

Insights / Innovation

Offsetting Member Cost in High Deductible Health Plans



COMMENTARY
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In the pharmacy benefit, year-over-year changes tend to be incremental adjustments to formularies or networks, or tweaks to plan design. However, as health care continues to evolve, the last few years have seen a sea change in the industry, driven primarily by escalating launch prices for drugs, and significant manufacturer-driven inflation in drug prices annually.

The trend over the last five to seven years — and a somewhat controversial one — has been toward consumer-directed health plans (CDHPs), also known as high deductible health plans (HDHPs), as a payor response to increasing health care and prescription drug costs. These plans have an upfront deductible — either a combined one for medical and pharmacy spending or separate ones — that the plan member must meet before the plan begins to share in the costs. Plans also have an out-of-pocket (OOP) maximum after which the plan pays for health care as well as medications.

As one of the people involved in decisions about what benefits CVS Health offers its own employees, I understand that many of the clients in our commercial book of business worry about the cost burden high deductible plans place on their members. That's why we have been innovating to come up with solutions that help alleviate the cost burden of rising drug costs on our own employees, and those of our pharmacy benefit management (PBM) clients.



A Quick History of Pharmacy Benefit Evolution

To better understand the current pharmacy benefit landscape, it helps to look at how commercial pharmacy plan design has evolved over time and the role that consumer behavior and manufacturer-set drug prices have played in it.

Flat Copay Design

Historically, many pharmacy benefit plans included low — or no — deductibles and flat, usually low copays. Members could fill any prescription, brand or generic, with the plan picking up a majority of the costs. The intent of such a plan design was to give members predictability for their cost at point-of-sale, and minimize their OOP cost. However, members had little reason or incentive to make cost-effective choices, such as generics over brands, resulting in a growing cost burden for payors over time as branded drug prices continued to rise.

Tiered Copays

As the cost of providing pharmacy benefits grew, it led to the introduction of tiered copays, designed to encourage the use of lower-cost, clinically appropriate alternatives, like generics. These plans placed drugs on different tiers in the formulary, with the intent of encouraging members to make better choices and pick more cost-effective options over higher-tier, more expensive branded drugs. This helped lead to incremental behavior change but the difference in the copay tiers was nominal in most cases compared to the cost of the drugs. And payors continued to foot a large portion of the bill, especially as manufacturers continued to side-step payor efforts with programs such as copay discount cards.

Coinsurance

Coinsurance plans based members' OOP cost on a percentage of the drug's price rather than a flat dollar amount, with the intent to drive further behavior change toward more cost-effective choices. This shifted a somewhat greater portion of the price difference to consumers. However, plans were still bearing a majority of the costs and therefore the brunt of the impact of copay discount cards, and other manufacturer loyalty programs, as well as continued drug price inflation.

At the same time, **supplemental indications** greatly helped expand the target markets for drugs.

Market Trends

The evolution of plan design reflects market trends. From the 1980s through the early 2000s — when these plan designs were most prevalent — **prescription drug spending continued to rise** steadily as part of health care spending as well as overall gross domestic product (GDP) putting an increasingly greater cost burden on payors. However, out-of-pocket **health care costs** for consumers actually fell during that time. Driving the increase, at least partly, was advertising by drug manufacturers designed to build and retain loyalty to high-cost brand drugs. From 1996 to 2000 alone, direct-to-consumer (DTC) **ad spending** grew an average of 32.9 percent annually — a vast majority of it for the most expensive branded medications.

The money spent by manufacturers on DTC advertising has only continued to grow. From 2012 to 2016, spend on **branded drug advertisements** grew 62 percent — more than any other ad category — to a projected \$6.4 billion in 2016 — leading the American Medical Association to call for a complete **ban** in 2015. So have prices. From 2012 to 2016, **spending on prescription drugs** was up 27 percent, driven by a roughly 25 percent jump in prices. And the pressures continue to build; **U.S. drug spending** is projected to increase by 6.3 percent on average **through 2025**.

CDHPs, a Response to Market Trends

As payors continued to look for ways to drive utilization toward more cost-effective options such as generics, new CDHP or HDHP plan designs emerged. Such plans are designed to drive more informed consumer choices. By shifting a greater portion of the cost to members, it also enables payors to continue providing a sustainable benefit, and keep overall plan costs, including premiums, low.

Tools to Offset the Cost Burden

However, HDHPs do pose concerns about consumer affordability. We recognize that cost can be a barrier to medication adherence. CVS Health as a large employer, in addition to being a health care company, has wrestled with many of the same challenges our PBM clients do to balance member cost and offer a sustainable benefit. We introduced CDHPs among our employees in 2012, transitioning completely in 2013. That's why, as an employer, we want to take every step to help lower the OOP cost burden for members.

- **Zero-dollar copay:** Our formulary includes a wide range of generic drugs that are used as preventive medications, available to members at a zero-dollar copay.
- **Point-of-sale (POS) rebates:** We also made the decision of passing along the estimated value of any brand drug rebates we will receive to our employees at the point of sale. This helps ensure that our members are getting the full value of the savings we negotiate for the medications they use.

We have been offering POS rebates to our employees since 2013. However, as someone who works in the benefits field, I know these solutions are not without complexity. This includes having to estimate the rebate to lower the net cost at POS, and having the pharmacy benefit manager (PBM) reconcile at the end of the year to ensure that the plan and plan members received all of the rebates earned. I encourage my benefit colleagues, particularly those with a high deductible plan design, to consider adopting such strategies to help ensure your members receive the lowest net price at the pharmacy counter.



The U.S. is expected to account for more than half of global growth in prescription drug spending through 2025. While PBM cost-management strategies can help payors and their members control costs, the real solution will have to come from **better drug pricing policy** in our country to help curb runaway prescription drug costs and spending.

Would a POS rebate solution be a good fit for your plan? **Ask Us**



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