New Analysis Finds Third-Party Drug Payments Lead to Higher Costs for Consumers

Health plans are committed to making health care affordable and accessible, offering a range of plan designs that allow patients to choose the premium and cost-sharing options that work best for them.

When a drug manufacturer uses a coupon to adjust a patient's cost-sharing for a more expensive drug or an out-of-network health care provider chooses to waive patient cost-sharing, patients often use more expensive drugs or costlier providers, increasing health care costs for everyone and disrupting the balance of premiums and cost-sharing.

This is why coupons and waived cost-sharing are prohibited in the Medicare and Medicaid programs under the Anti-Kickback Statute, and Health Savings Account plans also prohibit third-party payments from accruing to deductibles.

As policymakers consider whether to mandate that health plans accrue third-party payments towards patient cost-sharing, AHIP commissioned the actuarial firm Wakely to analyze the impacts of such a departure from the precedent set within Medicare and Medicaid.

Wakley found that accruing third-party payments toward patient cost-sharing would:

- **Increase premiums**, with the largest increases in the individual marketplace
- **Result in adverse selection** into lower premium plans, such as Bronze plans, resulting in **higher premiums and consumers dropping their coverage**
- **Reduce wages** for workers who receive coverage at work, due to **higher employer costs**
- **Encourage use of more expensive drugs** over cheaper alternatives
- **Increase health care spending** and undermine cost-saving networks by allowing providers to entice patients at out-of-network facilities

Policymakers should follow the precedent of the Medicare and Medicaid programs and define cost-sharing to exclude payments made by third parties. Without this exclusion, drug manufacturers and unscrupulous providers will have a blank check to drive health care costs up for everyone.

About AHIP

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

July 15, 2024

Sean Dickson
Senior Vice President, Pharmaceutical Policy and Strategy
America's Health Insurance Plans
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RE: IMPLICATIONS OF THIRD-PARTY PAYMENTS ON COMMERCIAL MARKET

Dear Sean:

Considerable uncertainty exists due to the possibility of new federal regulations that would require accumulation of third-party payments to count towards a consumer's deductible and maximum out-of-pocket. If such a change were to be made, this could have significant effects across the commercial health insurance markets. Given the importance such a change could have on the consumer experience and health insurance more generally, a better understanding of the potential impact is needed.

America's Health Insurance Plans ("AHIP") retained Wakely Consulting Group LLC, an HMA Company ("Wakely"), to explore the potential impacts new regulation could have on premiums, out-of-pocket costs, and the consumer experience in the commercial health insurance markets.

The attached report contains the results, assumptions, and methods used in our analysis, and satisfies reporting requirements in Actuarial Standards of Practice (ASOP) 41. Reliance on this report is at AHIP's discretion. This information has been prepared for the sole use of the management of AHIP although we understand it may be made public.

Sincerely,

Michelle Anderson

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Introduction

Drug costs are high and rising rapidly in the US. Prices for new, brand-name prescription medications, and biologics (drugs made from living cells) are particularly high. From 2008 to 2021, launch prices for new drugs increased by 20% per year, while in 2020-2021, 47% of new drugs were initially priced above $150,000 per year[1]. Such prices are a significant barrier to most patients unless the costs are fully covered by health insurance, and increasing evidence shows that patients who forego the use of prescribed drugs due to cost concerns have worse health outcomes[2].

Under most circumstances, if a patient incurs medical bills, those bills are subject to cost-sharing requirements. These could run the gamut from a relatively nominal copay to coinsurance with a sizeable out-of-pocket maximum. If a patient has a high deductible under their health insurance plan, their cost-sharing could amount to thousands of dollars for a single high-cost prescription. Eventually, under most plans, a patient will hit an annual out-of-pocket maximum payment limit and their insurance will cover all costs beyond that threshold.

Insurers establish cost-sharing requirements for their customers to discourage overuse of health care services that are not useful or necessary and to reduce premiums. Cost-sharing and premium are inversely related – if more of the total cost of care is covered by consumers through cost-sharing, there will be a commensurate reduction in their monthly premium for coverage. If there is less cost-sharing, more of the total cost will be covered by the premium. Actuarial value (AV) is a rough measure of this relationship: a higher AV reflects that more of the total costs of care are covered by the premium, rather than consumer cost-sharing. For example, if an individual is shopping for health insurance on the Marketplace, a gold plan, where 20% of costs are covered out-of-pocket by the member, will have a higher premium than a silver plan, where 30% of costs are covered by cost-sharing.

To avoid having patients face a large out-of-pocket expense for a high-cost drug, which might deter them from using a drug altogether, manufacturers and copay assistance programs may offer so-called copay coupons. Copay coupons allow the pharmacy to bill the drug manufacturer or assistance program for a portion of the cost that would otherwise be incurred by the patient. Essentially, this amounts to a discount on the drug price, but it is structured to limit the out-of-pocket cost that the patient would otherwise face. The federal government does not allow the use of such coupons in the Medicaid program and they are not allowed in the Medicare program (both traditional and Part D) unless the coupon is provided by an independent charitable organization or if a consumer chooses to use the coupon instead of their prescription drug plan.3 Use of these coupons in Medicare or Medicaid would be considered a violation of the federal Anti-Kickback

[1] Rome BN, Egilman AC, Kesselheim AS. Trends in Prescription Drug Launch Prices, 2008-2021. JAMA. 2022;327(21):2145–2147. doi:10.1001/jama.2022.5542

[2] cms.gov/files/document/manufacturer-discount-program-final-guidance.pdf. Accessed June 18, 2024

Statute because it would induce a beneficiary to use one drug over another, increasing federal healthcare spending and the manufacturer's revenue. Also, while coupons are allowed in high deductible health plans (HDHPs), they cannot be counted towards any cost-sharing limits until the patient has met their deductible.

Copay coupons can limit patients' out-of-pocket cost exposure in two ways: by reducing the cost to the patient at the point of purchase; and by applying the amounts to the patient's deductible or other annual cost-sharing requirements, so that they exhaust the deductible and reach the point where their insurer is covering the full cost of their care more quickly than would otherwise be the case. Both effects have been the source of some controversy in recent years. Because the use of copay coupons is prohibited or greatly restricted in Medicaid and Medicare, the controversy centers primarily around the commercial insurance market (both fully insured and self-insured).

The discounted price a patient receives with a copay coupon may encourage use of high-cost drugs more readily than would otherwise be the case, plus using coupons to reduce patients' overall cost-sharing diminishes incentives for overall cost constraint. Both undermine long-standing cost containment efforts by insurers and pharmacy benefit managers (PBMs) that encourage the use of generics and other lower-priced alternatives before a high-priced specialty drug. As a recent Health Affairs article notes:

> *For many years, the primary counterweight to high US brand-name drug spending resides with US insurers and their counterparts/partners in the area of pharmaceuticals, pharmacy benefit managers. Mechanisms to reduce unnecessary costs of medications include the use of formularies to foment price competition between manufacturers; prior authorization of expensive medications to ensure they are clinically reasonable; and differential patient cost-sharing to direct patients toward lower cost and equally effective (often generic) alternatives*[4]*.*

Insurers argue that drug coupons can undermine cost containment efforts that benefit all consumers. If the lower cost-sharing contributes to an increase in the use of high-cost drugs, premiums rise. If it contributes to less overall cost exposure for the insured, and they use more services overall, premiums also rise. For these reasons, insurers and PBMs have largely opposed unrestricted use of drug copay coupons. They argue that coupons should either not count toward a patient's deductible and maximum out-of-pocket or this effect should be limited.

The debate over copay coupons arose in part from two developments. First, with the passage of the Patient Protection and Affordable Care Act (the ACA) in 2010, the federal government set an annual cap on the amount that health insurers can require insured individuals to pay out-of-pocket for their medical expenses. Once this cap is reached, the insurer is responsible for covering additional medical bills incurred during the year. With an overall limit on patients' out-of-pocket

[4] Brennan TA & Kesselheim AS, Accumulators and Maximizers: A New Front in the Battle Over Drug Costs (Part 1), 2022. Health Affairs Forefront.

expenditures, insurers had a heightened sensitivity to the potential impact of any market changes on patient cost-sharing, patient incentives, claim costs, and cost growth.

Second, the rapid introduction of breakthrough drugs with very high prices has created a barrier to consumer access. The copay coupon was a potential solution: reduce the price of a drug to the consumer, without actually reducing the price of the drug. This limits a patient's financial liability but does not constrain the manufacturer in setting their price. The coupon programs were successful. The use of copay coupons has grown markedly in this decade, as have efforts by insurers and PBMs designed to limit the impact of coupons on the use of high-cost drugs[5]. Alarmed at the potential inflationary effects of the coupons, insurers and PBMs began disallowing all or part of the coupon amounts as cost-sharing, meaning patients could reap the benefit of the reduced drug price but continued to face the same cost-sharing requirements that they would have without the coupon. The mechanism used by insurers and PBMs to counteract the effect of copay coupons is known as a "copay accumulator." It works like this:

- A patient presents a copay coupon card at the pharmacy counter. The pharmacy uses the copay coupon to receive payment from the drug manufacturer to pay the patient's cost-sharing, and the patient pays either $0 or a payment amount established by the coupon program.
- The health insurer pays the pharmacy for the insurer's share of the drug cost. Because a copay coupon was used instead of a payment by the patient themself, the insurer does not record the amount of the coupon as accumulating to the patient's deductible or out-of-pocket maximum.
- The patient continues to fill prescriptions using the copay coupon with no cost-sharing. If the copay coupon has a total value limit set by the manufacturer, the patient will face no cost-sharing until the maximum value on the coupon/card is reached.
- After that, the patient will pay the cost-sharing set by their health plan themselves and the patient's actual out-of-pocket costs count toward their annual deductible and out-of-pocket maximum.
- A copay accumulator delays the patient's progress toward meeting their deductible and out-of-pocket maximum. The patient does not, however, spend more money than they would have without the use of the coupon. Indeed, because the coupon delays the number of prescriptions filled before the patient begins making their own payments, patients may spend less over the course of a year than they would if no coupon were available.

[5] Cavalier, D., Doherty, B., Geonnotti, G., Patel, A., Peters, W., Zona, S., & Shea, L. (2023). Patient perceptions of copay card utilization and policies. Journal of market access & health policy, 11(1), 2254586

Policy options for addressing the tension between the use of drug coupons and cost-sharing incentives range from allowing the coupon to count toward the deductible to banning coupons from being offered to insured consumers for drugs with a generic equivalent, as California[6] and Massachusetts[7] have done. In the middle are some more limited constraints:

- Include a portion of the coupon in the patient's cost-sharing or include coupons only up to an allowable dollar amount.
- Include coupons in cost-sharing only if there is no generic or biosimilar equivalent to the name-brand drug.

Unsurprisingly, this debate has spilled over to other arenas and prompted both regulatory and legal action.

Regulatory and Legal History of Prescription Drug Cost-Sharing

Prior to 2019, the federal government was largely silent on the treatment of copay coupons and accumulators by commercial insurers and self-insured employers: "Federal rules did not explicitly state whether issuers or group health plans had the flexibility to determine how to factor in direct drug manufacturer support amounts towards the annual limitation on cost-sharing."[8] The one exception predating 2019 was a 2004 Frequently Asked Question (FAQ)[9] from the Internal Revenue Services (IRS) on the treatment of prescription drug discounts when used with health savings account (HSA) qualified high deductible health plans (HDHPs).[10] In an August 2019 FAQ jointly issued by the Departments of Labor (DOL), Health and Human Services (HHS), and Treasury, the 2004 IRS guidance was referenced and explained as requiring "…an HDHP to disregard drug discounts and other manufacturers' and providers' discounts in determining if the minimum deductible for an HDHP has been satisfied and only allows amounts actually paid by the individual to be taken into account for that purpose."[11]

In April 2019, the Department of Health and Human Services (HHS) published a rule stating: "Notwithstanding any other provision of the section, and to the extent consistent with state law, amounts paid toward cost-sharing using any form of direct support offered by drug manufacturers to enrollees to reduce or eliminate immediate out-of-pocket costs for specific prescription brand

[6] https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB265

[7] https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter175H/Section3

[8] https://www.federalregister.gov/documents/2019/04/25/2019-08017/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2020

[9] https://www.irs.gov/pub/irs-drop/n-04-50.pdf

[10] The IRS reiterated this treatment in a 2021 letter: https://www.irs.gov/pub/irs-wd/21-0014.pdf

[11] https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-40

drugs that have an available and medically appropriate generic equivalent are not required to be counted toward the annual limitation on cost-sharing…"[12]

In short, this meant that insurers could use a copay accumulator program to exclude coupons from counting towards an annual cost-sharing limit if there was no generic equivalent available. It also allowed for state law to add additional restrictions. Such a state law would only apply to health plans regulated by the state, and thus would exempt self-insured plans that operate under federal law.

The August 2019 FAQ, which was jointly issued by DOL, HHS, and Treasury, was issued in response to feedback from stakeholders indicating confusion and requesting additional information about the potential conflict between this new rule and the previous IRS guidance directing HDHPs to disregard drug discounts when determining if a consumer's minimum deductible had been satisfied. The Departments acknowledged the ambiguity and announced they would undertake further rulemaking in the 2021 Notice of Benefit and Payment Parameters (NBPP) and, until then, would not take enforcement action on any plan that excluded copay coupons from the annual cost-sharing limits, even if there were no medically appropriate generic.[13]

In May 2020, HHS published the annual NBPP for 2021, which outlines, among other things, federal requirements for individual and small-group fully insured insurers. The 2021 NBPP allowed coupons to be excluded from deductibles and out-of-pocket maximums for all drugs, regardless of the availability of a generic equivalent. Shortly thereafter, in August 2022, three national patient advocacy organizations filed a complaint challenging the 2021 NBPP. In the Fall of 2023, a judge in the US District Court for the District of Columbia struck down the 2021 NBPP provisions related to copay coupons.

The Court found that "the ACA's definition of cost-sharing does not speak clearly as to the treatment of manufacturer assistance [the general category into which copay coupons fall]."[14] Essentially, the Court found that HHS had not made a choice between potential competing statutory meanings of cost-sharing and, therefore, the Court could not deem the Agency's interpretation correct or incorrect. Further, the Court found that agency faced a similar choice in their own regulations.[15]

This court decision applies to all private, non-grandfathered, and commercial health insurance plans that cover essential health benefits (EHBs), including employer-sponsored health plans under the purview of the DOL.[16] The court decision vacated the 2021 NBPP rule which reverted

[12] https://www.federalregister.gov/documents/2019/04/25/2019-08017/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2020

[13] https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-40

[14] HIV and Hepatitis Policy Institute et al versus United State Department of Health and Human Services et al. United State Court for the District of Columbia. Civil Action 22-2604. September 29, 2023.

[15] ibid

[16] https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-66

federal requirements back to the 2020 NBPP. From a December 22, 2023, Memorandum Opinion and Order: "The prior (and thus reinstated) rule is the '2020 NBPP.'"[17]

The Court remanded the issue back to HHS and left it to the Departments to further clarify federal policy on copay coupons and accumulators. In a subsequent motion, HHS noted that it "…intends to address, through rulemaking, the issues left open by the Court's opinion, including whether financial assistance provided to patients by drug manufacturers qualifies as 'cost-sharing' under the Affordable Care Act."[18] Pending the issuance of that new rule, the previous (2020) rule that allows copay accumulator programs where a generic equivalent is not available remains the standard. However, HHS has made clear that they do not intend to enforce that standard while rulemaking is pending. Among the issues that could be addressed in the new rule are the impact of copay coupon and accumulator rules on HSA-eligible HDHPs and the tax treatment of HSA account holders, as that was left vague in the now effective 2020 rule. Meanwhile, 23 states and Puerto Rico have banned or restricted copay accumulators and similar programs.[19] HHS' future rule will have to consider a myriad of issues, some of which are discussed in the next section.

Qualitative Considerations of the Impact of Policy Choices on Commercial Insurance on Premiums, Enrollment, and Federal and State Spending

Several additional concerns about the implications of the court's decision and state and federal policy on the use of copay coupons are worth noting:

- **What will insurers do following the court's decision?** Insurers and PBMs will continue to seek ways to hold down health insurance costs and resulting premiums, and particularly costs associated with high-priced drugs. The latest frontier is a mechanism called copay maximizers, which aim to exhaust all patient assistance and achieve the maximum possible manufacturer discount for patients before insurance kicks in. Insurers likely will continue to seek new benefit designs and rules regarding use of specialty drugs that help contain these costs. Depending on the flexibility available, this could include additional utilization management techniques or could include changes to formularies or benefits.
- **What effects could be specific to the individual market?** In the individual market, issuers have less flexibility in how they design plans than in the group market. Plans must meet specific actuarial value and EHB requirements. Furthermore, there are more stringent anti-discrimination requirements. Consequently, the additional plan liability costs

[17] HIV and Hepatitis Policy Institute et al versus United State Department of Health and Human Services et al. United State Court for the District of Columbia. Civil Action 22-2604. December 22, 2023.

[18] HIV and Hepatitis Policy Institute et al versus United State Department of Health and Human Services et al. United State Court for the District of Columbia. Civil Action 1:22-cv-2604. November 27, 2023.

[19] National Conference of State Legislatures. Access, Affordability Were Top Priorities in 2023 Prescription Drug Bills - National Conference of State Legislatures (ncsl.org) Accessed June 14, 2024.

likely would more directly translate into higher premiums than in the group market. The higher premiums would be borne by consumers (if they do not receive premium tax credits) or the federal government (for consumers that do receive premium tax credits).

- **What effects could be specific to the small group market?** Similar to the individual market, small group issuers have less flexibility because of actuarial value and EHB requirements. However, the small group does not receive premium tax credits so the full effect of premium increases would be borne by employers and employees.
- **What effects could be specific to low-cost premium plans in the individual and small group market?** Lower premium plans, such as Bronze plans, have the highest out-of-pocket expenses and are generally designed for consumers who are healthy and anticipate utilizing little to no health care services. Conversely, high utilizing consumers tend to purchase richer benefit plans, such as Gold or Platinum plans, which have high monthly premiums and low cost-sharing which reduces point of service out-of-pocket costs and generally spreads health care spending more evenly throughout a given year. If copay coupons were allowed to count towards member cost-sharing without any limitations, adverse selection in lower premium plans will be incentivized. A high utilizing member could enroll in a lean plan, pay lower premiums, and face low to no cost-sharing while using a high amount of services. This would defeat the intent of the leaner, low premium plans and could have the unintended impact of increasing their monthly prices and forcing or enticing healthier consumers to drop coverage.

- An additional consideration is the impact of high utilization of new and high-cost treatments on the ACA's risk adjustment program, which is an instrumental mechanism for market sustainability. Risk adjustment is designed to account for morbidity and to protect insurers from bearing the full cost of covering sicker and more costly members. However, the risk adjustment model does not always fully account for the impact and cost of new and high-cost drug treatments, which can result in insurers not receiving adequate reimbursement in the risk adjustment formula.
- **What effects would be specific to the large group market?** It is important to note that the third-party payment issue could affect not only the fully insured large group market but also any ERISA (self-insured) plan. The large group market has greater flexibility in plan design including greater flexibility around cost-sharing and benefits offered. Consequently, employers/issuers in this area may change cost-sharing or benefits to offset plan liability increases. This may mean that, rather than increasing premiums, there may be a shift in out-of-pocket costs from those benefiting from third-party payments to employees (and employers) that do not benefit from the third-party payments. It is also important to note that prior research has shown that higher premium costs on employers tends to reduce wages for employees.[20]

[20] Arnold, Daniel and Christopher Whaley. 2020. "Who Pays for Health Care Costs? The effects of health care pricing on Wages"

- **Will copay coupons expand to other health care services?** Should the federal government allow for coupons to be counted as cost-sharing in future rulemaking, manufacturers and purveyors of other high-cost health care devices and services might start using coupons to lessen the cost impact on consumers at the point of service without actually reducing the price of the device or service. This could potentially lead to perverse incentives where consumers are enticed to select higher cost and/or out-of-network devices and services, and less need for manufacturers and providers to compete on price and quality.
- **What will be the impact of disallowing co-pay accumulator programs on the use of high-cost drugs and on state and federal spending?** Restrictions on copay accumulators can reduce drug costs for some patients who face some of the highest costs and have some of the most acute needs for high-cost treatment. That is laudable, but there is no escaping the fact that it will lead to increased use of expensive services, higher spending for employers, states and the federal government, and pressure to reduce costs elsewhere in the delivery system. To avoid the need to increase premiums in response to laws that prohibit co-pay accumulator programs, insurers may make other changes to their plans benefit designs, such as increasing co-pays on other services.

Illustrative Examples on the Potential Third-Party Payment Effects

The impact of the potential changes to third-party payments depends on a variety of factors, including the plan type and benefit richness. There is a wide range of plan benefit richness as well as morbidity of members in those plans in the Commercial market today. The leaner the plan, the greater the effects.

High deductible health (HDHP) plans are one example of a lean plan. HDHP plans offer lower monthly premiums for enrollees in exchange for higher deductibles/maximum out-of-pocket costs (MOOPs). These higher cost-sharing structures are often paired with an HSA for tax-free medical expense savings. Pairing increased cost-sharing with the ability to save and invest funds tax-free allows plans to set lower premiums. Consequently, small increases in the number of people that would reach their MOOP, as is possible under a scenario of third-party payments, would have a large effect on premiums for HDHP plans. Similarly, plans that have integrated deductibles or MOOPs in which third party drug payments apply would result in plan liability increasing for medical spending leading to more dramatic premium effects. Conversely, plans with higher benefit richness or with sicker members would have smaller impacts.

A recent impact analysis was included in a California bill[21] that would require health plans regulated by the state of California to apply third party patient assistance programs to the

[21] https://www.chbrp.org/sites/default/files/bill-documents/AB2180/AB%202180%20-%2010April24%20amends%20-%20FINAL.pdf

enrollee's annual cost-sharing requirements. Their analysis aligned with the idea that higher benefit would result in a lower premium but markets that have a greater number of members in lower premium/higher deductible plans had larger increases. For example, while the large group market, which tends to have richer benefits, would have a premium increase of 0.21%, the individual market, which has more enrollment in high deductible plans, was estimated to incur a premium increase of 0.32%.

To further illustrate the dynamics, Wakely modeled various member scenarios under both a standard ACA market rich plan design and a leaner plan design (or 90% and 70% actuarial values, which correspond to Platinum and Silver plans). Insurer and member cost changes were modeled based on a proxy for average ACA costs for:

1) a member with an average cost condition, with the option of a cheaper or more expensive drug;
2) a high-cost member utilizing expensive drugs; and
3) a low-cost member that opts to utilize a higher cost maintenance drug when a coupon is provided; and
4) a member with diabetes utilizing a high degree of drug and medical services, such as dialysis.

The four scenarios were modeled to illustrate potential phenomenon that could occur if a policy allowed for the full manufacturer drug coupon to count towards member deductible and maximum out-of-pocket costs. The following assumptions pertain to these scenarios:

- A rich plan design included a deductible of $0 and integrated MOOP of $3,000. The lean plan design included a deductible of $2,850 and MOOP of $9,200.
- The model was adjusted to assume third-party drug coupons would be utilized by members at the beginning of the year, equal to their plan specific maximum out-of-pocket.
- The entire coupon amount would accumulate towards their cost-sharing resulting in the member reaching their specific maximum out-of-pocket at the beginning of the plan year; the remaining dollars incurred by the member through pharmacy and medical utilization during the year would be the insurer's paid liability.
- The average annual member spend varies by member before and after coupons are applied, as displayed in Table 1 below. When a coupon was utilized, medical utilization was assumed to increase by 15% to reflect higher usage of services after reaching the initial maximum out-of-pocket.[22]
- Member cost-share before a coupon applies was assumed to be maximized at the MOOP in scenarios 1, 2, and 4. For scenario 3, minimal member cost-share before a couple applies was assumed given low usage of services. After a coupon applies, it was assumed that all member cost-share would be reduced to $0 in all four scenarios. We are assuming

[22] The 15% increase is based on the state of Utah's analysis of SB 184 which would have applied third-party drug payments to deductible/MOOPs.

the low utilizer with high-cost maintenance drug usage (scenario 3) only occurs in the environment that a coupon can be used to reach their MOOP for an elective drug (i.e., weight loss).

Table 1: Annual Total Average Member Spend, by Scenario

Average Annual Member Spend, Without Coupon Use				Average Annual Member Spend, With Coupon Use			
1	2	3	4	1	2	3	4
Avg Member w/Condition	High-Cost Drug Member	Low Utilizer w/High-Cost Drug	High-Cost Diabetic Member	Avg Member w/Condition	High-Cost Drug Member	Low Utilizer w/High-Cost Drug	High-Cost Diabetic Member
$60,960	$350,000	$1,400	$75,000	$328,704	$372,500	$12,230	$140,000

The resulting impacts are displayed in Table 2 below. In scenario 1, an average member with a chronic condition is assumed to utilize a drug coupon for a higher cost drug in lieu of the cheaper alternative without a coupon. This could be illustrative of impacts for members with multiple sclerosis between using Trikafta versus the lower alternative Creon. Under this scenario, insurer liabilities are modeled to increase over $250K.

In scenario 2, a high-cost member with a chronic condition utilizing both a large amount of medical services and high-cost drugs, regardless of whether a coupon is present, would shift insurer liability by over 6.5%, or up to $25K.

Scenario 3 presents an illustrative scenario in which a healthy member decides to purchase a high-cost drug contingent on an available coupon. The parallel may be a member that utilizes nutritional counseling for weight control but purchases high-cost weight loss drugs when a coupon is available. This scenario could result in endless potential costs being passed to the insurer, only reduced by the amount of the plan MOOP (below assumes a high-cost drug equal to $1,000 a month).

The results of scenario 4 could apply to a high-cost member with diabetes who is in end state renal disease. While high-cost drug coupons have been the focus of the illustrative scenarios in 1-3, third-party payments covering dialysis or other medical procedures could also broaden potential use and increase insurer liability. As discussed in the sections above, there are also implications outside of insurer cost that could be substantial for the member and insurer if third-party payment applications were to broaden outside of high-cost drug usage. In the event that third-party payments count towards cost-sharing for medical services, we have assumed those would be incurred at an out-of-network facility rather than in-network, doubling medical costs to the insurer on top of assumed increased utilization.

Table 2: Impact to Insurer Liability, by Scenario

			Increase to Insurer Liability $$ With Coupon Use				Increase to Insurer Liability % With Coupon Use			
			1	2	3	4	1	2	3	4
Average Benefit Richness	Deductible	Integrated MOOP	Avg Member w/Condition	High-Cost Drug Member	Low Utilizer w/High-Cost Drug	High-Cost Diabetic Member	Avg Member w/Condition	High-Cost Drug Member	Low Utilizer w/High-Cost Drug	High-Cost Diabetic Member
90%	**$0**	**$3,000**	$270,144	$24,900	$7,950	$64,500	486.2%	7.2%	621.1%	89.0%
70%	**$2,850**	**$9,200**	$267,744	$22,500	$1,990	$63,300	517.3%	6.6%	191.3%	93.8%

As can be seen above, the effects of inclusion of third-party payment drug coupons could have a tremendous effect on plan liability, depending on the plan design. Plans that offer higher cost-sharing in exchange for lower premiums, would likely require higher premiums to compensate for the higher plan liability. A key unknown as to the broader market implications is how pervasive usage of third-party payments are in the individual market. However, as the above examples illustrates, it would not take a large portion of a market to receive third-party payments for all participants of the plan to be affected, especially for enrollees in higher deductible plans.

Conclusion

The recent court ruling opens uncertainty as to how potential drug coupon third-party payments will be credited towards deductibles and MOOPs. Currently, issuers have flexibility as to if drug coupons would be included. However, there is the possibility that issuers and employers could be required to count drug coupons towards deductibles and MOOPs. Such a change would increase plan liability which, ultimately, would result in higher spending by consumers, employers, and the federal government. Depending on the market this could mean higher premiums, higher cost-sharing on other benefits, or loss of benefits. Public programs such as Medicaid and Medicare currently have restrictions on third-party payment coupons to avoid potential negative effects for members that do not receive the benefits of third-party payments.