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Trusted Advice for Multiemployer Plans

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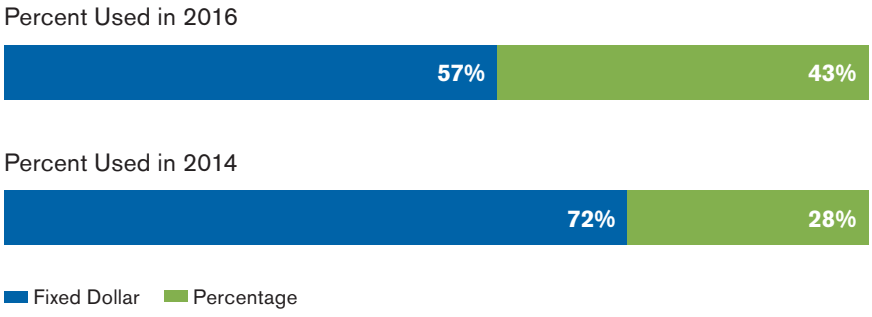
Crafting an Effective Prescription Drug Plan Copayment Strategy

Fixed-Dollar vs. Percentage Copayments in Rx Plan Design

The number of Segal Consulting's multiemployer health plan clients using percentage copayments, also known as coinsurance, has increased dramatically in just two years. Currently, more than 40 percent of Segal's multiemployer health plan clients use percentage copayments instead of traditional fixed-dollar copayments for at least some portion of their prescription drug benefit plan.

Pharmacy Benefit Copayments Used by Multiemployer Plans



Source: Segal Consulting's Multiemployer Health Plan Database, 2014 and 2016

The percentage copayment approach is most often used for brand-name drugs. Fixed-dollar copayments continue to be more common for generic drugs. Often, the plan designs utilizing coinsurance also include set minimum and maximum copayment amounts.

Fixed-Dollar and Percentage Copayments Compared

The appeal of fixed-dollar copayments lies in their simplicity. They are easy for participants to understand and, more important, there are no out-of-pocket surprises at the point of purchase. The fixed cost simplifies cash flow and budgeting for the plan sponsor. Pharmacy benefit managers (PBMs) prefer fixed-dollar copayments because they require minimal system support and reduce calls from participants when abrupt pricing changes occur as the fixed-dollar copayment insulates the participant from any price increases made by the drug manufacturer.

However, over time, as costs go up, a fixed copayment erodes the value of cost sharing to the plan sponsor, which increases plan cost trends to plan sponsors. Percentage copayments keep pace with drug price inflation and do not erode over time. Addressing fixed-dollar copayment erosion requires periodic resets (usually increases in the fixed-dollar copayment amount). Moreover, fixed-dollar copayments do not provide an incentive for participants to seek lower-cost alternatives.

The greatest disadvantage associated with percentage copayments is that they result in uncertainty about costs for participants. Most sponsors of plans with percentage copayments address that concern by including maximum dollar amounts per prescription. Those maximums protect participants from excessive out-of-pocket expenses at the point of purchase. Given that only about 15 percent of all prescriptions now dispensed are for brand-name drugs,[1] plan sponsors can limit the amount of change for participants by adopting percentage-copayment plans with maximums for just brand-name drugs.

Another disadvantage is the fact that is it difficult for participants to find information about prescription drug prices. Many PBMs have the technology to share real-time drug prices, but not all are willing to promote that service.

The chart on the next page summarizes these primary advantages and disadvantages of fixed-dollar copayments and percentage copayments.

> “Percentage copayments keep pace with drug price inflation and do not erode over time.”

[1] This statistic is based on actual claims data from Segal clients. PBM data is similar.

Primary Advantages and Disadvantages of Both Copayment Types

	Fixed Dollar	Percentage
Advantages	▪ Cost certainty for participants ▪ Cash flow and budgeting relatively easy for the plan sponsor ▪ Easy to communicate and administer	▪ Cost sharing increases consistently with prescription drug price inflation ▪ Watchdog effect on excessive price increases imposed by drug manufacturer or PBM ▪ Financial incentive for participants to become aware of and seek the lowest-cost alternatives ▪ No need to reset the copayment coverage level*
Disadvantages	▪ Value to plan sponsor erodes over time, adding to cost trends ▪ Periodic copayment increases required ▪ Participants not encouraged to seek the lowest-cost alternatives ▪ Drug companies are able to pass on higher price increases with less consumer backlash	▪ Cost uncertainty for participants ▪ Increases participant responsibilities and creates challenges to cash flow for lower-wage earners ▪ More complicated to communicate

* The exception is potential adjustments to the maximum, if there is one.

There are also secondary advantages associated with percentage copayments:

- The standard Part D plan design uses a 25 percent copayment and is the most common design offered by the Centers for Medicare & Medicaid Services (CMS). To maximize the reinsurance payments from CMS under Employer Group Waiver Plans (EGWPs), private plans generally use percentage copayment designs for brand-name drugs for Medicare-eligible retirees. Percentage-copayment designs result in more patients reaching their out-of-pocket maximums, which results in maximum CMS reinsurance payments to the plan sponsor.
- Manufacturer coupon programs are attractive to participants because they reduce the copayment, but they can encourage the use of higher-cost brand-name drugs when lower cost generics are available, resulting in higher costs for the plan sponsor. Percentage copayment plans increase the value of any manufacturer's copayment coupons offered to patients, which can help reduce the combined cost to both the participant and the plan sponsor.

Why Percentage Copayments May Be Useful for Generic Drugs in Addition to Brand-Name Drugs

When a generic drug first comes to market, the Food and Drug Administration grants a six-month exclusive marketing period for the first approved generic drug manufacturer. During this period when one generic drug maker has sole market access to sell its drug, pricing is only slightly lower than the brand-name version.

Plan sponsors need to make sure that a plan's fixed-cost copayment for generic drugs does not result in excessive plan payments during this short-term marketing period.

Consider the following example:

> The discounted price for a 30-day supply of the brand-name drug Crestor® is $250. After the participant pays a 20 percent copayment ($50), the cost to the plan sponsor is $200.
>
> A new generic equivalent, Rosuvastatin, becomes available with a discounted price for a 30-day supply of $225. Although that is lower than the brand-name price, the cost to the plan sponsor is higher because the plan has a $5 fixed-dollar copayment for generic drugs. That means the plan sponsor cost is $220.
>
> Over the six-month generic exclusivity period for use of the generic, the net cost increase to the plan sponsor is $120 ($20 more per month).

Moving to a percentage copayment design for both the brand-name drug and its generic equivalent would eliminate the temporary pricing anomaly. As the exclusivity period ends, multiple suppliers of the generic drug come to market and the generic drug price typically drops dramatically relative to the brand-name version of the medication.

Furthermore, Segal has observed substantial variation in generic drug pricing and price changes of generic drugs on some PBM maximum allowable cost (MAC) lists.[2] Having a fixed-dollar copayment for all generic drugs insulates the manufacturer and PBM from abrupt increases in price changes for generic drugs that may be occurring by product and pharmacy. A percentage copayment for generic drugs could serve as an effective check against predatory pricing changes made by some generic manufacturers and help plan sponsors become aware of these price increases more quickly, putting pressure on their PBMs to better manage the price changes that now occur with some MAC lists.

> "Having a fixed-dollar copayment for all generic drugs insulates the manufacturer and PBM from abrupt increases in price changes for generic drugs."

[2] A MAC list is a list of prices that PBMs use to reimburse network pharmacies for generic drugs dispensed.

> Copayments are just one tool to help lower the cost of prescription drug coverage.

Intrigued? Considerations before Making a Change

Plans that are still grandfathered under the Affordable Care Act should consult with legal counsel prior to modifying any prescription drug benefit reimbursement levels. Certain changes in copayments, coinsurance or drug tiers have a significant possibility of triggering loss of grandfathered status.

Non-grandfathered plans must comply with the law's annual limit on cost sharing, also known as an out-of-pocket maximum. That maximum applies to out-of-pocket costs for all health plan deductibles, copayments and coinsurance, including out-of-pocket costs for outpatient prescription drugs. For the 2016 plan year, the maximum for both prescription drugs and medical benefits is $6,850 for an individual and $13,700 for a family.

Any changes to prescription drug coverage must also comply with other federal laws that affect group health plans. For example, the Mental Health Parity Addiction Equity Act (MHPAEA) requires parity between medical/surgical benefits and mental health/substance use disorder benefits. Compliance with the MHPAEA requires that health plans provide parity in both numerical or "quantitative" financial requirements or treatment limits (*e.g.*, cost-sharing and day or visit limits) and "nonquantitative" treatment limits (*e.g.*, tools to manage the mental health or substance use disorder benefit).

The Bottom Line

Copayments are just one tool to help lower the cost of prescription drug coverage. They should be part of a comprehensive cost-management strategy that includes appropriate clinical and utilization management rules.

Questions? Contact Us.

For more information about introducing percentage copayments for at least new generic drugs and/or to discuss how Segal Consulting can help you to assess your overall strategy for managing the cost of your prescription drug coverage, contact your Segal benefits consultant, the nearest Segal office or one of the following experts:

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