



**To:** Coalition for Accessible Treatments  
**From:** Avalere Health  
**Date:** August 30, 2013  
**Re:** Estimated Impact of Patients' Access to Treatments Act of 2013

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## Summary

The Coalition for Accessible Treatments (“Coalition”) asked Avalere Health to estimate the impact of the Patients’ Access to Treatments Act of 2013 (H.R. 460) on premiums and cost sharing in commercial health plans. Specifically, this proposal would require plans to limit cost-sharing requirements for specialty drug tiers to the level of cost sharing required for non-preferred brand drug tiers. H.R. 460 requires that there be no more than a 10 percent difference in total dollar costs for any drugs on a tier. The Coalition asked Avalere to determine the impact on plan premiums as well as on cost sharing for other drugs. Avalere examined how changes to cost sharing for specialty drugs would affect demand for those drugs and determined overall impact on premiums. Avalere evaluated how changes to cost sharing for other drug tiers could offset premium increases associated with the proposal.

We estimate that H.R. 460 would increase annual premiums on average \$3 for plans with specialty tiers, absent any other changes to the average benefit design. Plans that use co-pays for specialty tiers will see a negligible annual average increase of \$0.37. Plans that use co-insurance for specialty tiers will see an annual average increase of \$7.78.

Additionally we estimated the average change in cost sharing for other drug tiers needed to offset the average annual premium increase for plans. Table 1 below displays the estimated cost-sharing changes for other drug tiers needed to offset the \$3 average annual premium increase.

**Table 1: Estimated Change in Cost Sharing for Other Drug Tiers to Offset Premium Changes**

Cost-sharing Category	Cost-sharing Change
<b>Non-Preferred Tier*</b>	Increase co-pays by \$6
<b>Preferred Tier</b>	Increase co-pays by \$0.75
<b>Generic Tier</b>	Increase co-pays by \$0.50

Source: Avalere Health analysis

\*Increase assumes a 10 percent difference in pricing between non-preferred and specialty drugs.

## Background

Health plans generally use a tiered cost-sharing structure for drugs. Typically the first tier (tier I) is for generic drugs, the second tier (tier II) is for preferred brand drugs and the third tier (tier III) is for non-preferred brand drugs. Most plans use a fixed co-pay amount for each of these tiers; for example, a plan may have co-pay amounts of \$10/\$30/\$50 for each tier respectively. Some plans have an additional tier for higher cost drugs, often known as a specialty tier. Specialty tiers often have higher co-pays, or these tiers may use co-insurance that can shift even more of the costs for using these drugs to enrollees.

Plans use cost sharing to adjust the actuarial value (AV) of the plan. The AV represents the average total spending for all enrollees that is covered by premiums: a plan with an AV of 80 percent will pay, on average, 80 percent of all the costs of enrollees, while enrollees will pay, on average, 20 percent of the total costs via cost sharing and deductibles. The premium of a health plan reflects the expected AV of the plan: if a plan is required to cover 80 percent of the total spending of its enrollees, it must set a premium high enough to cover these medical and pharmacy costs as well as any administrative expenses of operating the health plan.

The use of specialty tiers is increasing among plans as they look for ways to control spending on high cost medications and keep total premium growth at a reasonable level. In 2008, approximately 7% of commercial plans had four or more tiers on their formularies.<sup>1</sup> In 2012, this doubled to 14% of health plans using four or more tiers.<sup>2</sup>

### *Specialty Drug Spending and Specialty Tier Use by Commercial Health Plans*

Specialty drug spending represents a relatively small portion of total commercial health plan costs. An Avalere analysis of data underlying the Center for Consumer Information and Insurance Oversight's (CCIIO) Actuarial Value (AV) Calculator for health plan spending found that specialty drug spending represents approximately 2.0-2.5 percent of total health plan costs (see Table 2 below). While total drug costs were generally about 20-23 percent of health plan costs, specialty drug costs were a small percentage of this spending, representing only 10-11 percent of total drug costs. Note that these costs include both the plan and beneficiary spending amounts.

In part, this low percentage of spending on specialty drugs can be explained by the relatively limited use of specialty drugs currently. While the cost of a single course of specialty drug therapy can be quite significant, this spending is concentrated among a small proportion of enrollees. Based on the AV Calculator data, Avalere estimates that only 5 percent of commercial enrollees account for over 90 percent of specialty spending.

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<sup>1</sup> Kaiser Family Foundation and Health Research & Educational Trust, Employer Health Benefits 2012 Annual Survey, Exhibit 9-1, available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8345-employer-health-benefits-annual-survey-full-report-0912.pdf>.

<sup>2</sup> Ibid.

Specialty tier use in commercial plans is still limited with approximately 14 percent of commercial plans using four or more tiers.<sup>3</sup> According to information in the Kaiser/HRET Employer Health Benefits 2012 Annual Survey, 55 percent of plans with four or more tiers use co-pays for their specialty tier and 36 percent use co-insurance with the remaining plans using other cost-sharing structures.<sup>4</sup> Plans that use co-pays for their fourth tier had an average co-pay of \$79. Plans that use co-insurance for their specialty tier had an average co-insurance of 32 percent.

However, specialty drug spending is expected to continue to increase and become a larger share of health plan drug spending.<sup>5</sup> Additionally, a growing number of patients are expected to be taking specialty drugs in future years.<sup>6</sup> Patients taking specialty drugs are likely to pay a growing share of the costs for these medications as well.<sup>7</sup>

**Table 2: Specialty Drug Spending in Health Plan Spending at Various Actuarial Value Levels**

	Bronze Level Plans	Silver Level Plans	Gold Level Plans	Platinum Level Plans
AV Value (%)	60%	70%	80%	90%
Average Spending (annual)	\$4,064	\$4,737	\$4,996	\$6,154
Specialty Average Spending (annual)	\$103	\$109	\$115	\$136
Drug Spending as a % of Total Spending	23.0%	22.6%	21.5%	19.7%
Specialty Drug Spending as a % of Total Spending	2.5%	2.3%	2.3%	2.2%
Specialty Drug Spending as a % of Total Drug Spending	11.0%	10.2%	10.7%	11.2%

Source: Avalere Health analysis of CClIO AV Calculator

*The Patients' Access to Treatments Act (H.R. 460)*

The Patients' Access to Treatments Act (H.R. 460) was introduced in Congress to limit cost sharing on specialty tiers.<sup>8</sup> The proposed legislation limits cost-sharing requirements applicable to drugs in a specialty drug tier to the dollar amount applicable to drugs in a non-preferred brand drug tier.

The bill restricts co-insurance for these specialty drugs to that of the non-preferred drug tier and requires that there be no more than a 10 percent difference in total dollar cost sharing for any drugs on a tier. If the plan contains more than one non-preferred brand drug tier, than the

<sup>3</sup> Ibid.

<sup>4</sup> Ibid.

<sup>5</sup> See for example Specialty Pharma Journal News, "Medco Report: Specialty Trend Growth Will Challenge Payers," 2011 available at [http://www.specialtypharmajournal.com/index.php?option=com\\_content&view=article&id=2663:medco-report-specialty-trend-growth-will-challenge-payers-&catid=403:business-news&Itemid=841](http://www.specialtypharmajournal.com/index.php?option=com_content&view=article&id=2663:medco-report-specialty-trend-growth-will-challenge-payers-&catid=403:business-news&Itemid=841)

<sup>6</sup> See Kaiser Health News, "Patients' Share of Expensive Specialty Drugs is Rising", May 2012 available at <http://www.kaiserhealthnews.org/features/insuring-your-health/2012/costs-specialty-drugs-michelle-andrews-050812.aspx>

<sup>7</sup> Ibid.

<sup>8</sup> H.R. 460 introduced February 4, 2013 by Rep. David McKinley (R-WV) and Rep. Lois Capps (D-CA) available at <http://www.govtrack.us/congress/bills/113/hr460>.

specialty drug cost sharing is limited to the non-preferred brand drug tier with the lowest enrollee cost sharing. The legislation defines "specialty drug tier" as a drug tier "for which beneficiary cost-sharing is greater than drug tiers for generic drugs, preferred brand drugs, or non-preferred drugs in the plan's formulary".

## **Findings and Discussion**

Since plans must ensure they collect enough premiums to cover the expected spending of enrollees after cost-sharing contributions, legislation that would lower enrollees' costs for specialty drugs must result in either an increase in plan premiums or an increase in cost sharing for other benefits. While it is possible that plans would reduce their administrative expenses as an offset to this benefit structure change, we do not believe most plans would select this option. As a result, we have estimated the potential impact of either increased premiums or increased cost sharing, and note that it is also possible for plans to use a combination of any of these options.

### *Impact on Annual Premiums*

Overall, we find a minimal impact on plan premiums of limiting cost sharing for drugs on the specialty tier to that of drugs on the non-preferred tier. We estimate that, for the 14 percent of commercial plans with a specialty tier, annual premiums would increase by an average of \$3 to offset the reduced cost sharing for specialty drugs. However, the impact will vary based on whether the plan uses a co-pay for the specialty tier or a co-insurance for the specialty tier. Plans that currently use co-insurance for specialty drugs will have a greater increase in annual premiums than plans that currently use co-pays for these drugs.

We estimate that limiting the cost-sharing for specialty drugs will have an almost negligible impact on premiums for the 55 percent of plans that use co-pays for a fourth tier, amounting to an average annual increase of \$0.37. This co-pay structure currently limits cost-sharing exposure for high cost drugs since the co-pay amount is fixed. These plans will experience a small change in actuarial value due to the proposed legislation since they have already capped the cost-sharing level for these drugs to a fixed amount.

We started with average estimated co-pays of \$79 for fourth tier drugs and \$51 for non-preferred (third) tier drugs. The difference between the average co-pay for these tiers is \$28. However, H.R. 460 permits a 10 percent dollar value between the tiers, and we assumed that plans would apply a higher co-pay to specialty drugs when possible. This would suggest that plans would charge on average \$56.10 for specialty drugs due to the proposed legislation. Therefore, we estimate that the average decrease in specialty drug co-pays in these plans will be \$22.90. Since specialty drug spending is largely concentrated among a few plan enrollees, the total increase in costs borne by the plan is relatively small, leading to the negligible \$0.37 estimated increase in annual premiums.

Although only 36 percent of plans with a specialty tier used co-insurance in 2012, the reduction in out-of-pocket costs on specialty drugs for enrollees in these plans due to the legislation is likely to be higher than enrollees in plans with a co-pay. We continued to assume that plans had a \$51 co-pay for third tier drugs. For 2012, the average co-insurance for a fourth tier is 32%. The change from co-insurance to the non-preferred tier cost-sharing level resulted in an estimated increase in annual premiums of \$7.78.<sup>9</sup>

Decreases in cost sharing will result in changes in demand. Studies have found that specialty drug use is relatively inelastic, meaning changes in cost sharing should not lead to significant changes in demand.<sup>10</sup> We estimate that total spending on specialty medications would increase by 3 percent due to the lower cost sharing, or less than 0.1 percent of the total average spending.

In total, we find that the weighted average premium change for all plans using a fourth tier including increased demand is \$3. Note that, for the majority of plans that do not currently use a fourth tier, there would be no impact on premiums due to the proposed legislation.

#### *Changes in Cost Sharing for Other Tiers*

Avalere also tested changes to cost sharing for other drug tiers to determine what amount would be needed to offset the estimated premium increase discussed above. We found that relatively minor changes in cost sharing on other drug tiers could offset the expected premium increase.

We first tested a change to the non-preferred tier cost sharing, which would also change the new cost sharing for specialty drugs. Again assuming that plans will use a co-pay for non-preferred drugs, a \$6 increase in the co-pay on the non-preferred tier would lower total costs of the plan by the same amount that lowering co-pays of specialty medications would increase total costs. This change would increase the non-preferred co-pay from \$51 on average to \$57. Since we assume a differential in co-pays for non-preferred drugs and specialty drugs on this tier, this would in turn raise the amount charged for specialty drugs from \$56.10 to \$62.70 on average.

We also tested changes in co-pays for the preferred brand tier as well as for the generic drug tier. We found that smaller changes to co-pays in both these tiers could offset the increased costs from lowering the co-pays for specialty drugs. A \$0.75 increase in co-pays for preferred drugs, from \$29 to \$29.75 on average, would offset the premium increase due to the specialty tier cap. A \$0.50 increase in co-pays for generic drugs, from \$10 to \$10.50 on average, would also offset the premium increase due to the specialty tier cap. Note that all of these estimates include a change in overall demand due to the change in out-of-pocket costs.

These small changes in cost sharing for other drug tiers suggest that plans could adopt even smaller changes in multiple tiers to cover the premium increase from the legislation. For

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<sup>9</sup> Again we assume that plans will charge 10% more in total dollars for specialty drugs.

<sup>10</sup> Goldman, Data P., et al., "Benefit Design and Specialty Drug Use." Health Affairs. Vol. 25, No. 5. 2006.

example, plans could increase cost sharing for generics \$0.25 and for preferred drugs approximately \$0.40 to cover costs. Alternatively, plans could make a \$3 increase in non-preferred drug tier cost sharing and a \$0.25 change in generic cost sharing.

Finally, we note that seventy-two percent of all plans currently use co-pays for the third tier.<sup>11</sup> Since the proposed legislation requires that there be no more than a 10 percent dollar value difference in cost sharing on a tier, we believe it is very unlikely that plans will be able to transition to co-insurance for third tier drugs as a means to offset the costs of limiting cost sharing for specialty drugs. Plans would not be able to meet the dollar difference requirement using a co-insurance if there were large differences between prices for non-preferred and specialty drugs. For example, if a non-preferred drug cost \$100, and the specialty drug cost \$1000, using a single co-insurance rate for these drugs would lead to \$25 out-of-pocket for the non-preferred drug and \$250 out-of-pocket for the specialty drug, violating the requirements of the legislation. We believe it would be very difficult for plans to use a co-insurance for the preferred tier under this legislation, and have therefore assumed that plans would use co-pays for specialty drugs.

### **Data Sources**

We used the following data sources to develop our estimates:

- Center for Consumer Information and Insurance Oversight's (CCIIO) Actuarial Value (AV) Calculator, available at <http://www.cms.gov/ccio/resources/regulations-and-guidance/index.html>
- CCIIO "Actuarial Value Calculator Methodology" available at <http://www.cms.gov/CCIIO/Resources/Files/Downloads/av-calculator-methodology.pdf>
- Kaiser Family Foundation and Health Research & Educational Trust, Employer Health Benefits 2012 Annual Survey, available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8345-employer-health-benefits-annual-survey-full-report-0912.pdf>
- Goldman, Data P., et al., "Benefit Design and Specialty Drug Use." Health Affairs. Vol. 25, No. 5. 2006.
- Ringle, Jeanne S. et al., "The Elasticity of Demand for Health Care: A Review of the Literature and Its Application to the Military Health System", RAND Health, October 2000.

### **Assumptions and Methodology**

Avalere used the CCIIO AV Calculator to determine how changes in enrollee cost sharing affected the actuarial value of the plan offering for consumers.<sup>1</sup> In order to estimate the premium amounts, Avalere used the data underlying the plan calculator to determine the average total

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<sup>11</sup> Kaiser Family Foundation and Health Research & Educational Trust, Employer Health Benefits 2012 Annual Survey, available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8345-employer-health-benefits-annual-survey-full-report-0912.pdf>

spending for each metal category. Using the calculator, Avalere then tested changes in all four metal categories representing different plan AV levels. Using the change in AV we calculated the change in premiums and then took a population-weighted average of the premium changes.

In using the calculator, Avalere established an average benefit offering based in part on information from the 2012 Kaiser/HRET Employer Health Benefits Survey. Based on the survey information, we assumed plans would have \$733 deductible. The Affordable Care Act requires plans to have a maximum out of pocket amount beginning in 2014.<sup>12</sup> Based on information available for the calculator, this is estimated to be approximately \$6500 in 2014.<sup>13</sup> Avalere assumed a flat co-insurance rate for medical services of 80 percent, in line with the general data available in the annual survey data.

For the drug benefit structure, we based our calculations on a typical plan benefit offering using information from the same 2012 Kaiser/HRET Employer Health Benefits Survey for plans with four drug cost-sharing tiers. Table 3 shows the co-insurance values used in our calculations for the four drug tiers.

**Table 3: Average Cost Sharing by Drug Tier**

Drug Tier	Cost-sharing Estimate
Generic drugs (Tier 1)	\$10 co-pay
Preferred brand drugs (Tier 2)	\$29 co-pay
Non-preferred tier (Tier 3)	\$51 co-pay
Specialty tier (Tier 4)	\$79 co-pay or 32% co-insurance

Source: 2012 Kaiser/HRET Employer Health Benefits Survey

To determine changes in AV value, benefit changes were made in the calculator and differences in AV were calculated for each metal level.

Avalere also accounted for estimated changes in demand due to cost-sharing changes. Studies have suggested that demand for specialty drugs is relatively inelastic. We used a -0.1 elasticity for specialty drug costs.<sup>14</sup> This means that for every 10 percent decrease in out-of-pocket costs for specialty drugs there would be a 1 percent increase in total spending on these drugs. Avalere also assumed changes in demand for non-preferred drugs, preferred drugs and generics. Based on the literature, Avalere assumed a -0.3 elasticity of spending for non-preferred drugs and -0.2 for preferred and generics.<sup>15</sup>

<sup>12</sup> Section 1302(c)(1), 111th United States Congress. Patient Protection and Affordable Care Act available at <http://housedocs.house.gov/energycommerce/ppacacon.pdf>.

<sup>13</sup> See footnote 11 in the CCIIO "Actuarial Value Calculator Methodology" available at <http://www.cms.gov/CCIIO/Resources/Files/Downloads/av-calculator-methodology.pdf>.

<sup>14</sup> Goldman, Data P., et al., "Benefit Design and Specialty Drug Use." Health Affairs. Vol. 25, No. 5. 2006.

<sup>15</sup> Ringle, Jeanne S. et al., "The Elasticity of Demand for Health Care: A Review of the Literature and Its Application to the Military Health System", RAND Health, October 2000.