

Policies to Help *Patients Pay Less* for their Medicines: *Offer Lower, More Predictable Cost Sharing Options*

For many patients with commercial health insurance, the amount they pay for medicines continues to increase, even as the amount insurance companies pay continues to grow more slowly, if at all. Unfortunately, when patients must pay more out of pocket for their medicines, they often fail to fill the medicines their doctors prescribe or ration medicines to make them last longer. This can lead to serious complications and worse health for patients, which could ultimately lead to higher overall health care costs.



The Problem

Historically, more patients paid fixed-dollar copays for their medicines – one price for a generic and another for a brand medicine. **In recent years, however, the use of deductibles and coinsurance for prescription drug coverage has risen dramatically.**

First, let's take deductibles. Deductibles require patients to pay in full for their medicine, sometimes up to thousands of dollars, before their insurance coverage kicks in. **Between 2012 and 2017, the percentage of health insurance plans that employed deductibles for prescription drugs almost doubled from 23% to 52%.**

In addition to employing deductibles for prescription drug coverage, insurers have increasingly replaced fixed-dollar copays with percentage-based coinsurance, which requires patients to pay a percentage of the medicine's price.

For prescription drugs, **these increasing out-of-pocket costs are further exacerbated by the fact that, while health insurance companies often receive substantial rebates and discounts from prescription drug manufacturers, the amount patients subject to a deductible or coinsurance must pay is typically based on a drug's list price, not the discounted price being paid by their health insurance company.** For example, for a drug with a \$100 list price, the health insurance company may negotiate a discount or rebate of \$40, for a net cost to them of \$60. But a patient still in their deductible pays the full \$100. That \$40 rebate may go to the health insurance company, which has paid nothing on that patient's claim. It does not go to the manufacturer of the medicine.

The same is true for coinsurance. A patient with a 25% coinsurance pays \$25 for a medicine with a \$100 list price (.25X100), rather than \$15 (.25X60). The additional \$10, paid by the patient, does not go to the manufacturer of the medicine and instead may go to the health insurance company or others in the supply chain.

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The Solution: Offer Lower, More Predictable Cost Sharing Options

Patients should have more choices when it comes to their medicine coverage. States can help patients immediately by requiring each insurer to have at least 50% of its health insurance plans offered in a given market to include the following cost sharing options for patients:

1. **No deductible:** Medicines must be covered by insurers from day one – without subjecting patients to deductibles;
2. **Copayment-only cost sharing:** patients pay only a flat-dollar copay per prescription, not percentage-based coinsurance; and
3. **Limited copayments:** the highest-allowable copayment may not exceed 1/12 of the patient's annual out-of-pocket spending maximum.

While health insurance companies would still have flexibility to offer different plan designs to meet various patient preferences, requiring each insurer to offer at least 50% of its plans to include these three features would provide patients with lower, fairer and more predictable prescription drug coverage options.