering WAC across the board, the formulary coverage opens up for all 3 therapies. In short: no longer is one therapy preferred over the other.

2. The second finding was that rebates will continue to narrow coverage. **Figure 2** shows that when rebates are lowered for just 1 of the products to a net cost lower than WAC for equivalent products **(Scenario 2)**, the rebated product will face fewer access restrictions. Scenario 2 demonstrates that rebates are a double-edged sword; rebates are important to payers but also likely to continue to hinder the impact of other pricing efforts aimed at broadening coverage and expanding the number of therapies.

Scenario 1

Eliminating a known rebate reduces coverage

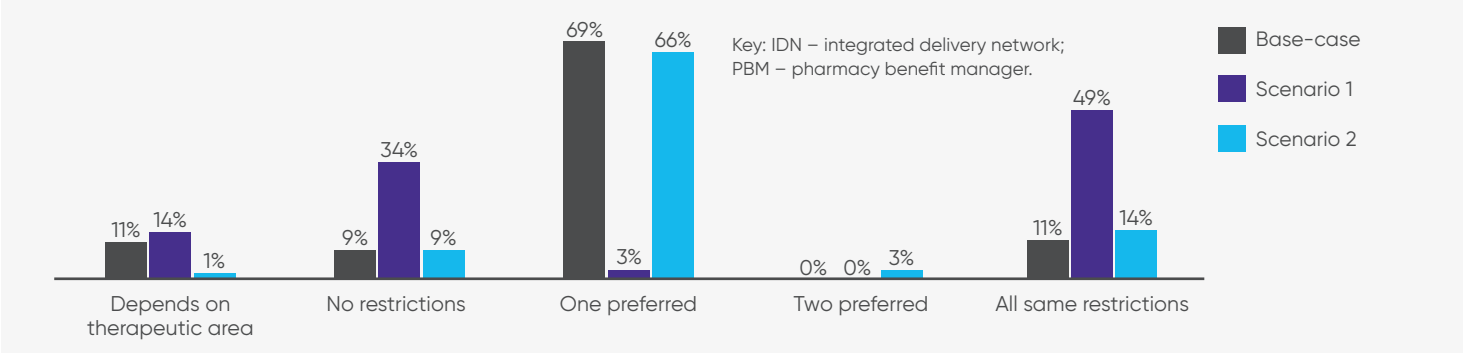
The therapy with the rebate removed, even if all WACs are the same, triggers lower tier placement; suggesting that once rebates are offered, they need to be maintained to secure formulary positioning

Scenario 2

Rebating will continue to diminish the impact of other pricing efforts

Even if rebating results in a lower net cost, the WAC is what drives better coverage (better tier placement and preference for more than 1 brand)

Figure 2. Scenario-dependent formulary changes considered by payers, PBMs, and IDNs (N=35)



Almost half of payers would not change formularies in the case of state-driven reform

Payer response to state-driven price reductions is harder to assess; there is no dominant strategy for how payers would react to actions that reduce drug spending by 15% **(Figure 3)**. Some payers would plan to do nothing (40%) and won't be swayed to change their formulary; some would implement formulary changes only in affected states (31%), and some would make national formulary changes if the summative discounts across states were large enough (23%).

Figure 3. Formulary management approach

40%
no formulary changes

31%
adjust formulary in key states

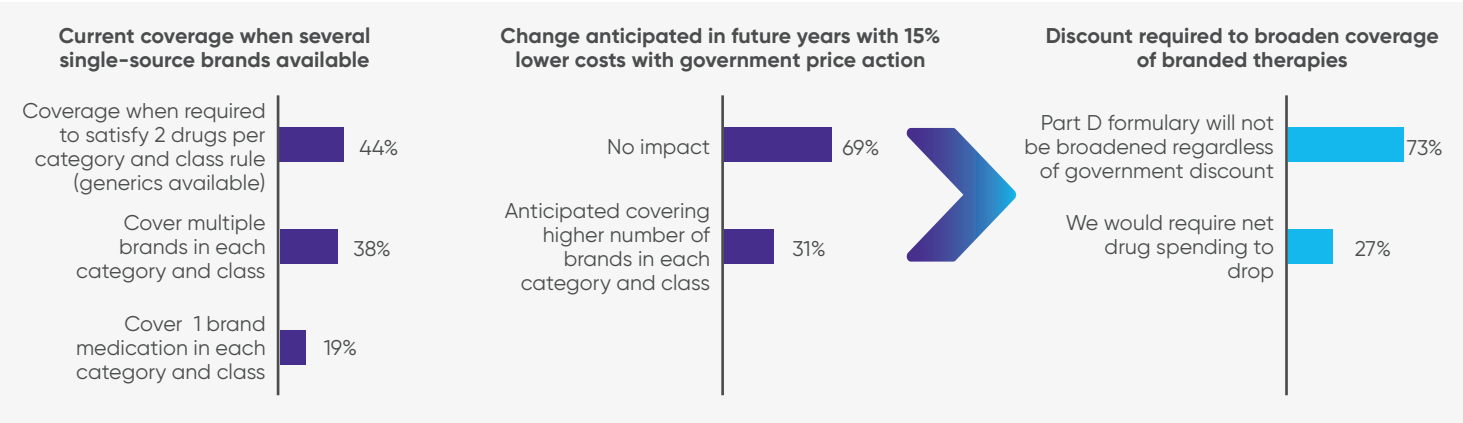
23%
national changes with favorable discount

6%
wait and see—depends on discount

Most payers would not change Part D coverage even if price regulation created 15%+ savings

When asked about the impact of price regulation on Medicare Part D, at a 15% savings or higher, almost 3 in 4 payers stated that this would be unlikely to change or broaden Part D coverage for branded medications on their organization's formulary **(Figure 4)**.

Figure 4. Impact of price regulation on Medicare Part D



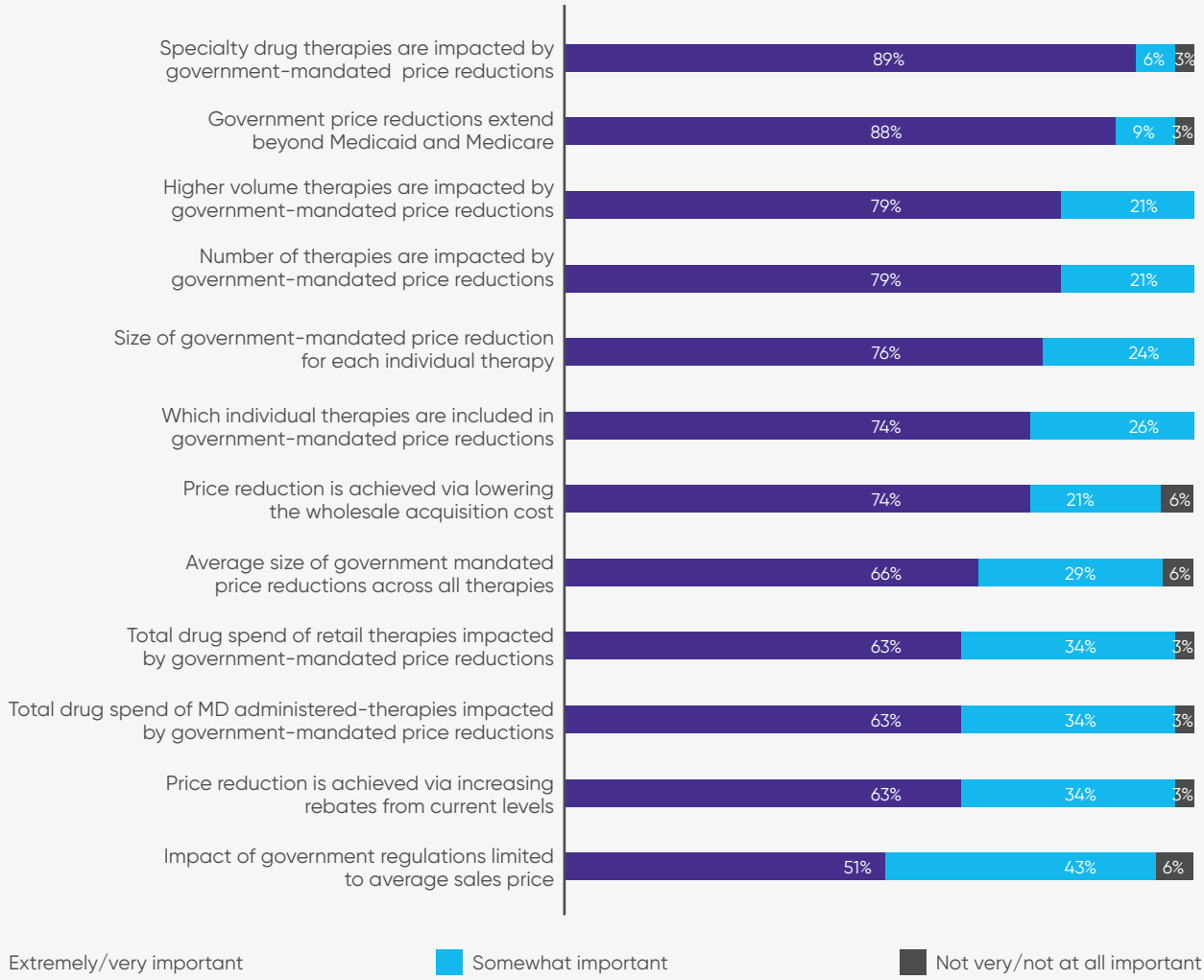
Drivers of impact of government price regulation on access

The survey also looked at the drivers of impact of potential government price regulation on access. In other words, what areas would have to be impacted by government price regulation to make a difference in access.

Roughly 9 of 10 respondents stated they consider specialty therapies and further possible price reductions beyond Medicaid/Medicare when evaluating the impact of government price reductions on formularies. Another 8 of 10 interviewees said they consider higher-volume therapies and number of therapies as factors influencing price reductions.

~75% of interviewees stated that the size of the price reduction, the specific therapies included, and lowering of WAC were the important considerations.

Figure 5. Influential factors in determining the impact of price regulations on formularies (N=35)



Drug pricing is not affordability

Federal price action could trigger some payers to modify formulary benefit design, shift coverage, and use of utilization management tools. However, the findings suggest that as long as rebates continue to be prevalent, other pricing efforts are unlikely to impact coverage and patient access substantially. Payers also suggested that they will continue to pursue rebates and value-based contracting mechanisms, regardless of federal price action.

Although nearly half of respondents mentioned they would reduce premiums at a 15% reduction in drug prices, most were doubtful federal price action would result in a reduction in patient copays for their commercial plans. As many high-cost therapies are on non-preferred formulary tiers, a reduction in cost would likely have to be significant to affect a tier change that moved a drug to the preferred brand tier and to reduce copay in standard tiers.

Likewise, patients may see limited impact on coinsurance.

The coinsurance percentage amount will remain the same, regardless of price action, according to most payers.

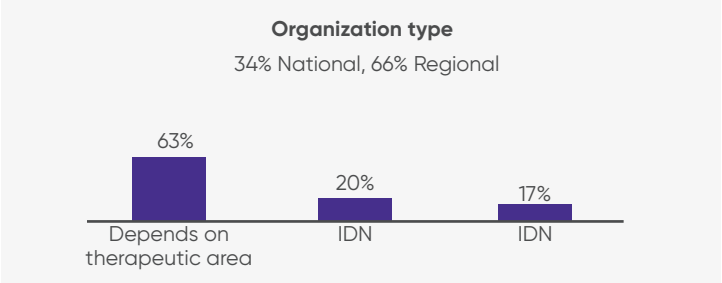
Lowering drug costs for a specific drug will reduce the amount a patient pays for it by 15%, even if the coinsurance rate stays the same. Nevertheless, a 15% reduction in coinsurance for a therapy that costs thousands of dollars per year will not considerably reduce a beneficiaries' OOP spending. Given that Medicare Part D does not have an annual OOP cap, beneficiaries will continue to face financial responsibility and the burden for catastrophic coverage costs, instead of plan sponsors, regardless of federal price action.

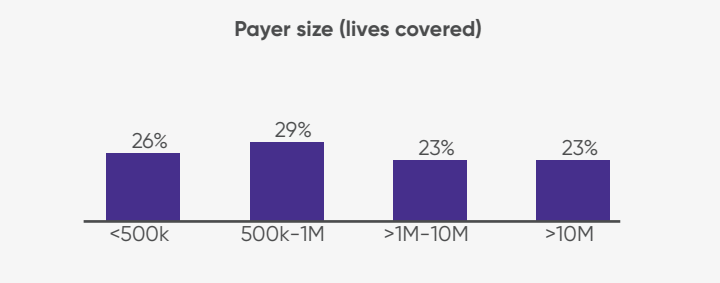
This drives home the need to distinguish between drug pricing and affordability. Reducing drug pricing does not necessarily correlate with a reduction in OOP spending for patients, and even when it does reduce OOP spending, it doesn't necessarily make it affordable for patients.

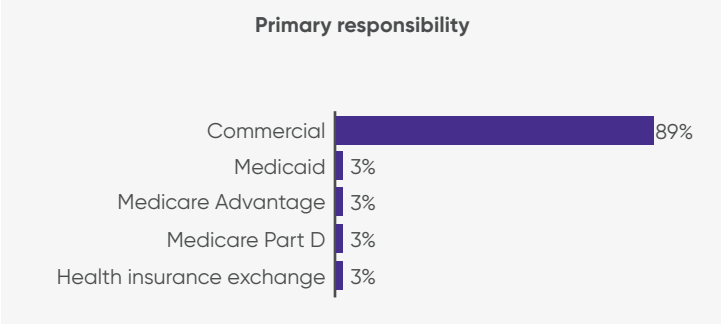
Policymakers need to be thinking more broadly about drug spending and affordability. There is a tension between premiums, benefit design, and adverse selection; however, if rules were in place that leveled the playing field between plans, perhaps access and affordability could improve. One step in that direction would be an annual OOP cap in Medicare Part D. Additionally, there are many legislative proposals recommending capping beneficiary spending, such as H.R. 19/S. 3129, Prescription Drug Pricing Reduction Act (PDPRA) of 2019, and H.R.3. All 3 proposals have suggested limiting Part D patient OOP and shifting liabilities to payers and manufacturers, while reducing government reinsurance liability. There is no question that the perfect solution may not exist, but a better option could.

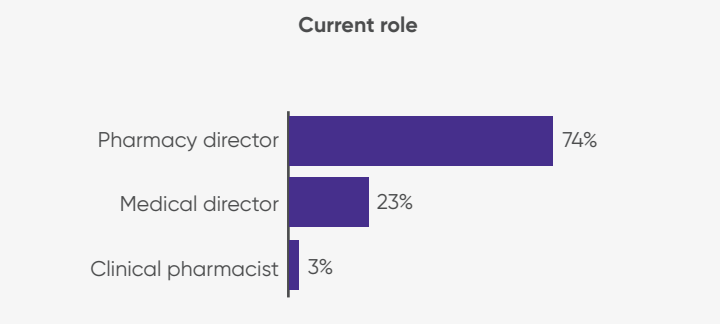
Methodology

A web-based double-blinded survey of advisors, including payers, PBMs, and IDNs (N=35), was conducted from December 2020 to January 2021. An honorarium was paid to survey respondents.









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