

# Capping Copays Will Raise Premiums and Drug Prices

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*The number of diseases and conditions that can be treated using drug therapy has grown tremendously over the past 25 years. The vast majority of prescription drug costs are paid directly by drug plans sponsored by insurers and health plans, while the share of prescription costs Americans pay out of pocket has been falling for decades.*

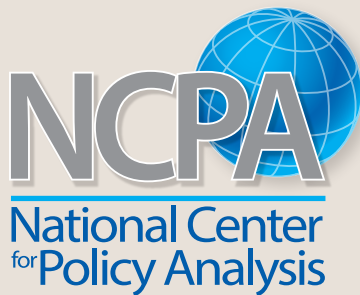


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## Executive Summary

Drug therapy represents the greatest value in the U.S. health care system. Compared to the funds spent on doctors and hospitals, most prescription drug therapies are a bargain. Americans consume nearly \$3 trillion in medical care annually, about half of which is spent on physician and hospital care. Spending on drugs has actually grown at a slower rate than other forms of medical care over the past 50 years.

Most prescriptions are filled with generic drugs that have lost patent protection. These drugs are inexpensive and require little — if any — copays. However, name-brand drugs still protected by patents can be expensive and often require significant copays.

Today, most health plans include some drug benefits and most Americans belong to a drug plan. Unaffordable drug cost-sharing is a significant problem for a small fraction of patients (less than 1 percent) and only for the duration of their therapy. Insurers and health plans use multiple techniques to make drugs affordable. One of the ways is through drug formularies with multiple tiers of patient cost-sharing and copays. Thus, pharmacy benefit managers (PBMs) and health plans steer enrollees toward generic drugs by requiring little, if any, cost-sharing, such as the list of common generic drugs available for \$4 for a month's supply at Walmart. Nearly nine of every 10 drugs Americans take are inexpensive generic drugs.

However, drug makers are increasingly developing very costly medications, unofficially known as specialty drugs. Only about 1 percent of drugs fall into this category, while about 11 percent are name-brand drugs. Some specialty and name-brand drugs are truly breakthrough therapies; but some are merely priced high in an attempt to test what the market will bear. Due to the higher costs for specialty medications and brand drugs, health plans must carefully manage the procurement and dispensing of these drugs.

To lower consumers' drug bills, some policymakers have proposed limits on patient copays. Nearly one-third of states have either passed legislation or have introduced bills that seek to limit cost-sharing:

- So far seven states have passed legislation limiting cost-sharing for drug therapies.

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- An eighth state, California, passed a law due to take effect in January 2017, that limits copays to \$250 for a 30-day outpatient prescription (\$500 for people with high-deductible Bronze plans).
- Montana also caps copays at \$250 per prescription. Laws in Delaware, Maryland and Louisiana limit cost-sharing to no more than \$150 per 30-day supply.
- A law in Vermont limits copays to no more than \$1,300 per year (plus the deductible), while in Maine copays cannot exceed \$3,500 per year.
- It is against the law in New York State for health plans to place specialty drugs into tiers that have higher cost-sharing than name-brand drug tiers.

At the federal level, Senator Ron Wyden (D-Ore.) has championed a bill that would eliminate all prescription drug cost-sharing for Medicare beneficiaries above the threshold (currently, \$7,500 per year).

These proposals and laws are unnecessary and ill-advised. The Manhattan Institute estimates a \$250 per month cap on out-of-pocket drug spending would benefit only about 1 percent of all Americans who take any prescription drug in a given year. Furthermore, nearly half of the benefits from a copay cap would accrue to families earning more than four times the federal poverty level. Such a law would also raise premiums for all policyholders and facilitate drug price hikes.

The purpose of cost-sharing is to align consumers' incentives with the PBM and drug plan sponsor, and

encourage use of preferred drug therapies. Drug plan formularies impose little cost-sharing for generic drugs because they are such a great value. But PBMs often require higher cost-sharing (and copays) for patients who prefer to take more costly name-brand drugs — especially brand drugs for which cheap, effective substitutes exist. Some drug plans also have tiers for costly, so-called “specialty drugs.”

Most Americans belong to a drug plan that manages drug benefits on patients' behalf. Moreover, drug plans impose little in the form of cost-sharing. Nearly one-fourth of retail prescriptions are fully covered by insurers and require no copayment by the patient. Just over three-fourths of prescriptions cost the patient \$10 or less. By contrast, less than 8 percent of prescriptions require copays of more than \$30, and just over 2 percent require copays of \$70 or above.

Cost-sharing is a method employers, insurers and drug plans use to hold down drug spending and keep premiums affordable, by giving enrollees an incentive to ask for generic drugs when appropriate. Cost-sharing also provides drug makers with an incentive to limit price hikes or risk alienating customers who could see their out-of-pocket costs rise.

Unfortunately, state and federal proposals to cap drug cost-sharing could actually lead to higher drug prices, higher premiums and force millions of Americans to pay more, albeit indirectly. If policymakers are successful in their attempts to limit cost-sharing, you can bet there will be drugs whose prices reach the stratosphere.

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## Introduction

The number of diseases and conditions that can be treated using drug therapy has grown tremendously over the past 25 years. The vast majority of prescription drug costs are paid directly by drug plans sponsored by insurers and health plans, while the share of prescription costs Americans pay out of pocket has been falling for decades. Most prescriptions are filled with generic drugs that have lost patent protection. These drugs are inexpensive and require little — if any — copays. However, name-brand drugs still protected by patents can be expensive and often require significant copays.

Because of the increasing use of drug therapy, out-of-pocket drug costs have become a political issue in Washington and across many states. To lower consumers' drug bills, some policymakers have proposed limits on patient copays. For instance, Hillary Clinton has proposed capping prescription drug copays at no more than \$250 per month, and some state politicians have enacted or proposed similar caps. Unfortunately, these arbitrary limits could actually lead to higher drug prices and health insurance premiums, forcing millions of Americans to pay more, albeit indirectly, for drug therapies.

## Managing Drug Benefits

Today, most health plans include some drug benefits and most Americans belong to a drug plan. Unaffordable drug cost-sharing is a significant problem for a small fraction of patients (less than 1 percent) and only for the duration of their therapy.

Drug plan sponsors — including insurers, employers, Medicare Part D drug plans and many state Medicaid programs — often employ pharmacy benefit managers (PBMs), large firms that specialize in designing drug benefits and managing drug plans. Health plans, which are responsible for reimbursing providers, have an incentive to encourage the appropriate use of drugs,

## State Limits on Copays

New York	Prohibits specialty tiers	Effective 2010
Vermont	\$1,300 self-only \$2,600 family	Effective 2012
Maine	\$3,500/ annually	Effective 2013
Delaware	\$100/per drug/ per mo. \$200 total cost sharing	Effective 2014
Maryland	\$150/per specialty drug tier	Effective 2014
Montana (regulatory review and approval)	Plans must offer at least one plan with flat copays for Silver plans and higher*	Effective 2015
Louisiana	\$150/per specialty drug tier	Effective 2015
California	\$250 /per month/per drug (\$500 bronze plans)	Effective 2017
* Note: Applies to plans sold in the state health insurance exchange.		
Sources: Michael Ollove, “States Limiting Patient Costs For High-Priced Drugs,” Stateline, July 6, 2015; Janet Kaminski Leduc, “State Laws Limiting Prescription Drug Cost Sharing,” Office of Legislative Research, Connecticut General Assembly, Research Report 2016-R-0134, July 13, 2016; Office of the Montana State Auditor.		

because skimping on drug therapies often leads to higher medical costs. Thus, it makes sense for health plans to coordinate with PBMs to manage chronic diseases, to analyze the effectiveness of drugs and to track patient compliance.<sup>1</sup> PBMs also check for drug interactions and inappropriate or duplicate prescriptions. Finally, they assemble pharmacy networks, contract with mail-order pharmacies and process payments.

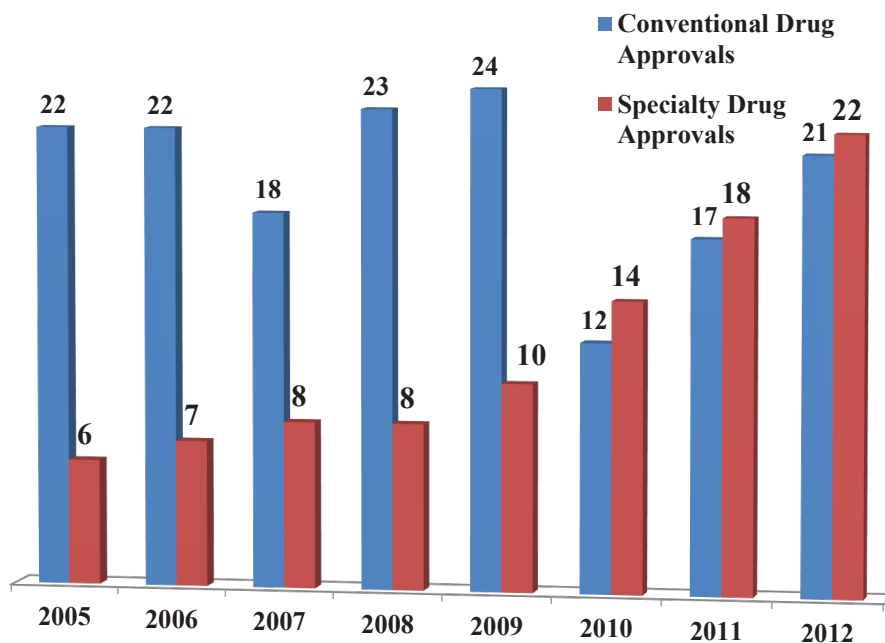
**Pharmacy Benefit Managers.** Insurers and health plans use multiple techniques to make drugs affordable. Large, national PBMs with many clients negotiate lower prices from manufacturers and have far more bargaining power than individual firms. They also partner with pharmacies and build preferred pharmacy networks.

One of the ways employers, insurers and PBMs hold down prescription costs is through drug formularies with multiple tiers of patient cost-sharing and copays. PBMs also consult with health plan sponsors to determine which drug therapies to include in plan formularies. Within the same therapeutic class, multiple drugs with vastly different costs may be available. The purpose of



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**Figure I**  
Number of Food and Drug Administration Drug Approvals



Source: "Medical Cost Trend: Behind the Numbers, 2014," PricewaterhouseCoopers Health Research Institute, June 2013, Figure 6.

tiered formularies is to encourage enrollees to choose lower-cost alternatives when appropriate. Thus, PBMs and health plans steer enrollees toward generic drugs by requiring little if any cost-sharing for them, such as the list of common generic drugs available for \$4 for a month's supply at Walmart. Nearly nine of every 10 drugs Americans take are inexpensive generic drugs.

**State Laws and Legislative Proposals.** Nearly a third of the states have debated legislation to limit cost-sharing, and so far, eight have passed bills.<sup>2</sup> The caps on copays vary. For instance [see the table]:

- Delaware, Maryland and Louisiana limit cost sharing to no more than \$150 per 30-day prescription.<sup>3</sup>
- Vermont limits copays to no more than \$1,300 per year (plus the deductible).
- Maine limits copays to \$3,500 per year.<sup>4</sup>
- In addition, it is against the law in New York State to place specialty drugs into tiers that have higher cost-sharing than the tiers for other brand-name drugs.

Some states, such as Montana and Florida, have used regulatory oversight through their state insurance departments to disapprove plans that impose coinsurance and copays on specialty drugs, arguing the practice violates the antidiscrimination rules of the Affordable Care Act. It is too soon to determine the full effects of these measures, but premiums are rising across many states and PBMs report high-cost drugs are a significant driver of spending.<sup>5</sup>

In 2015, Covered California became the first state health insurance exchange to limit cost sharing. The limit is \$150 to \$500 per month, depending on the plan.<sup>6</sup> The California Assembly later passed legislation restricting cost-sharing by private insurers in both the exchange and the commercial market, to take

effect in January 2017.<sup>7</sup> The law limits copays to \$250 for a 30-day outpatient prescription (\$500 for people with high-deductible Bronze plans).<sup>8</sup>

Other states are considering similar measures. For instance, in 2015, bills were introduced in both Illinois and Oregon.<sup>9</sup> In 2016, legislation was introduced in New Jersey.<sup>10</sup>

**Capping Medicare Coinsurance.** Most Medicare-eligible seniors are enrolled in Part D prescription drug plans. In 2016, once a senior's total drug spending (including the deductible and spending by the drug plan) has reached \$3,310, he encounters an initial coverage limit. This threshold varies slightly by plan. At this point, a senior's out-of-pocket costs may have been only \$1,000 to \$1,100, while the drug plan paid \$2,200 or more in reimbursements. Seniors then face a coverage gap until their personal out-of-pocket drug spending has reached \$4,850 in 2016. While in the coverage gap, seniors receive 45 percent discounts on name-brand drugs and 58 percent discounts on generics, as required by the ACA.<sup>11</sup> Yet, seniors receive credit for the nondiscounted price toward their out-of-pocket spending, allowing them to emerge from

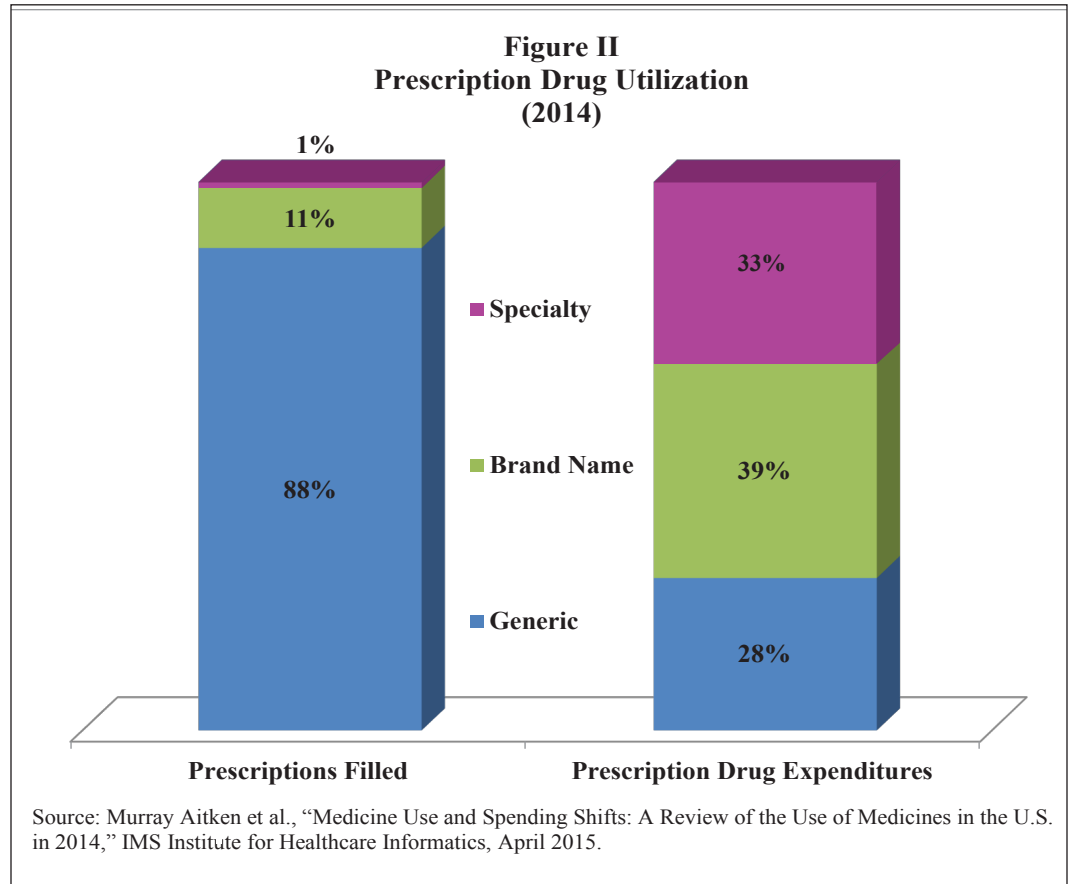
the coverage gap sooner. The coverage gap, also known as the donut hole, is being slowly phased out under provisions of the ACA and will close by 2020.<sup>12</sup>

However, seniors also face unlimited cost-sharing of 5 percent on drug spending that surpasses about \$7,500 per year.<sup>13</sup> At the federal level, Senator Ron Wyden (D-Ore.) has championed a bill that would eliminate all prescription drug cost-sharing for Medicare beneficiaries above the threshold (currently, \$7,500 per year).

### Do Copay Caps Help?

How much of a difference would capping drug cost-sharing make? Manhattan Institute Fellow Yevgeniy Feyman estimates a \$250 per month cap in out-of-pocket drug spending would benefit only about 1.5 million people annually, because that is the number of patients who face higher drug cost-sharing. This is less than 1 percent of all Americans who take any prescription drug throughout the year. Patients affected by a \$250 per month drug cap would save about \$3.5 billion per year in cost-sharing, nearly half of which (45 percent) would benefit families earning more than 400 percent of the federal poverty level.<sup>14</sup> The drug costs not paid by patients would presumably be shifted to health plans and ultimately borne by all Americans through higher health plan premiums. Feyman also argues that copay caps obscure the ability to determine a given drug therapy's value. Drug caps encourage costly therapies, taking away the tools PBMs use to encourage patients to be sensitive to prices. Otherwise, patients might have little reason to reject a costly drug with little additional benefit over a cheaper, effective therapy.<sup>15</sup>

The National Coalition on Health Care believes provisions limiting cost-sharing are unlikely to

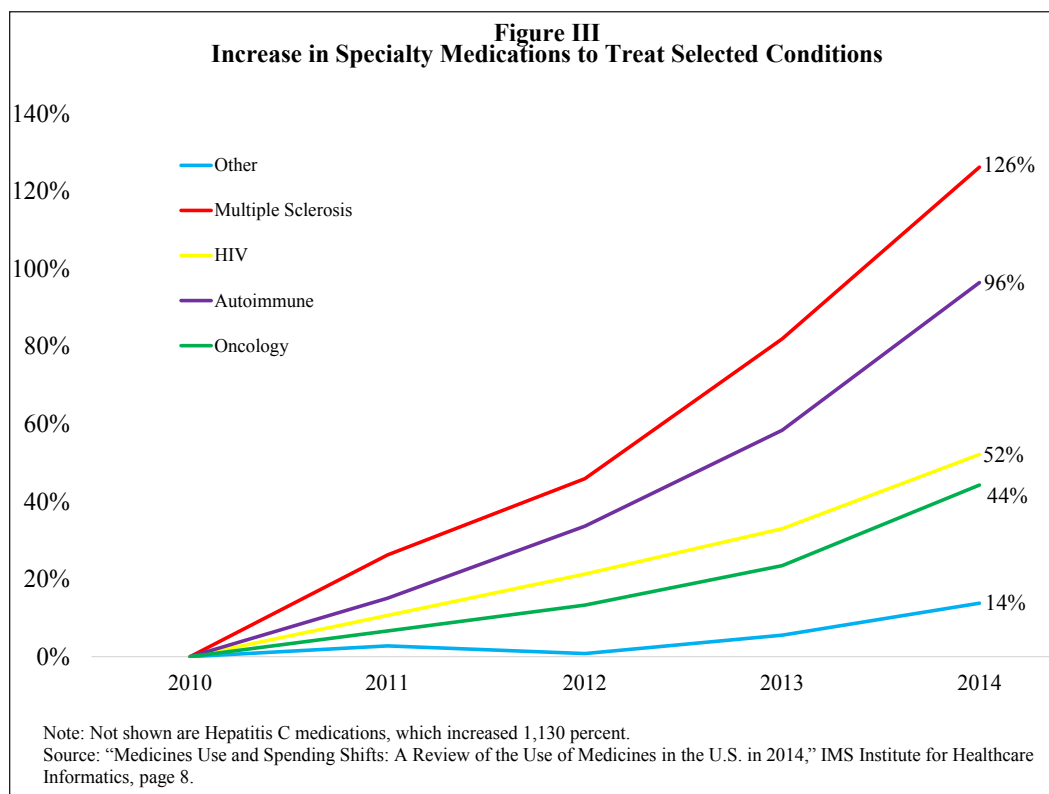


succeed for long because the underlying problem is the rising cost of some newer drugs. Limiting cost sharing may lower costs for a few individuals, but increase premiums for all enrollees.<sup>16</sup> Moreover, many consumers willingly trade higher cost-sharing in return for lower premiums. "Cap the Copay" regulations take away this option. Finally, the ACA already caps out-of-pocket medical spending for the privately insured, including drugs, at \$6,850 in 2016.<sup>17</sup>

### Newer Drugs Are Often Costly

Drug makers are developing an increasing number of very costly medications that are unofficially known as specialty drugs. Although less than one-fourth of newly approved drugs were considered specialty drugs a decade ago, a few years later about half were. [See Figure I.] However, compared to the universe of all drugs Americans take, specialty drugs are relatively uncommon. Only about 1 percent of drugs used annually fall under this category, compared to 11 percent in the category of brand drugs. [See Figure II.] Some of these specialty drugs are truly breakthrough therapies, but some are merely priced

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conditions like rheumatoid arthritis cost \$105 per private health plan member.

- Cancer drugs cost \$105 per member.
- Other miscellaneous specialty categories combined average nearly \$100 per member.<sup>18</sup>

Due to the higher costs for specialty medications and brand drugs, health plans must carefully manage their procurement and dispensing. [See Figure III.]

**Background: Americans' Drug Therapies.** An estimated 4.3 billion retail prescriptions were filled in 2014 — about a dozen per person in the United States, on average.<sup>19</sup> More than 60

high in an attempt to test what the market will bear.

Newer therapies are often derived from living substances and expensive to produce. When purchased in retail pharmacies in pill or tablet form (in contrast to drugs administered intravenously), specialty drugs tend to have the highest cost-sharing and would be most affected by a cap on copays.

**Drugs and Biologics.** Increasingly, health plan costs rise as highly advanced specialty drugs and biological agents are used to treat rare diseases and disorders that only a few years ago had no treatment, or relatively ineffective treatments. For example:

- In 2013, Hepatitis C therapy cost insurers and drug plans only \$5 per covered individual per year, on average, when the cost was spread over the entire insured population.
- Due to new, costly drugs for Hepatitis C, annual per-member costs rose from \$5 to \$35 in 2014.

Treatment costs for other chronic conditions are also rising. For example:

- Multiple sclerosis drugs cost an average of \$53 per covered individual per year and inflammatory

percent of Americans take a prescription drug in any given year, including 90 percent of all seniors.<sup>20</sup>

The bulk of drugs consumed are generally prescribed for chronic conditions, such as gastrointestinal conditions, cardiovascular conditions, respiratory conditions and metabolic agents. For instance, a mere handful of therapeutic drug classes account for two-thirds of seniors' drug spending.<sup>21</sup>

Drugs are convenient. Nearly 80 percent of the time when Americans experience a health complaint, they first turn to an over-the-counter drug.<sup>23</sup> If their condition does not resolve, many schedule an appointment with a physician, and about three-fourths of physician visits result in prescription drug therapy.<sup>24</sup> Arguably, one of the main reasons patients visit their doctors is to obtain or renew prescriptions.

Drug therapy is also the most efficient method to treat many ailments, health concerns and chronic conditions in particular. Drugs are less invasive than many other forms of care. Drugs often eliminate, lessen or delay the need for more expensive treatments such as surgery or inpatient care. Most patients likely prefer medication over

surgery to treat significant health problems. Broader use of prescription drugs for chronic conditions could improve health status and reduce medical costs by avoiding expensive emergency room visits, costly complications and hospitalizations.

### Most Drugs Are a Great Value

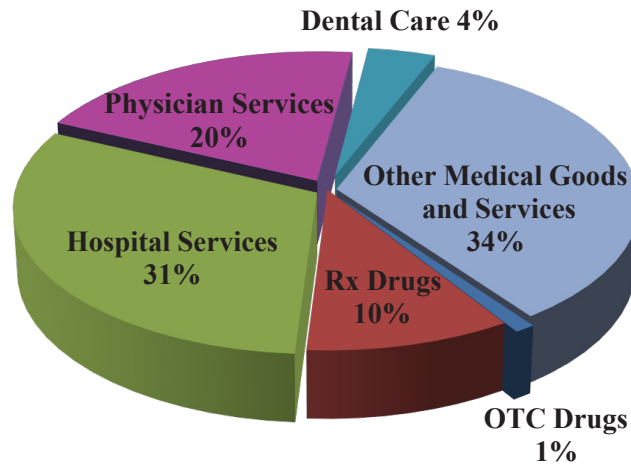
Americans consume nearly \$3 trillion in medical care annually, about half of which is spent on physician and hospital care.<sup>25</sup> Spending on prescription drugs has grown tremendously over the past few decades; spending on drugs has grown at a slower rate than other forms of medical care over the past 50 years. Drug therapy represents the greatest value in the U.S. health care system. Compared to the funds spent on doctors and hospitals, prescription drug therapies are a bargain.

Americans spend twice as much for physician care and three times as much on hospital care as they do for retail drugs. [See Figure IV.]

**Generic Drugs Are America’s Health Care Bargain.** Often ignored in discussions of so-called “miracle drugs” is a type of drug that costs consumers comparatively little and produces benefits far in excess of its cost: generic drugs. Generics include the expensive blockbuster drugs approved years ago that have lost patent protection.

The *Drug Price Competition and Patent Term Restoration Act of 1984* (sometimes referred to as the Hatch-Waxman Act) created a pathway for multiple firms to produce generic versions of name-brand drugs once their patents expire. When a patent for a medication expires, competing firms can submit an abbreviated new drug application to the FDA to produce chemically similar versions. Prior to Hatch-Waxman, generic drug makers had to perform clinical trials for their version similar to

**Figure IV**  
Drug Spending as a Proportion of All Health Care Expenditure (2012)



Sources: “National Health Expenditures by Type of Service and Source of Funds, CY 1960-2012,” Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, January 7, 2013; and Jay Sirois and Stefanie Ferreri, “OTC Combination Products in Pharmacist-Assisted Self-Care,” American Pharmacists Association, June 1, 2013.

the innovator drug maker.<sup>26</sup> Generic drugs are not required to be identical to the branded drug they compete with; rather, they have to be very similar in important ways.<sup>27</sup>

Generic drugs account for 88 percent of prescriptions but only 28 percent of drug therapy expenditures, according to industry data and the U.S. Department of Health & Human Services. Branded drugs, by contrast, represent 39 percent of drug spending, despite only comprising 11 percent of drugs prescribed. Specialty drugs account for about one-third of the nation’s drug costs. [See Figure V.]

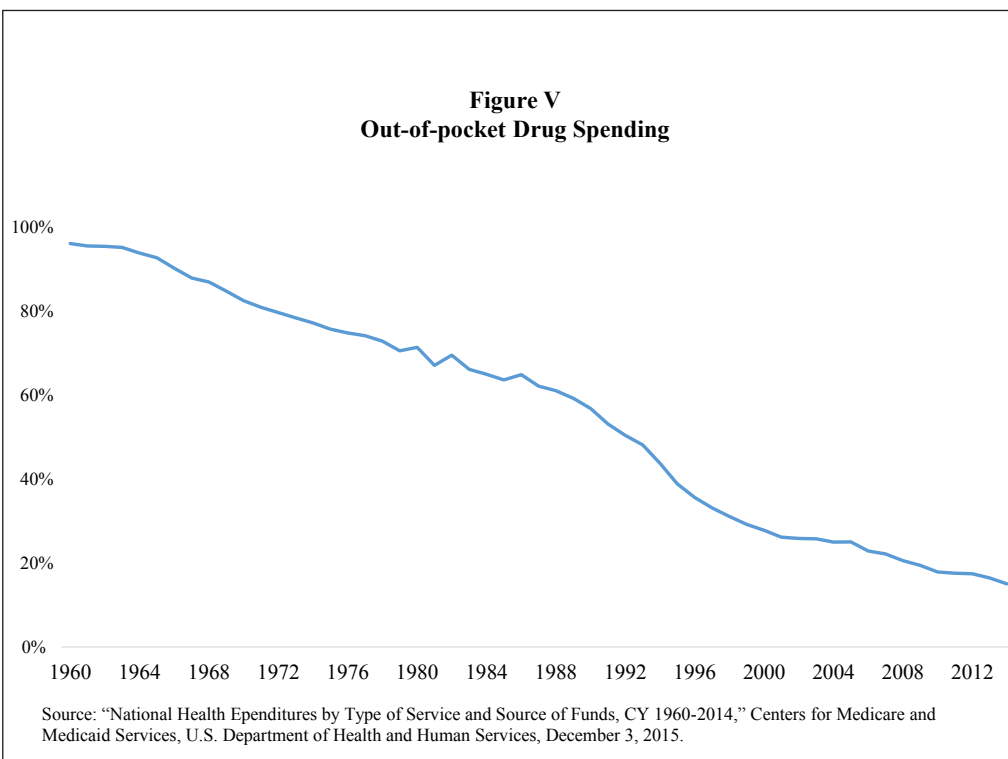
**Most Drugs Are Affordable.** Patients benefit enormously from safe and effective drug therapies. The reality is that the proportion of drug costs Americans pay out of their own pockets has been falling for decades. [See Figure V.] For example:

- Around 1960, Americans paid for nearly all of their prescription drugs.
- By 1980, that figure was down to about 75 percent.
- By 1995, the figure was 50 percent.



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Figure V  
Out-of-pocket Drug Spending



sharing for generic drugs, but often require higher cost-sharing (and copays) for more costly name-brand drugs — especially drugs for which cheap, effective substitutes exist. Many drug plans rely on copays (57 percent) and coinsurance (38 percent) to provide the appropriate incentives to control spending. A few use higher levels of cost-sharing for specialty drug therapies.<sup>28</sup>

**Specialty Drugs.** Some PBMs have tiers for specialty drugs. Specialty drugs, which are more expensive than typical brand-name drugs, are sometimes administered in hospitals and clinics. When drugs are infused, injected or administered in hospitals and

- Today, Americans pay for only about 16 percent of their prescription drug costs.

Moreover, most Americans belong to a drug plan that manages drug benefits on their behalf. According to industry data [see Figure VI]:

- Nearly one-fourth of retail prescriptions are fully covered by insurers and require no copayment by the patient.
- An additional one-third cost the patient \$5 or less.
- Just over three-fourths cost the patient \$10 or less.

Few people pay more than a nominal charge. Those who do often prefer name-brand drugs or are taking a drug not yet available in generic form. Consider:

- Less than 8 percent of prescriptions require a copay of more than \$30.
- Just over 2 percent of prescriptions require copays of \$70 or above.

### The Purpose of Cost-Sharing

The purpose of cost-sharing is to align patients' incentives with those of the PBM and drug plan sponsor. Drug plan formularies require little cost-

sharing for generic drugs, but often require higher cost-sharing (and copays) for more costly name-brand drugs — especially drugs for which cheap, effective substitutes exist. Many drug plans rely on copays (57 percent) and coinsurance (38 percent) to provide the appropriate incentives to control spending. A few use higher levels of cost-sharing for specialty drug therapies.<sup>28</sup>

clinics, the drugs are generally paid for as a medical benefit rather than by a prescription drug plan. When paid for as a medical benefit, injected drugs are generally not subject to the same cost-sharing rules discussed in this analysis. For instance, a cancer patient undergoing chemotherapy would likely not pick up their oncology drug at a retail pharmacy and pay a copay.

Economic studies and commonsense confirm that patients are more careful with their medical spending when they bear a portion of the cost. The classic Rand Health Insurance Experiment found that when exposed to significant cost-sharing, patients consumed approximately 30 percent less medical care.<sup>29</sup> With few exceptions, patients' health did not suffer as a result. Yet, research at Rand also found cost-sharing does negatively affect adherence to drug therapies to some degree. For example, when cost-sharing copays were about \$5 per 30-day supply of cholesterol-lowering medication, average compliance was about 77 percent. When copays were increased to around \$30, compliance declined to about 65 percent.<sup>30</sup> However, drug compliance varied greatly among the employer plans studied even when holding the copay constant. At one employer, a copay of about

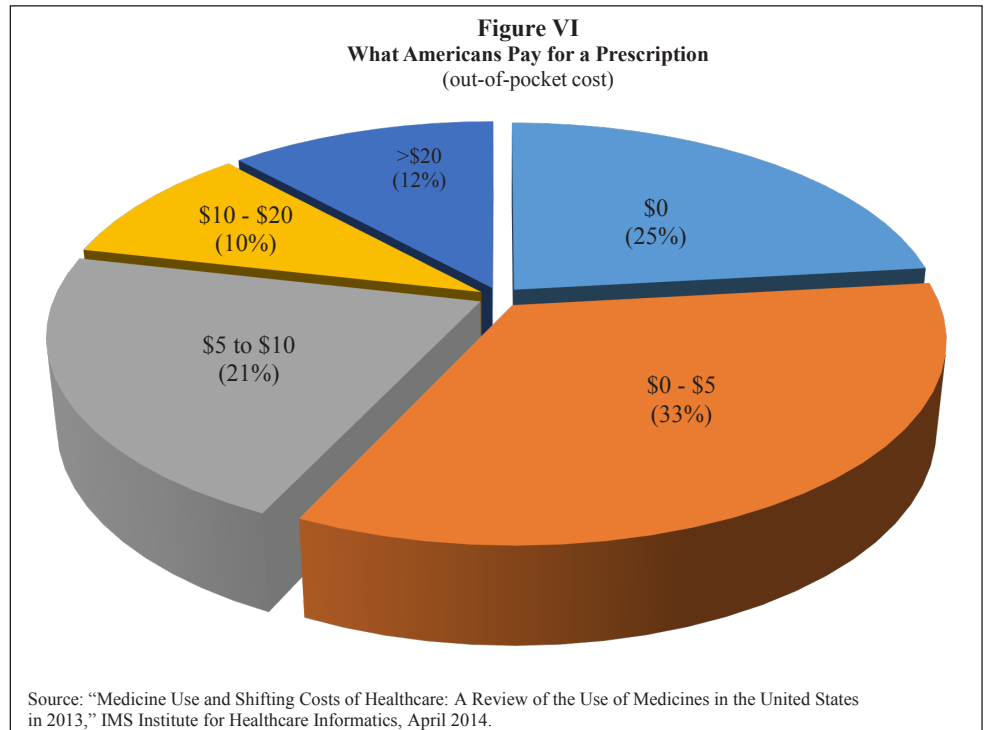


\$14 had a compliance rate of only 54 percent; at another, a similar copay (\$12) had compliance of nearly 88 percent.<sup>31</sup>

Obviously, some other factors account for large differences in adherence to drug therapy even when the copay is low. It could be that marginal patients stopped cholesterol therapy and altered their diets instead. It could be that people destined to stop at some point were motivated to stop sooner. An earlier study found that all medications and drug therapies are not equal. Doubling copays caused patients to reduce nonsteroidal anti-inflammatory pain relievers by 45 percent and antihistamines by 44 percent. Yet doubling copays had a much less pronounced effect on use of drugs for high blood pressure, depression and diabetes (about one-quarter).<sup>32</sup>

Another positive effect of cost-sharing is to encourage patients to opt for drug therapies that are a better value. The primary reason that 88 percent of all the drugs Americans take are generic is because of value and favorable cost-sharing.

**Why It Is Important to be Vigilant About Drug Prices.** In 2015, drug maker Valeant Pharmaceuticals was accused of using various strategies to aggressively raise drug prices, most of which was passed on to insurers, employers and health plans. One strategy was to partner with a so-called “captured pharmacy” that worked exclusively with Valeant and agreed not to substitute generic drugs for name-brand drugs costing a multiple of the cheaper drugs. Another strategy was to waive expensive copays so patients would not request a generic substitute. If reimbursement for a drug was declined, the pharmacy would also resubmit a prescription multiple times with different quantities and different prices to see if it could game the automated payers into paying for a lesser quantity or slightly lower price. About the same time, another drug company, Turing Pharmaceuticals, carefully sought out and acquired old generic drugs



that had little competition, and then raised prices aggressively — in one instance by 5,000 percent.

People with severe allergies and asthma often carry an EpiPen with them at all times. Indeed, children with serious peanut allergies are advised to have two EpiPens available at all times. In fact, that is the only way to buy EpiPens: two at a time. That means that families with children who have serious allergies or asthma often have two EpiPens at school and two at home in case of emergency. Since drug maker Mylan acquired EpiPen in 2007, a two-pen set has increased in price from just over \$100 to just over \$600 in 2016. An EpiPen has an expiration date of about 1 year, which means families often have to throw them out and replace them each school year.

The company dismisses charges that it is price gouging by saying it offers a \$100 coupon to help cover copays so most families pay nothing.<sup>33</sup> But obviously the insurer is paying \$500 per set or \$1,000, with the spares. This is an example of why consumers need to be enlisted in the battle to control drug spending. Without consumers complaining about cost-sharing, there would be no stopping price hikes.

Valeant, Turing and Mylan developed these

elaborate strategies because the firms know there are limits to what consumers are willing to pay. But if consumers can be insulated from high prices and discouraged (or limited) from selecting lower-priced options, the sky is the limit on the prices that could be charged for drugs.

### Conclusion

Most Americans have health coverage that includes some form of drug benefits. Cost-sharing is a method employers, insurers and drug plans use to hold down drug spending and keep premiums affordable by giving enrollees an incentive to ask for generic drugs when appropriate. Cost-sharing also provides drug makers with an incentive to limit excessive price hikes or risk alienating customers who could see their cost-sharing rise. If policymakers are successful in their attempts to limit cost-sharing, you can bet there will be even more drugs with prices that reach the stratosphere.

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30. Ibid.

31. Dana P. Goldman, Geoffrey F. Joyce, Jose J. Escarce, Jennifer E. Pace, Matthew D. Solomon, Marianne Laouri, Pamela B. Landsman and Steven M. Teutsch, “Pharmacy Benefits and the Use of Drugs by the Chronically Ill,” *Journal of the American Medical Association*, Vol. 291, No. 19, May 18, 2004, pages. 2,344–2,350.

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### Recent NCPA Health Care Research Publications

**John R. Graham**, “The “Doc Fix” Is In: An Initial Assessment of Medicare’s New Rule over the Practice of Medicine,” National Center for Policy Analysis, Policy Report No. 386, July 20, 2016. - <http://www.ncpa.org/pub/the-doc-fix-is-in-an-initial-assessment-of-medicare-s-new-rule-over-the-practice-of-medicine>

In March 2015, an overwhelming bipartisan majority in Congress voted for the Medicare Access and CHIP Reauthorization Act (MACRA). The so-called “doc fix,” a component of MACRA, was an attempt to fix the very flawed method Medicare uses to pay doctors and other health professionals. Unfortunately, MACRA is fiscally irresponsible and increases the federal government’s control over how clinicians practice medicine.

**Devon Herrick**, “E-Prescribing: A Commonsense Solution to Opioid Abuse that Is Being Ignored,” National Center for Policy Analysis, Policy Report No. 385, July 8, 2016. - <http://www.ncpa.org/pub/e-prescribing-a-commonsense-solution-to-opioid-abuse-that-is-being-ignored>

Congress has taken up the growing problem of opioid abuse. Yet for all the talk there appears to be little discussion of a commonsense solution: mandatory electronic prescribing (e-prescribing).

**Devon Herrick**, “A Bogus Solution for High Drug Costs,” National Center for Policy Analysis, Issue Brief No. 194, June 21, 2016. - <http://www.ncpa.org/pub/a-bogus-solution-for-high-drug-costs>

Lately, a few politicians (and lobbyists for pharmacies and drug makers) have been attempting to divert some of the blame for high drug prices to the administrators of employee drug plans. They worry that pharmacy benefit managers (PBMs) mark up drug prices well above the PBMs’ costs or fail to pass along manufacturers’ drug rebates and other discounts to their clients (employers and insurers) and consumers with drug plans. The blame-shifters have suggested that employers and their workers could potentially benefit if PBMs were forced to disclose the (net) wholesale prices they paid for drugs. Economists, the U.S. Federal Trade Commission (FTC) and even the actuarial consulting firm Milliman, Inc. are rather skeptical of this argument.

**Andrew J. Rettenmaier and Thomas R. Saving**, “How to Pay for Medicare,” National Center for Policy Analysis, Policy Report No. 384, May 31, 2016. - <http://www.ncpa.org/pub/how-to-pay-for-medicare>

Medicare now provides insurance coverage for over 50 million Americans, and accounts for 20 percent of health care spending. One of the goals of the Affordable Care Act and of the majority of Medicare reform proposals has been to reduce or eliminate excess cost growth as it applies to federal spending. Without significant changes in the current program, it is not realistic to think that federal Medicare spending per capita can be constrained to grow at the same rate as per capita GDP.

**Devon Herrick**, “Congressional Brief: NCPA Health Reform Agenda,” National Center for Policy Analysis, May 11, 2016. - <http://www.ncpa.org/pub/congressional-brief-ncpa-health-reform-agenda>

Health reform must replace Obamacare with increased flexibility in health plan design; tax fairness regardless of where Americans get their health coverage; increased access to primary care by removing barriers to innovative medical practices and services; reform of hospital regulation to better serve patients; reduced costs through price transparency to boost competition and innovation in medical services and prescription drugs; strengthened Medicare, Medicaid and Veterans Health that better serve the needs of patients; and changes in the financing of medical care so that individuals have control over their health care dollars and the means to pay for medical care over their lifetimes.

**Devon M. Herrick**, “Proposed Drug Plan Legislation Could Hurt Oklahoma Consumers, Raise Costs,” National Center for Policy Analysis, Brief Analysis No. 826, April 21, 2016. - <http://www.ncpa.org/pub/proposed-drug-plan-legislation-could-hurt-oklahoma-consumers-raise-costs>

High drug costs are a problem that ultimately affects consumers and their drug plans, but can also impact drugstores by temporarily reducing profit margins on a few drugs. In an attempt to insulate their industry from the effects of rising wholesale drug prices, and boost profits, drugstores are lobbying Oklahoma lawmakers to allow pharmacies to ignore negotiated discounts and pass the price hikes on to consumers in violation of contractual agreements.