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ENROLLEE COST-SHARING FOR PRESCRIPTION DRUGS

Analysis in the commercial employer insurance market, 2014–2019

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Kurt Giesa, FSA, MAAA
Peter Kaczmarek, FSA, MAAA
James Bao, FSA, MAAA
Peter Scharl, FSA, MAAA

Marsh GuyCarpenter Mercer

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EXECUTIVE SUMMARY

At the request of the Blue Cross Blue Shield Association, we examined trends in enrollee cost-sharing for prescription drug benefits in the employer-sponsored health insurance (ESI) market from 2014-2019. Our key findings include the following:

- Health plan sponsors have been absorbing a larger share of the cost of prescription drugs over time, largely shielding enrollees from increasing prices, particularly those enrollees with the highest expenditures. We calculated the average enrollee's share of total pharmacy costs, with total pharmacy (or prescription drugs) costs defined as enrollee cost-sharing requirement plus the health plan's financial responsibility, less estimated drug manufacturer rebates.[1] From 2014 to 2019, the average enrollee's share of total pharmacy costs declined from 16% to 13%. During the study period, the average enrollee's share of total health care costs (medical and prescription drug benefits, combined) remained essentially unchanged at 14% (see Exhibit 1).
- Relative to total health care costs, health plan sponsors have been successful in restraining the growth in spending on prescription drug benefits. While the total cost of care per enrollee increased by 23% over the study period, costs for prescription drug benefits increased by 14%, and enrollee cost-sharing for prescription drugs declined by 5% (see Exhibit 2).
- The 14% increase in prescription drug costs is the result of a unit price increase of 10% and a utilization increase of 4%. The utilization increase comes primarily from an increase in the use of generic drugs; the unit price increase is driven by increases in the use and average price of specialty drugs (see Exhibit 3).[2] That is, not only has the average price of specialty drugs increased, but utilization of specialty drugs, relative to utilization of other, less expensive drugs, has also increased.
- The share of prescription drug costs taken up by specialty drugs grew from 43% in 2014 to 61% in 2019, driven primarily by growth in utilization. Utilization of specialty drugs grew from 1.7% of prescription drug utilization in 2014 to 2.3% of prescription drug utilization in 2019. Its share of total prescription drug utilization is still small but very high average prices result in its accounting for a very large share of total prescription drug costs (see the Appendix).
- For enrollees using specialty prescription drugs, high unit prices drove higher claims costs and higher enrollee cost-sharing compared to all prescription drug users (see Exhibit 5).

1 Note: Unless otherwise indicated, "cost" in this report refers to the allowed costs, the sum of the health plan's financial responsibility and the cost-sharing requirement of the enrollee. Also, our analysis does not include the impact of cost-sharing assistance programs that prescription drug manufactures may make available to enrollees through copay cards and other means.

2 We followed the Medicare Part D program in defining specialty drugs as those where the cost of a 30-day supply exceeded $600 from 2014 to 2016 and $670 from 2017 through 2019.

- For both the top quartile of enrollees who use prescription drugs (i.e., those incurring the greatest prescription drug costs) and the top 5% of such enrollees, costs increased, by 17% and by 34%, respectively (see Exhibit 6).
- For an even larger majority of enrollees, cost-sharing for prescription drugs declined, including for the top quartile of prescription drug users. Cost-sharing increased by 22%, however, for the top 5% of enrollees (see Exhibit 7).
- Although enrollee cost-sharing increased for the top 5%, their cost-sharing still decreased when measured as a percentage of total prescription drug costs. Put another way, while the dollar amount of enrollee cost-sharing increased for the top 5%, the amount that health plans paid increased more quickly. This finding highlights the ability of health plans to manage prescription drugs so that the enrollees' share of total prescription drug cost is trending downward.
- The Centers for Medicare & Medicaid Services (CMS) projects that prescription drug costs will increase from 2019 to 2024 by double the rate observed over the period of this study (2014–2019), a matter of concern for both health plans and policymakers.

INTRODUCTION AND BACKGROUND

INTRODUCTION

Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman) was retained by the Blue Cross Blue Shield Association to analyze trends in total costs and enrollee cost-sharing for pharmacy benefits in the ESI market. This report contains four sections: the executive summary describing the main results; this introduction and background section providing information about ESI enrollees' cost-sharing trends and benefit designs; a results section; and a section on methodology and data sources. The report also includes two appendices: Appendix A includes additional results; and Appendix B includes data from the National Health Expenditures (NHE) projections.

BACKGROUND

According to NHE projections by CMS, personal health care expenditures within the private health insurance (PHI) market (insurance paid for by individuals and businesses) steadily increased from $810 billion in 2014 to $1.04 trillion in 2019, an average annual growth rate of 4.9%,[3] while prescription drug expenditures in the PHI market increased at a slower average annual rate of 2.3% during that same time. CMS projects that prescription drug expenditures will grow from $140 billion in 2019 to $160 billion in 2024, an average annual rate of 3.2% compared to an estimated 5.3% growth rate for total personal health care expenditures.

Spending on enrollee cost-sharing across all services has been steadily increasing in the ESI market, keeping pace with total claims costs. However, as noted in the executive summary, the percentage of total costs enrollees were required to pay remained steady at 14%.

Prescription drug expenditures are highly concentrated among a small number of high-cost users, even relative to medical expenditures.[4] As discussed in this report, the majority of those with health plan coverage in the ESI market have been shielded from the increasing cost of prescription drugs, having experienced only modest increases in average enrollee cost-sharing. And while those with the highest drug spending (the top five percentile) and specialty drug users have seen increases in enrollee cost-sharing, they still pay, on average, less than 10% of the total cost (including both the health plan's financial responsibility and the cost-sharing required of the enrollee) of their prescription drugs.

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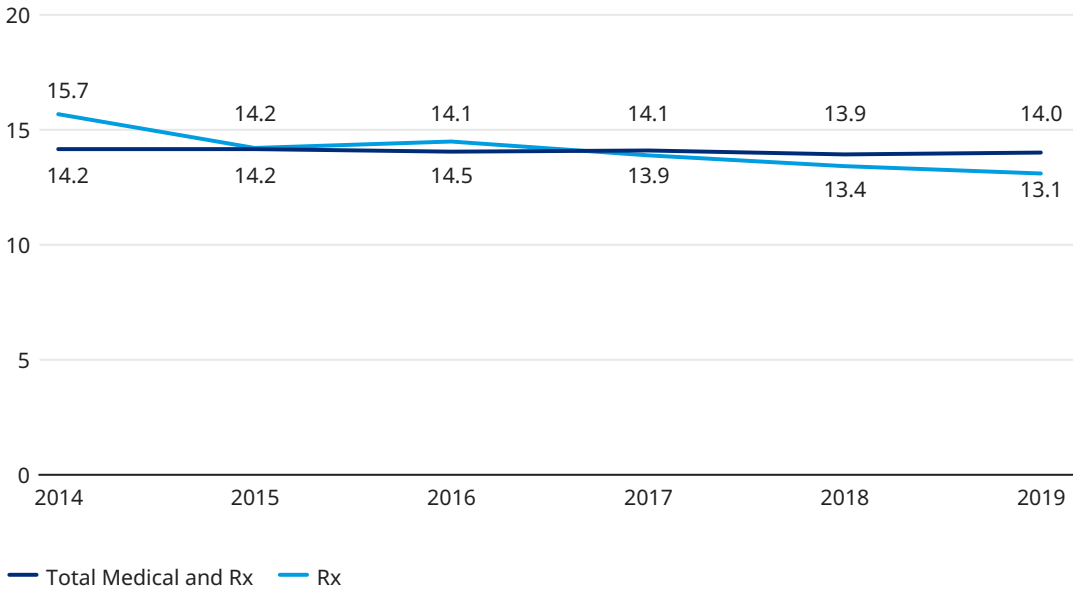
3 www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.

4 Oliver Wyman analysis of MarketScan data for ESI enrollees suggest that 20% of enrollees account for 95% of prescription drug expenditures. In comparison, 20% of ESI enrollees account for 85% of medical only expenditures.

RESULTS

This section examines trends in prescription drug expenditures and cost-sharing for ESI enrollees. As shown in Exhibit 1, enrollee cost-sharing for pharmacy benefits as a percentage of total pharmacy costs declined over the study period. In 2014, enrollees were responsible for paying 16% of the total cost of their pharmacy benefits. By 2019, that had declined to 13%. Including all health care costs, enrollees paid 14% of their total costs throughout the study period.

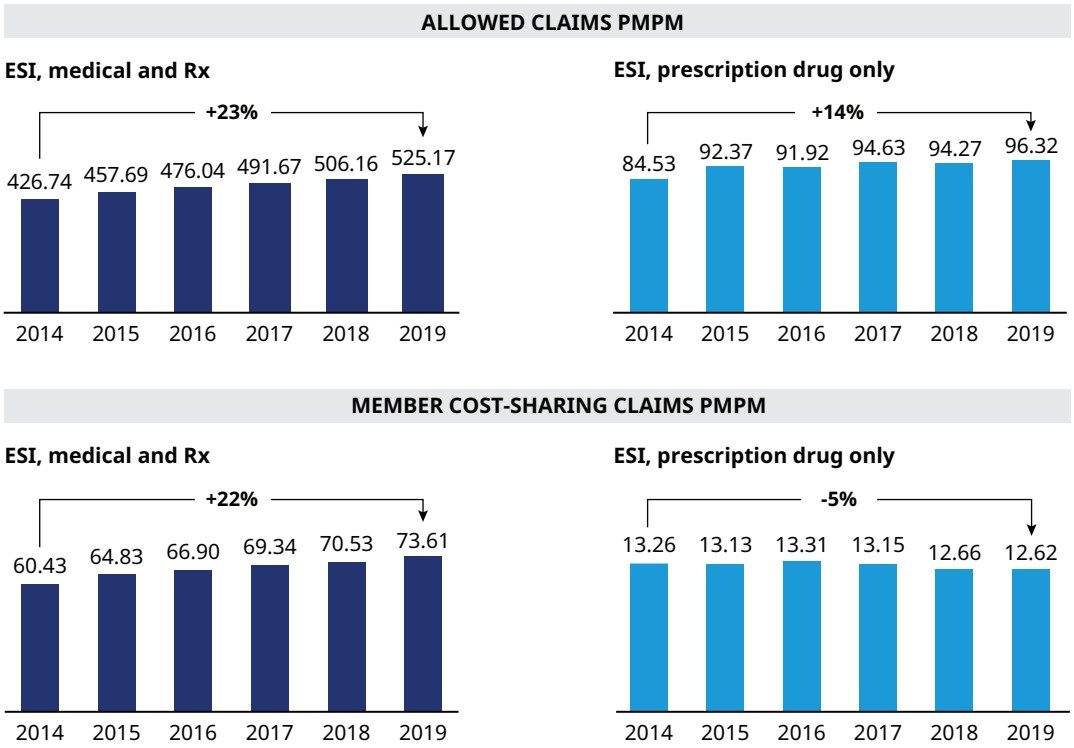
Exhibit 1: Enrollee cost-sharing as a percentage of total costs (ESI), in percent



Source: Oliver Wyman analysis

The dollar amount of enrollee cost-sharing for prescription drugs declined by 5% over the study period as shown in Exhibit 2. By contrast, on a combined basis for all health care costs (including medical benefits and prescription drug benefits), the dollar amount of enrollee cost-sharing increased by 22%. We note that these changes are similar to those from the NHE (see Exhibit 12 in Appendix B).

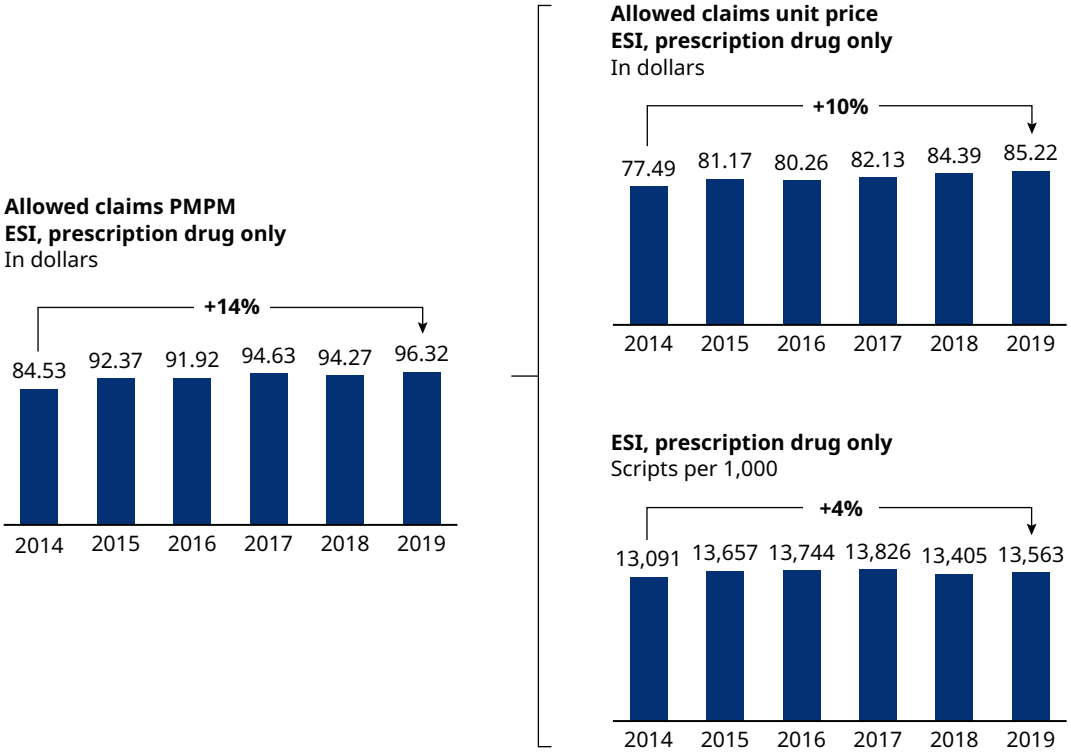
Exhibit 2: Total and prescription drug only claims and cost-sharing per month, 2014–2019, in dollars



Source: Oliver Wyman analysis

We break prescription drug spending into its component parts — the number of scripts per 1,000 enrollees and the price per script (unit price) in Exhibit 3. Roughly two-thirds of the cost increase (14%) is due to unit prices (10%), and one-third is from utilization (4%).

Exhibit 3: Prescription drug unit price and utilization trends, 2014–2019

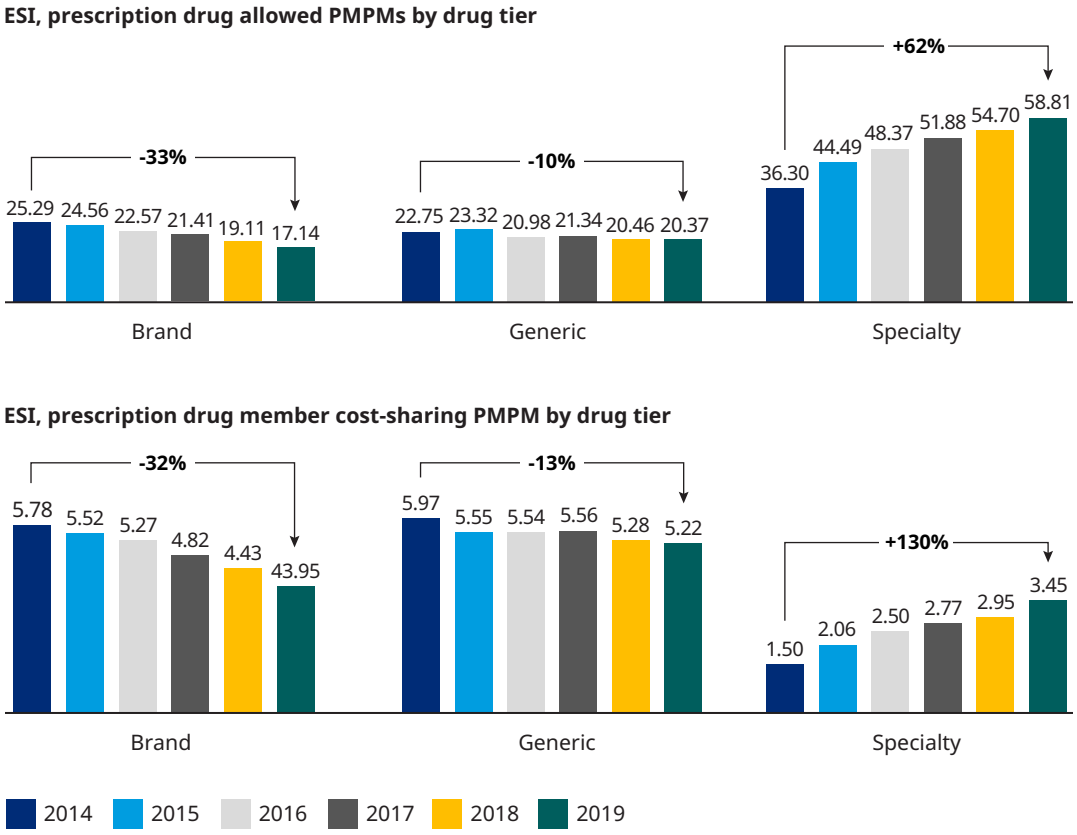


Source: Oliver Wyman analysis

Grouping drug costs into brand, generic and specialty categories (Exhibit 4) highlights two divergent trends. Costs for both brand and generic drugs fell during the study period. Total costs for brand drugs fell 33% and total costs for generic drugs fell 10%. On the other hand, costs for specialty drugs grew 62% — from $36 to $59 per enrollee per month over the study period — and is responsible for the pharmacy costs in total rising from $85 to $96 per enrollee per month (Exhibit 2).

Enrollee cost-sharing shows a similar pattern, with increases in specialty drug cost-sharing and decreases in enrollee cost-sharing for brand and generic cost-sharing. Because relatively few enrollees are treated with specialty drugs, the average member cost-sharing for specialty drugs — spread over all enrollees — was only $3 per enrollee per month in 2019. Even with the increase in both cost-sharing and total costs for specialty drugs, in 2019, enrollee cost-sharing on specialty drugs represented only 5% of the total amount being spent on specialty drugs with the remaining nearly 95% being paid by health plans.

Exhibit 4: Prescription drug total costs and cost-sharing monthly averages by drug tier 2014–2019, in dollars

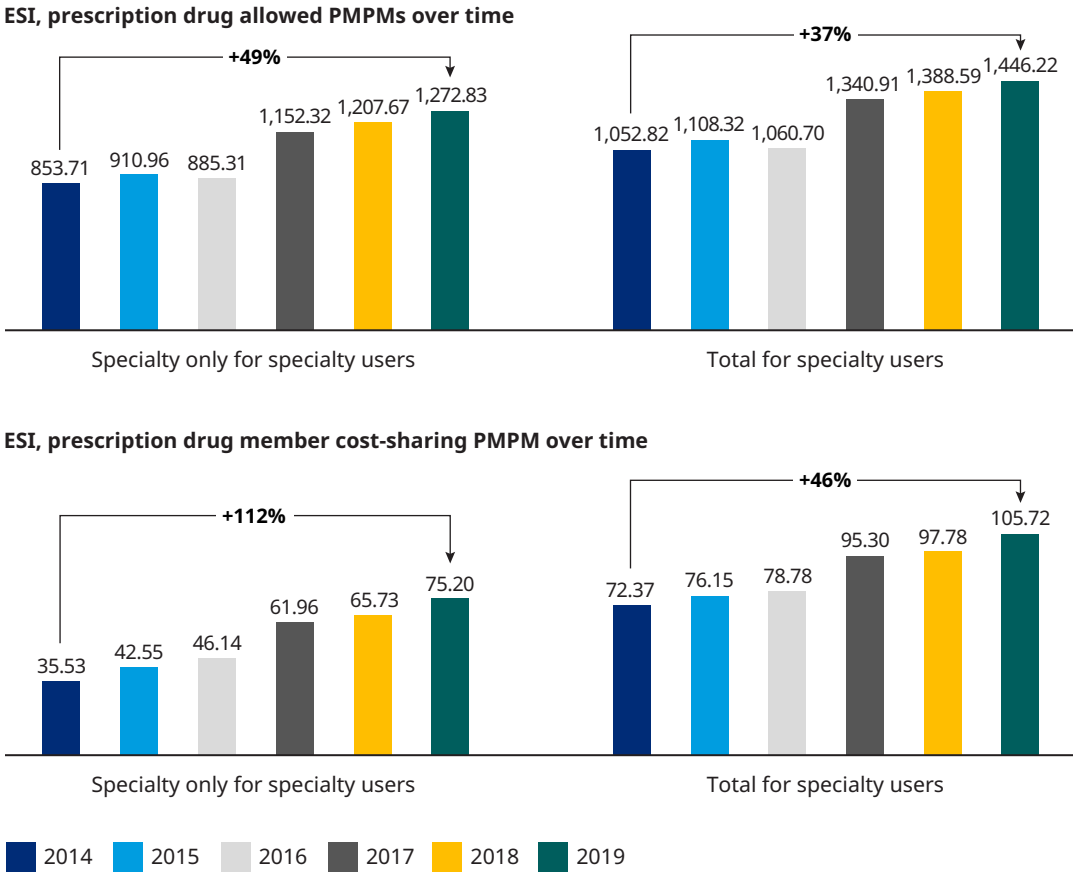


Source: Oliver Wyman analysis

In Exhibit 5, we focus on prescription drug costs for enrollees who are prescribed specialty drugs (note that these enrollees typically also are prescribed non-specialty drugs).[5] Specialty drug users have much higher prescription drug costs in general ($1,446 per enrollee per month in 2019) as well as higher cost-sharing ($106 per enrollee per month in 2019) compared to the average ESI enrollee as shown in Exhibit 2 ($96 per enrollee per month in total costs and $13 per enrollee per month in cost-sharing in 2019). Specialty users' average cost-sharing for all drug types increased by 46% over the study period compared to a decrease of 5% for the total ESI population due to a combination of higher unit prices (14% increase) and utilization increase (42% increase) (see Exhibit 11 in Appendix A). For specialty users in 2019, total cost-sharing is around 7% of the total amount being spent on these high-cost drugs.

5 We define a specialty drug user as a Plan enrollee with at least one specialty drug type on their claim records in a given year.

Exhibit 5: Prescription drug total costs and cost-sharing trends for specialty drug users 2014–2019, in dollars



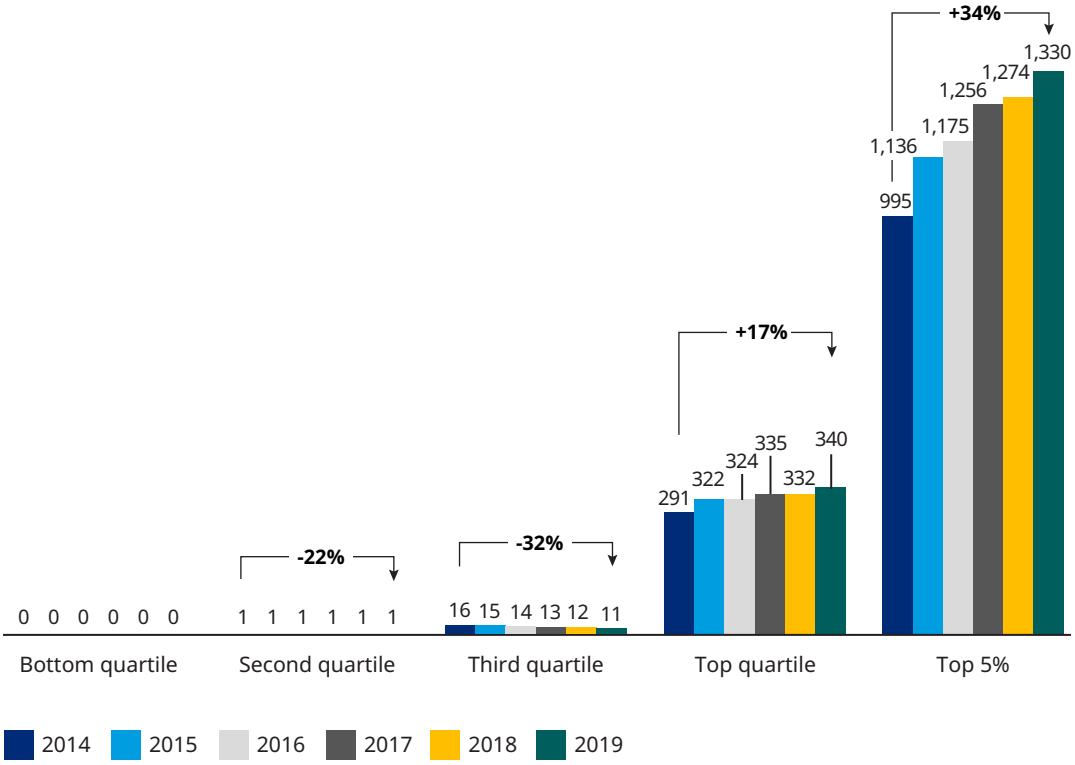
Source: Oliver Wyman analysis

In addition to looking at specialty drug users, we analyzed the prescription drug spending trends by prescription drug claim cohort where the cohorts are created by separating ESI enrollees into quartiles based on their prescription drug claims in each reporting year. We also analyzed the spending for ESI enrollees with the highest 5% of prescription drug claims. Total prescription drug costs and enrollee cost-sharing over the study period are shown below in Exhibits 6 and 7, respectively.

Over the study period, costs rose fastest for those with the highest spending on prescription drugs. As Exhibit 6 displays, the top 5% cohort saw an increase of 34% in prescription drug costs. The costs for the top quartile increased over the same period by 17%, costs for the middle two quartiles decreased slightly, while the cost for the lowest drug cost quartile was $0 across the period because more than 25% of the enrollees in the data set had no prescription drug costs at all.

Exhibit 6: Change in prescription drug total costs by quartile and top 5%, 2014–2019, in dollars

ESI, prescription drug allowed PMPM by Rx claims quartile

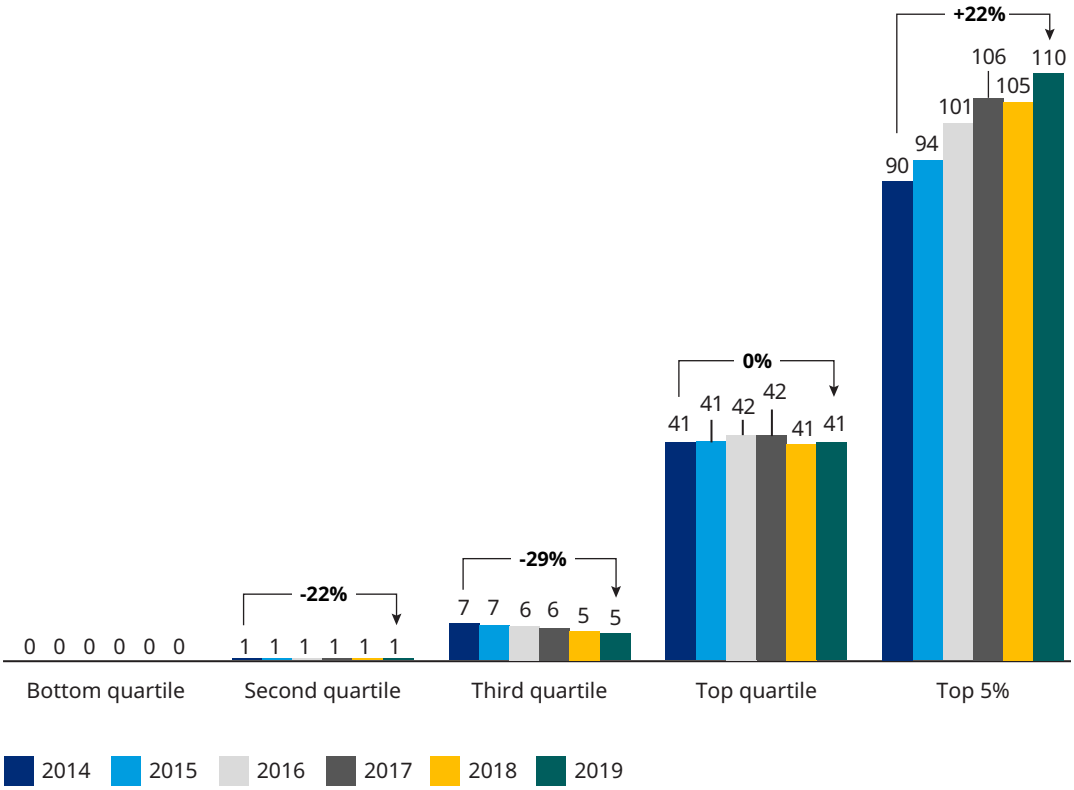


Note: Numbers have been rounded
Source: Oliver Wyman analysis

The prescription drug benefits that health plans make available to enrollees help protect those enrollees with the highest expenditures from high cost-sharing, including caps on cost-sharing for covered medical services and prescription drugs. As shown in Exhibit 7, in 2019, the average enrollee's cost-sharing for the top quartile ($41 per enrollee per month) was eight times that of the third quartile ($5 per enrollee per month); however, the total prescription drug costs per enrollee per month for the top quartile is more than 30 times as high as the costs for the third quartile ($340 vs $11 per enrollee per month). The increase in enrollee cost-sharing is lower for the top quartile (0%) and the top 5% cohort (22%) compared to the five-year increase in total prescription drug costs (17% for the highest quartile, and 34% for top 5% cohort). As portrayed in Exhibit 8, enrollee cost-sharing as a percentage of total prescription drug costs decreased over the study period for both the top quartile and top 5% cohort. These charts highlight the protection provided by ESI coverage against high prescription drug costs for all enrollees, and especially for those who use prescription drugs the most.

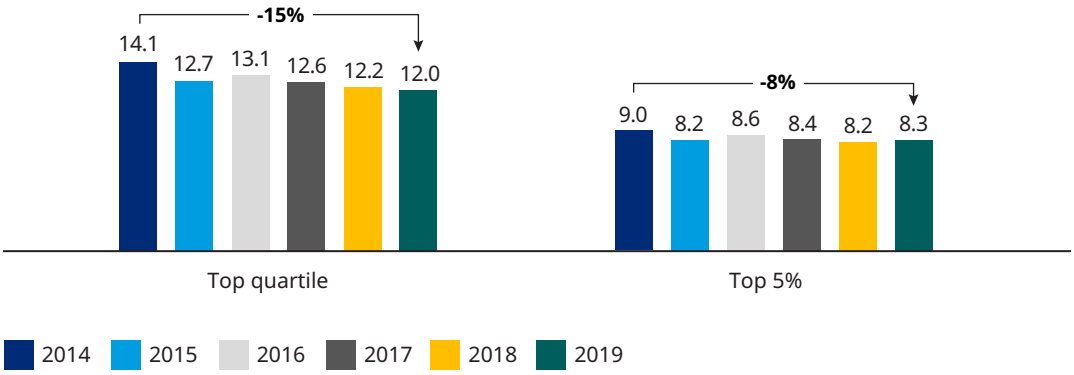
Exhibit 7: Change in prescription drug enrollee cost-sharing by cost quartile and top 5%, 2014–2019, in dollars

ESI, prescription drug member cost-sharing PMPM by Rx claims quartile



Note: Numbers have been rounded
Source: Oliver Wyman analysis

Exhibit 8: Change in prescription drug enrollee cost-sharing as a percentage of total prescription drug costs for top quartile and top 5%, 2014–2019, in percent



Source: Oliver Wyman analysis

METHODOLOGY AND DATA SOURCES

We utilized the MarketScan[6] database covering calendar years 2014 to 2019 to do this work. The database includes 1.46 billion enrollee months of experience and $156 billion in prescription drug allowed claims.[7] The results in this report are based on the calculated allowed, paid and enrollee cost-share (i.e., allowed less what was paid by the health plan) for the following categories: brand,[8] generic and specialty.[9]

We show enrollee cost-sharing on a per enrollee per month basis and in total as a percentage of allowed claims. Prescription drug utilization metrics (e.g., scripts per 1,000) are based on a 30-day supply. We did not adjust for variation in enrollee risk scores between years of data because the risk profile of the study population has not changed over the study period in a way that would materially affect our results.[10]

Note that we account for the impact of pharmacy rebates using data from the federal Medical Loss Ratio (MLR) Rebate reports.[11] This results in a downward adjustment to the allowed pharmacy amount and the amount paid by the health plan. Rebate amounts in the MLR Rebate reports are not split among the generic, brand and specialty tiers. In this work, we attributed no rebates to the generic drug tier. We applied twice the percentage of pharmacy rebates to the brand-drug tier compared to the specialty drug tier.[12]

In estimating the percentage of total costs that are the enrollee's responsibility, we have not included employer contributions to Health Savings Accounts or Health Reimbursement Arrangements due to a lack of data. If these contributions had been included, enrollee cost-sharing for both medical benefits and prescription drug benefits would be lower, but likely by different amounts.

6 www.ibm.com/products/marketscan-research-databases.

7 The allowed amount is the contractually determined total price for the drug or service. The allowed amount less the Plan's payment is the enrollee's cost-sharing responsibility.

8 An indicator provided on the MarketScan data allows for the identification of brand vs generic drugs.

9 We followed the Medicare Part D program in defining specialty drugs as those where the cost of a 30-day supply exceeded $600 from 2014 to 2016 and $670 from 2017 through 2019.

10 Risk score profile was calculated utilizing the HHS ACA risk adjustment model.

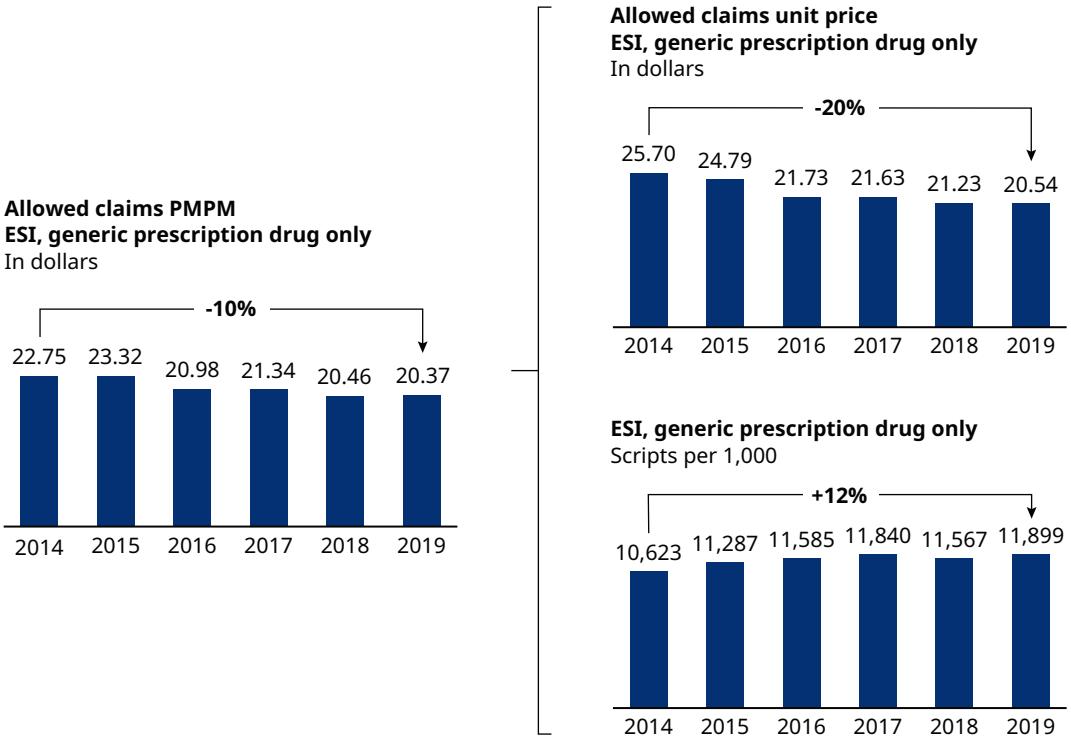
11 www.cms.gov/CCIIO/Resources/Data-Resources/mlr.

12 This assumption is based on analysis of the CIVHC Prescription Drug Rebates Data in Colorado.

APPPENDIX A
UTILIZATION AND UNIT PRICES

In Exhibit 9, we show the negative trend on generic pharmacy claims is driven entirely by unit price. Utilization of generic drugs increased by 12% over the period.

Exhibit 9: Generic prescription drug unit price vs utilization 2014–2019

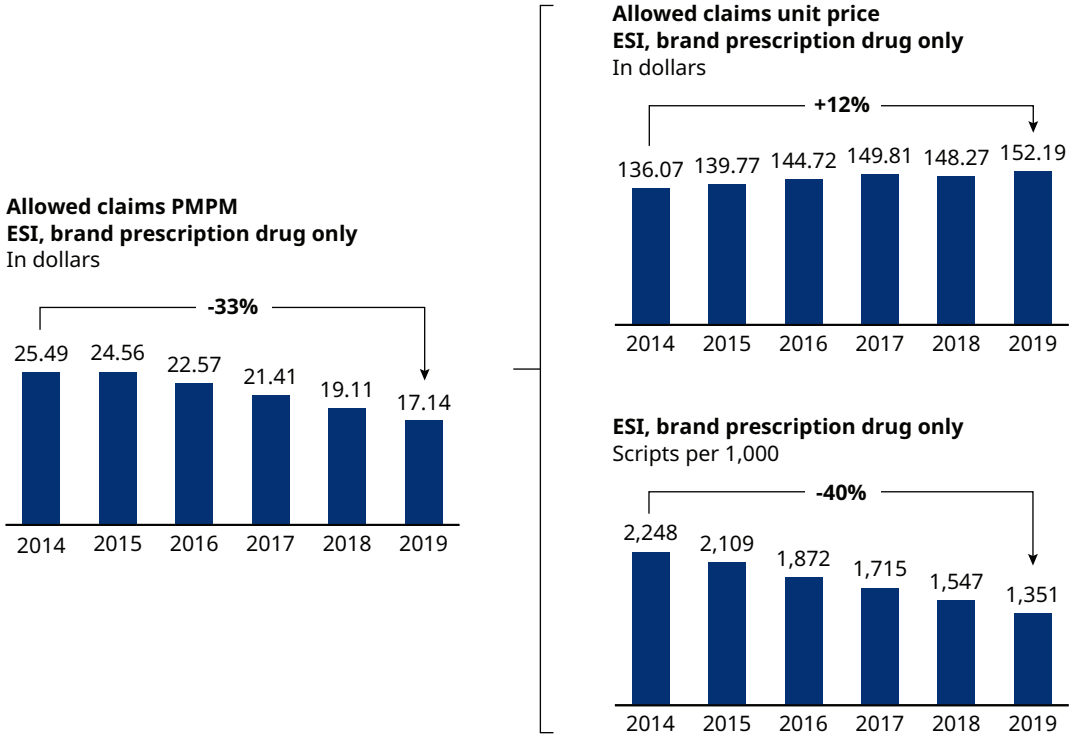


Source: Oliver Wyman analysis

In contrast to generic drugs, the large decrease in brand allowed costs is driven entirely by a 40% decrease in brand utilization, with a 12% increase in unit prices over the period.

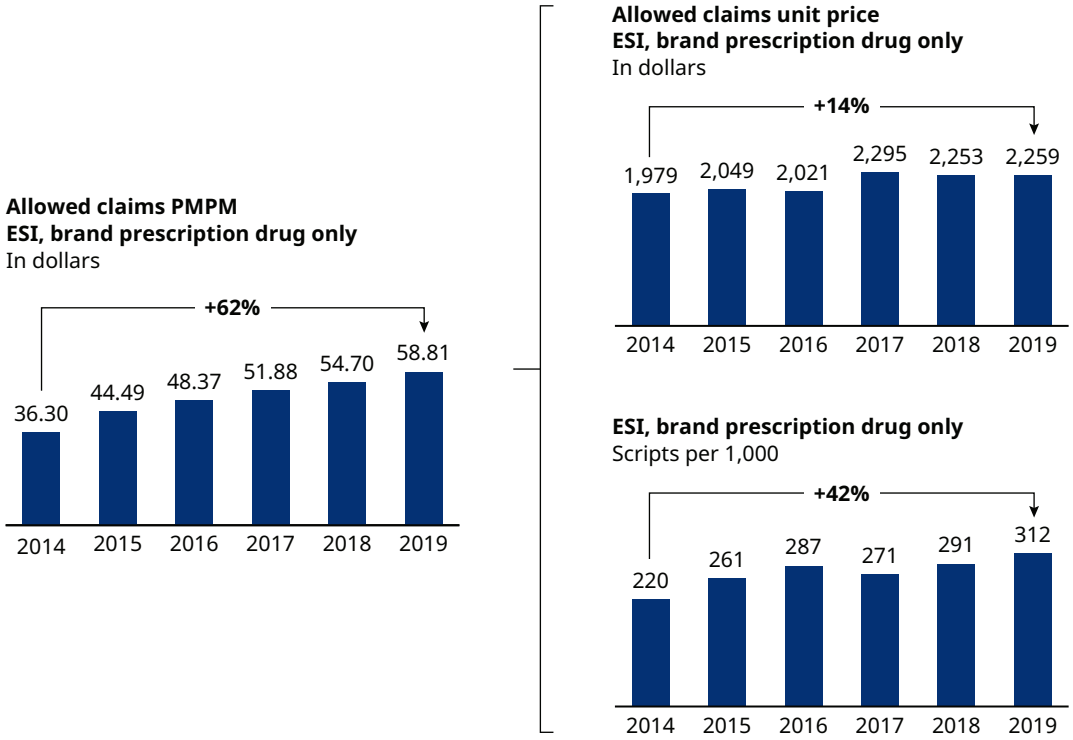
The 62% trend in specialty pharmacy claims is driven by both utilization and unit price increases. Specialty prescription utilization increased by 42% over the period, and unit prices increased by 14%.

Exhibit 10: Brand prescription drug unit price vs utilization 2014–2019



Source: Oliver Wyman analysis

Exhibit 11: Specialty Prescription Drug Unit Price vs Utilization 2014 to 2019



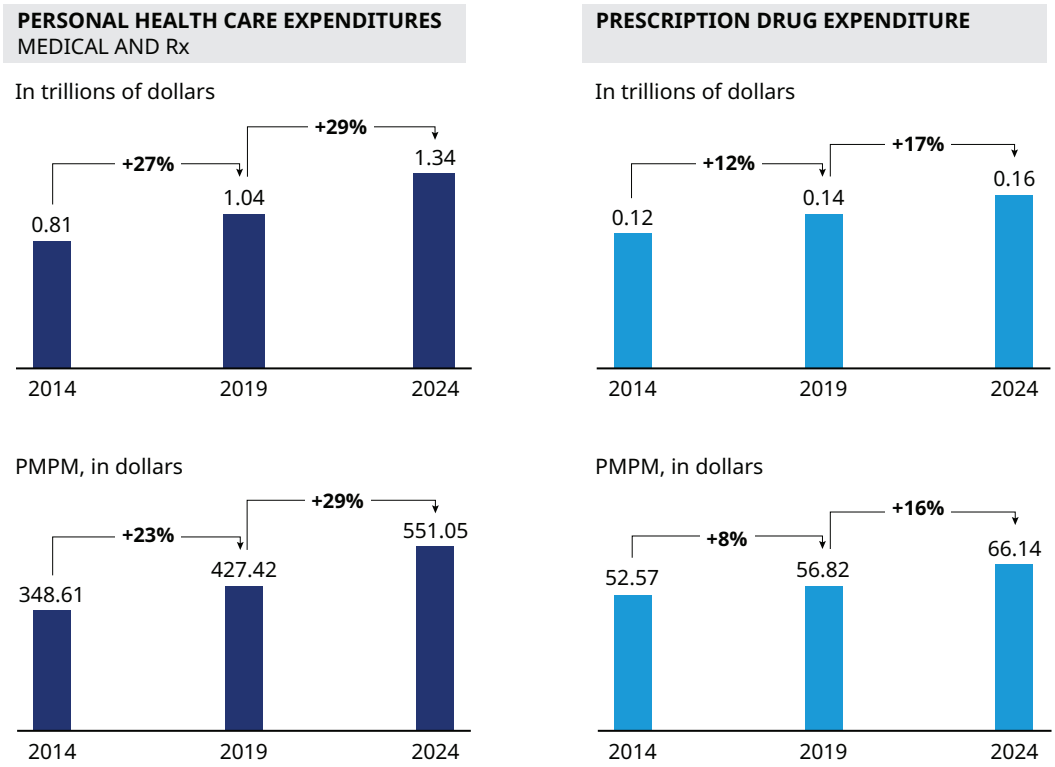
Source: Oliver Wyman analysis

APPENDIX B

NHE TRENDS IN PERSONAL HEALTH CARE AND PRESCRIPTION DRUG EXPENDITURES

As shown in Exhibit 12, the CMS-calculated growth rates for PHI expenditures (+23%) and prescription drugs (+8%) from 2014 to 2019 are largely consistent with our report findings when compared to our report findings shown in Exhibit 12 (+23% growth for medical and prescription drug costs, and +14% for prescription drug costs only).[13] CMS projects prescription drug expenditures will increase from 2019 to 2024 by 16%, double the historical five-year growth rate. CMS estimates that in 2021, PHI spending growth will have accelerated as utilization increased in line with faster growth in physician visits and projects that in 2023 and 2024, the prices and utilization for prescription drugs will increase, due to increasing use of new drugs introduced in 2021 and 2022.

Exhibit 12: Personal health care and prescription drug expenditure, nationwide — private health insurance only



Source: Oliver Wyman analysis

13 CMS National Health Expenditures by type of service and source of funds: calendar years 1960 to 2030. PHI includes Employer Sponsored Insurance and Direct Purchase; Enrollment estimates from NHE projection Table 16: www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData

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The authors are Fellows in the Society of Actuaries, members of the American Academy of Actuaries, and meet that body's qualification standards to perform the work herein. This work conforms with the Actuarial Standards of Practice.

AUTHORS

Kurt Giesa, FSA, MAAA
Kurt.Giesa@oliverwyman.com

James Bao, FSA, MAAA
James.Bao@oliverwyman.com

Peter Kaczmarek, FSA, MAAA
Peter.Kaczmarek@oliverwyman.com

Peter Scharl, FSA, MAAA
Peter.Scharl@oliverwyman.com