PBMs and Impact on Access and Affordability

Amy Killelea, JD
Senior Director, Health Systems & Policy
NASTAD

1) Formulary Inclusion, UM, and Pharmacy Network Design

- PBMs play an outsized role in prescription drug access, including through:
  - P&T committee administration; evaluating clinical efficacy and clinical justification for formulary inclusion and any UM
  - Value committee; evaluating cost-effectiveness of formulary inclusion, tiering, and UM based on net price, including rebates
  - Pharmacy network design, including specialty pharmacy and mail order requirements

Note: Models 22 and 74 address some but not all of these activities

Access Challenges

Formulary inclusion	Utilization management	Pharmacy network
Formularies exclude drugs with a lower list price; preference cost over clinical efficacy	The use of prior authorization for certain specialty medications is increasing, and research shows is arbitrarily used*	Limited pharmacy networks and specialty and mail order requirements burden patients

** Paper forthcoming examining prior authorization applied to certain HIV medications, University of Virginia and NASTAD*

2) Transparency

- Consumers need to know how much they will be paying for their prescription drugs, particularly when co-insurance is used
- Health plans, regulators, and consumers need to know how rebates are being spent and where they are being reinvested (each group may require different levels of information)

3) Affordability

- PBMs play a significant role in the ultimate prescription drug cost passed to the consumer
- Rebates generated are generally used to defray premiums, not to reduce prescription drug cost sharing for consumers (see GAO report re Medicare Part D rebates)
  - This disproportionately impacts people who rely on high-cost medications, who are subject to an inflated list price when calculating pre-deductible costs and co-insurance
- Practices like co-pay accumulator policies put the consumer in the middle of the insurer and the manufacturer and are not a substitute for sound drug pricing reforms

Patient Cost Sharing for Preferred Specialty Drugs Is Unaffordable

- 69% of individual market silver plans use co-insurance, with a median co-insurance level of 40%
  - Most HIV regimens are ~$2,000/month WAC; a 40% co-insurance represents $800 per fill
- Less than 10% of silver plans in the individual market use co-payments that are not subject to the deductible; for those that do, the median co-pay is $550
- High deductible plans are becoming more prevalent
  - Consumers pay list price for prescription drugs pre-deductible

Source: Hempstead, K. Robert Wood Johnson Foundation, February 28, 2019

Manufacturer Co-pay Cards Are a Symptom of A Broken System

- Consumers depend on manufacturer co-pay cards to afford their deductibles and cost sharing for specialty medications
- Co-pay accumulators allow plans to double dip; charging the co-pay card up until its annual maximum and then charging the consumer up until the plan annual OOP maximum
  - CCIIO guidance announced non-enforcement of NBPP 2020 protections limiting co-pay accumulators to brand-name drugs w/generic equivalent
- Solution is not to remove a safety net; fix underlying problem of drug pricing and high consumer drug costs
  - Carl Schmid, Briefing on State Legislative and Administrative Actions to Address Prescription Drug Cost-Sharing, NAIC National Meeting (November 2018)

Co-pay Accumulator Impact

CASE STUDY FOR PREP

SILVER LEVEL HIGH DEDUCTIBLE PLAN (CO-PAY)

- Plan annual OOP maximum: $6,000; Deductible (combined medical and Rx): $3,000
- Drug cost sharing for preferred brand: $50 after deductible
- Industry co-pay assistance program (CAP) annual max: $7,200
- WAC monthly drug price: $1,676

COSTS WITHOUT CO-PAY ACCUMULATOR POLICY

Month	Consumer Pays	Co-pay Card pays
January	$0	$1,676
February	$0	$1,374
March	$0	$50
April	$0	$50
May	$0	$50
June-December	$0	$50
Total	**$0**	**$3,550**

Total plan payments (consumer and co-pay card) $3,550

COSTS WITH CO-PAY ACCUMULATOR POLICY

Month	Consumer Pays	Co-pay Card pays
January	$0	$1,676
February	$0	$1,676
March	$0	$1,676
April	$0	$1,676
May	$1,180	$496 (max co-pay assistance hit)
June	$1,676	$0
July	$194	$0
June-December	$50	$0
Total	**$3,300**	**$7,200**

Total plan payments (consumer and co-pay card) $10,500

Considerations for the Subgroup

- Strengthen and reinforce the applicability of relevant formulary and access protections included in Model 22
- Strengthen conflict of interest standards to ensure that formulary and access decisions are based on clinical justifications and not PBM self dealing
- Review network adequacy standards in Model 74 and ensure that pharmacy network nuances (e.g., mail order and specialty pharmacy requirements and potential abuses arising from vertical mergers) are addressed
- Develop transparency standards for PBM practices
- Ensure rebates are used to defray consumer prescription drug cost sharing, not just premiums

Thank you!

- Amy Killelea (akillelea@nastad.org)