

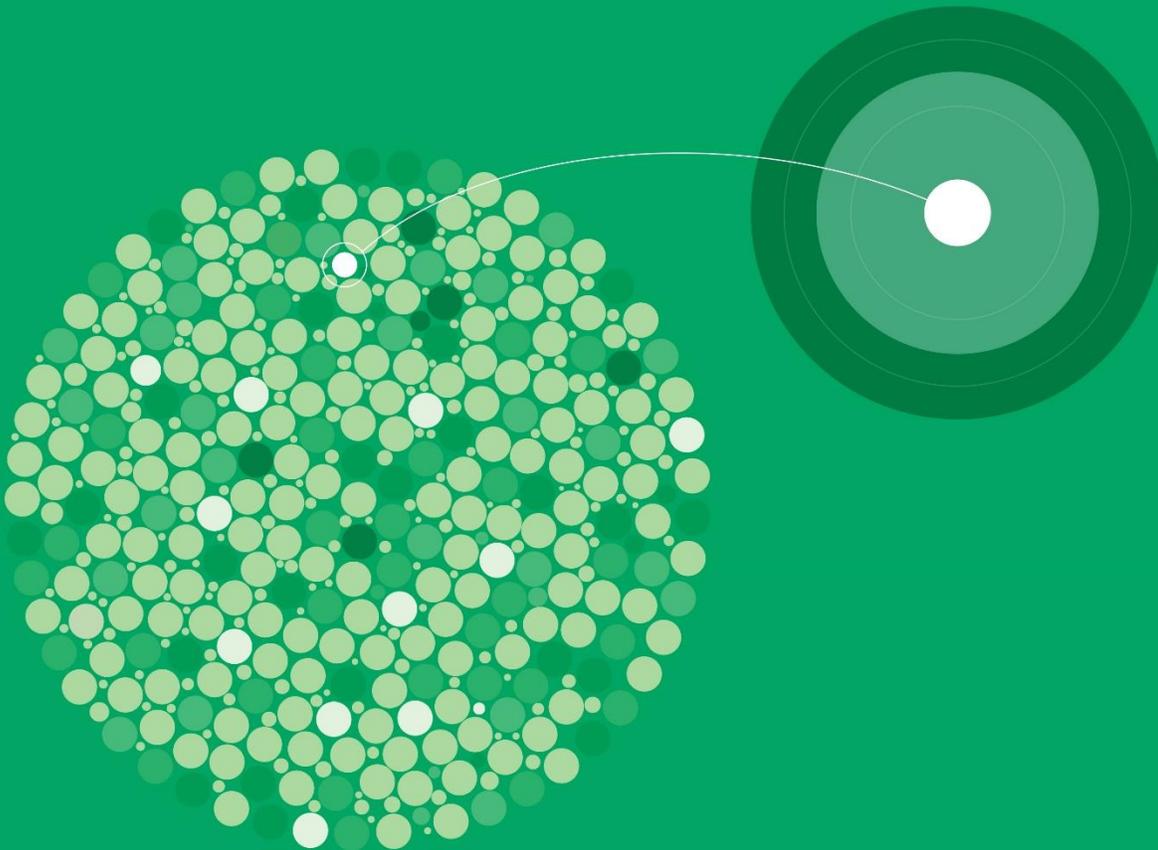
MILLIMAN REPORT

Measuring the Impact of Point of Sale Rebates on the Commercial Health Insurance Market

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Sharing rebates with members may lower patient costs with minimal impact on health insurance premiums

Pharmaceutical manufacturers often pay significant rebates to pharmacy benefit managers (PBMs) or payers (including plan sponsors and health plans) on brand medications for favorable formulary placement and other demand incentives. Traditionally, payers do not share these rebates directly with members¹. Instead, rebates reduce a payer's pharmacy liability, which they often use to lower premium rates across all members. Under this approach, all members benefit from reduced premium, and members using brand medications pay the same out-of-pocket (OOP) costs regardless of whether or not a payer received a rebate.

There has been heightened interest in understanding the dynamics, challenges, and impacts of passing pharmacy rebates directly to members at the point of sale (POS). This interest stems from two main trends in the commercial (under age 65) employer group market:²

- The rise in prevalence of high-deductible health plans (HDHPs) and coinsurance-based benefit designs, which expose members to the underlying list price of medications
- Increasing list prices of brand medications and the corresponding rise in rebates

Most PBMs can administer rebates at POS and have expressed a willingness to do so.^{3,4,5} We explored how applying rebates in this manner would affect both member premiums and cost sharing for an average member as well as hypothetical patients with selected chronic conditions.

Results

We modeled the impact of applying all manufacturer rebates at the POS and observed the resulting reallocation of payer and member costs among various plan designs typically found in the employer market. The selected plans include:

- A traditional preferred provider organization plan (PPO) with brand pharmacy benefits subject to copays (Copay PPO)
- A traditional PPO plan with brand pharmacy benefits subject to a set coinsurance percentage (Coinsurance PPO)
- An HDHP with brand pharmacy benefits subject to copays after a member satisfies the deductible (Copay HDHP)
- An HDHP with brand pharmacy benefits subject to coinsurance after a member satisfies the deductible (Coinsurance HDHP).

To better gauge the variation in member cost sharing, we also worked with PhRMA to develop hypothetical “patient profiles”—each with a unique set of conditions represented by specific pharmacy utilization. These include patients with:

- Diabetes and cardiovascular disease (CVD)
- Diabetes and chronic respiratory disease (CRD)
- Auto-immune disease

¹ <https://www.milliman.com/en/insight/A-primer-on-prescription-drug-rebates-Insights-into-why-rebates-are-a-target-for-reducing>

² In addition to the items noted, recent legislative attention has further underscored the heightened interest. For instance, West Virginia requires passing rebates to consumers in the commercial market, and it is expected POS rebates will be required in the Medicare market beginning 2023. Retrieved May 23, 2021 from https://www.wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=HB2263%20SUB.htm&yr=2021&sesstype=RS&i=2263 <https://healthpayerintelligence.com/news/what-the-new-rebate-rule-means-for-medicare-part-d-plans-mcos>.

³ CVS Health (March 27, 2018). Aetna to provide pharmacy rebates at time of sale, encourages transparency from drug manufacturers. Press release. Retrieved May 24, 2021 from <https://cvshealth.com/news-and-insights/press-releases/aetna-to-provide-pharmacy-rebates-at-time-of-sale-encourages>.

⁴ Drug Channels (September 19, 2019). Employers Slowly Warm to Point-of-Sale Rebates—But Must Move Faster for Insulin. Retrieved May 23, 2021 from <https://www.drugchannels.net/2019/09/employers-slowly-warm-to-point-of-sale.html>.

⁵ Roberts, J. (June 7, 2017). Consumer Transparency: Helping Members With High-Cost Drugs at the Point of Sale. CVSHHealth. Retrieved February 27, 2020 from <https://payorsolutions.cvshealth.com/insights/consumer-transparency>.

Our analysis demonstrates moving rebates to the POS would result in the following:

1. **Minimal plan cost increases.** Depending on the plan design, we project payer costs would increase by an average of 0.6% or less. The additional costs could lead to slightly higher premium rates or possibly benefit reductions commensurate with the payer cost changes. Figure 1 shows the variation in payer costs across all modeled plans, with the last row quantifying the overall expected outcomes.

FIGURE 1: TOTAL PAYER COST IMPACT OF REBATES AT POINT OF SALE (PER MEMBER PER MONTH)

	PLAN TYPE			
	COPAY PPO	COINSURANCE PPO	COPAY HDHP	COINSURANCE HDHP
Net Payer Spend (Baseline)	\$509.19	\$505.31	\$451.00	\$449.87
Net Payer Spend (POS Rebates)	\$509.42	\$507.22	\$452.89	\$452.56
Change in Payer Costs \$	\$0.23	\$1.91	\$1.89	\$2.69
Change in Payer Costs %	0.0%	0.4%	0.4%	0.6%

2. **Largest reductions in out-of-pocket costs are for members enrolled in coinsurance plans.** Of the plan designs studied, members in coinsurance plans—specifically the “Coinsurance HDHP”—would experience the greatest cost sharing reduction if rebates were applied at the POS. The amount of the decrease would depend on the individual member’s annual OOP spend and how much of that spend is for rebatable products purchased within the benefit plan’s deductible and/or coinsurance phase.

We present the average annual reduction in cost sharing across all patient profiles enrolled in a Coinsurance PPO and HDHP in Figure 2. Appendix A contains similar tables for all modeled plan designs.

Using the Coinsurance HDHP as an example, 20% of “average” members incur annual costs between \$3,250 (deductible) and \$5,900 (OOP limit) while between 40% and 60% of the two diabetes profiles fall into the same cost range. Given the high cost of medications for patients with an auto-immune disease, a greater proportion incur costs in excess of the OOP limit, which reduces the overall benefit of POS rebates for them.

FIGURE 2: AVERAGE ANNUAL COST SHARING REDUCTION IN A COINSURANCE HDHP AND PPO PLAN

OOP RANGE	MEMBER PROFILE			
	AVERAGE*	DIABETES/ CVD	DIABETES/ CRD	AUTO-IMMUNE DISEASE
Coinsurance HDHP				
\$0 - \$3,250	\$19.39	\$767.86	\$945.15	\$207.82
\$3,250 - \$5,900	\$75.78	\$768.33	\$555.74	\$120.90
\$5,900+**	\$11.58	\$302.60	\$222.65	\$13.37
Total	\$32.00	\$639.98	\$357.61	\$37.41
Coinsurance PPO				
\$0 - \$1,300	\$7.71	\$280.82	\$403.77	\$68.14
\$1,300 - \$4,100	\$55.70	\$777.42	\$402.96	\$129.04
\$4,100+**	\$14.84	\$323.31	\$163.92	\$8.99
Total	\$22.76	\$548.77	\$240.96	\$27.36

*All members receive average assumed rebates rather than rebates specific to a condition.

**Cost sharing beyond the individual OOP limit reflects the impact of family OOP limits or members that originally reached the OOP limit but do not reach the limit after the impact of POS rebates.

Methodology

We measured changes in payer and member liability caused by shifting pharmaceutical manufacturer rebates to the POS. We leveraged information in the 2020 Kaiser Family Foundation Employer-Sponsored Coverage survey to develop “typical” 2022 plan designs with different cost-sharing structures. All benefits for our chosen plans reflect individual, in-network coverage. We provide the main plan details in Appendix B.

We leveraged our clinical and pharmaceutical expertise to develop the selected patient profiles. We defined these profiles as patients filling at least one medication in each of the underlying categories:

PATIENT WITH DIABETES AND CVD

- Brand dipeptidyl peptidase-IV inhibitor (DPP-IV) and combination products, sodium-glucose co-transporter-2 inhibitor (SGLT2) and combination products, or glucagon-like peptide-1 agonist (GLP-1)
- Brand insulin (including pre-mixed, short, intermediate, and/or long-acting products)
- Generic angiotensin-converting-enzyme (ACE) inhibitor and combination products, or angiotensin receptor blocker (ARB)
- Generic statin (HMG-CoA reductase inhibitor)

PATIENT WITH DIABETES AND CRD

- Brand dipeptidyl peptidase-IV inhibitor (DPP-IV) and combination products, sodium-glucose co-transporter-2 inhibitor (SGLT2) and combination products, or glucagon-like peptide-1 agonist (GLP-1)
- Brand insulin (including pre-mixed short, intermediate, and/or long-acting products)
- Combination anti-asthmatic/bronchodilator agents

PATIENT WITH AUTOIMMUNE DISEASE

- Tumor necrosis factor (TNF) inhibitor

We used 35% brand and 15% specialty medication rebate assumptions when modeling the average population. For the patient profiles, we modeled the following rebate assumptions:

- DPP-IV, SGLT2, GLP-1, and relevant combination medications received a 60% rebate for the diabetes/CVD and diabetes/CRD patient profiles.
- Insulins products received 70% rebates for the diabetes/CVD and diabetes/CRD patient profiles.
- TNF inhibitor products received 30% rebates for the auto-immune disease patient profile.
- Anti-asthmatic medications received 50% rebates for the diabetes/CRD patient profile.

While we model rebates by medication class, in practice, some rebate types are more complex and cannot be determined at the point of sale. We set the rebate levels in our analysis to reflect an estimated market average level across all rebate types.

We used the therapeutic classifications in the Medi-Span Master Drug Database v2.5 (MDDb) to identify the generic product identifiers (GPIs) for medications in the categories listed above.

To perform the analysis, we utilized Milliman’s proprietary Claims Simulation Model (CSM), populated with a representative sample of a 2019 national commercial dataset. We trended allowed claims to 2022 and adjusted consistently with the discounts noted above. The allowed cost in our datasets includes dispensing fees.

We did not account for changes in member, payer, or pharmaceutical manufacturer behavior resulting from moving rebates to the POS or new drug launches between 2020 and 2022. This could include increased brand utilization due to reduced POS costs or improved medication adherence with subsequent offsets in medical spending.⁶ We did not consider employer contributions to a member spending account or manufacturer coupon cards that offset a patient’s spend but are not accounted for within the data used. We also did not consider current or future regulations that may restrict member cost sharing for certain drug classes.

⁶ Roebuck, C. Medication Adherence Leads to Lower Health Care Use and Costs Despite Increased Drug Spending. Health Affairs 30, no. 1 (2011). Retrieved September 29, 2017.

Caveats, Limitations, and Qualifications

The results in this report have been prepared for PhRMA. We developed this information to illustrate the impact of moving pharmaceutical manufacturer rebates to the POS in the commercial market. This information may not be appropriate, and should not be used, for other purposes.

This report is intended for PhRMA. PhRMA may share this information with external parties with Milliman's prior written consent. We do not intend this information to benefit, and assume no duty or liability, to any third party that receives this work product. Any third-party recipient of this report that desires professional guidance should not rely upon Milliman's work product, but should engage qualified professionals for advice appropriate to its specific needs. Any releases of this report to a third party should be in its entirety.

Milliman developed certain models to estimate the values in this analysis. The intent of the models is to illustrate the potential impact of moving pharmaceutical manufacturer rebates to the POS for members with commercial benefits taking certain medications. It may not be appropriate for any other purpose. We reviewed the models, including the inputs, calculations, and outputs. We believe they are consistent, reasonable, appropriate for the intended purpose, and compliant with generally accepted practice and relevant actuarial standards.

The models reflect data as inputs. We relied on the following information:

- Data from SSR Health
- Data from MDDB
- Internal Milliman claim datasets
- The 2020 Kaiser Family Foundation Employer-Sponsored Coverage survey

We accepted this information without audit but reviewed it for general reasonableness. Our results and conclusions may not be appropriate if this information is not accurate. Actual results will differ from our estimates due to possible changes to regulations after the fact and random variation and will additionally vary for any specific member or payer.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Michelle Klein and Jason Petroske are actuaries for Milliman. They are members of the American Academy of Actuaries and meet the qualification standards to render the actuarial opinion contained herein. This report has been prepared under the terms of the consulting services agreement between Milliman and PhRMA, dated January 19, 2016, and extended effective December 19, 2018.



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Appendix A

AVERAGE ANNUAL MEMBER OOP COST REDUCTION

COINSURANCE HDHP		MEMBER PROFILE		
OOP RANGE*	AVERAGE	DIABETES / CVD	DIABETES / CRD	AUTO-IMMUNE DISEASE
\$0 - \$3,250	\$19.39	\$767.86	\$945.15	\$207.82
\$3,250 - \$5,900	\$75.78	\$768.33	\$555.74	\$120.90
\$5,900+	\$11.58	\$302.60	\$222.65	\$13.37
Total	\$32.00	\$639.98	\$357.61	\$37.41

COPAY HDHP		MEMBER PROFILE		
OOP RANGE*	AVERAGE	DIABETES / CVD	DIABETES / CRD	AUTO-IMMUNE DISEASE
\$0 - \$3,250	\$19.06	\$767.83	\$945.15	\$182.16
\$3,250 - \$5,900	\$35.81	\$368.58	\$245.11	\$97.74
\$5,900+	\$1.15	\$40.98	\$21.63	\$3.92
Total	\$22.55	\$343.09	\$141.54	\$22.68

COINSURANCE PPO		MEMBER PROFILE		
OOP RANGE*	AVERAGE	DIABETES / CVD	DIABETES / CRD	AUTO-IMMUNE DISEASE
\$0 - \$1,300	\$7.71	\$280.82	\$403.77	\$68.14
\$1,300 - \$4,100	\$55.70	\$777.42	\$402.96	\$129.04
\$4,100+	\$14.84	\$323.31	\$163.92	\$8.99
Total	\$22.76	\$548.77	\$240.96	\$27.36

COPAY PPO		MEMBER PROFILE		
OOP RANGE*	AVERAGE	DIABETES / CVD	DIABETES / CRD	AUTO-IMMUNE DISEASE
\$0 - \$1,300	\$1.84	\$9.24	\$16.45	\$64.16
\$1,300 - \$4,100	\$4.78	\$18.43	\$28.86	\$128.14
\$4,100+	\$0.21	\$0.79	\$1.59	\$8.78
Total	\$2.69	\$12.26	\$14.34	\$27.37

*Range will vary by plan based on major cost sharing parameters

Appendix B

MODELED PLAN DESIGNS

PLAN ATTRIBUTE	COPAY PPO	COINSURANCE PPO	COPAY HDHP	COINSURANCE HDHP
MEDICAL BENEFITS				
Deductible	\$1,300	\$1,300	\$3,250	\$3,250
Coinsurance	20%	20%	20%	20%
Primary Care	\$25	\$25	Deductible/Coinsurance	Deductible/Coinsurance
Specialty Care	\$50	\$50	Deductible/Coinsurance	Deductible/Coinsurance
PHARMACY BENEFITS				
Deductible	\$0	\$0	Included in Medical	Included in Medical
Generic - Tier 1	\$12	\$12	\$12 after Deductible	Deductible/Coinsurance
Preferred Brand - Tier 2	\$40	30%	\$40 after Deductible	Deductible/Coinsurance
Non-Preferred Brand - Tier 3	\$75	30%	\$75 after Deductible	Deductible/Coinsurance
Specialty - Tier 4	30%	30%	30% after Deductible	Deductible/Coinsurance
OUT OF POCKET MAXIMUM				
Global	\$4,100	\$4,100	\$5,900	\$5,900

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